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Assessing the Individual and Organizational Cultural Competence of Pediatric Mental Health Service Providers

by

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "Assessing the Individual and Organizational Cultural Competence of Pediatric Mental Health Service Providers" submitted by Tracy Wityk in partial fulfillment of the requirements for the degree of Master of Science.

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ABSTRACT

This study evaluated the individual and organizational cultural competence of Canadian pediatric mental health service providers. The author reviewed the history of and rationale for cultural competence. Ninety-two mental health workers and six managers completed self-report measures of individual competence, and the managers completed an additional self-report measure of organizational competence. Two factors, culturally competent Action and Attitudes, appear to underlie individual cultural competence as it was measured in this study. The participants' strengths seemed to be culturally competent Attitudes. Their culturally competent Actions, particularly relating to environment and resources, may require more improvement. Overall, the organizational cultural competence or managers' awareness of such competence may require improvement. The author discusses implications for practice and suggestions for future research.

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CHAPTER ONE: INTRODUCTION

The viability of mental health services in a diverse society is related to cultural competence. Culture is defined broadly, and includes many aspects of individuals' lives that influence their worldviews, including race, ethnicity, sex, sexual orientation, religion, and others (Pedersen, 2001). This study focuses primarily on the cultural aspect of ethnicity, as this was the aspect that was of greatest interest at this point in time to the mental health facility that participated in this study. Cultural competence may be defined as the therapist's ability to effectively provide services to individuals with a different worldview (Diller, 1999). According to Cross (1989), cultural competence is a "set of congruent behaviours, attitudes, and policies that come together in a system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13).

The rationale for cultural competence is focused on improving the delivery of mental health services. Cultural differences in conceptualizations and expressions of pathology must be considered in assessment and treatment of mental health concerns. Routinely applying Western psychological concepts and treatments to individuals without taking into account their cultural backgrounds and influences is likely to have negative consequences (Gergen, Gulerce, Lock & Misra, 1996; Lewis-Fernandez & Kleinman, 1995). Utilizing a Western approach to classifying and understanding mental illness may result in incomplete and/or inaccurate understandings of individuals' experiences, misdiagnoses, and/or inappropriate or ineffective treatment. Culturally competent services are beneficial as they increase the utilization rates and decrease the dropout rates of culturally diverse clients (Takeuchi, Sue & Yeh, 1995; Takeuchi, Uehara, & Maramba,

1999; Wade & Bernstein, 1991). Culturally competent care also positively impacts the quality of therapy and its outcomes (Dana, 1998; Flaskerud, 1986; Phillips, Pearson, & Wang, 1994; Pumariega, 1996; Sue, Chun, & Gee, 1995). Cultural competence may help organizations that deliver mental health services to achieve accountability and help contain their costs (Abe-Kim & Takeuchi, 1996; Phillips et al.; Pumariega). Culturally competent mental health services are required in order to provide appropriate, effective, satisfying, and cost-effective care to members of non-dominant ethnic groups.

Research suggests that the cultural competence of Western mental health services for non-dominant ethnic groups requires improvement. Underutilization and premature termination of mental health services by ethnic groups indicates that mental health services are ineffective and unsatisfactory to members of non-dominant groups (Beiser et al., 1988; Casas, Pavelski, Furlong, & Zanglis, 2001; Hough et al., 1987; Sue et al., 1995). Cultural competence is necessary in order to have appropriate diagnoses and favourable therapeutic outcomes when serving culturally diverse populations. The misdiagnosis of non-dominant ethnic patients in the United States was found to be higher than that of patients from the dominant population (Good, 1992/1993). The likelihood of members of diverse ethnic groups experiencing successful outcomes with Western therapies is relatively poor (Flaskerud, 1984). A literature review revealed that individuals from non-dominant ethnic backgrounds have not consistently had better mental health service outcomes than Caucasian Americans have experienced (Sue et al., 1995). Clearly, mental health services need to increase their competence in order to

provide culturally diverse individuals with quality care that is equivalent to services received by members of the dominant culture.

Perspectives about the importance of cultural competence have largely developed during the last two decades (Arthur & Stewart, 2001). Demographic changes in North America were highlighted, traditional counselling service delivery was called into question, and the value of culturally responsive counselling practices was demonstrated (Arthur & Stewart). The field of counselling psychology has witnessed vast growth in its attention to multicultural issues in training, supervision, and counselling over the past two decades (Constantine & Ladany, 2001). Political and legal requirements, as well as developments in counselling theory and practice have also contributed to the call for culturally competent mental health services (Sue et al., 1998). Professional associations of mental health practitioners have ethical guidelines demanding cultural competence from their members, including the Canadian Counselling Association (CCA, 1999), the Canadian Psychological Association (CPA, 2000), and the American Psychological Association (APA, 1992). Cultural competence is now frequently conceptualized as an integral aspect of quality care to ethnically diverse populations (Abe-Kim & Takeuchi, 1996). The need for cultural competence is widely acknowledged, and psychological research, education, and practice are all striving to reach higher standards of practice

In order for services to be responsive to cultural diversity, mental health practitioners must be competent in serving diverse populations. Sue, Arredondo and McDavis (1992) articulated Multicultural Counseling Competencies to guide interpersonal counselling interactions with attention to culture, ethnicity, and race. They

proposed three domains of competence: awareness, knowledge, and skills. The tripartite definition of multicultural counsellor competence (attitudes/beliefs, knowledge, and skills) is well known and established. Emerging frameworks (i.e., Constantine & Ladany, 2001; Sodowsky, Taffe, Gutkin & Wise, 1994) designed to enhance counsellors' understanding of cultural competence, are primarily based upon Sue et al.'s (1992) seminal work.

A fourth dimension of multicultural competence was added to address the influence of organizational structures, policies, and practices on the delivery of mental health services. In addition to the efforts of individual mental health practitioners, the systems within which they work need to change in order to support cultural competence (Arredondo et al., 1996). It appears that being flexible, responsive, self-examination, and building cultural diversity into organizational structures and processes are key components of becoming a culturally competent organization (Barr & Strong, 1987, as cited in Sue et al., 1998; Sue et al., 1998). Some of the most important instrumental factors in planning for cultural diversity and competence are building support, facilitating leadership, developing policies, and implementing change via administrative procedures (Sue et al., 1998). A strong mandate has been issued for organizational competence. Organizations that do not successfully implement diversity into the very structures of their practice will fail to be relevant to the people that they serve, and as a consequence, will fail to compete and survive in the marketplace (Sue et al., 1998).

The Current Study

The first step for any organization desiring to improve its cultural competence is a cultural competency assessment (Sue et al., 1998). Many approaches to assessing cultural competence focus only on individual practitioners (Constantine & Ladany, 2001). Assessment of multicultural counselling competence in the context of larger systems and organizations is also recommended (Constantine & Ladany). The current study assesses both the individual and organizational cultural competence of mental health service providers. Baseline assessment of cultural competence is an important foundation for research examining the actual development of multicultural competencies (Arthur & Januszkowski, 2001). Further empirical evaluation of cultural competence and methods to improve such competence is recommended. This study will provide a baseline against which to compare future ratings of cultural competence following the introduction of interventions designed to enhance competence.

With the exception of a few expansions and adaptations, the historical conceptualization of multicultural counselling competence as consisting of the aforementioned three domains has remained essentially unchallenged by multicultural scholars and practitioners in counselling and psychology (Constantine & Ladany, 2001). Therefore, conceptualizations supporting and/or refuting the constructs believed to underlie the construct of multicultural counselling competence are needed (Constantine & Ladany). Further research to determine which, and how many, dimensions underlie the construct of multicultural counselling competence is also required. The current study

assesses the number and type of factors underlying cultural competence. It also adds to the literature by examining the relationship between such factors.

The multicultural counselling competence literature is largely based on American counsellors, and there has been a call for further research with Canadian counsellors (Arthur & Januszkowski, 2001). In one of the few Canadian studies (Arthur & Januszkowski), counsellors reported barriers to interventions with culturally diverse clients at both personal and systemic levels. This research reaffirms that cultural competence is multifaceted and is located within individuals as well as within organizations. The current study adds to existing research by studying the cultural competence of mental health service providers in a Canadian context.

Compared to the adult population, there is little information regarding the mental health issues and needs of ethnically diverse children and adolescents. Although there is knowledge available about how to better serve non-dominant ethnic groups, culturally sensitive models have focused almost exclusively on adult populations (Casas et al., 2001). The topic of the unique needs of non-dominant ethnic youths was all but ignored by the APA Multicultural Conference participants (Sue, Bingham, Porche-Burke, & Vasquez, 1999). There is still a need for the implementation of policy initiatives, research programs, and service programs that address the issues and diverse needs of culturally diverse youths, especially those with serious emotional and behavioural disorders (APA Multicultural Conference, as cited in Casas et al.). Further research on mental health, mental health services, and cultural competence issues with ethnically diverse youth is required. The current study assesses the cultural competence of pediatric mental health

service providers, with surveys that directly relate to mental health services for children and adolescents. This will add to the literature in the area of pediatric cultural competence.

Chapter Two includes a review of previous literature and research pertaining to individual and organizational cultural competence. The discussion outlines the background and rationale for the present study and the overall purposes of the current study. Chapter Three describes the methodology used to examine the research questions. In Chapter Four, the findings of this study are presented. The implications, strengths, and limitations of the current study are discussed in Chapter Five, along with suggestions for future research on cultural competence in mental health services.

CHAPTER TWO: LITERATURE REVIEW

Canada is a multicultural society and its cultural diversity continues to grow. In 1996 there were 928,690 external migrants to Canada (Statistics Canada, 1996a) and only 5,326,995 out of the total population of over 28 million were of Canadian ethnic origin (Statistics Canada, 1996b). About one in nine Canadian residents are of a visible non-dominant ethnicity (Statistics Canada, 1996c). By 2016, an estimated 20% of adults and 25% of children in Canada will be of visibly non-dominant ethnicity (Statistics Canada, 1995). Due to the cultural diversity of Canada's population, it is highly probable that mental health service providers will encounter non-dominant ethnic individuals in their practice. Therefore, mental health practitioners need to be culturally competent and serve culturally diverse individuals in appropriate and effective ways. This includes acquiring and maintaining culturally competent attitudes, knowledge, and skills (Sue et al., 1992). Although the ethnic diversity of mental health professionals has increased significantly since the 1970s (Jones, 1990), the majority of such professionals are White and members of the dominant culture (Myers, 1993). There needs to be an increase in the number of mental health professionals from diverse cultural backgrounds in order to better reflect the number of culturally diverse individuals in the general population. Issues of representation and culturally responsive services are paramount for addressing multicultural competence.

Culturally competent services are more appropriate, effective, and satisfying to diverse clients. Definitions of normality and pathology differ significantly across cultures (Lewis-Fernandez & Kleinman, 1995). A consideration of cultural influences and

differences helps services to be appropriate and effective. Historical underutilization rates of mental health services by non-dominant ethnic groups (Flaskerud, 1984; Switzer, Scholle, Johnson, & Kelleher, 1998) suggest that Western mental health services are not entirely appropriate or effective for ethnically diverse clients. Premature termination rates among non-dominant ethnic groups also suggest that such services are not effective, appropriate, and/or satisfactory to these clients (Beiser, 1988; Sue 1977, as cited in Sue et al., 1995). Care that is not culturally competent is likely to have negative consequences (Gergen et al., 1996; Lewis-Fernandez & Kleinman), including incomplete and/or inaccurate understandings of individuals' experiences, misdiagnoses, and/or inappropriate or ineffective treatment. Culturally competent mental health services increase the utilization rates and decrease the dropout rates of culturally diverse clients (Takeuchi et al., 1995; Takeuchi et al., 1999; Wade & Bernstein, 1991). Culturally competent care also positively influences the quality of therapy and its outcomes for such clients (Dana, 1998; Flaskerud, 1986; Phillips et al., 1994; Pumariega, 1996; Sue, et al., 1995). Mental health practitioners and organizations should develop and maintain cultural competence because it helps them provide appropriate, effective, and satisfying care to all clients.

In addition to being effective, appropriate, and satisfactory, cultural competence is also ethical. Ethical guidelines of professional associations require mental health practitioners to be culturally competent (APA, 1992; CCA, 1999; CPA, 2000). Political and legal requirements also support culturally competent mental health services (Sue et

al., 1998). Mental health service providers and organizations must be culturally competent in order to provide ethical care to their clients.

Terminology

It is necessary to define the way in which the terms culture, ethnicity, and cultural competence are used throughout this discussion. In this paper, culture is defined broadly and includes many aspects of a person's life that influence worldview (Pedersen, 2001), including race, ethnicity, sex, sexual orientation, religion, and others. Although there are many aspects of culture that need to be considered in psychological research, education, and practice, this paper largely focuses on ethnicity, because the data used in the current study came from a research project that acknowledges a broad view of culture but is focusing on ethnicity at this time. Ethnicity is here defined as conveying group membership according to race or ethnic group, as this is how it is used in most research and practice (Sue et al., 1995). However, the strict sense of the term refers to a social and psychological sense of shared membership in a group with a unique social and cultural heritage (Sue et al., 1995). Cultural competence may be defined as the therapist's ability to effectively provide services to individuals with a different worldview (Diller, 1999). According to Cross (1989), it is a "set of congruent behaviours, attitudes, and policies that come together in a system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). Cultural competence is synonymous with many other terms, including "cross-cultural counseling" (Pedersen, Draguns, Lonner & Trimble, 1989) and "multicultural counseling" (Ponterotto, Casas, Suzuki, & Alexander, 1995).

Chapter Outline

This chapter will present and discuss the historical development of cultural competence in the field of psychology, the rationale for cultural competence, individual and organizational cultural competencies, barriers and resistance to cultural competence, the assessment of cultural competence, cultural competence as it relates to Canadian practitioners and pediatric services, and the connection of the background literature to the current study.

Early History of Multicultural Competence

Cultural competence is a recent development in the field of psychology. Its roots can be found in research regarding cultural diversity that was conducted throughout the 20th century (Cauce, Coronado, & Watson, 1998). Researchers discovered and began to document differences in mental health and illness across cultures, both within and outside of North America. In the earliest research, issues concerning diverse cultures and/or ethnic backgrounds were usually viewed from the perspective of cultural deviance. Any difference from the dominant White cultural patterns and lifestyles was viewed as a culturally deviant and inferior adaptation. The cultural deviance perspective did not recognize the intrinsic value of diverse cultures and helped perpetuate culturally biased and discriminatory views. Albee (1994) describes the cultural encapsulation displayed by the early leaders of psychology. Most of the early leaders in psychology believed in Social Darwinism, the inferiority of women, and the inferiority of the brunette races. Psychology supported societal emphasis on economic success. Many early leaders of psychology were also proponents of Anti-Semitism, homophobia, and the eugenics

movement. During the late 1800s and early 1900s, the concept of cultural competence did not yet exist, and psychological leaders and research supported the view that any deviation from the White male ideal was inferior.

Cauce et al. (1998) describe the shift from viewing cultural diversity as deviant to viewing such diversity in terms of cultural equivalence and cultural variance. During and after the Civil Rights movement in North America, individuals from non-dominant ethnic backgrounds began viewing their differences in an increasingly positive manner. The cultural deviance model began to give way to the cultural equivalence model, which acknowledged that "the superior socioeconomic status of Whites accorded them many of the advantages that the cultural deviance research perspective attributed to culture" (p. 306). Most of the differences between White and diverse cultures disappeared when socioeconomic status was statistically controlled for in research. Differences between dominant and non-dominant cultures began to be viewed as caused by external factors rather than a source within cultures. The cultural variance perspective explains diversity based on internal characteristics of each culture while acknowledging the influence of external forces on cultural differences. The cultural variance perspective examines cultural differences as strengths in the face of oppressive external forces. Society has begun to recognize and acknowledge the value of cultural differences rather than denigrating such differences.

Recognition of the relationship between societal barriers and cultural diversity had a major impact on the development of the concept of cultural competence. Cultural differences could no longer be ignored or attributed to the inherent inferiority of different

cultures (Cauce et al., 1998). Society's influence on people from diverse cultural backgrounds and resulting inequalities between cultures were acknowledged (Cauce et al.). There began to be a desire to improve the level of equality between diverse cultures (Cauce et al.), which would include the areas of mental health care access and service delivery. Cultural competence intends to provide individuals from diverse cultural backgrounds with the same access to quality mental health care as individuals from dominant cultural backgrounds receive (Cross, 1989; Diller, 1999). Cultural competence appears to reflect a belief that members of diverse cultural groups share the same worth and value, and therefore, deserve the same opportunities and services.

Historically, Western psychology has failed in the arena of cultural competence. Western psychology is a result of particular cultural and historical conditions; it is not universally correct or appropriate (Gergen et al., 1996). Diverse cultures have diverse conceptualizations, expressions, and treatments relating to mental health and illness, all of which need to be taken into account when serving diverse populations. However, North American psychology has made the Western European White man the norm of human behaviour (Strickland, 2000). Viewing people from other cultures through Western constructs has resulted in misunderstanding, exoticizing, or disregarding the psychologies and realities of non-Western societies (Gergen et al., 1996). When Western psychologies and norms are applied to culturally diverse individuals, such individuals may feel that their identities, beliefs, and conceptual repertoires are out of place (Gergen et al.). Misdiagnosis and inappropriate and/or ineffective treatment may also result from viewing diverse populations through a Western mental health and illness framework.

The Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV, American Psychiatric Association, 1994), the major diagnostic manual used with mental disorders and problems, reflects Western psychology's treatment of cultural diversity. Although it strives to address cultural issues that relate to mental illness, the DSM-IV is not completely free from bias against non-dominant societies and cultures. Lewis-Fernandez and Kleinman (1995) note that the categorical specificity of the DSM-IV forces diagnostic dismemberment of some illnesses, such as neurasthenia in China, which contains anxiety, somatoform, affective, and dissociative elements (Kleinman, 1980, as cited in Lewis-Fernandez & Kleinman). It also excludes many unique non-Western symptoms, such as those associated with possession states (Varma & Chakrabarti, 1995). Diagnoses are made based on the intensity, severity, and duration of symptoms, all of which vary across culture (Manson, 1995). For example, in the DSM-IV, only 2 weeks of a dysphoric mood is required for the diagnosis of a depressive episode, but sadness is so prevalent in the Hopi population that periods of at least one month are needed to reach any kind of significance (Manson). Utilizing a Western approach to classifying and understanding mental illness may result in incomplete and/or inaccurate understandings of individuals' experiences, and may also result in misdiagnoses. Such misunderstanding of mental illness and health can result in ineffective or inappropriate treatment of mental disorders for culturally diverse individuals.

Routinely applying Western psychological concepts and treatments to individuals without taking into account their cultural backgrounds and influences is likely to have

negative consequences. Conventional Western psychology may not be flexible or complete enough to be effective and appropriate with individuals from diverse cultural backgrounds. However, the limitations of Western psychological frameworks regarding cultural diversity have been recognized, and the field is striving to improve its ability to serve diverse cultures. The need for cultural competence is now widely acknowledged, and psychological research, education, and practice are all striving to reach this goal.

Recent History and Trends

Originally, cultural competence was not considered an issue unless one was working in agencies that served clients from culturally diverse backgrounds (Diller, 1999). Prior to the 1960s, group differences were minimized by most service providers and such differences went unrecognized in policy (Dana, 1998). Cultural competence was not perceived to be necessary for acceptable and beneficial services (Dana). The rationale for and development of cultural competence occurred largely during the past century (Arthur & Stewart, 2001). Demographic changes in North America were given increased attention, traditional counselling service delivery was questioned, and the importance of culturally responsive counselling practices was shown (Arthur & Stewart). The field of counselling psychology has witnessed vast growth in its attention to multicultural issues in training, supervision, and counselling over the past couple of decades (Constantine & Ladany, 2001). Political and legal requirements, as well as developments in counselling theory and practice have also contributed to the trend of culturally competent mental health services (Sue et al., 1998). Professional associations of mental health practitioners have ethical guidelines demanding cultural competence from their members, including

the Canadian Counselling Association (CCA, 1999), the Canadian Psychological Association (CPA, 2000), and the American Psychological Association (APA, 1992). Cultural competence is now frequently conceptualized as an integral aspect of quality care to ethnically diverse populations (Abe-Kim & Takeuchi, 1996).

Pedersen (2001) discusses the field of psychology's current move towards greater inclusion of cultural variables. Psychology used to focus on dissonance reduction, but is beginning to emphasize tolerance of ambiguity. The field of psychology is moving from a monocultural to a multicultural basis. Psychology is moving toward becoming a culture-inclusive science that will routinely include cultural variables. Pedersen proposes that a culture-centered perspective will become the major fourth alternative in psychology, after psychodynamism, behaviourism, and humanism. He argues that adding a culture-centered perspective to their expression strengthens these conventional approaches. It seems that this move towards greater inclusion of culture in psychology will influence, and likely enhance, efforts towards increased cultural competence in psychological research, theory, education, and practice.

Pedersen (2001) lists several trends that should enable the field of psychology to overcome its ethnocentric bias and become increasingly culturally competent. Psychology and psychological publications are growing much more rapidly outside the U.S. than within the U.S. (Rosenzweig, 1992). As a result of technology, all fields are becoming more global in their focus. There is also a multicultural movement within the social sciences, which has increased attention to cultural issues. The topic of cultural and multicultural issues has become more accepted in psychological publications and

meetings. The growing emphasis on cultural competence in psychology is reflected by APA's first Multicultural Conference, which took place in January 1999 (as cited in Casas et al., 2001). The conference covered various issues and challenges relating to increasing cultural competence, as well as their influence on and implications regarding psychological research, education, training, and practice. There is also a re-examination of cultural bias in psychological services. A major convention being held in 2003 by CPA has a number of presentations on topics dealing with international and cross-cultural psychology (CPA, 2003). The University of Toronto will also be hosting a one-day conference solely devoted to multicultural counselling in a Canadian context in 2003 (University of Toronto, 2003). These factors reflect the field of psychology's growing cultural competence and should enhance the field's efforts to continue to increase its cultural competence.

The field of psychology has undergone self-examination, growth, and development in order to increase its cultural competence in the areas of research, education, and practice. The relationship between culture and psychology is now recognized and is under continual exploration. The way in which Western psychology has developed within, and been influenced by, particular historical and cultural factors is acknowledged and is under exploration (Gergen et al., 1996). Psychology widely accepts that culture significantly influences the symptoms, expression, and course of mental health problems (Manson, 1995). There appears to be a shift away from viewing culturally diverse individuals and their experiences from a Western psychological framework. Multicultural counselling theory emphasizes the importance of seeing the

individual in context, considering the client's cultural background, and finding culturally appropriate solutions (Sue, Ivey, & Pedersen, 1996). There is continual examination of existing paradigms for inclusion of cultural diversity, and psychological practitioners and researchers have explored the concept of mental health and its application to diverse populations for some time (Lefley, 1990; Sue, 1990).

This exploration of psychology and cultural diversity has led to many specific developments that are helping psychology increase its cultural competence. Mental health service providers, researchers, and other scientists are moving toward adapting Western theoretical orientations of psychotherapy to culturally diverse populations (Plummer, 1997). Western concepts and treatments related to mental health are beginning to be adapted for individuals with diverse cultural backgrounds. Numerous culturally valid treatments for different cultural groups have been developed and have proven to be effective (Phillips et al., 1994; Takeuchi et al., 1995). Rather than viewing culturally diverse individuals through a Western perspective, the field of cross-cultural psychology is making efforts to create ethnographies that offer valid and rigorous descriptions of indigenous illness syndromes as cultural experiences (Lewis-Fernandez & Kleinman, 1995). Professional associations of mental health practitioners have made a commitment to cultural competence by developing ethical guidelines that require members to demonstrate cultural competence (APA, 1992; CCA, 1999; CPA, 2000). These developments reflect Western psychology's attempts to be more flexible and inclusive of cultural differences, and demonstrate its movement towards increased cultural competence.

Rationale for Cultural Competence

The rationale for cultural competence has developed over the past century, especially in the last two decades (Arthur & Stewart, 2001), and is now well established. This rationale will be elaborated upon within the next section.

Conceptualization and Expression of Pathology

Mental health services need to consider cultural diversity because there are significant differences in the conceptualization and expression of mental health and illness across cultures. Diverse cultural groups frequently have significantly different definitions of normality and pathology (Lewis-Fernandez & Kleinman, 1995). For example, some members of Mediterranean, Balkan, and Middle Eastern countries believe in a concept known as the "evil eye," whereby mental and/or physical illness may be imparted with just a look from certain individuals (Dionisopoulis-Mass, 1976; Spooner, 1976). This belief is "normal" in these in certain parts of these countries, but in North America, it would likely be classified as delusional or "pathological." Concepts of mental health and illness are not equivalent across cultures. Most non-dominant ethnic groups approach illness as affecting a person as a whole and as a generalized lack of well being, rather than differentiating and categorizing symptoms as Western psychology tends to do (Flaskerud, 1984). Considering and exploring diverse conceptualizations of mental health and illness would help practitioners improve their understanding of their clients and their clients' issues and would also help them develop interventions that would be individualized, appropriate, and sensitive to cultural influences. The expression of emotion varies by culture (Manson, 1995). For example, some cultures have complex

systems and means of expressing anger while others rarely express this affective state (Manson). Social and cultural conventions also influence somatic symptoms of distress (Manson). In Nigeria, individuals frequently express somatic distress associated with depression as a feeling of bodily heat and a crawling sensation in the body (Sijuwola, 1995), which is rare in Western society. Considering culturally diverse expressions of emotions and other behaviours helps practitioners provide quality care to clients because it enhances their understanding of their clients and helps them to interpret their clients' expressions and behaviours correctly. A more complete understanding of clients helps mental health service providers to provide their clients with appropriate and effective care. Ethically, mental health practitioners are required to consider and adequately deal with their clients' culture and its influence on their issues and concerns (APA, 1992; CCA, 1999; CPA; 2000). Psychological assessment and treatment need to be culturally competent and need to consider cultural influences and differences in order for these processes to be appropriate, effective, and ethical.

Utilization of Mental Health Services

There is a historical underutilization of mental health services by non-dominant ethnic groups (Flaskerud, 1984; Switzer et al., 1998). Numerous studies (cited in Switzer et al.) reveal that the lower rates of mental health service utilization by diverse ethnic groups are present even after other predictors of service use are statistically controlled. There is a general problem of underutilization of mental health services in Canada (Beiser et al., 1988). Immigrants and refugees resist such services even more than dominant culture Canadians do (Beiser et al., 1988). From utilization rates, it appears that

individuals from non-dominant ethnic backgrounds are not receiving adequate treatment for their mental health problems. The pattern of underutilization of mental health services suggests that Western psychological treatments are not entirely appropriate or effective for ethnically diverse clients.

Underutilization of mental health services by non-dominant ethnic groups reflects barriers they face to accessing and receiving such services. Non-dominant ethnic groups' underutilization of mental health services does not appear to be due to fewer or less severe presenting needs (Hough et al., 1987). Individuals from non-dominant ethnic groups recognize the need for mental health services but face contextual barriers to receiving such services (Casas et al., 2001). Language differences, communication difficulties, and cultural beliefs are some factors that may discourage individuals from utilizing the mental health system (Casas et al.). Abe-Kim and Takeuchi (1996) reported that non-dominant ethnic individuals in the United States may (a) have a greater need for health services than White Americans, (b) encounter the greatest number of barriers to accessing mental health services, (c) are least able to afford such services, and (d) experience lower quality of care when they do obtain such services. Ethnic groups in Canada also avoid the mental health care system because of barriers that impede access to appropriate services (Beiser et al., 1988). Such barriers that impede access include fear of stigmatization, lack of information or misinformation about services, and inability to pay (Beiser et al., 1988). Canadian ethnic groups also underutilize services because they feel that, even if they succeed in overcoming barriers, the treatment they receive is inappropriate or ineffective (Beiser et al., 1988). Mental health services with barriers to

access for certain populations are not culturally competent. Underutilization of such services by ethnic groups reflects that such barriers need to be removed and that the cultural competence of such services requires improvement.

Premature Termination of Services

Length of treatment is one indication of service efficacy and of client satisfaction with services. Research has shown that more change occurs with clients the longer that they stay in treatment (Pekarik, 1986, as cited in Sue et al., 1995). Premature termination of treatment prevents clients from receiving the maximum benefit that such treatment could potentially provide. Early termination of mental health treatment relates to cultural variables, such as agency location and lack of therapist-client match on language, ethnicity and attitudes (Acosta, 1980; Flaskerud, 1986). Findings on the length of treatment of non-dominant ethnic clients are somewhat inconsistent (Sue et al., 1995). However, Sue (1977, as cited in Sue et al., 1995), found a higher rate of dropout from mental health services among African, Latin, Asian, and Native Americans than among Caucasian Americans. Canadian migrants and refugees, often from non-dominant ethnic backgrounds, frequently terminate treatment prematurely (Beiser et al., 1988). In fact, as many as half of non-dominant ethnic clients receiving mental health services terminate treatment before the completion of five sessions (Beiser et al., 1988). Higher rates of premature termination of services among non-dominant ethnic groups may indicate that for these groups, immediate need for assistance is paramount, which may be one reason they do not remain in therapy for many sessions. The premature termination rates among

non-dominant ethnic groups receiving mental health services also suggest that such groups may find these services inappropriate, unsatisfactory, and/or ineffective.

Diagnosis and Outcomes

Cultural competence is necessary in order to have appropriate diagnoses and favourable therapeutic outcomes when serving culturally diverse populations. Race, ethnicity, and associated constructs have significant influence on which individuals become ill, where and how they are diagnosed and treated, and how effective interventions are in reducing their symptoms and improving their quality of life (Abe-Kim & Takeuchi, 1996). If these factors are not taken into account, culturally diverse individuals may receive inaccurate diagnoses and/or experience poor therapeutic outcomes when receiving Western mental health services.

Individuals from diverse cultural backgrounds face certain issues relating to the diagnosis of mental health concerns. Sociocultural differences among groups can lead to difficulties in performing valid psychological assessments (Jones & Thorne, 1987), which would negatively impact the validity of any consequent diagnoses that are made. Good (1992/1993) found the misdiagnosis of non-dominant ethnic patients in the United States to be higher than that of patients from the dominant population. One Canadian study revealed that the race of patients influenced their diagnosis as depressed or schizophrenic (Beiser et al., 1988). Failure to properly consider cultural influences can negatively impact the validity of assessments and diagnoses being made. Possible negative consequences of such misdiagnosis include inappropriate labeling, mistaken treatment, and inappropriate use of medication (Good).

There are few treatment outcome studies for different ethnic groups and they often provide conflicting explanations (Sue et al., 1995). The likelihood of members of diverse ethnic groups experiencing successful outcomes with Western therapies is relatively poor (Flaskerud, 1984). Sue et al. (1995) reviewed the literature and found that in no study did individuals from non-dominant ethnic backgrounds consistently fare better than Caucasian Americans did. Ethnically diverse clients receiving Western mental health services are at a disadvantage, as they are more likely to receive inappropriate diagnoses and less likely to achieve successful outcomes. Clearly, mental health services need to increase their competence in order to provide culturally diverse individuals with quality care that is equivalent to that received by members of dominant cultures.

Benefits of Competence

The benefits of culturally competent mental health services are well established. Culturally competent mental health services appear to increase the utilization rates and decrease the dropout rates of culturally diverse clients receiving such services. Ethnic and language matching between client and mental health professional is one method of increasing the cultural competence of services. This type of matching related to an increase in the use of mental health services by non-dominant ethnic clients, as well as to a decrease in the rate of dropout from such services (Takeuchi et al., 1999). Clients assigned to a counsellor with cultural sensitivity training returned for more counselling sessions than those who saw a counsellor without such training (Wade & Bernstein, 1991). Ethnic-specific programs for three different non-dominant ethnic groups were associated with a significantly greater number of treatment sessions even after

statistically controlling for the effects of other variables (Takeuchi et al., 1995). An increase in utilization and a decrease in dropout rates suggest that culturally competent services increase culturally diverse clients' satisfaction with services and increase the efficacy of services for such clients. Decreased dropout rates, or longer therapy, may enhance client change and may allow clients to more fully benefit from the therapy that they receive (Pekarik, 1986, as cited in Sue et al., 1995). Culturally competent services are beneficial as they increase the utilization rates and decrease the dropout rates of culturally diverse clients.

Culturally competent care may also positively impact the quality of therapy and its outcomes. Acknowledgement of race, ethnicity, and language in service delivery has been shown to improve the quality of care provided (Dana, 1998). Identifying and addressing cultural differences also makes programs more clinically effective (Pumariega, 1996). Culturally valid treatment has been found to increase the functioning of mental health patients, and to decrease the amount of patient suffering (Phillips et al., 1994). Principle components of culturally competent care have been empirically associated with positive mental health outcomes for ethnically diverse clients (Flaskerud, 1986). Many studies reveal that clients may tend to judge culturally sensitive therapists as more competent and more favourable than those who are not (Sue, et al., 1995). Clients assigned to a counsellor with cultural sensitivity reported greater satisfaction with the counselling process than those who saw a counsellor without such training (Wade & Bernstein, 1991). Mental health service providers ought to provide culturally competent

services because such services are likely to improve the quality of the care given, the effects of therapy, and clients' perceptions of therapy.

Culturally competent mental health services also benefit mental health service providers and organizations. Mental health service providers benefit from the cost-effectiveness of culturally competent mental health services. Culturally valid treatment increases the cost-effectiveness of care (Phillips et al., 1994). Accountability for treatment approaches as well as the types of treatment provided is a major strategy for cost containment within managed care systems (Abe-Kim & Takeuchi, 1996). Cultural competence may help such systems to achieve such accountability and help contain their costs. Identifying and addressing cultural differences and how to address them, which is part of cultural competence, makes mental health programs more cost-effective (Pumariega, 1996). The cost-effectiveness of culturally competent services provides another, economically appealing, reason for organizations and mental health service providers to increase their cultural competence.

Cultural competence also provides broader benefits to the field of psychology and society as a whole. Pedersen (2001) advocates making culture central to the fields of counselling and psychology. Pedersen (1997) describes the positive advantages of a culture-centered perspective for the fields of psychology and counselling, as well as for society, including:

1. Considering the cultural context of behaviour makes accurate assessment, meaningful understanding and appropriate interventions relative to that cultural context possible and decreases the chance of misattribution due to interpreting behaviour out of context.

2. Cultural diversity allows individuals to find common ground and understand that similar goals or values may be expressed through different culturally learned behaviours.
3. A diversity of cultural perspectives increases the psychological health of a society. Considering different perspectives is also useful in problem solving, as it is less likely that individuals will overlook a beneficial solution.
4. By challenging our assumptions, cultural diversity helps to keep individuals from imposing their self-reference criteria inappropriately on others.
5. By learning to work with different cultures now, people are developing the facility for working with future, as yet unknown, cultures.
6. The contrasting cultural perspectives of multiculturalism act to prevent any single group from determining the standards of justice and morality for other groups.
7. Cultural diversity enhances people's ability to examine similarities and differences simultaneously, which helps to identify nonlinear alternatives to rigidly absolutist thinking.
8. Considering the different cultural perspectives and beliefs of others can complement individuals' understandings of the Ultimate Spiritual Reality and can enhance their spiritual completeness.
9. Cultural pluralism provides a potential political alternative to the extremes of absolutism and anarchy.

10. A culture-centered perspective would enhance psychology's relevance and applicability because such a perspective would more adequately reflect the dynamic and complex reality that individuals inhabit.

Summary of the Rationale for Cultural Competence

The rationale for cultural competence in mental health services is well documented. Culturally competent mental health services are necessary due to the number of ethnically diverse individuals living in North America, cultural differences in conceptualizations and expressions of pathology, underutilization of services by non-dominant ethnic groups, premature termination of services by non-dominant ethnic groups, issues surrounding therapeutic diagnosis and outcomes, and numerous specific benefits of cultural competence to clients, service providers, and organizations. This rationale needs to be developed into effective counselling practices, at both individual and organizational levels (Arthur & Stewart, 2001).

Individual Cultural Competence

The rationale for culturally competent mental health services has been well debated and supported by research. One of the major developments towards translating this rationale into actual cultural competence is the articulation of the Multicultural Counseling Competencies (Sue et al., 1992). The Multicultural Counseling Competencies guide interpersonal counselling interactions with attention to culture, ethnicity, and race. They propose three domains of competence: awareness, knowledge, and skills, which are outlined in detail below. Within each of these components, attitudes and beliefs, knowledge, and skills may also be considered (Arredondo et al., 1996). Recently,

Arredondo et al. expanded upon Sue et al's (1992) work and developed detailed explanatory statements that operationalize, clarify, and further define the Multicultural Counseling Competencies.

Self-Awareness

Sue and Sue (1990) describe culturally self-aware counsellors. Culturally competent counsellors actively seek awareness of their worldviews, including assumptions, values, biases, personal limitations, and preconceived notions. They understand how their own culture has influenced their worldviews and experiences. Counsellors should be aware of how they are the product of their cultural conditioning, and how this cultural conditioning may be reflected in their work with clients from diverse cultural backgrounds. Self-awareness helps to prevent ethnocentrism and unintentional racism.

Knowledge

Culturally competent counsellors require cultural knowledge (Sue & Sue, 1990). This knowledge includes an understanding of one's own worldview, specific knowledge of the cultural groups one works with, and an understanding of sociopolitical influences (Sue et al., 1982). In order to be culturally competent, counsellors must have knowledge, respect, and appreciation for cultural influences and differences (Sue & Sue). Counsellors also need knowledge of how cultural differences and influences will influence their therapy and therapeutic relationships with clients.

Skills

In addition to self-awareness and knowledge, counsellors also require culturally sensitive and appropriate counselling skills and interventions in order to competently work with their culturally diverse clients (Arredondo et al., 1996). A culturally skilled counsellor actively develops and practices relevant, appropriate, and sensitive intervention strategies and skills in serving his or her culturally diverse clients (Sue & Sue, 1990). When counsellors use methods and define goals that are consistent with the life experiences and cultural values of clients, the effectiveness of counselling is improved (Sue & Sue). Cultural skills include both individual and organizational competencies (Sue et al., 1982).

Other Cultural Competence Frameworks

The tripartite definition of multicultural counsellor competence (attitudes/beliefs, knowledge, and skills) is well known and established. However, there are other theories and frameworks that enhance one's understanding of cultural competence. Most other theories and frameworks of multicultural competence appear to be based on Sue et al.'s (1992) work. Sodowsky et al. (1994) expanded the three general domains to include a fourth factor, the multicultural counselling relationship. Constantine and Ladany (2001) propose that multicultural counselling consists of six dimensions: (a) counsellor self-awareness, (b) general knowledge about multicultural issues, (c) multicultural counselling self-efficacy, (d) understanding of unique client variables, (e) an effective counselling working alliance, and (f) multicultural counselling skills. With the exception of a few expansions and adaptations, the historical conceptualization of multicultural

counselling competence as consisting of the aforementioned three domains has remained essentially unchallenged by multicultural scholars and practitioners in counselling and psychology (Constantine & Ladany). Therefore, conceptualizations supporting and/or refuting the constructs believed to underlie the construct of multicultural counselling competence is needed (Constantine & Ladany). Further research to determine which, and how many, dimensions underlie the construct of multicultural counselling competence would also be beneficial.

Education and Training

Ethical demands for cultural competence have spurred a recent and rapid growth in multicultural curricula (Arthur & Achenbach, 2002; Ridley et al., 1997). There is no longer any debate as to whether or not professional education programs should provide multicultural training (Ridley et al.). The APA Committee on Accreditation's decision to make diversity in clinical training a requirement for the accreditation of clinical training programs will help ensure that future psychologists will have greater exposure to cultural diversity (Plummer 1997), which will help them to become more culturally competent. Most graduate training programs attempt to provide future mental health service providers with training in multicultural issues. Such education varies greatly from one program to another, and multicultural education programs require further direction and consistency (Ridley et al.). In multicultural training programs, there is often a focus on cultural skills/culturally appropriate interventions and data on cultural differences/characteristics of different groups (Plummer). However, it is also important for therapists to learn to understand themselves as cultural beings and to attend to this

aspect of their selves in the therapeutic process, which is usually given less emphasis in training programs (Achenbach, 1999; Plummer). Despite the inclusion of multicultural courses in training programs across the United States, mental health practitioners remain seriously undertrained in culturally competent practice (Plummer). A Canadian study of graduate counselling students revealed that many do not believe that graduate programs provide adequate preparation for working with culturally diverse clients (Arthur & Januszkowski, 2001). Multicultural training programs and curricula are in the beginning stages of development (Arthur, 1998). Further research is required to determine effective methods of training future counsellors to be culturally competent (Arthur & Achenbach).

Organizational Cultural Competence

Counselling does not occur within a vacuum; it occurs within an organizational context. In addition to the efforts of individual mental health practitioners, the systems within which they work need to change in order to bring about true change in cultural competence (Arredondo et al., 1996). Organizations that fail to successfully implement diversity into the very structures of their practice will fail to be relevant to the people that they serve, and will fail to compete and survive in the marketplace (Sue et al., 1998). Some characteristics of a culturally competent organization are outlined and discussed below.

Barr and Strong (1987, as cited in Sue et al., 1998) state that a multicultural organization: (a) is genuinely committed to diverse representation throughout all levels of its organization; (b) strives to maintain an open, supportive, and responsive environment; (c) purposefully includes elements of diverse cultures in its ongoing operations; and (d)

authentically responds to cultural diversity issues that it faces (including a commitment to changing policies and practices that block cultural diversity).

Sue et al. (1998) propose that a multiculturally competent mental health organization will: (a) value diversity, (b) possess capacity for cultural self-assessment or cultural auditing, (c) clarify its visions, (d) understand the dynamics of difference, (e) institutionalize its cultural knowledge, and (f) adapt to diversity.

The process of becoming a culturally competent organization is complex and involves many factors and steps. The lists of characteristics of culturally competent organizations provided above are only examples. As of yet, there seems to be no definitive definition of organizational cultural competence and understanding of its underlying factors. However, these two lists summarize some of the main steps or components involved in organizational cultural competence in a simple and accessible manner. From the descriptions presented above, it appears that flexibility, responsiveness, self-examination, and building cultural diversity into organizational structures and processes are key components of becoming a culturally competent organization.

There are many methods of actually implementing the necessary changes to become a culturally competent organization. Sue et al. (1998) suggest that building support and facilitating leadership are crucial in planning for cultural diversity and competence. Planners need to ensure that they have cultivated support within the organization for their cultural competency goals (Sue et al., 1998). Research strongly suggests that comprehensive implementation of multicultural practices cannot take place without the support of top decision- and policy-makers in the organization (Morrison &

Van Glinow, 1990; Schein, 1990). Sue et al. (1998) propose that organizations also need to develop leadership that is multiculturally diverse. This helps increase diversity within an organization and also increases initiation, support, and acceptance of multicultural changes.

Organizations desiring to improve their cultural competence must also develop multicultural policies and implement change through administrative processes (Sue et al., 1998). Policies ensure that cultural competency goals are met in a consistent manner across an organization (Calgary Health Region, 2002). Mental health service providers, community leaders, and consumers should all be consulted when developing policies to ensure that they are truly multicultural (Sue et al., 1998). Sue et al. (1998) discuss the role of administration in cultural competence. Policy is created, interpreted, and implemented on a daily basis at the administrative level of an organization. Therefore, in order to help an organization reach cultural competency, individuals must be able to use its administrative procedures to implement change effectively. Some strategies include collecting demographic data, developing staff training programs, and developing personnel policies that increase the ability of an organization to enhance its cultural competence. Multiculturally competent organizations need to infuse multiculturalism at the levels of leadership, policy-making, and administration (Sue et al., 1998). This will support, enhance, and encourage the efforts towards increasing cultural competence being made by individual mental health practitioners at the level of service delivery and direct interaction with clients.

Barriers and Resistance to Cultural Competence

Despite the widespread call for culturally competent mental health services, barriers, criticism, and resistance have surrounded cultural competence. Some barriers and resistances to cultural competence include ethnocentrism, unintentional racism, criticism of the Multicultural Counseling Competencies, criticism of multiculturalism, fear, and various difficulties relating to increasing the cultural competence of services.

Ethnocentrism

Ethnocentrism makes the development of cultural competence difficult, if not impossible. Ethnocentrism may be defined as the belief that one's view of the world is reality, and this belief has pervaded human history (Dana, 1998). In the history of psychology, White middle class men have been the norm and the ideal to which all other individuals were compared (Strickland, 2000). Ethnocentric bias in psychology has led to viewing cultural differences through a Western framework. Viewing culturally diverse individuals through a Western lens may result in misunderstanding, disregarding or exoticizing their experiences and realities (Gergen et al., 1996). Rigidly viewing diverse cultures from within a Western framework and routinely and directly applying Western therapies to culturally diverse individuals is likely to result in incomplete understanding of clients, misdiagnosis, and inappropriate and/or ineffective treatment. Believing that one's way of looking at things is the only way does not leave room for an understanding of, appreciation of, or respect for, cultural differences in such views. In this way, ethnocentrism effectively prevents cultural competence and must be overcome by counsellors and organizations in their quest for cultural competence.

Unintentional Racism

Unintentional racism hinders cultural competence. Pedersen (1995) discusses unintentional racism as it pertains to counsellors. He defines racism as "a pattern of systematic behaviours resulting in the denial of opportunities or privileges to one social group by another." (p. 197). Racism may be overt or covert. Even if counsellors are not overtly racist, intentionally judging another group as inferior, they may still engage in unintentional racism. Unintentional racism involves unconsciously acting in a way that denies another social group opportunities or privileges. For counsellors, misinformation or incorrect assumptions may lead to inaccurate assessments and/or inappropriate therapy. Ridley (1989) describes ways in which counsellors may express unintentional racism. These include attempting to treat all clients equally, regardless of colour; assuming that all of a client's issues stem from his/her cultural background; and misinterpreting the client's experiences. Even caring professionals with the best of intentions may engage in unintentional racism (Pedersen, 1995). A racist act is defined by the consequences of a behaviour, not the causes or intentions behind it (Ridley). Unintentional racism is dangerous and is less likely to be changed because individuals are not aware that their behaviour requires change. In the face of unintentional racism, counsellors must increase their self-awareness, reduce their reliance on self-referenced criteria, and understand that good intentions are not enough (Pedersen, 1995). Counsellors need to continually be aware of and explore the consequences of their actions in the cultural contexts of their clients (Pedersen, 1995).

Resistance to Multiculturalism and Cultural Competence

Pedersen (1999) discusses the debate that remains regarding whether this multicultural perspective is, or could become, psychology's fourth force after the psychodynamic, behavioural, and humanistic approaches. The validity of multiculturalism as an international phenomenon has been called into question. In addition, interpretations of multiculturalism differ from society to society. This lack of unity within the perspective may hinder its ability to become a dominant force in psychology. Although a multicultural or culture-centered perspective is playing an increasingly important role in psychology, it is not yet a truly dominant force, which may be reflected by the little coverage it receives in contemporary psychological textbooks. Multiculturalism remains an aspiration for the future, and requires further development before it may become a fourth force in psychology.

The Multicultural Counseling Competencies (Sue et al., 1992; Arredondo et al., 1996) have been critiqued by Weinrach and Thomas (2002). Weinrach and Thomas question the adoption of these competencies because there is almost no empirical data supporting their validity whatsoever. They claim that the Multicultural Counseling Competencies overemphasize the factors of ethnicity and race, and do not deal adequately with other aspects of culture, such as gender, age, and sexual orientation. Furthermore, they point out that there is no direct evidence linking mastery of such competencies and actual improvements in quality of service delivery to culturally diverse individuals. It appears that the Multicultural Counseling Competencies require further exploration and development.

Multiculturalism itself has also been critiqued and identified as problematic. Multiculturalism tends to promote an emphasis on between-group rather than within-group differences, which can be greater than the former (Lloyd, 1987; Suzuki, McRae & Short, 2001). Focusing on the influences of ethnicity, race, and culture in therapy may also minimize the influence of psychological factors (Weinrach & Thomas, 2002). Multiculturalism may emphasize group differences and to some extent promote cultural separatism and self-protection (Fowers & Richardson, 1996). Multiculturalism preaches respect and tolerance for all cultures (Fowers & Richardson). This respect and tolerance could be morally difficult and cause harm in certain situations (Fowers & Richardson; Weinrach & Thomas), such as involuntary virginity tests in Turkey or female circumcision in Africa (Fowers & Richardson). Practitioners do not want to impose their standards of behaviour onto other societal groups, but they also do not wish to condone harmful and perhaps morally abhorrent behaviour (Fowers & Richardson). The concept of multiculturalism is both desirable and problematic.

Although the rationale for increasing cultural competence is well articulated and understood, resistance to increasing the cultural competence of an individual or organization remains. Fears exist that multiculturalism will heighten conflicts, divisions and tensions based on ethnicity (Pedersen, 1999). Although such fears remain unsupported by evidence (Pedersen, 1999), they may cause individuals to resist increasing their cultural competence. Making culture central to all aspects of counselling is complex and makes research, education, and practice more difficult and inconvenient (Pedersen, 2001). This increased complexity, difficulty, and inconvenience has resulted

in cultural differences being viewed negatively or overlooked (Pedersen, 2001). Self-assessment of an organization's cultural competence often threatens people's power and/or sense of identity (Sue et al., 1998), and therefore, may not always be welcomed by staff and organizations. Increasing the cultural competence of an organization is complex and involves steps including, but not limited to: assessment, training, adaptation and/or creation of policies, community involvement, and recruitment of culturally diverse staff (Sue et al., 1998). All of these factors involved in increasing an organization's cultural competence demand a large amount of time and money. These difficulties are likely to create some resistance among such organizations striving to increase their cultural competence. These resistances hinder the development of increased cultural competence in mental health services, and ways to further overcome them require greater exploration.

Assessing Cultural Competence

Assessing the cultural competence of individuals and organizations is an important first step towards improving their cultural competence. Although there is widespread recognition that cultural competence is important and requires monitoring, there remains insufficient agreement on what cultural competence means or how to measure it (Switzer et al., 1998). Constantine and Ladany (2001) outline and discuss the various methods of assessing cultural competence, including portfolios, observer rated measures, and self-report measures.

Cultural competence may be assessed through the use of portfolios and through observer rated measures. Portfolios are collections of work that display a broad range of behaviours related to cultural competency in various domains across different treatment

modalities (Coleman, 1996). Portfolios have many benefits (Coleman), but are also time-consuming and lack reliable methods of scoring and evaluation (Coleman; Collins, 1992; O'Neill, 1992). Observer-rated measures may be more reliable, but are influenced by observer characteristics and require that the observers be culturally competent (Constantine, 1997; Priest, 1994). Each method of assessing cultural competence has its own strengths and weaknesses that require consideration when choosing a method for use in assessment and evaluation.

A common contemporary method of assessing cultural competence is self-report indices of competence. Several self-report instruments, based on Sue et al.'s (1982) work, have been developed to measure the multicultural competencies of counsellors. These include the (a) Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991); (b) Multicultural Counseling Inventory (MCI: Sodowsky et al., 1994); and (c) Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2000, as cited in Constantine & Ladany, 2001). Most self-reports of cultural competence use Likert-type scales and include measures of self-awareness, general knowledge, and skills pertaining to cultural competence. Self-report multicultural counselling competence instruments are a common method of measuring multicultural competence (Constantine & Ladany; Switzer et al., 1998), and appear to be an important first step in the assessment of such competence (Constantine & Ladany).

There are several issues that require consideration when using self-report measures to assess cultural competence. There is a lack of uniformity regarding what

these self-report scales actually assess (Pope-Davis & Dings, 1995; Sue, 1996). In fact, some scales appear to measure fundamentally different constructs (Pope-Davis & Dings). The measures also tend to vary in the number of factors thought to comprise multicultural competence (Constantine & Ladany, 2001). Furthermore, research using self-report measures reveals that they tend to measure anticipated rather than actual behaviours or attitudes correlated with multicultural competence (Pope-Davis & Dings; Sue, 1996). Two studies have found no significant relationship between self-reported multicultural counselling competence and an aspect of demonstrated competence (i.e., written multicultural case conceptualization ability) (Constantine & Ladany; Ladany et al., 1997). Self-report measurements are influenced by social desirability attitudes, which may need to be statistically accounted for when examining correlates of self-report multicultural counselling competence (Constantine & Ladany). Although self-report measures have limitations, they are used quite frequently, and appear to be a useful method of assessing cultural competence.

One view of cultural competence examines clients' perceptions of whether or not the mental health care that they receive is delivered in ways that respect their cultural beliefs and attitudes (Switzer et al., 1998). Clients' perceptions are important to assess because there may be a lack of congruence between service provider reports of cultural competence and client perceptions about the cultural competence of the care that they receive. The Client Cultural Competence Inventory (Switzer et al.) is a self-report measure developed to assess clients' perceptions of the cultural competence of care received. Typically, efforts to assess the cultural competence of mental health services

have focused exclusively on mental health professionals and organizations rather than on clients' perceptions of care. Although it may not always be feasible, clients' perceptions and views should also be considered when assessing the cultural competence of mental health services.

There appears to be a need for further empirical evaluation of cultural competence and methods of achieving this goal. Many approaches to assessing cultural competence deal with such competence as largely as it pertains to individual practitioners (Constantine & Ladany, 2001). Assessment of multicultural counselling competence in the context of larger systems and organizations may also be necessary (Constantine & Ladany). Due to diminished funding for mental health services, evaluation paradigms are needed to test their overall effectiveness and to identify essential components of model programs for replication (Pumariega, 1996). Such evaluation is crucial because it can test the effectiveness of resource utilization and assist in managing such resources in managed care organizations (Pumariega). There is a need for systematic research that critically evaluates whether cultural competence actually results in increased access, better quality of care, and more positive outcomes for culturally diverse individuals, which is currently lacking (Abe-Kim & Takeuchi, 1996). A method of empirically evaluating the effectiveness of interventions to increase the cultural competence of individual mental health service providers and organizations is also required.

Due to the growing demand for culturally competent mental health services, assessing the cultural competence of such services and service providers is of critical importance. Although there has been an increase in multicultural counselling competence

training, there has not been sufficient assessment of the effectiveness of such training (Constantine & Ladany, 2001). Recently, research has begun to focus on the evaluation of training effectiveness and acquisition of cultural competency in therapy (Neville et al., 1996). Research examining the actual development of multicultural competencies is only beginning to appear in the literature (Arthur & Januszkowski, 2001). Assessment of cultural competence is an important component of such research. There is insufficient literature on comprehensive assessments of the cultural competence of mental health services in Canada; further assessment is required. The cultural competence literature suggests that all settings where therapy is practiced should engage in a self-examination process and assess their systems, practices, and policies (Arredondo et al., 1996).

Cultural Competence of Canadian Counsellors

Arthur and Januszkowski (2001) assessed the cultural competence of a sample of Canadian counsellors. Counsellors reported barriers to interventions with culturally diverse clients at both personal and systemic levels. Many counsellors felt that using basic counselling skills in culturally appropriate ways led to positive working relationships with clients. Other features of interactions that went well with culturally diverse clients were knowledge about the clients' backgrounds and access to consultation and community resources. Both individual and systemic barriers to effective interventions with culturally diverse clients were noted. At the individual level, counsellors reported difficulties in overcoming issues of value conflict and in ability to bridge cultural differences. At the level of the system, counsellors considered a perceived inability to influence the environment surrounding the counselling relationship (e.g., lack

of resources, agency guidelines) to negatively affect the needs of multicultural clients. It appears that both individual counsellors and the systems they work within can enhance or diminish the cultural competence of services provided. This research reaffirms that cultural competence is multifaceted and is located within individuals as well as within organizations. Arthur and Januszkowski call for further research evaluating the cultural competence of Canadian mental health workers.

Research on Ethnically Diverse Children and Adolescents

Compared to the adult population, there is little information regarding the mental health issues and needs of ethnically diverse children and adolescents. There is an increasing need for and utilization of pediatric mental health services in the United States (Pumariega & Vance, 1999). Children from non-dominant ethnic backgrounds experience high levels of stressors (Pumariega & Vance). However, in the United States, non-dominant ethnic children and adolescents are often underserved or inappropriately served by mental health agencies (Casas et al., 2001). In Canada, there is a belief that migrant children and youth experience an elevated mental health risk due to unique problems and stressors that they face (Beiser et al., 1988). Convincing data for this plausible assertion are sparse and sometimes conflicting (Beiser, Dion, Gotowiec, Hyman, & Vu, 1995). Research suggests that the personal strengths and social resources of immigrant and refugee children may mitigate the relationship between migration stress and mental health concerns (Beiser et al., 1995). Although there is knowledge available about how to better serve non-dominant ethnic groups, culturally sensitive models have focused almost exclusively on adult populations (Casas et al.). The topic of the unique needs of non-

dominant ethnic youths was all but ignored by the APA Multicultural Conference participants (Sue et al., 1999). There is still a need for the implementation of policy initiatives, research programs, and service programs that address the issues and diverse needs of culturally diverse youths, especially those with serious emotional and behavioural disorders (APA Multicultural Conference, as cited in Casas et al.). Further research on mental health, mental health services, and cultural competence issues with ethnically diverse youth is required.

Connections to Current Study

The first step for any organization desiring to improve its cultural competence is a cultural competency assessment (Sue et al., 1998). Such assessment indicates resources available for making changes as well as barriers to making changes. Assessing the cultural competence of an organization and its workers allows an organization to assess multiple levels of its operations, to target specific areas for improvement, and to develop appropriate interventions to improve competence. Multicultural leadership development within mental health organizations also requires that all staff be assessed for their multicultural counselling competencies.

The current study provided the first step in increasing the cultural competence of a pediatric mental health service provider within a large Western Canadian city. The literature supports the importance of both individual and organizational cultural competence and this study assessed both components of competence. This study helped to identify specific areas that may require improvement at the individual and organizational levels in order to increase cultural competence. A knowledge of specific

areas for improvement will enable the organization to develop specific future interventions to improve its competence. Such improvement is likely to result in non-dominant ethnic groups increasing their utilization of, and satisfaction with, mental health services. The data gathered provided a baseline that will help the organization to empirically evaluate different methods that it may implement to increase its cultural competence. This study added to the literature on the cultural competence of Canadian counsellors and cultural competence as it relates to ethnically diverse children and adolescents.

Purposes

The goals for this research were (a) to evaluate the cultural competence of pediatric mental health service providers; (b) to identify strengths and specific areas in need of improvement; (c) to determine whether problems in competence are mainly organizational, individual, or both; and (d) to provide baseline data to help determine whether future attempts to improve competence are successful at the service provider level.

Chapter Summary

Early in its history, psychology was culturally encapsulated and ethnocentric (Albee, 1994). The gold standard of human behaviour against which all individuals were measured was the Western European White man (Strickland, 2000). This resulted in misunderstanding, exoticizing, or disregarding the diverse perspectives and realities of non-Western cultures (Gergen et al., 1996). Over time, Western society has moved away from denigrating cultural differences towards positions that recognize and acknowledge

the value of such differences (Cauce et al., 1998). Cultural competence has developed during the past century, and has gained momentum over the past two decades (Arthur & Stewart, 2001). Psychology is becoming increasingly culturally competent, and a culture-centered perspective may become the major fourth force or alternative in psychology (Pedersen, 2001).

The rationale for cultural competence has been well established (e.g., Arredondo et al., 1996; Arthur & Stewart, 2001; Dana, 1998; Sue et al., 1998). Due to the number of ethnically diverse individuals residing in North America, culturally competent mental health services are a necessity. They account for cultural influences and differences in assessment and treatment. Culturally competent services are likely to increase utilization of services, decrease premature termination of services, and improve therapeutic outcomes of non-dominant ethnic groups. Culturally competent services are more appropriate, effective, satisfactory, cost-effective, and ethical than services that do not adequately deal with issues relating to culture.

Guidelines have developed to help mental health service providers and organizations translate this rationale into culturally competent services (Arredondo et al., 1996; Sue et al., 1992; Sue et al., 1998). Three domains of individual cultural competence have been proposed: self-awareness, knowledge, and skills (Sue et al., 1992). Culturally competent organizations are flexible, responsive, engage in self-examination, and build cultural diversity into their organizational structures and processes (Barr & Strong, 1987; Sue et al., 1998). Culturally competent services require both individual and organizational cultural competence, which are mutually supportive (Sue et al., 1998).

Assessing the cultural competence of individuals and organizations is an important first step towards improving their cultural competence. Due to the growing demand for culturally competent mental health services, assessing the cultural competence of such services and service providers is of critical importance. The first step for any organization desiring to improve its cultural competence is a cultural competency assessment (Sue et al., 1998). The current study adds to the existing literature by examining the individual and organizational cultural competence of Canadian pediatric mental health service providers.

CHAPTER THREE: METHODOLOGY

This chapter outlines the methodology used to examine the overall purposes and research questions of the study presented in Chapter Two. First, the research procedures are presented, followed by descriptions of the research participants, instrumentation, and research design.

The author joined an ongoing research project and did not design the current study. The sampling, data collection, and instrumentation were not under the control of the author. There were resulting limits to the research process that readers should keep in mind when considering the findings and conclusions of this study.

Research Procedures

A survey assessing organizational cultural competence was given to the managers of a Western Canadian mental health facility. In addition, a survey assessing individual cultural competence was appended to a routine operational survey to be completed by staff at various sites. Approximately 200 mental health program employees, including managers and mental health service providers, were asked to complete the survey. The researcher was in no way involved in the administration of the surveys, the collection of data, or the storage of data. The administration of surveys, and the collection and storage of data was conducted by the facility in accordance with its own research purposes, policies, and standards.

The privacy and confidentiality of participants were protected throughout the research process. In order to maintain the privacy and confidentiality of participants, no names or other identifying information was associated with the completed surveys. The

researcher did not have access to individual questionnaires, and received the data in a computer spreadsheet format, completely separate from any individual surveys, from the mental health facility after it had finished collecting all of the data. In order to protect the identity of the institution where the research was conducted, the name of the institution was not, and will not be, mentioned in any presentations, conferences, or publications. Only group results were, and will be, published in any professional publications or presentations.

The mental health facility chose and carried out its own informed consent procedures. Staff were aware of the facility's goal to assess and enhance its cultural competency, and were therefore aware of the purposes of the study. There were no consent forms attached to the surveys. The facility decided that informed consent forms were not necessary because the surveys were completely anonymous and their completion was voluntary. Staff and managers were informed by the facility that the survey was optional and that they could withdraw at any time. They may have chosen not to complete the survey. It was determined that returning surveys implied consent.

Participants will be provided with a summary of the results of the study and the next steps the mental health facility's research team will be taking to help improve the cultural competence of their pediatric mental health services.

Research Participants

Ninety-eight mental health program employees, including six managers and ninety-two individual pediatric mental health workers, completed and returned surveys assessing their cultural competence. This equaled approximately one-half of the original

proposed number of potential participants (service managers and staff). The mental health services group chose to collect no identifying information on participants and non-participants in order to fully protect confidentiality and anonymity. Therefore, no comparisons between those individuals who did respond to the survey and those who did not respond to the survey can be made. This limits the generalizability of the research findings.

There is no demographic data available specifically for the participants in this research study, as no identifying information was collected in association with the cultural competency surveys. A Work Environment and Satisfaction scale was administered to the same group of employees, however, and thus provides some rough estimates of such data. The vast majority of respondents were female respondents. There were 71 females, 8 males, and 40 respondents whose gender was not specified. Ninety percent of respondents that recorded their gender were female, and ten percent were male. The mean age of respondents was 39.47, SE = 1.43. The mean number of years working for the organization was 5.20, SE = 0.80, and the mean number of years working for the department specifically was 3.44, SE = 0.62. It is important to note that these demographic data do not directly correspond to the participants in the present study. However, they represent the same group of individuals that were asked to complete the cultural competency surveys related to the present study.

All participants were at least 18 years of age. Participants were required to have a basic understanding of the English language and to be able to read English, as the questionnaire and other materials were presented in English.

Instrumentation

Staff were asked to complete a survey entitled *Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Needs and their Families* (Goode, 2000) (Appendix A). The scale was designed both to assess cultural competence in a variety of areas, and to promote competence though increasing workers' awareness of their own beliefs and practices. The National Center for Cultural Competence in Washington D.C. has not yet conducted any psychometric tests on this survey, including tests of reliability and validity (National Center for Cultural Competence, personal communication, March 19, 2003). No psychometric information pertaining to this survey was found in the professional literature. This limits the strength of the research findings and conclusions. The survey consisted of 32 statements reflecting cultural competency. Participants were asked to respond to each statement with either *frequently*, *occasionally*, or *rarely/never*. The survey contained a statement informing participants that there were no right answers. As defined by the survey, the competency statements fall under three general categories: (a) Physical Environment, Materials, and Resources; (b) Communication Styles; and (c) Values and Attitudes. Some of the cultural competency statements involve action, while others require only certain values and/or understanding. The statements appear to reflect the awareness, knowledge and skills components of the Multicultural Counseling Competencies (Arredondo et al., 1996; Sue et al., 1992). Some competency statements describe a respect of cultural influences and differences, which would fall under the general competency of awareness. Other statements describe certain knowledge and understanding of cultural differences,

reflecting the knowledge component of cultural competency. Certain culturally competent behaviours are also described in the survey, which would fall under the category of culturally competent skills.

Managers were asked to complete an additional survey, entitled *Cultural Competence Standards in Mental Health Care Delivery Systems for Underserved/Underrepresented Racial/Ethnic Groups: Self-Assessment for Managers* (Appendix B), which was based on the document entitled, *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups* (Center for Mental Health Services, 2001) (the parts of which were used are included in Appendix C). The standards within this document are taken to be the ideal or gold standard guiding principles for cultural competence relating to managed care mental health services. These standards were attached to the survey. This survey was developed in order to map managers' awareness of existing organizational policies and procedures relating to cultural competence. This survey was created for the purposes of this study by a researcher at the mental health facility, and there is not yet any psychometric information on this instrument. Again, this limits confidence in the research findings and conclusions. Participants were provided with, and asked to use as reference, detailed definitions of each cultural competency standard with the survey. The survey asks managers to "place a check mark in the columns representing the various levels of organization where evidence of the above statement is in operation." The various categories and levels at which cultural competence is in evidence were inherent within the instrument.

There were seventeen cultural competency standards that fell under four main categories: (a) Cultural Competence Guiding Principles, (b) Overall System Standards and Implementation Guidelines, (c) Clinical Standards and Implementation Guidelines, and (d) Provider Competencies. Under Overall System Standards and Implementation Guidelines there were the following areas: Cultural Competence Planning; Governance; Prevention, Education, and Outreach; Quality Monitoring and Improvement; Decision Support and Management Information Systems; and Human Resource Development. Clinical Standards and Implementation Guidelines included the areas of Access and Service Authorization; Triage and Assessment; Care Planning; Plan of Treatment; Treatment Services; Discharge Planning; Case Management; Communication Styles and Cross-Cultural Linguistic and Communication Support; and Self Help. Provider Competencies consisted of the managers' assessment of the Knowledge, Understanding, Skills, and Attitudes of the mental health service providers working for the organization.

Managers were asked if evidence of certain standards were evidenced in each of four organizational levels, including (a) Administration, (b) Tertiary Care Setting, (c) Community-Based Service, and (d) Existing Links with Community-Based Organizations. This reflects the need to assess cultural competency at various levels of an organization.

The managers' survey was designed to assess key components of culturally competent organizations, including being flexible, being responsive, self-examination, and building cultural diversity into organizational structures and processes (Barr & Strong, 1987; Sue et al., 1998). In addition, it assesses important methods of increasing

and maintaining an organization's cultural competence, including building support, facilitating leadership, developing policies, and implementing change via administrative procedures (Sue et al., 1998).

Research Design

The frequency of responses for each statement was calculated using data from the managers and data from individual staff. These frequencies formed the basis for exploring the individual and organizational strengths and weaknesses in cultural competency. Some participants responded *not applicable*, even though this choice was not present in the survey. These responses were not included when using the frequencies for exploring strengths and areas for improvement relating to cultural competency.

The cutoffs for competency levels have not been determined in the professional literature for the survey entitled *Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Health Needs and their Families* (Goode, 2000). The behaviours, attitudes, and values assessed by the surveys are meant to reflect cultural competence. Ideally, in a culturally competent organization, all of the employees would report engaging in such behaviours and holding such attitudes and values consistently, or frequently. Any statement where two-thirds or more of participants reported that they displayed that particular competency *frequently* was deemed to be a strength of the organization. Having one hundred percent of participants respond to any particular item as *frequently* is unrealistic at this point, and two-thirds is sufficient to indicate that a strong majority of employees are culturally competent according to that item. Any statement where two-thirds or more of participants reported that they displayed

that particular competency *occasionally* and/or *rarely/never* was deemed to be an area of cultural competency that required improvement. This indicates that a strong majority of participants are not frequently engaging in the behaviour or holding a particular attitude, and that there is room for improvement regarding that particular item.

The aggregated or summed frequencies of responses were calculated. These aggregated frequencies were used as the basis of Pearson's product-moment correlations of each of the response categories (*frequently*, *occasionally*, *rarely/never*, and *not applicable*) to each other.

Factor analyses were conducted to determine the underlying factor structure of the survey. This was important, because no factor analyses or other psychometric tests have yet been conducted on the Goode's (2000) *Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Health Needs and their Families* (National Center for Cultural Competence, personal communication, March 19, 2003). Exploratory factor analyses were conducted on the individual staff data. Confirmatory factor analyses were conducted to determine what number of factors produced the most statistically and logically sound model. Any variables that did not load clearly onto one factor or that had a factor loading of less than .50 were excluded. Another confirmatory factor analysis on the remaining variables was conducted. The Varimax method of factor rotation was chosen. The Varimax method is a common method that is often used as a default method of factor rotation. Varimax disperses the maximum amount of variance across factors while simultaneously trying to obtain simple structure. It is acknowledged that the factors would likely be correlated with each other,

however this method was chosen in order to find factors that were as independent from each other as possible. The rotated factor matrixes were used for interpretation, in order to ease interpretation of the factors and how variables loaded onto the factors. Correlations were computed between the resulting factors. Correlations were also computed to determine what relationship existed between all of the variables within each factor.

A Chi-Square was conducted on the summed value scores for each of the resulting Factors. The data was split into High and Low categories based on the average of the summed value scores for each factor.

There were an insufficient number of responses in the managers' data to be able to perform any statistical analyses. Some general overall indications, strengths, and areas for improvement were suggested based on data response frequencies.

Chapter Summary

This chapter describes the methods that were used to evaluate a mental health facility's cultural competence and to further explore the construct of cultural competence as it was measured in this study. This study examined frequencies to explore strengths and areas for improvement, factor analyses to explore factors underlying the survey, and correlations to examine the relationship between factors and individual statements, or variables. Participants were individual pediatric mental health service providers and managers at a Western Canadian mental health facility. The researcher received the data for analysis after it had been collected by the mental health facility as part of a routine

operational survey, and had no part in the sampling procedures, data collection, and choice of instrumentation. Chapter Four outlines the results of this investigation.

CHAPTER FOUR: RESULTS

This chapter presents the findings of this study. This study utilized factor analyses, correlations, and frequencies to evaluate a mental health facility's cultural competence and to further explore the construct of cultural competence. First, factor analyses were conducted to explore factors that might underlie the survey utilized in this study. Next, the relationship between the factors was examined. Finally, frequencies were utilized to evaluate the performance cultural competence of individual mental health workers and the organization as a whole, and to explore areas of strengths and areas for improvement in such performance.

Individual Mental Health Service Providers' Data

As outlined in Chapter Three, individual mental health service providers completed a survey entitled *Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Health Needs and their Families* (Goode, 2000), which assessed individual cultural competence in: (a) Physical Environment, Materials, and Resources; (b) Communication Styles; and (c) Values and Attitudes. The responses that participants could choose included: (a) Things I do *frequently*, (b) Things I do *occasionally*, or (c) Things I do *rarely/never*. A number of participants responded to some items with *not applicable*, although this was not a survey option. The researcher was interested in participant responses in cases where the statements could actually apply to the experience and practice of the individual mental health service providers, and chose to analyze only those responses where participants reported that the statements

were applicable to them. All responses of *not applicable* were excluded from statistical analyses.

Factor Analysis

All factor analyses used the Varimax method of factor rotation. An exploratory factor analysis was conducted on the individual staff data. This led to nine factors that accounted for 68.25 % of the variance. However, this led to a large number of factors and the factors accounted for an insufficient percentage of variation in the data. A scree plot, depicting the Eigen values of each factor, dropped sharply after two and leveled off after four factors, suggesting the presence of between two and four factors. Factor analyses were conducted with two, three, and four factors. Four factors accounted for 46.54 % of the total variance, and three factors accounted for 38.63 % of the total variance. Rotated component matrixes were examined. When examining which statements/variables loaded on each factor, cohesive and logical interpretation was difficult.

The factor analysis for two factors accounted for only 35.15% of the variance. However, the manner in which the statements were formed into the two factors was clear and logical. One factor almost entirely consisted of items requiring some sort of action, and the other consisted of items that required no action, and appeared to reflect culturally competent beliefs, values, and attitudes. The researcher chose to further explore the two-factor model. In a factor analysis, each variable should load onto one factor. Variables that loaded nearly equally onto both factors were removed. Variables should also load onto a factor with a value of at least .50, and ideally over .60 or .70. Variables that had factor loadings of .50 or less were also removed. Another factor analysis searching for

two factors was conducted with the remaining items. These factors were named Action and Attitudes, respectively. The resulting final factor matrix with two factors, Action and Attitudes, accounted for 48.37 % of the total variance, with Action accounting for 25.32% and Attitudes accounting for 23.05% of the variance. See Table 1 for a listing of survey items that loaded onto the Action factor and Table 2 for a listing of items that loaded onto the Attitudes factor.

Table 1

Survey Items Loading onto the Action Factor

Item	Item Description
1	I display pictures, posters, and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.
2	I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.
3	When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.
4	When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.
5	I insure that toys and other play accessories in reception areas and those which are used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.
7	I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions.
8	I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

Table 1

Survey Items Loading onto the Action Factor

Item	Item Description
9	I use bilingual staff or trained volunteers to serve as interpreters during assessment, meetings, or other events for parents who would require this level of assistance.
10c	When interacting with parents who have limited English proficiency I always keep in mind that they may or may not be literate in their language of origin or English.
15	I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency.
28	Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.
29	I seek information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.
30	I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

The Pearson's product-moment correlation on the two factors, Action and Attitudes, was .00. This indicates that there is no relationship, either positive or negative between the two factors. In other words, they are completely independent of each other. Pearson's product-moment correlations were computed between each variable within the Action factor and an overall Action factor score. As would be expected, each variable, or

Table 2

Survey Items Loading onto the Attitudes Factor

Item	Item Description
13	I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
20	I understand that age and life cycle factors must be considered in interactions with individuals and families.
22	I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.
23	I accept that religion and other beliefs may influence how families respond to illnesses, disease, and death.
25	I understand that traditional approaches to disciplining children are influenced by culture.
26	I understand that families from different cultures will have different expectations of their children for acquiring toiling, dressing, feeding, and other self help skills.
27	I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

item, was significantly and positively related to the factor, $p < .001$. Pearson's product-moment correlations were computed between for all variables within the Action factor (see Table 3). All of the resulting correlations were positive. The coefficients ranged from $r = .10, p = .36$ to $r = .72, p < .001$. Over two-thirds of the correlations were significant at $p < .05$. A common statistical rule of thumb asserts that correlations below .35 are of low strength, those between .35 and .65 are of moderate strength, and those

Table 3

Correlations between the Survey Items within the Action Factor

Item	1	2	3	4	5	7	8
1	1.00	.72***	.57***	.39**	.39**	.25*	.24*
2	.72***	1.00	.49***	.27*	.39**	.15	.19
3	.57***	.49***	1.00	.43***	.39**	.30**	.31**
4	.39**	.28*	.43***	1.00	.27*	.18	.15
5	.39**	.39**	.39**	.27*	1.00	.41***	.41***
7	.25*	.15	.30**	.18	.41***	1.00	.31**
8	.24*	.19	.31**	.15	.41***	.31**	1.00
9	.18	.16	.29*	.39**	.25*	.38**	.40***
10c	.10	.19	.06	.26*	.32**	.12	.40***
15	.32**	.32**	.40***	.24	.42***	.21*	.19
28	.21	.21	.31**	.27*	.38**	.47***	.23*
29	.20	.31**	.13	.20	.24*	.31**	.25*
30	.30**	.35**	.19	.26*	.19	.20	.18

Note. * $p < .05$, two-tailed. ** $p < .01$, two-tailed. *** $p < .001$, two-tailed.

Table 3

Correlations between the Survey Items within the Action Factor

Item	9	10c	15	28	29	30
1	.18	.10	.32**	.21	.20	.30**
2	.16	.19	.32**	.21	.31**	.35**
3	.29*	.06	.40***	.31*	.13	.19
4	.39**	.26*	.24	.27*	.20	.26*
5	.25*	.32**	.42***	.38**	.24*	.19
7	.38***	.12	.21*	.47***	.31**	.20
8	.40***	.40***	.19	.23*	.25*	.18
9	1.00	.42***	.21	.43***	.47***	.28*
10c	.42***	1.00	.18	.22	.26*	.15
15	.21	.18	1.00	.35**	.29*	.23*
28	.43***	.22	.35**	1.00	.38**	.39**
29	.47***	.26*	.29*	.38**	1.00	.38**
30	.28*	.15	.23*	.39**	.38**	1.00

Note. * $p < .05$, two-tailed. ** $p < .01$, two-tailed. *** $p < .001$, two-tailed.

above .65 are of high strength. According to this rule, the majority of the correlations between the items within the Action factor were of low and moderate strength.

Pearson's product-moment correlations were also computed for all variables within Attitudes and a factor score for Attitudes itself. As would be expected, each variable, or item, was significantly and positively related to the factor, $p < .001$. Pearson's product-moment correlations were also computed for all variables within the Attitudes factor (see Table 4). This resulted in 21 possible correlations, which, similar to the correlations between the variables on the Action factor, were all positive. The coefficients ranged from $r = .26$, $p < .05$ to $r = .61$, $p < .001$. All correlations between the variables that loaded onto the Attitudes factor were significant at $p < .05$. According to a previously mentioned statistical rule of thumb, the majority of the correlations between the survey items within the Attitudes factor were moderate in strength.

Table 4

Correlations between the Survey Items within the Attitudes Factor

Item	13	20	22	23	25	26	27
13	1.00	.40***	.41***	.37***	.26*	.49***	.33**
20	.40***	1.00	.43***	.50***	.38***	.44***	.40***
22	.41***	.43***	1.00	.51***	.42***	.61***	.36***
23	.37***	.50***	.51***	1.00	.57***	.50***	.43***
25	.26*	.38***	.42***	.57***	1.00	.54***	.52***
26	.49***	.44***	.61***	.50***	.54***	1.00	.45***
27	.33**	.40***	.36***	.43***	.52***	.45***	1.00

Note. * $p < .05$, two-tailed. ** $p < .01$, two-tailed. *** $p < .001$, two-tailed.

Relationship of Action and Attitudes

The researcher explored the relationship between the Action and Attitudes factors via a 2 X 2 Chi-Square analysis (see Table 5). Two new variables were created in order to compare participants' performance on the Action and Attitude factors. A sum of participants' Action variable scores and a sum of their Attitude variable scores were created. The resultant summed scores were adjusted for missing values, which included *not applicable* responses. Some cases were excluded due to the number of missing values they had. All cases that did not have responses for over half of the Action factor variables (at least 7 out of 13) as well as responses for over half of the Attitude factor variables (at least 4 out of 7) were excluded. This resulted in an exclusion of 7 out of 98 cases. The researcher wished to compare high and low scorers on Action to high and low scorers on Attitudes. An attempt was made to split the data in half by finding the median and considering values above the median as high and values below the median as low. However, when frequencies were conducted, 69.8% of participants had a summed Attitudes score of 7.00, which was also the median value of the summed Attitudes scores. Therefore, a median split was not possible. The average value of both the summed Action and the summed Attitudes scores were calculated. All values below the average were categorized as low and all values above the average were categorized as high, for both the summed Action and the summed Attitudes variables.

The Pearson Chi-Square value was 3.13 (*df* 1), with a statistical significance (Fisher's Exact Test) = .11. The Chi-Square was not statistically significant. However, its results and patterns are worth reporting. Those participants who scored within the low

range on the Attitudes Factor tended to score within the low range on the Actions factor as well. Those participants who scored within the high range on the Attitudes Factor tended to score within the high range on the Actions factor as well.

Table 5

Chi-Square Analysis of Relationship between Action and Attitudes Factors

			Action		
			High	Low	Total
	High	Count	39	25	64
		% within Attitudes	60.9%	39.1%	100.0%
		% within Action	78.0%	61.0%	70.3%
		% of Total	42.9%	27.5%	70.3%
Attitudes	Low	Count	11	16	27
		% within Attitudes	40.7%	59.3%	100.0%
		% within Action	22.0%	39.0%	29.7%
		% of Total	12.1%	17.6%	29.7%
	Total	Count	50	41	91
		% within Attitudes	54.9%	45.1%	100.0%
		% within Action	100.0%	100.0%	100.0%
		% of Total	54.9%	45.1%	100.0%

Individual Cultural Competence Strengths and Areas for Improvement

The strengths and areas for improvement of the mental health service providers were explored based on frequencies of responses, which are presented below in Table 6.

Table 6

Frequencies of Responses to Individual Cultural Competence Survey

		Frequently	Occasionally	Rarely or Never	Not applicable
PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES					
1	I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency	13	34	37	14
2	I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency	12	25	36	25
3	When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency	22	36	24	16
4	When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency	20	15	31	32
COMMUNICATION STYLES					
5	I insure that toys and other play accessories in reception areas and those which are used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general	26	23	33	16
6	For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions	35	39	19	5

		Frequently	Occasionally	Rarely or Never	Not applicable
COMMUNICATION STYLES					
7	I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions	53	39	2	4
8	I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency	63	25	6	4
9	I use bilingual staff or trained volunteers to serve as interpreters during assessment, meetings, or other events for parents who would require this level of assistance	40	26	17	15
10	When interacting with parents who have limited English proficiency I always keep in mind that:				
a	* Limitations in English proficiency is in no way a reflection of their level of intellectual functioning	95	2	0	1
b	* Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin	94	3	0	1
c	* They may or may not be literate in their language of origin or English	83	10	2	3
11	When possible, I insure that all notices and communiqués to parents are written in their language of origin	22	21	43	12
12	I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information	52	31	8	6
VALUES & ATTITUDES					
13	I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own	87	11	0	0
14	In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others	85	6	3	4
15	I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency	54	27	10	7
16	I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity or prejudice	54	34	3	5
17	I understand and accept that family is defined differently by different cultures	93	3	0	0

		Frequently	Occasionally	Rarely or Never	Not applicable
VALUES & ATTITUDES					
18	I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture	91	5	0	0
19	I accept and respect that male-female roles in families may vary significantly among different cultures	81	15	0	0
20	I understand that age and life cycle factors must be considered in interactions with individuals and families	89	7	0	0
21	Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children	85	9	0	2
22	I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures	86	10	0	0
23	I accept that religion and other beliefs may influence how families respond to illnesses, disease, and death	88	8	0	0
24	I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs	81	13	1	1
25	I understand that traditional approaches to disciplining children are influenced by culture	83	12	0	1
26	I understand that families from different cultures will have different expectations of their children for acquiring toilet training, dressing, feeding, and other self help skills	84	11	1	0
27	I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture	81	13	0	2
28	Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency	30	40	5	21
29	I seek information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency	55	37	1	3
30	I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence	29	43	21	3

Individual cultural competence strengths. The strengths of the mental health service providers were based on frequencies of responses. Any statement where two-thirds or more of participants reported that they displayed that particular competency *frequently* was deemed to be a strength of the mental health service providers. Having one hundred percent of participants respond to any particular item as *frequently* is unrealistic at this point, and two-thirds is sufficient to indicate that a strong majority of employees are culturally competent according to that item. A list of the items that were determined to be strengths is presented in Table 7.

Table 7

Individual Cultural Competence Strengths

Item	Item Description
8	I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.
	When interacting with parents who have limited English proficiency I always keep in mind that:
10a	Limitations in English proficiency is in no way a reflection of their level of intellectual functioning.
10b	Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
10c	They may or may not be literate in their language of origin or English.
13	I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
14	In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

Table 7

Individual Cultural Competence Strengths

Item	Item Description
17	I understand and accept that family is defined differently by different cultures.
18	I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
19	I accept and respect that male-female roles in families may vary significantly among different cultures.
20	I understand that age and life cycle factors must be considered in interactions with individuals and families.
21	Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.
22	I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.
23	I accept that religion and other beliefs may influence how families respond to illnesses, disease, and death.
24	I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs.
25	I understand that traditional approaches to disciplining children are influenced by culture.
26	I understand that families from different cultures will have different expectations of their children for acquiring toilet training, dressing, feeding, and other self help skills.
27	I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

The mental health service providers had a far greater number of strengths (over twice as many) than areas for improvement. Nearly all of the strengths (13 of 17) fell under the survey category of Values and Attitudes. From an examination of the items, it appears that nearly all of the strengths, no matter what survey category they are from, are based on knowledge/understanding, values, and/or attitudes. Only three (items 8, 13, and 14) seem to be based on any sort of action on the part of the mental health service provider. Two items fall under the Action factor and seven items fall under the Attitudes factor. It appears that the mental health service providers that participated in this study have some cultural competency strengths that are related to action, but that most relate to values, attitudes and knowledge/understanding.

Potential areas for improvement for individual cultural competence. The areas in need of improvement of the mental health service providers were explored based on frequencies of responses. Any statement where two-thirds or more of participants reported that they displayed that particular competency *occasionally* and/or *rarely/never* was deemed to be an area of cultural competency that may require improvement. This indicates that a strong majority of participants are not frequently engaging in the behaviour or holding a particular attitude or value, and that there is room for improvement regarding that particular item. A list of the items that were determined to be areas for improvement is presented in Table 8.

Over half of the areas that may need improvement (4 of 7) fell under the survey category of Physical Environment, Materials and Resources; two fell under Communication Styles; and one fell under Values and Attitudes. From an examination of

Table 8

Individual Cultural Competence Potential Areas for Improvement

Item	Item Description
1	I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.
2	I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.
3	When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.
4	When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.
5	I insure that toys and other play accessories in reception areas and those which are used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.
11	When possible, I insure that all notices and communiqués to parents are written in their language of origin.
30	I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

the items, it appears that all of the items that may require improvement, no matter what survey category they are from, are based on some sort of action. Six out of seven of the areas for improvement are from the Action factor. It appears that the cultural competence of the mental health service providers that participated in this study may require

improvement in some areas, all of which relate to action, and most of which relate to their physical environment, materials, and resources.

Not Applicable Responses

Although the *not applicable* responses were excluded from the statistical analyses, they are still reported in Table 6. The number of *not applicable* responses per item ranged from 0 to 29. The highest number of *not applicable* responses was under the survey category of Physical Environment, Materials, and Resources, with an average of 19.50 *not applicable* responses per item. There was an average of 5.30 *not applicable* responses per item under the Communication Styles category and an average of 3.61 *not applicable* responses per item under the Values and Attitudes category. On average, there were more *not applicable* responses under the Action factor (average of 10.31 not applicable responses per item) than under the Attitudes factor (average of 4.57). It appears that the number of *not applicable* responses is higher for the Physical Environment, Materials and Resources category and the Action factor than for the other survey categories and the Attitudes factor.

There is a positive relationship between the overall number of *rarely/never* responses and the overall number of *not applicable* responses. Pearson's product-moment correlations were conducted between each of the response categories. The overall number of *not applicable* responses correlated strongly with the overall number of *rarely/never* responses, $r = .77$, $p < .001$. In addition, the overall number of *not applicable* responses correlated strongly and negatively with the overall number of *frequently* responses, $r = -.82$, $p < .001$.

Manager's Data

Six managers completed and returned the survey entitled *Cultural Competence Standards in Mental Health Care Delivery Systems for Underserved/Underrepresented Racial/Ethnic Groups: Self-Assessment for Managers*, which assessed managers' awareness of existing organizational policies and procedures relating to cultural competence. The managers were each asked to report on 17 areas of competence at each of 4 levels of the organization. This left 68 squares or categories for analysis, and 6 participants provided an insufficient number of responses in the managers' data to be able to perform adequate statistical analyses. The managers' data was examined based on frequencies of response data, which are presented in Table 9.

Most of the areas of cultural competency at each level (a total of 68 categories) were endorsed by zero (17 out of 68 categories, or 25.00%), one (24 categories, or 35.29%), or two (14 categories, or 20.59%) managers. The largest number of endorsements of areas of cultural competence was at the level of Community-Based Service. An average of 3.12 managers reported awareness of competency in each of the 17 areas within the level of Community-Based Service. The average number of managers reporting awareness of competency in each of the 17 areas within the level of Administration was 1.59, within Tertiary Care Setting was 1.06, and within Existing Links with Community-Based Organizations was 0.24. Provider Competencies appeared to be a relative strength for the organization, an average of 2.50 managers endorsed this area of competency at each organizational level that was assessed. There appears to be a major need for improvement in cultural competence as it relates to Existing Links with

Table 9

Frequencies of Responses to Organizational Cultural Competence Survey

	Administration	Tertiary Care Setting	Community-based Service	Existing Links with community-based organizations
I. Cultural Competence Guiding Principles				
Exist and are apparent	2	1	2	0
II. Overall System Standards and Implementation Guidelines				
Cultural Competence Planning s	3	1	2	0
Governance	2	1	3	0
Prevention, Education, and Outreach	1	1	2	0
Quality Monitoring and Improvement	3	0	2	0
Decision Support and Management Information Systems	1	1	1	0
Human Resource Development	2	1	3	0
III. Clinical Standards and Implementation Guidelines				
Access and Service Authorization	1	1	4	1
Triage and Assessment	2	2	6	2
Care Planning	1	2	3	0
Plan of Treatment	1	1	4	0
Treatment Services	1	1	6	0
Discharge Planning	1	1	4	0
Case Management	1	1	4	0
Communication Styles and Cross-cultural Linguistic and Communication Support	2	1	2	0
Self Help	0	0	1	0
IV. Provider Competencies				
Knowledge, Understanding, Skills, and Attitudes	3	2	4	1

Community-Based Organizations. Only three (18%) areas of competence with regards to links with community-based organizations were endorsed: Access and Service Authorization (by one manager); Triage and Assessment (by two managers); and

Knowledge, Understanding, Skills, and Attitudes (by one manager). There appeared to be room for improvement in the area of Self Help, as only one manager endorsed the existence of that area of cultural competency, and only at the level of Community-Based Service.

Chapter Summary

This chapter presents the findings of this study. This study utilized factor analyses, correlations, and frequencies to evaluate a mental health facility's cultural competence and to further explore the construct of cultural competence.

First, the individual mental health service provider data was analyzed. Two factors were uncovered that accounted for 48.37% of the total variance. The Action factor almost entirely consisted of cultural competency statements that require some sort of action, and the Attitudes factor consisted of statements that appeared to reflect culturally competent knowledge/understanding, values, and attitudes. The Action factor accounted for 25.32% of the total variance, and the Attitudes factor accounted for 23.05 % of the total variance. The factor analysis was conducted using a Varimax method of rotation, which maximizes the difference between any resulting factors. The two factors were, indeed, completely independent of each other. As would be expected, each item/variable within each factor was significantly and positively related to the factor, $p < .0001$. All of the variables within the Action factor were positively related to each other; sixty-eight percent of the correlations were significant at $p < .05$. All of the variables within the Attitudes factor were positively and significantly related to each other, $p < .05$.

A Chi-Square was conducted to explore the relationship between the Action and Attitudes factors. Summed values scores were calculated for each factor, and the data was split into High Action vs. Low Action, and High Attitudes vs. Low Attitudes, based on values above and below the average summed value score for each factor. The Pearson Chi-Square value was 3.13, and was not statistically significant ($p = .11$). Results suggest that culturally competent Actions and Attitudes are positively related to each other. Those participants who scored within the low range on the Attitudes Factor tended to score within the low range on the Actions factor. Those participants who scored within the high range on the Attitudes Factor tended to score within the high range on the Actions factor.

Most of the cultural competency strengths of the individual mental health service providers seem to relate to values, attitudes and knowledge/understanding. It appears that the cultural competence of the mental health service providers that participated in this study requires improvement in some areas, all of which relate to action, and most of which relate to physical environment, materials, and resources.

It appears that the number of *not applicable* responses is higher for the Physical Environment, Materials and Resources category and the Action factor than for the other survey categories and the Attitudes factor. The *not applicable* responses correlated positively and significantly with the *rarely/never* responses and negatively and significantly with the *frequently* responses.

Second, the managers' data was examined based on frequencies. There was an insufficient amount of data to be able to conduct more complex statistical analyses. Most of the areas of cultural competency at each organizational level were endorsed by zero,

one, or two of the six participating managers. The organizational level of Community-Based Service, and the cultural competency area of Provider Competencies appeared to be relative strengths for the mental health facility. The cultural competency area of Self Help and the organizational level of Existing Links with Community-Based Organizations appear to require improvement.

CHAPTER FIVE: DISCUSSION

Mental health service providers need to respond to the needs of Canada's ethnically diverse population. They must provide ethnically diverse individuals with effective, appropriate, and satisfactory mental health care. This consists of both individual and organizational cultural competence. This research provided the first step in increasing the cultural competence of a pediatric mental health service facility by assessing its individual and organizational cultural competence. This study helped to identify potential strengths and areas that require improvement at the individual and organizational levels of cultural competence. This awareness will enable the mental health service facility to better utilize its strengths as well as specifically target its areas for improvement in future interventions to improve its competence. The data will also provide a baseline that will help the organization to empirically evaluate different methods that it may implement to increase its cultural competence. There is a need for increased description and understanding of the cultural competence of Canadian mental health service providers (Arthur & Januszkowski, 2001) and of cultural competence relating to ethnically diverse youth (APA Multicultural Conference, as cited in Casas et al., 2001). This study contributes to the professional literature by reporting on and increasing the knowledge about Canadian pediatric mental health service providers.

This chapter discusses the findings of the current study and connects them to the existing literature in the area of cultural competence. The main findings are listed, and then discussed individually in detail. The limitations and strengths of the present study are reviewed. Implications of the findings for mental health service providers,

organizations that deliver mental health services, and the general field of counselling are discussed. The strengths and limitation of the study are reviewed, and future research suggestions are outlined. The chapter ends with a presentation of the major conclusions of the study.

Main Findings

The main findings of the study include the following:

1. Two factors, Action and Attitudes, underlie individual cultural competence as it is assessed by the survey.
2. The performance of individuals on Attitudes and Action tend to be in the same direction.
3. Individual strengths seem to be mainly related to attitudes/values.
4. Competence relating to Action appears to require the most improvement.
5. Responses include a number of *not applicable* responses, mainly under the Action factor.
6. Overall, the organizational competence appears to require improvement.
7. The organizational strengths appear to be Provider Competencies and Community-Based Service.
8. Self Help and Existing Links with Community-Based Organizations may require the most improvement in the area of organizational cultural competence.

Each of these findings will be discussed in this chapter, along with their implications.

Discussion of Main Findings

Action and Attitudes Factors

This study suggests that two factors underlie the individual cultural competence of pediatric mental health service providers, as assessed by the *Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Health Needs and their Families* (Goode, 2000). One component of this cultural competence, termed the Attitudes factor, consisted of cultural competence statements that required no action, and appeared to reflect culturally competent beliefs, values, and attitudes. Specifically, this factor included an avoidance of imposing one's values onto culturally diverse clients. The majority of statements within this factor related to acknowledging that many beliefs, values, and practices vary across cultures. This avoidance of value imposition and acknowledgement of cultural differences is likely to help fight ethnocentrism. Expressions of ethnocentrism have resulted in misunderstanding, exoticizing, or disregarding the psychologies and realities of non-Western societies (Gergen et al., 1996). Ethnocentrism may also result in misunderstandings, misdiagnoses, and inappropriate and/or ineffective treatment of culturally diverse clients. Self-awareness helps to prevent practitioners' values and biases from interfering with their ability to work effectively with culturally diverse clients (Sue et al., 1992). Culturally competent Attitudes may help fight ethnocentrism by reminding practitioners that their beliefs, values, and customs form only one way of living in this world, and one that is not inherently better than any other method chosen by culturally diverse clients. This acknowledgment specified no action as a result of such understanding. Staff only needed

to know such differences existed, and did not have to adapt their services accordingly. The Attitudes component of cultural competence seems to be personal, internal, and largely passive. An important component of pediatric cultural competence appears to be acknowledging that cultural differences exist and avoiding imposing values on clients.

The Attitudes factor seems to relate to the self-awareness and knowledge competencies proposed by the multicultural counselling literature (Arredondo et al., 1996; Sue et al., 1992; Sue et al., 1998). It reflects an awareness that individuals from diverse cultures may not share one's own beliefs and values. Some statements also reflect a personal acceptance of such diversity. This connection with the self-awareness component of cultural competency is important because therapist self-awareness may be seen as a prerequisite to the development of culturally competent knowledge and skills (Sue et al., 1992; Sue et al., 1996). The Attitudes factor also appears to reflect the knowledge dimension of cultural competence, as it assesses general knowledge of cultural differences (Arredondo et al.; Sue et al., 1992; Sue et al., 1998).

The other major component of pediatric mental health cultural competence uncovered by this particular study was an Action factor, which almost entirely consisted of cultural competence statements that required some sort of action. It included cultural competency statements relating to the Physical Environment, Materials and Resources. Such statements dealt specifically with ensuring that culturally diverse posters, brochures, toys, films, and food are available to children and families being served. Communication Styles also formed part of the Action factor. It included using some awareness of communication issues and the use of interpreters and other communication aids with

children and families who have limited English proficiency. Seeking information about diverse cultures before providing services in the home setting and in order to adapt services to diverse needs was a part of the Action factor. The Action factor also included advocacy within the organization for organizational cultural competency. Culturally competent action may consist of ensuring that (a) the physical environment and materials provided are culturally sensitive and representative, (b) children and families with limited English proficiency understand communication, (c) seeking knowledge about diverse cultures, and (d) advocating for organizational cultural competency. Culturally competent action may require effort beyond what most practitioners are required to do when serving individuals from dominant cultural backgrounds. These aspects of cultural competency appear to be strongly connected with the organization's ability to support such competencies. The amount of funding and resources available would likely have a major influence on the ability of staff to have these competencies. This study suggests that an important component of cultural competency consists of taking concrete and observable action towards providing culturally competent services.

The Action factor appears to correspond mostly with the skills dimension of multicultural counselling competency (Arredondo et al., 1996; Sue et al., 1992; Sue et al., 1998). Having knowledge inform practice, creating a culturally sensitive environment, and communicating effectively with culturally diverse clients may all definitely be seen as culturally competent skills. Culturally appropriate communication within the therapy process is integral to the skills component of cultural competence. Culturally competent skills include an ability to flexibly engage in a variety of verbal and nonverbal helping

styles (Sue et al., 1992). Culturally competent practitioners are able to communicate with culturally diverse clients and to send and receive messages both accurately and appropriately (Sue et al., 1992). It is also important for practitioners to value bilingualism and not to view another language as detrimental to therapy (Sue et al., 1992). The Action factor also mentions seeking culture-specific information about beliefs, customs, values, expectations and needs to inform one's service of individuals from particular cultural backgrounds, which corresponds with the knowledge dimension of cultural competence (Arredondo et al.; Sue et al., 1992; Sue et al., 1998).

This study provided some support for the tripartite model of cultural competence, which consists of the self-awareness, knowledge, and skills domains (Arredondo et al., 1996; Sue et al., 1992; Sue et al., 1998), which are outlined in detail in Chapter Two. It appears that the skills component of cultural competence is quite distinct from the attitudes and knowledge components. The distinction between the awareness and knowledge components of cultural competence was less clear. This is almost certainly because the items within the *Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Needs and their Families* were not based on the tripartite model of cultural competence and did not clearly distinguish between awareness and knowledge aspects of competence. The Attitudes factor primarily reflects the awareness and knowledge components of cultural competence, while the Action factor primarily reflects the skills component. The Attitudes and Action factors do not appear to correspond with any of the added or revised cultural competence dimensions in models that build upon Sue et al.'s (1992) model. These models include the work of Constantine

and Ladany (2001) and Sodowsky et al. (1994), which added other dimensions of cultural competence that are not directly addressed by Sue et al. (1992), including counsellor self-efficacy and the counselling relationship.

The fact that the two factors do not completely coincide with Sue et al.'s (1992) Multicultural Counseling Competencies might be explained in a number of different ways. Self-awareness was not revealed as a factor in this study, and this is likely due to the fact that the questionnaire itself barely assessed this concept as it is defined by Sue et al. (1992). The survey utilized was not based on Sue et al.'s (1992) work and did not cover the same components of cultural competence that they proposed. Therefore, it is not surprising that this study provided only partial support for Sue et al.'s (1992) model of cultural competence. Studies based on Sue et al.'s (1992) work on cultural competence have largely focused on adult populations. The factors uncovered by this study might be different from those proposed by Sue et al. because different factors underlie pediatric cultural competence than those that underlie adult cultural competence.

The study suggests that the cultural competence of pediatric mental health service providers is multidimensional. Both culturally competent attitudes and actions might be important components of the cultural competence of pediatric mental health service providers. Neither one alone seems sufficient for cultural competence. In this study, Attitudes and Actions were completely independent of one another in the factor analysis, which indicates that they might be completely different concepts. It is recommended that pediatric mental health service providers be aware of cultural differences, avoid imposing their values onto their clients, and move beyond such attitudes and take action to ensure

their physical environment, communication, services, and the overall organization they work within are culturally competent.

The Relationship of Culturally Competent Attitudes and Action

There appears to be a weak but positive relationship between the Attitudes and Action components of cultural competence as revealed by this study. The Chi-Square conducted on summed scores for both factors was not statistically significant. There was an 11% chance that the patterns found would be found by chance alone. Although not statistically significant, the results of the Chi-Square may still be reviewed as they suggest a trend for the relationship of the Attitudes and Action factors.

It appears that Actions and Attitudes relate to each other in a positive direction. Those participants who scored within the low range on the Attitudes Factor tended to score within the low range on the Actions factor as well. Those participants who scored within the high range on the Attitudes Factor tended to score within the high range on the Actions factor as well. One might expect that individuals who hold culturally competent attitudes would be more likely to engage in culturally competent actions. Conversely, one might also expect that individuals engaging in culturally competent actions are likely to hold culturally competent attitudes.

Culturally competent awareness, knowledge, and skills interact to help practitioners provide culturally competent services (Arredondo et al., 1996; Sue et al., 1992; Sue et al., 1998). Self-awareness may be seen as necessary for the understanding of diverse worldviews and having a range of culturally competent skills in one's repertoire (Sue et al., 1992; Sue et al., 1996). None of the competencies is a stand-alone construct;

all three are necessary for cultural competence (Arredondo et al.; Sue et al., 1992; Sue et al., 1998). Individuals usually strive to be congruent between their thoughts and actions, and it appears that this might also apply to the different components of cultural competence. This positive relationship might also suggest that increases in one area of cultural competence might increase competence in the other component.

There are various possible explanations for the non-significance of the Chi-Square attempting to relate the Attitudes and Actions factors. The analysis may not have been statistically powerful enough to discover a significant difference due to the insufficient number of participants. The way in which the data was split into high and low was also less than ideal, and may have influenced the significance of the Chi-Square. There was very little variation in the Attitudes scores, with 70.3% having the median score, which was a response of *frequently* to each Attitudes factor statement. Only 29.7% did not respond *frequently* to each statement, but still responded *frequently* to the majority of the attitudes being assessed. Splitting the Attitudes data into high and low based on individuals who responded *frequently* to each item vs. those responding *frequently* to nearly every item likely did not provide enough variation for a Chi-Square based on such a division to be significant.

Individual Cultural Competence Strengths and Areas for Improvement

Nearly all of the cultural competency strengths of this sample seem to be related to knowledge/understanding, values, and/or attitudes. There were also a few strengths that may relate to culturally competent action. Values, attitudes, and knowledge may be seen as the basis for, or first steps towards, other forms of cultural competence (Sue et al.,

1992; Sue et al., 1996). Overall, the individual mental health workers at this facility appear to have culturally competent values, attitudes, and knowledge. These are mostly based on general awareness and some acceptance of cultural competency and diversity issues. The employees and organization seem to have done very well to gain competence in these areas. This suggests that employees are taking personal responsibility for their own values, attitudes, and knowledge relating to cultural competency. There are various possible reasons that the values, attitudes and beliefs appear to be strengths for the individual mental health workers. In its push for cultural competence, the organization may have initially focused on the development and/or maintenance of culturally competent values, attitudes, and knowledge. These areas might be easiest for the organization to increase and provide support for. Additionally, it might be easier to hold culturally competent values, beliefs and attitudes than it is to act in a culturally competent manner. One merely needs to think and reflect, which requires little overt effort. It might also be easier to develop and maintain culturally competent values, attitudes, and knowledge because they are solely one's own personal responsibility, and they do not require social or organizational support. It appears that the mental health service providers that participated in this study have some cultural competency strengths that are related to action, but that most relate to values, attitudes and knowledge/understanding.

All of the cultural competence items that may require improvement appear to be based on some sort of action. Approximately half of the items requiring some sort of culturally competent action appear to be in need of improvement. Every item that fell under the survey category of Physical Environment, Materials and Resources seemed to

require improvement. Two-thirds of staff reported using culturally representative and appropriate materials and resources only *occasionally* or *rarely/never*. It appears that more individual staff need to be using culturally representative films, food, printed materials, posters, pictures, and other materials. Another statement that might require improvement was ensuring that all notices and communiqués are written in the family's language of origin. These potential areas for improvement share a connection with organizational support. The ability of individual workers to ensure the cultural appropriateness of resources and that written materials are provided in languages of origin may require the support of organizational funding. There might also be time constraints underlying the inadequacy of these areas of competence. In addition, the above statements may not be required at the mental health facility; these goals may not be supported by clear policies and accountability. It appears that the majority of individual mental health providers at this facility do not advocate for organizational competence within the levels of policy and governance. Perhaps they do not feel that this is their responsibility, perhaps they do not feel that such advocacy would result in actual change, and perhaps they are not aware that this is another expression of cultural competence. It appears that the cultural competence of the mental health service providers that participated in this study may require improvement in some areas, all of which relate to action, and most of which relate to their physical environment, materials, and resources.

The results suggest that culturally competent beliefs, values, attitudes, and knowledge are easier to acquire and maintain than culturally competent actions. It may be difficult to move beyond internal competencies to external, observable competencies,

especially due to possible financial and time constraints. The facility appears to have a strong basis of culturally competent values, attitudes, beliefs, and knowledge. Effort and organizational support may help the continued improvement of the competence of individual workers in these areas. It appears that the facility might best spend its time, energy, and resources in improving the culturally competent actions of its workers, particularly those relating to the physical environment, materials, and resources.

Not Applicable Responses

A number of participants responded *not applicable* to the individual cultural competence items, although this was not one of the options provided on the questionnaire. The overall number of *not applicable* responses was higher for the Physical Environment, Materials and Resources category than for the Communication Styles and Values and Attitudes categories. The overall number of *not applicable* responses was also higher other for the Action factor than the Attitudes factor. Some items might simply not have applied to particular individuals completing the survey. For example, not all practitioners would visit or provide services in the home setting, so Item 28 pertaining to visitation would not apply to them. Or they might not ever use food in an assessment, so Item 4 pertaining to culturally diverse food would not be applicable. The actions inherent within one's job requirements as well as the physical environment and resources one works with are almost certain to differ from practitioner to practitioner. It is plausible that for some participants, the cultural competency statements in these areas simply did not apply to them. It is likely that there are fewer *not applicable* responses to the Values and Attitudes categories and the Attitudes factor because these are widely, and

in fact should always be, applicable. Perhaps some individuals reported that certain items were not applicable to them because they felt that these items were not in their control or not part of their responsibility. This would help explain the fairly large number of *not applicable* responses pertaining to physical environment, resources, and materials. These might be seen as the responsibility of the organization, and practitioners might not have the resources to be able to influence these areas of competence.

The *not applicable* responses correlated positively and significantly with the *rarely/never* responses and negatively and significantly with the *frequently* responses. This suggests that the items to which the majority of participants responded *frequently* are those that are more widely applicable. In addition, this finding suggests that some participants may have responded *rarely/never* because certain statements did not apply to them; not everyone may have thought of adding a not applicable category as they deemed fit. Frequency of engaging in various aspects of cultural competence may relate not only to cultural competence, but also to whether one has perceived control over that aspect or whether it is possible to have that particular competence.

There are several potential reasons for the *not applicable* responses to items on this survey. Another potential reason not previously mentioned is that some practitioners might have responded *not applicable* simply because they do not have any culturally diverse clients. It is not possible to determine why some participants responded that some cultural competency items did not apply to them. It seems likely that either they do not provide the services mentioned or do not use the resources mentioned, or that they do not feel that a particular item is the responsibility of an individual worker.

Overall Organizational Cultural Competence

The individual cultural competence of the mental health facility appears to be quite strong, especially in the areas of values, beliefs, and attitudes. However, individual competence is insufficient to make an organization fully culturally competent. In addition to the efforts of individual mental health practitioners, the systems within which they work need to change in order to bring about true change in cultural competence (Arredondo et al., 1996). Overall, it seems that either the facility's organizational cultural competence requires improvement or the managers need to increase their awareness of such competence. The vast majority (80.29%) of the areas of cultural competency at each organizational level were endorsed by only zero, one, or two of the six participating managers. Being flexible, responsive, self-examination, and building cultural diversity into organizational structures and processes are key components of becoming a culturally competent organization (Barr & Strong, 1987, as cited in Sue et al., 1998; Sue et al., 1998). It appears that the organization requires further development in the aforementioned main components of organizational competence as they are measured by the survey utilized in this study.

It is not possible to determine if this lack of endorsement of organizational cultural competencies reflects a genuine lack of systemic or organizational competency or a lack of awareness of such competence. If this indicates a lack of organizational cultural competence, then the individual mental health workers may not be working within an environment that will best enhance and support their individual efforts. Some of the individual cultural competence issues appear to relate to monetary funding;

improvement in this area on the part of the organization might greatly benefit the ability of individual workers to engage in culturally competent actions. If the results reflect the fact that managers need more awareness of the organization's cultural competence, then the organization likely needs to improve its internal communication regarding its progress towards cultural competency goals.

Organizational Cultural Competence Strengths and Areas for Improvement

The largest number of endorsements of areas of cultural competence was at the level of Community-Based Service. The managers endorsed more cultural competency areas at the level of Community-Based Service than at the levels of Tertiary Care Setting and Administration. It appears that the more connected services are with the communities that they serve, the greater the organizational cultural competence is in evidence. This might be due to an increased number of culturally diverse individuals receiving such services, because the services are closer to where they live and perhaps perceived as more accessible. Serving a greater number of culturally diverse clients might make cultural competence issues more salient and would likely make such issues more of a priority. Community-based services might need to deal with cultural competence issues more directly and more frequently than other care settings. Community-based services might also be more organizationally culturally competent because they might have more flexibility to be responsive to the needs of the communities that they serve.

It seems that one of the areas in which the organization is most competent is in the knowledge, understanding, skills, and attitudes of its staff. The area of Provider Competencies appeared to be a relative strength for the organization. Nearly half of the

managers report that their staff is receiving ongoing cultural competence training in order to remain culturally competent and responsive. The individual staff data support this managerial endorsement. Nearly half of the individual mental health workers also endorsed engaging in most of the culturally competent behaviours and attitudes *frequently*, and the vast majority reported engaging in most of the culturally competent behaviours and attitudes either *frequently* or *occasionally*. Triage and Assessment seems to be another relative strength of the organization. It appears that the organization is striving to have multidimensional and culturally appropriate assessment procedures. However, these strengths are relative to the other areas of cultural competence; improvement may also be required in these areas.

There appeared to be room for improvement in the area of Self Help, as only one manager endorsed the existence of that area of cultural competency, and only at the level of Community-Based Service. It appears that there are few self-help groups provided by the organization to help meet the needs of culturally diverse clients. Such groups are intended to provide an extension of the continuum of care (Center for Mental Health Services, 2001). Self-help groups might foster a sense of community, and might give culturally diverse groups a sense of agency regarding pediatric mental health services that they receive. It appears that developing agency and responsibility within culturally diverse communities is an area of competence to which the organization might need to pay increased attention. The organization might currently be focusing on more direct care to such diverse groups. This could be due to insufficient client demand, insufficient

knowledge and skills in setting up such culturally diverse community self-help groups, and/or insufficient funding.

There appears to be a strong need for improvement in cultural competence as it relates to links with community-based organizations. Only 18% of cultural competency areas were endorsed regards to links with community-based organizations, and these were only endorsed by one or two out of six managers. The results might suggest that the existing links with community-based organizations are not optimally strong. More likely, they suggest that there are very few existing links with community-based organizations. Community-based organizations are another way to develop credible relationships with culturally diverse groups. They might increase the organization's visibility and might provide it with an opportunity to increase knowledge of its services in members of the communities that it desires to serve. Community-based organizations also might be able to help provide information and knowledge about culturally diverse groups and their needs. Community-based organizations might also provide an avenue for disseminating knowledge to, and uncovering the opinions and needs of, members of culturally diverse groups. Links with community-based organizations appears to be a largely untapped area that with further development could have major positive impact on the facility's organizational competence.

The lack of endorsement of certain areas of cultural competence and/or cultural competence at certain levels of the organization may or may not indicate lack of competency in such areas. The participants were asked to check the areas where evidence of the cultural competence statements is in operation. Certain cultural competence

statements might not apply equally to all levels of the organization. For example, participants might not view statements relating to direct provision of service as applicable at the level of Administration. They might not think that administrative competencies are applicable at the level of tertiary care setting. Additionally, the organization might be making efforts in any of these areas and not adequately communicating such efforts to all managers. This survey was intended to reflect managers' awareness of diverse facets of organizational competence and may or may not accurately and directly reflect actual levels of competence in such areas. However, they do indicate which areas are relative strengths and which may require the most effort and improvement for the organization, which might help direct its efforts towards increased cultural competence.

Implications

The individual pediatric mental health practitioners appeared to be more culturally competent in their values, attitudes, beliefs, and knowledge than in their actions. They seem to have a fairly solid foundation of culturally competent values, attitudes, beliefs, and knowledge. This base might need to be built upon to increase the frequency of culturally competent behaviours and skills. Additional training might be required to help maintain and continue improving upon the individual workers' culturally competent values, attitudes, beliefs, and knowledge. Training in culturally competent actions or skills is also recommended. The mental health facility should consider making culturally competent skills and action a priority area for improvement and training because individuals' culturally competent values, attitudes, beliefs and knowledge appear to be

quite strong, and because there seems to be more room for improvement in the area of culturally competent action and skills.

Culturally competent Attitudes and Actions appear to be related. It appears that those with more culturally competent attitudes will have more culturally competent actions, and vice versa. Those with less developed culturally competent attitudes tend to engage in fewer culturally competent actions, and vice versa. These results suggest that training and effort in the area of Attitudes might help to increase the individual workers' culturally competent Action, which might be a priority area for improvement. Conversely, training in culturally competent Action might influence and improve culturally competent Attitudes. Additional training in both culturally competent Action and Attitudes is recommended, as these areas are likely to have a reciprocal influence on each other and further enhance and capitalize on any efforts being made to increase the individual cultural competence within the organization (Arthur, 1998; Sue et al., 1992; Sue et al., 1996).

Over two thirds of all participants did not endorse having a physical environment, materials, and resources that were reflective of cultural diversity and culturally appropriate on a frequent basis. This seems to be the main area that likely requires improvement relating to culturally competent skills and actions. It seems that the individual pediatric mental health practitioners would benefit from some organizational support, especially in the area of physical environment, resources, and other materials. It is difficult, time-consuming, and expensive for practitioners to place posters, show films, use toys, or provide food that is not provided by the organization. It is possible that part

of the reason that practitioners appear to be lagging behind in this area of cultural competence is because they do not have the time and funding to be able to locate and purchase culturally reflective and appropriate materials. The organization might need to provide funding and allot time for such purposes in order to have culturally competent environments, resources, and materials. In addition, having policies and accountability measures that would demand the presence and utilization of such materials might increase the cultural competence of the organization's physical environment, materials, and resources.

Policies ensure that cultural competency goals are met in a consistent manner across an organization (Calgary Health Region, 2002). The development of policies is one of the most important instrumental factors in planning for cultural diversity and competence (Sue et al., 1998). The responses of the individual mental health practitioners are not consistent; some report engaging in culturally competent actions and having culturally competent attitudes *frequently*, some *occasionally*, and some *rarely/never*. This organization would likely benefit from an increased number of direct, specific policies to support their specific cultural competence goals. Policy might also help to increase awareness of cultural competency goals. Additionally, it may promote the consideration of culturally competent attitudes, knowledge, and/or actions as necessary, and not as mere ideals. The development of policies is often followed by the assessment of whether such policies are being met. The development of policies relating to cultural competence would potentially foster further critical self-examination of the organization regarding its cultural competence. It is also recommended that culturally competent policies be

supported with additional funding and plans with concrete steps and timelines to help the organization meet such policy goals. Otherwise, staff may be overwhelmed with a number of goals to reach while feeling that they have no additional guidance and resources with which to meet them.

It is unclear whether the managers were not endorsing certain areas of cultural competence because they know for certain that there is a lack of competence in that specific area or whether they were sometimes unaware of evidence of such competence. Either way, the organization might benefit from increasing its internal communication of its cultural competency goals and the progress different departments and levels are making towards those goals. Knowledge of others' progress may motivate individuals, departments, and levels of the organization to improve their performance in order to equal or surpass the performance of others. It might also provide mutual support for all of the diverse efforts taking place within the organization. Furthermore, it might provide different groups with ideas to help improve their cultural competence that they might otherwise not have thought of or been aware of. Such communication of goals and progress might help staff perceive that there is support, involvement, and open communication from the leaders of the organization.

Limitations of the Study

Many of the results were not as clear, as significant, or as powerful as would be desirable or expected. The final factor matrix accounted for less than half of the variance of the data, leaving over half of the variance to be explained by chance alone. Many items did not load highly onto one single factor and were removed from subsequent analyses.

The Chi-Square analysis, which was used to examine the relationship between the Action and Attitudes factors, was not statistically significant. These less than ideal results were likely due to the number of individuals that participated in the study. In general, there should be 15 participants for every variable in a factor analysis, which for this study would have required 480 participants instead of 98. There might have been more variance in the responses if a greater number of participants had been surveyed, which might have led to a significant Chi-Square analysis. The lack of strong and clear results was likely due to the number of participants being insufficient for the statistical analyses conducted to have been sufficiently powerful to uncover clear, strong, and significant results.

The surveys used in this study may not have been the most appropriate ones for the types of analysis that were conducted. It was difficult to compare them to the prominent multicultural counselling literature because they were not based on similar divisions of the construct of cultural competence. The manager and staff surveys were so different that it was also difficult to compare the individual and organizational cultural competence of the facility that was surveyed. Numerous items within the individual cultural competence survey did not perform well statistically. Many items in the individual cultural competence survey were removed because they did not load strongly onto any single factor. These items did not appear to be very good discriminators between factors. There was a small range of responses for the participants to choose from, which may have limited the variance of the data. The researcher had no control over which surveys were used in the study. The surveys that were utilized were chosen by the mental health facility for the purposes of self-evaluation, and not for statistical

analysis of the data. Perhaps other surveys might have been more suitable for statistical analysis of the resulting data.

No psychometric information exists for either of the surveys utilized in this study. This undermines the results and conclusions of this study. Psychometric information is crucial to the credibility of the results and conclusions of any study (Kerlinger & Lee, 2000). Reliability is a measure of the dependability of an instrument. The reliability of the instruments, and therefore the data, is unknown. The data may or may not be stable, and may or may not reflect great fluctuations in, and/or errors of, measurement. Validity assesses the extent to which researchers are measuring what it is they intend to be measuring. The validity of the instruments, and therefore the data, is also unknown. The extent to which the instruments measure individual and organizational competence cannot yet be asserted with any great amount of certainty. The lack of psychometric information regarding the surveys utilized in this study limits the confidence and faith that can be placed in the results and in the conclusions made from such results. The sampling procedures may also limit the reliability, validity, and generalizability of the findings and conclusions.

Many of the results were difficult to interpret. This was partially due to an inability to ask staff and managers how they interpreted and responded to the surveys. It was not possible to determine why some individual practitioners responded *not applicable* to statements of cultural competence, and why others did not. It was difficult to determine whether the lack of endorsement of cultural competence statements by managers was due to an awareness of a lack of competence in those areas, or due to a

lack of manager awareness of evidence of progress in that area at that level of the organization. It was also not possible to separate the lack of endorsement by managers from those areas that may not have been applicable at certain levels of the organization. Ideally, with sufficient time, resources, and ability to contact individual staff and managers, the researcher would have followed up with the organization to clarify the results, which were difficult to interpret without participant input.

Strengths of the Study

This study may help to fill some of the gaps found within the cultural competence literature. This study surveyed two groups that have been underrepresented in the existent literature. It assessed the individual and organizational cultural competence of (a) pediatric mental health service providers, and (b) Canadian mental health service providers. Most of the previous literature has assessed cultural competence as it relates to adults and pertains to American counsellors and mental health workers (Arthur & Januszkowski, 2001; Casas et al., 2001). Another strength of the study is that it assessed both organizational and individual cultural competence. Few surveys address organizational competence. Most studies do not explore individual and organizational competence with one sample. It is important to study both because they interact and because they are both necessary for truly culturally competent service and organizations (Sue et al., 1998). This study also adds to the research on organizational cultural competence in Canada.

In addition, this study made an important and unique contribution to the psychometric information available regarding the *Self-Assessment Checklist for*

Personnel Providing Services and Supports to Children with Special Needs and their Families (Goode, 2000) by being the first study to conduct a factor analysis on results obtained through the use of the survey. This study uncovered two main factors underlying the survey and its assessment of cultural competence. This suggests that two factors, Attitudes and Action, underlie the survey, rather than the three categories inherent within the survey: Physical Environment, Materials, and Resources; Communication Styles; and Values and Attitudes. This research may also add to the understanding of the construct of cultural competence in general by suggesting that there are two separate components to individual cultural competence, Attitudes and Action.

The lack of personal researcher involvement until after collection of the data helped to reduce researcher bias and researcher effects. The methods of survey administration and data collection fully protected the privacy and confidentiality of all participants. This would have likely encouraged participants to respond truthfully rather than merely striving to respond in a socially desirable manner. This research was based on work that a mental health facility was already beginning, and will provide tangible, specific, practical, and detailed results and suggestions to the mental health facility that participated in the survey.

Suggestions for Future Research

Several recommendations are offered for future investigations of cultural competence. A number of measures should be taken in order to give greater credibility to both the instrumentation used in this study and to the results and conclusions drawn from this study. Further research is needed to determine the psychometric properties of the

cultural competence surveys used in this study. The reliability and validity of the instruments need to be established; otherwise, their utility and credibility will be limited. In addition, this study should be replicated in order to validate and support its findings. Such replication should occur with a larger number of participants, which would increase the statistical power and the ability of future studies to find statistically significant results. In particular, further factor analyses should be conducted to support or refute the two-factor structure of individual cultural competence determined by this study.

This study was not able to fully explore the relationship between the underlying factors of culturally competent Attitudes and Actions. Research should be conducted to determine if there is a causal relationship between these two factors, or between other factors uncovered by other researchers with different surveys. This would have major implications for measures to improve cultural competence of mental health services and service providers.

A suggested area for future research is further empirical evaluation of the effectiveness of efforts to improve the cultural competence of mental health service providers. The surveys should be re-administered in order to assess reactivity, which is the extent to which simply administering the surveys leads staff, managers, and organizations to increase their cultural competence. After measures are implemented by the mental health facility to continue to improve their individual and organizational competence, the surveys should be re-administered to measure changes in cultural competence. This would be one method of evaluating whether or efforts to improve cultural competence actually lead to differences in self-reporting of increased cultural

competence. In the future, there is also a need for research that evaluates whether improved cultural competence actually results in increased access, more positive outcomes, and better quality of care for culturally diverse clients (Abe-Kim & Takeuchi, 1996).

Although this research adds to the literature, more research should be conducted that assesses the cultural competence of Canadian mental health service providers. Further research should be conducted to determine if Sue et al.'s (1992, 1998) work applies equally well to pediatric mental health service providers as providers of mental health services to adults. A variety of surveys pertaining to adult cultural competence, or cultural competence in general, should be adapted and administered to pediatric mental health service providers. Results from these studies should be factor analyzed to determine what factors underlie cultural competence for serving children and their families.

The utilization of diverse research methods would likely increase and broaden the knowledge and understanding of cultural competence. Self-reports are a beneficial and convenient method of evaluating cultural competence. However, they are subject to social desirability bias, and may not be as objective as other measures (Constantine & Ladany, 2001). In addition, self-report measures of cultural competence do not always correlate with actual behaviors or attitudes associated with cultural competence (Constantine & Ladany; Ladany et al., 1997; Pope-Davis & Dings, 1995; Sue, 1996). If possible, the individual and organizational cultural competence of pediatric mental health facilities should also be observed. Further research should also be conducted that includes

client views, including their assessment of the individual and organizational cultural competence of pediatric mental health service providers. In future studies, follow-ups with participants should be arranged to provide opportunities to clarify responses that are ambiguous and unclear. A quantitative method is only one method of assessing and understanding cultural competence. This type of quantitative research should be supplemented with qualitative research to more fully understand the personal experiences of staff, managers, and clients with regards to the individual and organizational cultural competence of pediatric mental health service providers.

Conclusions

The research suggests that cultural competence is not a unitary dimension. The majority of the literature supports Sue et al.'s (1992) model of self-awareness, knowledge, and skills, or adaptations of that model. This study suggests that two factors, Attitudes and Action, underlie the individual cultural competence of pediatric mental health service providers as such competence was assessed by the survey utilized in this particular study. These factors are statistically independent, suggesting that they might measure entirely different aspects of cultural competence. Both culturally competent actions and attitudes appear to be important components of individual cultural competence.

The pediatric mental health service providers surveyed appeared to have a strong basis of culturally competent values, attitudes, beliefs, and general knowledge. However, there seemed to be some room for improvement in the area of culturally competent actions. Perhaps it is easier to be culturally competent in one's attitudes, beliefs, values,

and knowledge. These aspects of cultural competence appear to be internal, not particularly expensive, depend little on the support of others, and require less overt effort than actions. Culturally competent actions seem to require overt effort, resources, and organizational support. If it is easier to have culturally competent attitudes, beliefs, values, and knowledge, and if there appears to be a stronger performance in these areas, then perhaps culturally competent actions or skills should be the priority for improvement through training and further assessment and evaluation.

This study suggests that individual and organizational cultural competence are intricately related and may both be necessary for an individual and/or organization to be culturally competent. An organization may only as culturally competent as its individual mental health practitioners. In turn, the cultural competence of individual mental health practitioners may be enhanced or hindered by the presence or lack of adequate organizational support. Organizations should consider providing specific and direct policies to their employees that would help them to meet their overall cultural competence goals. These policies might be followed by support and guidance in the forms of additional funding, resources, and step-by-step plans for individuals and departments to follow. Individual and organizational cultural competence are extremely valuable because they have the potential to improve the quality of the care given to diverse clients, the effects of therapy on these clients, and clients' perceptions of therapy.

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APPENDIX A

Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Health Needs and their Families (Goode, 2000)

A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

_____ 1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.

_____ 4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5. I insure that toys and other play accessories in reception areas and those which are used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.

COMMUNICATION STYLES

_____ 6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

_____ 7. I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions.

_____ 8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 9. I use bilingual staff or trained volunteers to serve as interpreters during assessment, meetings, or other events for parents who would require this level of assistance.

10. When interacting with parents who have limited English proficiency I always keep in mind that:

_____ * Limitations in English proficiency is in no way a reflection of their level of intellectual functioning.

_____ * Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____ * They may or may not be literate in their language of origin or English.

_____ 11. When possible, I insure that all notices and communiqués to parents are written in their language of origin.

_____ 12. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

VALUES & ATTITUDES

_____ 13. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 14. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____ 15. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency.

_____ 16. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity or prejudice.

_____ 17. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, and godparents).

_____ 18. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 19. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).

_____ 20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).

_____ 21. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

_____ 22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 23. I accept that religion and other beliefs may influence how families respond to illnesses, disease, and death.

_____ 24. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs.

_____ 25. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 26. I understand that families from different cultures will have different expectations of their children for acquiring toiling, dressing, feeding, and other self help skills.

_____ 27. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 28. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 29. I seek information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 30. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key with correct responses. However, if you frequently responded "**C**", you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children and families.

APPENDIX B

Cultural Competence Standards in Mental Health Care Delivery Systems for Underserved/Underrepresented Racial/Ethnic Groups: Self-Assessment for Managers (based on Center for Mental Health, 2001)

Instructions: A separate self-assessment should be completed with reference to each major racial/ethnic groups to examine whether or not there is an awareness of Cultural Competence and whether its requisite components exist and are observable within the overall organization. **Completed with reference to: _____(Target Population)** **Read the following statement:** Cultural competence includes attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems 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 racial/ethnic 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. **For each of the items shown in the rows below place a check mark in the columns representing the various levels of organization where evidence of the above statement is in operation for the identified target groups. Use accompanying definitions of standards for reference.**	Administration	Tertiary Care Setting	Community-based Service	Existing links with community-based organizations*
I. Cultural Competence Guiding Principles				
Exist and are apparent				
II. Overall System Standards and Implementation Guidelines				
Cultural Competence Planning				
Governance				
Prevention, Education, and Outreach				
Quality Monitoring and Improvement				
Decision Support and Management Information Systems				
Human Resource Development				
III. Clinical Standards and Implementation Guidelines				
Access and Service Authorization				
Triage and Assessment				
Care Planning				
Plan of Treatment				
Treatment Services				
Discharge Planning				
Case Management				
Communication Styles and Cross-cultural Linguistic and Communication Support				
Self Help				
IV. Provider Competencies				
Knowledge, Understanding, Skills, and Attitudes				

* Where existing links with community-based organizations are identified please provide contact information.

APPENDIX C

From *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups*
(Center for Mental Health Services, 2001)

Cultural Competence Guiding Principles

Principle of Cultural Competence

Cultural competence includes attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems 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 racial/ethnic 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.

Overall System Standards and Implementation Guidelines

Cultural Competence Planning Standard

A Cultural Competence Plan shall be developed and integrated within the overall organization using an incremental strategic approach for its achievement, to assure attainment of cultural competence within manageable but concrete timelines.

Governance Standard

Each health plans' governing entity shall incorporate a board, advisory committee, or policy-making and -influencing group which shall be proportionally representative of the consumer populations to be served and the community at large, including age and ethnicity. In this manner, the community served will guide policy formulation and decision-making, including Request for Proposals development and vendor selection. The governing entity responsible for the Health Plan shall be accountable for its successful implementation, including its cultural competence provisions.

Prevention, Education, and Outreach Standard

Each Managed Care Mental Health Plan shall have a prevention, education, and outreach program which is an integral part of the Plan's operations and which is guided in its development and implementation by consumers, families, and community-based organizations.

Quality Monitoring and Improvement Standard

The Health Plan shall have a regular quality monitoring and improvement program that ensures (1) access to a full array of culturally competent treatment modalities, (2) comparability of benefits, and (3) comparable successful outcomes for all service recipients.

Decision Support and Management Information Systems Standard

The Health Plan shall develop and maintain a database to track utilization and outcomes for the four groups across all levels of care, ensuring comparability of benefits, access, and outcomes. The Health Plan shall also develop and manage databases of social and mental health indicators on the covered population and the community at large.

Human Resource Development Standard

Staff training and development in the areas of cultural competence and racial/ethnic mental health shall be implemented at all levels and across disciplines, for leadership and governing entities, as well as for management and support staff. The strengths brought by cultural competence form the foundation for system performance rather than detract or formulate separate agendas.

Clinical Standards and Implementation Guidelines

Access and Service Authorization Standard

Services shall be provided irrespective of immigration status, insurance coverage, and language. Access to services shall be individually- and family-oriented (including client-defined family) in the context of racial/ethnic cultural values. Access criteria for different levels of care shall include health/medical, behavior, and functioning in addition to diagnosis. Criteria shall be multidimensional in six domains: psychiatric, medical, spiritual, social functioning, behavior, and community support.

Triage and Assessment Standard

Assessment shall be multi-dimensional including individual, family, and community strengths, functional, psychiatric, medical, and social status as well as family support.

Care Planning Standard

Care plans for consumers shall be compatible with the cultural framework and community environment of consumers and family members. When appropriate, care plans shall involve culturally indicated family leaders and decision-makers.

Plan of Treatment Standard

The Treatment Plan for consumers shall be relevant to their culture and life experiences. It shall be developed by or under the guidance of a culturally competent provider in conjunction with the consumer and, where appropriate, family.

Treatment Services Standard

The Health Plan shall assure that the full array of generally available treatment modalities are tailored such that they are culturally acceptable and effective with populations of the four groups (e.g., education, psychiatric rehabilitation, family therapy, specialized group therapy, behavioral approaches, use of traditional healers, and outreach).

Discharge Planning Standard

Discharge planning for consumers and families shall include involvement of the consumer and family in the development and implementation of the plan and evaluation of outcomes. Discharge planning shall be done within a culturally competent framework and in a communication style congruent with the consumer's values. The plan shall allow for transfer to less restrictive levels of care in addition to termination of treatment based on accomplishment of mutually agreed upon goals in the Treatment Plan.

Case Management Standard

Case management shall be central to the operation of the interdisciplinary treatment team and shall be based on the level of care needed by the primary consumer. Case managers for consumers shall have special skills in advocacy, access of community-based services and systems, and interagency coordination. Case management shall also be consumer- and family-driven. Case managers shall be accountable for the cost and appropriateness of the services they coordinate. The Managed Care Plan shall maintain responsibility for the successful and appropriate implementation of the Case Management Plan and provision of adequate administrative resources and endorsement.

Communication Styles and cross-cultural Linguistic and Communication Support Standard

Cross-cultural communication support across all levels of care shall be provided at the option of consumers and families at no additional cost to them. Access to these services shall be available at the point of entry into the system and throughout the course of services.

Self Help Standard

Culturally competent self-help groups shall be created to provide services to consumers and their families. The self-help groups shall function as part of a continuum of care. Self help groups for consumers shall incorporate consumer-driven goals and objectives that are functionally defined and oriented towards rehabilitative and recovery outcomes. Equal consideration and support shall be given to family and primary consumer self help groups.

Knowledge, Understanding, Skills, and Attitudes Standard

There are specific areas of knowledge, understanding, skills, and attitudes that shall be essential components of core continuing education to ensure cultural competence among clinical staff and to promote effective response to the mental health needs of individuals from the four groups.