A Review of Clinical Cultural Competence:
Definitions,
Key Components,
Standards and
Selected Trainings

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General Psychiatry Program
&
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Executive Summary

Definitions of Clinical Cultural Competence

For the purposes of this review, definitions of the individual/clinical level of cultural competence were the focus and are a representation of those found in the literature across the disciplines of social work, psychology, nursing, and psychiatry. Only one definition from the field of occupational therapy was found in this review.

One of the challenges cited in the mental health literature on cultural competence is the lack of an operationalized definition for clinical cultural competence (CCC) contributing to a lack of validated, comprehensive measures needed for research and training (Lo & Fung, 2003; Miyake Geron, 2002).

The literature in this review on cultural competence reveals more similarities than differences across disciplines in the conceptualization of cultural competence. Difference lies primarily in areas of emphasis among disciplines. Terry Cross’s (1988) definition of cultural competence, originating from the social work field and considered to be a classic, is the most widely cited across disciplines in the academic literature, among governmental mental health agency documents and among training programs.

“Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations” (p.1).

The prevalence of Cross’s definition may be due to its recognition of the connection among the individual, organizational, and structural levels of cultural competence. In addition, like many of the definitions found in the literature, it refers to the clinician’s acquisition of competencies under the three domains of: (1) awareness of attitudes, values, and biases (affective domain); (2) knowledge (cognitive domain), and (3) skills required to be effective in cross-cultural encounters (behavioural domain). These three domains, referred to as a “tripartite framework” developed by Sue and colleagues (1992), is possibly the most widely used model for understanding, training and researching culturally competent care across disciplines and has formed the basis of most standardized measures of culturally competent care developed to date (Miyake Geron, 2002).

The Centre for Addiction and Mental Health (CAMH) definition of cultural competence developed by the Diversity Programs Office (2003) is more comprehensive than many definitions cited in the literature and those adopted by training programs. ‘Culture’ is defined broadly to be diversity-inclusive as with definitions used by the training programs and the colleges and association standards for cultural competence examined in this review.

Clinical Cultural Competence Practice Components / Competencies

This review revealed the applicability and usefulness across disciplines for a quadripartite framework for understanding and training in clinical cultural competence as shown below.
(1) Awareness
   1. Own cultural values & biases
   2. Client worldview

(2) Knowledge
   1. Culture-specific (Emic)
   2. Culture-generic (Etic)

(3) Skills
   1. Pre-engagement
   2. Engagement
   3. Assessment/feedback
   4. Treatment/intervention
   5. Closure/discharge
   6. Research & Education

(4) Power/ Relationship Issues
   1. Client-therapist dyad (Micro-Level)
   2. Client-system (Macro-Level)

Many of the same competencies are being identified across the disciplines of psychology, social work, nursing and psychiatry; divergence occurs more in the areas of emphasis. Much of the literature focusing on clinical cultural competence derives from the counselling psychology field from which other disciplines have borrowed. However, Kleinman’s (1988) work linking anthropology and psychiatry has been very influential particularly with regard to the development of the cultural formulation of the DSM-IV and Explanatory Model of Illness/Health as a framework for assessment and treatment.

The findings of this review revealed the consistency across disciplines of using the tripartite framework developed by Sue and colleagues (1992) for understanding cultural competence. However, it also revealed the usefulness and applicability of a fourth domain-- Power/ Relationship Issues--identified by Sodowsky et al., (1994). This domain refers to the dynamics of the clinician-client relationship including an examination of the therapeutic relationship between clinicians and clients with similar and different cultural values, racial identity attitudes and issues of power, control, and oppression. While not explicitly defined as a fourth domain, cross-cultural competencies identified across the disciplines examined in this review in addition to the training programs addressed the Power/ Relationship Issues domain. Power Relationship/ Issues is a particularly important domain due to the power differential inherent in the client-clinician relationship. Moreover, in many cases the clinician will represent the dominant group in society. In addition to the client-
clinician level or micro-level, this review identified a macro-level of this domain to be **client-system**
power/relationship issues. This level focuses on the impacts of systemic oppression, discrimination,
racism and deprivation at the socio-cultural, institutional, and political levels on psychosocial, political,
and economic development.

One of the criticisms noted throughout the literature is that the competencies are global and non-
specific.

**Professional Colleges and Association Standards & Guidelines for Cultural Competent Practice**

Although in the last two decades an abundance of writing and training in the area of cultural
competence can be seen, national standards and guidelines for cultural competence among various
professional colleges and associations are lacking.

The following professional colleges and associations were found to have standards and guidelines on
cultural competence:

1. College of Nurses of Ontario
2. Canadian Psychological Association (CPA)
3. American Psychological Association (APA)
4. National Association of Social Workers (NAS) (United States)

While the CPA refers to its guidelines as *Guidelines for Non-discriminatory Practice*, the content
contains attributes consistent with culturally competent practice.

There are more similarities than differences among the above colleges and associations with regard
to cultural competence standards. None of the colleges/associations have standards for pre-
engagement skills. All the above colleges/associations have standards for:

1. Awareness-Own & Client Worldview
2. Knowledge-Culture-Specific & Culture-Generic
3. Skills-Engagement, Treatment/Intervention
4. Power/Relationship Issues-Client-System

The CPA contains many more guidelines under both levels of *Power/Relationship Issues—Client
Therapist Dyad and Client-System* than other colleges and associations. In fact, most of the CPA
guidelines fall under this domain.

**Training Modules/ Approaches**

The following six modules are included in this review and analysis:

1. **Introduction to Diversity** at CAMH
2. **Culture of Emotions Cultural Competence Training Program** (Office of Minority
Health’s Center for Linguistic and cultural Competence in Health Care, U. S. Department of
Health and Human Services)
3. **Cultural Competence for Social Workers** - C. Williams (CAMH)

4. **Cross-Cultural Mental Health: Perceptions, Assessment & Health Approaches** - G. Allibhai (Canadian Mental Health Association - Toronto Branch)

5. **Working in Culturally Diverse Health Care Environments** - R. Srivastava (CAMH)

6. **An Integrative Model of Clinical Practice with Diversity** - A. Ka Tat Tsang (Faculty of Social Work, University of Toronto)

These modules were selected for review, as the trainers were available for consultation with the exception of the Culture of Emotions Cultural Competence Training Program. Other training programs outside of Ontario were contacted but either program manuals were unavailable for public distribution or the programs did not respond to inquiries.

With the exception of Williams' training, all the training modules are targeting multidisciplinary participants. The major differences lie in whether or not the objectives of the training/education have a skills-based component and this determines the length of the trainings as well as the content.

All trainings:

1. are organized according to the tripartite framework of cultural competencies but include both client-clinician and client-system levels of a fourth domain – *Power/Relationship Issues*

2. are based on an integrated culture-specific and culture-generic philosophical underpinning

3. define ‘culture’ broadly to be diversity-inclusive; i.e. not limited to an ethnicity-based conceptualization

4. base training on both clinical cultural competence and anti-racist/anti-oppression conceptual models with the exception of the *Culture of Emotions* module

5. consist of activities and presentation of theory to raise awareness of own attitudes, beliefs, biases and worldviews and client worldviews

6. with the exception of the *Introduction to Diversity at CAMH* training, introduce skills for eliciting the client’s Explanatory Model of Illness (Kleinman, 1988)

7. utilize self-exploration/experiential activities

8. introduce skills required for cross-cultural work even if they do not have a skills-training component

**National and International Standards and Mandates for Culturally Competent Clinical Care**

Although an abundance of initiatives that are evolving in the area of cultural competence can be found on the Internet, there is a lack of a clear, coordinated national framework for training models.
While the U.S. is moving towards a consensus on many major points of what constitutes cultural competence in primary health care much less work has been done in the area of culturally competent mental health care and what has been done tends to be aimed at the organizational level.

As with the United States, in Australia there is a lot of activity with regard to multicultural training and research but there appears to be a more coordinated effort with regard to the clinical level of cultural competence in mental health. In fact, Multicultural Mental Health Australia (MMHA) links a wide range of state and territory mental health specialists and services, advocacy groups and tertiary institutions to promote the mental health and well being of Australia's diverse communities.

Internationally, the ICD-9 Classification of Mental and behavioural Disorders of the World Health Organization (WHO) (1992), incorporated major methodological developments based on advances in transcultural psychiatry (Lu, Lim, & Mezzich, 1995). However, WHO has not published standards or guidelines for culturally competent clinical care.

**Evaluation Research**

While the specification of awareness, knowledge, and skills in cultural competence has been widely discussed in the mental health professions and testing attempts have been made, more empirical research is necessary before conclusions can be drawn about specific competencies, measures/indicators and/or training approaches. More research is needed which employs:

1. Mixed methods (qualitative & quantitative) for evaluating clinical interventions and training to eliminate problems with social desirability factors and researcher-defined measures
2. Research on client perceptions of mental health care
3. Process research on client-therapist dyads to identify or delineate specific clinical cultural competencies/indicators
4. Outcome studies examining context using qualitative methodologies

While more research is needed before we can make definitive conclusions with regard to training, the literature has contributed some helpful strategies for training in the area of cultural competence. The following are some tentative recommendations based on this literature and on consultations with several trainers.

**Training in Clinical Cultural Competence (CCC)**

1. Conduct comprehensive training evaluation to determine transfer of learning and whether indicators/measures of CCC are being met
2. Begin evaluation research concurrently with training development to inform training program decisions
3. Extract core skills and competencies specific to the professional role based on a detailed analysis of workplace expectations and job requirements
4. Develop clear and operationalized learning objectives to facilitate evaluation and measurement
5. Allow for time between sessions to apply new learning to practice
6. Structure ongoing follow-up sessions
7. Provide organizational support (space, time & resources)
8. Implement (centre-wide) assessment tools, policies and practice guidelines
**Pedagogical Strategies/Tools**

1. Implement regular case-based learning, modelling, role play, and interviewing practice (relevant to the learner's needs)
2. Include structured evaluation of audio- and video-taped role-play with peer supervision and coaching (helpful for transfer of learning)
3. Ensure an environment where participants feel safe to express their feelings, beliefs, and attitudes openly and freely without negative repercussions
4. Provide activity-based learning as it has been shown to be more successful in generating behavioural change than didactic sessions

If we are providing excellent clinical care are we culturally competent?

The findings of this report suggest that the answer to this question is yes and no. Yes in the sense that the aspects of providing a high standard of practice, such as effectiveness in establishing the therapeutic alliance, establishing goals collaboratively, ensuring tasks/interventions for achieving goals are relevant to the client, conveying empathy, engaging in critical self-reflection, assuming a client-centred holistic approach, and empowering the client, are all attributes of excellent clinical care and are consistent with cultural competence. However, there are at least two fundamental ways that culturally competent practice can be distinguished from excellent clinical practice.

1. Cultural competence promotes critical reflection on and questioning of the biases/assumptions inherent in Euro-American scientific inquiry/knowledge, theories, approaches, and assumptions that are the very foundation of psychiatry. This is not standard practice in traditional mental health care (Sue & Sue, 2003). The implications for clinical care are that clinicians need to: 1) Explore the client's perception of cause, meaning, conceptualization and care of the condition in relation to norms of the cultural reference group [Kleinman's (1988) Explanatory Model] and 2) Facilitate indigenous support systems and collaborate with folk healers, medicine persons, or community leaders, for example. In other words, “To really exercise cultural competence the mental health worker has to be willing to accept alternative treatments and alternative explanations of mental illness and health as defined by the group/individual” (Fernando, 2000 as cited by Allibhai, 2004).

2. There is a prominent social justice value embedded in cultural competence. In terms of orientation, individual problems are understood in relation to social factors such as racism, oppression, discrimination and deprivation (Sue et al., 1992). This means focusing on social change as opposed to changing the client and assuming a prevention stance as opposed to merely individual remediation. Therefore, the clinician should be willing to expand her/his role from one-to-one therapy to alternative helping roles to impact systemic oppression, discrimination and racism through such out-of-office activity as—consultant, change agent, teacher and advocate. Such intervention at the socio-cultural, institutional, and political levels is not typical of clinical practice.
CHAPTER 1  INTRODUCTION

Structure of the Report
This report of the literature review on cultural competence in clinical care training is divided into four main sections. **Chapter One** describes the rationale, aims and objectives of the report and presents background information on cultural competence training. **Chapter Two** describes the method for the literature review including the strategies involved in the review and data analysis. **Chapter Three** presents the findings of the review. In section A, the various definitions of clinical cultural competence found in the literature across disciplines are presented. Also in section A, an overview of the components or competencies of cultural competence is presented according to the lens for examination outlined in the Methods section. Section B introduces standards and guidelines for cultural competence outlined by the American Psychological Association, National Association of Social Work, the College of Nurses of Ontario, and the Canadian Psychological Association. Section C is an overview of national and international mandates and guidelines for Cultural Competence in mental health care. Section D focuses on training in clinical cultural competence for mental health practitioners and includes a description of three main philosophical assumptions underlying multicultural training approaches. Learning goals for training collected from the literature and considered to be the most important are presented in this section. Also in this section, four primary conceptual training models are introduced. An overview of training components of cultural competence is presented. In addition, pedagogical tools/strategies for cultural competence training are briefly described. Section E compares six training modules currently being delivered at CAMH and at other hospitals/organizations in Toronto and area. Section F presents a brief overview of findings from evaluation research literature on cultural competence and training. Finally in **Chapter Four**, recommendations for cultural competence training and implications for future research are discussed.

Project Rationale
The **General Psychiatry Program and the Culture, Community and Health Program** of the Centre for Addiction and Mental Health (CAMH) joined their interests and resources to initiate a research project on approaches to cultural competence training in clinical care for the Diversity Level II Committee that is developing a curriculum for training clinical staff at CAMH. Cultural competence education and training will increase clinicians’ confidence in cross-cultural practice by helping equip them with knowledge, tools, and skills to better understand and manage socio-cultural issues in the clinical encounter. This project is a response to a growing emphasis on evidence-based practice (Butterill, 2004; Sue, 2003) and involves a review, analysis, and synthesis of the relevant literature on cultural competence training/education. Ultimately, the findings will inform the development of the curriculum for the **Level II Diversity Training**.

Aims and Objectives
The aim of this literature review is to provide a sound foundation for the development of the **Level II Diversity Training** curriculum.

In addition to the academic literature on cultural competence, current training modules (including some from CAMH) will be examined to clarify theoretical or conceptual perspectives, definitions of cultural competence, goals and objectives, key components of training approaches, and pedagogical tools and strategies.
Research Questions
This review and synthesis focuses on clinical cultural competence in mental health and will seek to answer the following questions:

1. How is cultural competence being defined across disciplines?
2. What components/competencies are being identified across disciplines for clinical culturally competent practice?
3. What are the standards & guidelines for cultural competent practice for various professional colleges & associations?
4. What training models/approaches are currently being used at other mental health facilities to train clinical staff in cultural competence?
5. What are the national and international standards & mandates for culturally competent care?
6. What does empirical research reveal about the relationships between cultural competence training, the level of competence, and clinical outcomes?

Background
Cultural competence is increasingly being recognized as a critical component of quality mental health care services as a result of several studies that have raised awareness of bias and discrimination in health care services ranging from those at the organizational level to those of the individual clinician (Betancourt, Green, Carrillo, & Ananeh-Firempong II, 2003; Sue, 2003).

Two leading documents recently coming out of the United States report marked disparities for minorities in mental health services. The US Surgeon General’s (2001) report on mental health revealed that racial and ethnic minorities have less access than whites to mental health services and when health care is accessed it is more likely to be poor in quality. The second document, released by the Office of Minority Health, US Department of Health and Human Services (2001), contains 14 national standards for culturally and linguistically appropriate services (CLAS) in health care. Both the APA (1992) and the Canadian Psychological Association (1991) have revised their ethical guidelines to address cultural issues.

The necessity of cross-cultural training for mental health practitioners has been emphasised as early as 1962 (Gompertz, 1997) and a burgeoning literature has developed since the late 70’s and 80’s (Hulnick, 1977; Sue, 1978; Pedersen & Lefley, 1986; Ridley, Mendoza, & Kanitz, 1997). In fact, the need for cross-cultural competence for professionals has been defined as an ethical imperative:

...White culture is such a dominant norm that it acts as an invisible veil that prevents people from seeing counseling as a potentially biased system...What is needed is for counselors to become culturally aware, to act on the basis of a critical analysis and understanding on their own conditioning, the conditioning of their clients, and the sociopolitical system of which they are both a part. Without such awareness, the counselor who works with a culturally different [sic] client may be engaging in cultural oppression using unethical and harmful practices. (Sue et al., 1992, p.72-73) [Emphasis added]

Paul Pedersen (1986), a leading researcher in the field of cross-cultural counselling, has outlined some of the major reasons for the necessity of cross-cultural training as cited in the literature:

1. Conventional descriptions of mental health in the textbooks and research literature reflect, to a greater or lesser extent, the cultural bias of a dominant (White, male, urban, young and affluent) cultural stereotype...
2. Some cultural groups have developed their own endogenous “self-righting” approaches for promoting mental health without relying on exogenous “outside-the-system” resources. We need to know more about these strategies to supplement conventional counseling and therapy methods.

3. The failure of counselling and therapy in multicultural settings is both emotionally and financially expensive...

4. The constructs of healthy and normal, which guide counsellors and therapists, are not the same for all cultures and need to be translated to be accurately applied.

5. There is a greater perceived need for reciprocity and interdependence across national, ethnic, and socio-cultural boundaries than previously. Cross-cultural training helps prepare counsellors and therapists to understand the socio-political implications of counselling and therapy.

6. Finally, since most therapists come from dominant culture backgrounds and most clients do not share those assumptions, training provides a bridge of understanding from one cultural perspective to the other. (p.75)

As part of an initiative to strive to provide services that are culturally sensitive and competent and to ensure that cultural competence is fully integrated as a professional obligation for clinicians, CAMH has been providing Introduction to Diversity training for all staff since 2001.

At CAMH cultural competence is defined as:

...the level of knowledge-based skills required to provide effective, respectful clinical care to clients from marginalized groups (e.g. gender, race, ethnicity, age, abilities, socio-economic status, language, religion, gender identity, sexual orientation, immigrant status, religion, invisible and visible disability, language ability)...Cultural competence in clinical care begins with a critical understanding of the dynamics of power and social location in our society. It demands personal reflection, accountability, transparency and respectful inclusion and collaboration with diverse communities. It understands that communities come with complexities and diversities. Cultural sensitivity is a component of cultural competence but cannot stand on its own. It is the psychological willingness to adjust one’s practice styles to the needs of different marginalized groups. We make no assumptions that providers who possess one of these qualities will possess both (Diversity Programs Office, May 2003, p.2).
Strategies
The review involved three strategies:

1. **A systematic review of available literature on training, course syllabi, and program descriptions and academic literature on theory, research and training using:**
   - PubMed database (MEDLINE, PreMEDLINE),
   - PsycINFO,
   - PsycARTICLES
   - CINAHL
   - Sociological Abstracts,
   - Social Science Abstracts and
   - Internet search engines.

The following keywords were used: cultural competence, training, cross-cultural sensitivity, multicultural health, cross-cultural care, cross-cultural skills, cross-cultural interventions, cultural diversity, multicultural mental health, both alone and in combination.

2. **A review of Government, Colleges and Association and Mental Health Service Organization publications:**
   - U.S. Department of Health and Human Services, Mental Health: Surgeon General’s report, the Office of Minority Health;
   - Community and Family Health Multicultural Work Group, Washington State Department of Health;
   - Ministry of Children and Family Development, Government of British Columbia
   - Substance Abuse and Mental Health Services Administration (SAMHSA) National Mental Health Information Centre, United States Department of Health and Human Services;
   - American Psychological Association: Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists;
   - American Psychological Association, Public Interest Directorate: APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations;
   - Canadian Psychological Association: Guidelines for Non-Discriminatory Practice (2002);
   - College of Nurses of Ontario: Guide to Nurses Providing Culturally Sensitive Care;
   - CAMH Diversity Programs Office Policy Reports and Documents;
   - Greater Vancouver Mental Health Service;
- Central East (Whitby) Mental Health Implementation Task Force.

3. **On-site visits to local programs and consultation with leaders in the field of cross-cultural training:**

   - Dr. A. Ka Tat Tsang, Faculty of Social Work, University of Toronto;
   - Everton Gordon, Anti-racism trainer, Across Boundaries;
   - Gulshan Allibhai, Canadian Mental Health Association (Toronto Branch);
   - Dr. Lisa Andermann and Dr. T. Lo, Mount Sinai Hospital;
   - Rani Srivastava, CAMH;
   - Vincenza Spiteri DeBonis, Toronto East General Hospital.

**Data analysis-lens for examination**

The following lens was modified from the one originally developed by Rani Srivastava for the CAMH Culturally Sensitive/Competent Clinical Care Training Framework Committee and provides the basis for analysis and clarification of cultural competence components/competencies, standards and guidelines for professional colleges and associations and training modules for cultural competence in clinical care examined in this review.

The *Pedagogical Strategies/Tools* category was added to demonstrate training strategies employed. The *Models of Cultural Competence* category was added to clarify frameworks of cultural competence in clinical care. Competencies were organized under the added categories of: *Pre-Engagement, Engagement, and Closure/Discharge*, based on Lo & Fung (2003), to clearly illustrate the application to practice across disciplines. Finally, the *Power/Relationship Issues* domain was added based on the research of Sodowsky, Taffe, Gutkin, & Wise (1994) which identified it as important for cross-cultural counselling. Power Issues/Relationship refers to the dynamics of the clinician-client relationship including an examination of the therapeutic relationship between clinicians and clients with similar and different cultural values, racial identity attitudes and issues of power, control, and oppression. This is a particularly important domain, as in many cases the clinician will represent the dominant group in society. This review identified a macro-level of this domain to be *client-system* in addition to the client-clinician level or micro-level thus it is included in the lens for examination.

1. Definitions of Cultural Competence
2. Philosophical Underpinnings—Etic, Emic, or Integrated
3. Conceptual Training Model
4. Goals/Objectives
5. Models of Cultural Competence
6. Pedagogical Strategies & Tools
7. Components/Competencies:
   a. Awareness of attitudes, beliefs, & values
      i. Awareness of own cultural values and biases
      ii. Awareness of client worldview
   d. Knowledge
      i. Culture-Specific (Emic)
      ii. Culture-Generic (Etic)
   e. Skills:
      i. Pre-engagement (Help-seeking pathways)
ii. Engagement (Establishing the therapeutic alliance)
iii. Assessment/Feedback
iv. Clinical Interventions/Treatment
v. Closure/Discharge
vi. Research & Education
f. Power/Relationship Issues
   i. Client-Therapist Dyad (Micro-Level)
   ii. Client-System (Macro-Level)
8. Clinical Skills Training
A. What is Clinical Cultural Competence?

Definitions of Clinical Cultural Competence
For the purposes of this review, definitions of the individual/clinical level of cultural competence were the focus. Though some definitions cited combine the individual, organizational and structural levels of cultural competence, those that were strictly organizational were not included.

Lack of Consensus for an Operationalized Definition of Cultural Competence
One of the challenges cited in the mental health literature on cultural competence is the lack of an operationalized definition for clinical cultural competence contributing to the lack of validated, comprehensive measures needed for research and training (Lo & Fung, 2003; Miyake Geron, 2002). The following are a representation of the definitions found in the literature across the disciplines of social work, psychology, nursing, and psychiatry. Only one definition from the field of occupational therapy was found in this review.

Cultural Competence as:

Connecting organizational, structural and individual levels
Of the most widely cited definitions in the mental health literature across disciplines and one which is considered to be a classic (Williams, 2003) is Terry Cross's (1988): “Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations” (p.1). In this definition, originating from the field of social work, the connection among organizational, structural and individual levels of cultural competence is recognized.

An extensive array of governmental mental health agency documents, theoretical and research literature, and training programs cite Cross's definition. For example, it is cited in the U.S. Department of Health and Human Services, Office of Minority Health (2001) National Standards for Culturally And Linguistically Appropriate Services in Health Care. It is also used by the Culture of Emotions (2002), a Cultural Competence and Diversity Training program for psychiatry, the Canadian Mental Health Association (Toronto Branch) Cultural Competence Training, the Ministry of Children and Family Development, Government of British Columbia, and is cited in the National Association of Social Work (2001) standards. The National Centre for Cultural Competence (2003) also incorporates a modified version of Cross's definition.

Tripartite Framework
Many definitions of clinical cultural competence refer to the clinician’s acquisition of competence in the three domains of (1) awareness of attitudes, values, and biases (affective domain); (2) knowledge (cognitive domain), and (3) skills required to be effective in cross-cultural encounters (behavioural domain). These three domains, referred to as a “tripartite framework” developed by Sue and colleagues (1992), is possibly the most widely used model for understanding, training and researching culturally competent care across disciplines and has formed the basis of most standardized measures of culturally competent care developed to date (Miyake Geron, 2002). Cross's (1988) definition above addresses these three domains.

The following definition, which originates from the field of occupational therapy, also addresses these three domains. “Cultural competence relates to the promotion of quality health services to underserved racial and ethnic groups, on the basis of valued differences and the integration of cultural attitudes, beliefs, and practices into diagnostic and treatment methods” (Dickson, 2003).
Focusing on Client-System Outcomes and Client Perceptions

Other definitions, such as McPhatter’s (1997) and Miyake Geron’s (2002) from the social work literature, include improved client-system functioning outcomes. McPhatter (1997) defines cultural competence as “…the ability to transform knowledge and cultural awareness into health and/or psychosocial interventions that support and sustain healthy client-system functioning within the appropriate cultural context” (p.261). She also cites a definition by Dana, Behn, & Gonwa (1992) which focuses on the perceived experience of the service user in which cultural competence is described as: “an ability to provide services that are perceived as legitimate for problems experienced by culturally diverse persons” (p.261).

Developmental and Ongoing

Most definitions across disciplines emphasize that the attainment of cultural competence is developmental, “a life-long, evolving activity” (Ponterotto, 1998) and refer to a process of learning and striving, rather than an endpoint (Anand, 2003; Community and Family Health Multicultural Work Group, Washington State Department of Health, 2003, Dean, 2001; Greater Vancouver Mental Health Service, 1999; NASW, 2001; Sue, 2003; Sue & Sue, 2003; Williams, 2002). The Greater Vancouver Mental Health Service (1999) reiterates that, “Cultural competence cannot be ‘dealt with’ through one-time initiatives. Rather, it involves a continuous process of improvement, evolution, appraisal, and feedback over time” (p.3). Salimbene (1999) also discusses the importance of regular follow-up cultural competence training for nurses. Dickson (2003), quoting Carole Dennis, an Occupational Therapy educator, reiterates that becoming culturally competent is a process; “there is no endpoint”.

An Ethical Responsibility

Most professions in the mental health field describe the attainment of cultural competence among clinicians as an “ethical responsibility” (APA, 2002; Gopaul-McNicol, 1997; NASW, 1996; NASW, 2001; Srivastava, 2004; Sue, Arredondo, & McDavis, 1992) and view it as an integral component of professional practice.

Synonymous with Client-Centred Care

Similarly, CAMH defines clinical cultural competence as tantamount to a client-centred approach to care, an approach applicable cross-disciplines that promotes client participation in all stages of care recognizing that each client and each situation is unique requiring individual assessment and planning (Carrillo, Green, & Betancourt, 1999; College of Nurses of Ontario, 2003). “To be culturally competent as a service provider at [CAMH] means having the ability to effectively engage a client-centred orientation, in the actual delivery of care, recognizing the significant impact of power and hierarchy often inherent in the interaction between clients from marginalized groups and organizations” (Diversity Programs Office, May 2003, p.2). The power differential between service provider and client is also emphasized in this definition.

In the College of Nurses of Ontario’s (2003) Guide to Nurses for Providing Culturally Sensitive Care, the principles of client-centred care are described as fundamental to cultural competence. “Client-centred care requires that nurses recognize the client’s culture, the nurse’s culture and how both impact the nurse-client relationship...There is no single right approach to all cultures or all individuals with a similar cultural background. The focus of care is always the client's unique needs” (p.3).

Focusing on Outcome, Individual, Organizational and Structural Levels and Social Justice

D. W. Sue (2001) proposes a definition of cultural competence that refers to client outcome, draws connections among individual/clinician, organizational and structural levels, includes an advocacy role, recognizes the need for generation of new theories, approaches to care and policies and incorporates important social justice attributes:
Cultural competence is the ability to engage in actions or create conditions that maximize the optimal development of client and client systems. Multicultural counseling competence is defined as the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. (p.802)

**Cross-Cultural Versus Multi-Cultural**

Leong (1998) attempts to clarify the use of the terms “multi-cultural counselling”, “cross-cultural competence” and “cultural competence”. He defines multi-cultural counselling as counselling with many different cultures simultaneously and argues that this is rarely what counsellors are doing unless they happen to be conducting group psychotherapy with a culturally heterogeneous group of clients. He also points to the problematic use of the concept of “cultural competence” and distinguishes it from “cross-cultural competence”. He defines cultural competence as:

To be able to adapt and function effectively in one's culture. In the same way, African American counsellors and psychotherapists are also culturally competent psychologists with reference with their African American cultural heritage. So, the problem is not with cultural competence but with limited cross-cultural competence, i.e., the knowledge and skills to relate and communicate effectively with someone from another culture different from your own (Italics added, p.3).

However, one could argue that all encounters are cross-cultural when considering the multiple diversities of both clinician and client (APA, 2002). As Dolhun, Muñoz, & Grumbach (2003) explain: “Every interaction between two individuals is a cultural exchange that flows bi-directionally and is, as such, a dialectic and mainly an unconscious process” (p. 620). The dimensions of race, gender, class, sexual orientation, religion, differential abilities, and so forth are simultaneously present in all individuals (Tsang & George, 1998; Sue, 2001). In the above definition, Leong appears to be using the term 'culture' narrowly, focusing on ethnic/racial identities only.

**Culture-Matching Versus Values/Worldview-Matching**

Related to the conceptualization of identity is the issue of culture matching of clinician and client. Proponents of culture matching propose that matching clinicians with clients based on the same racial/ethnic identity will enhance therapeutic outcomes and increase the cultural competence of the clinician. While culture-specific knowledge and experience can be helpful, cultural groups are heterogeneous and the assumption that members of particular ethnic or racial groups behave in characteristic ways risks stereotypic oversimplification (Foulks, Westermeyer, & Ta, 1998; Tsang & George, 1998; Carrillo, Green, & Betancourt, 1999; Dyche & Zayas, 2001; Suzuki, McRae & Short, 2001). Sue (1998) points out that even when therapists and clients are of the same ethnicity, cultural matches are not guaranteed. He argues that psychological aspects such as identity, attitudes, and personality may be more important.

The matching literature suggests that clients prefer to have counsellors who are similar to themselves in values and worldview. However, in the absence of this guarantee, they may select counsellors on visible demographic criteria in the hopes of obtaining a counsellor who shares some similar elements in these characteristics (Hays, 2001; Coleman et al., 1995 as cited in Pope-Davis, Toporek, Ortega-Villalobos, Ligiéro, Brittan-Powell, Liu, Bashshur, Codrington, & Liang, 2002). Tsang and colleagues point out that counselling competence of the practitioner, including cultural competence is probably a more important variable for successful engagement than ethnic group similarity (Tsang, Bogo, & George, 2003). They also underline the importance of other within-group difference variables such as the extreme variation of internalized cultures or ethnocultural identification and degree of acculturation (Tsang et al., 2003).
Tsang & George (1998) advocate intensive analysis on a micro-level of client-practitioner interaction to avoid viewing individuals as members of only one social category. Cultural biases can be particularly difficult to identify when the clinician and client are of a similar cultural background due to clinicians imposing their own values on the client, assuming they are identical (College of Nurses of Ontario, 2003). Furthermore, it is often pointed out in the cultural competence literature that cultural difference and power differential exist simply as a result of client-professional locations (Carrillo et al., 1999; Dyche & Zayas, 2001; Srivastava, 2002).

**Understanding and Accepting Alternative Worldviews**

In much of the literature on cross-cultural mental health counselling, influenced largely by the transcultural psychiatry field and Kleinman’s (1988) critique of science-based knowledge and Euro-American notions of the psyche and of ways of being in the world, the importance of questioning the validity of standard theories and techniques in assessment and practice is emphasized (O’Bryne, Undated). According to Sue and Sue (1999), “In order to be culturally competent, mental health professionals must be able to free themselves from the cultural conditioning of their personal and professional training, to understand and accept the legitimacy of alternative worldviews, and to begin the process of developing culturally appropriate intervention strategies in working with a diverse clientele” (p. ix).

The Greater Vancouver Mental Health Service (1999) highlight the necessity for culturally competent practitioners “…to work within the person’s values and reality conditions” and states that, “Cultural competence acknowledges and incorporates variance in normative acceptable behaviours, beliefs, and values in determining an individual’s mental wellness/illness, and incorporates these variables into assessment and treatment (p.2).

**Deep Understanding and Therapeutic Gain**

Most of the aforementioned definitions are consistent with tripartite models of cultural competence broken down into the components of skills, knowledge, and attitudes. Ridley, Baker, & Hill (2001) cite Wood and Power (1987) who have argued that the acquisition of these three components is not sufficient for competence. They assert that cultural competence is founded on “an integrated deep structure (‘understanding’) and on the general ability to coordinate appropriate internal cognitive, affective and other resources necessary for successful adaptation” (p.414). Ridley et al., (2001) further point out that a flaw in many definitions is the failure to clarify the “superordinate purpose of cultural competence” which is “therapeutic gain—the purposeful, positive change elicited by the therapeutic process” (p. 824). Clarification of this purpose and integrating it explicitly into the definition of cultural competence, according to the authors, is essential to the operationalization of cultural competence.

**Evidence-Based**

The evidence-based definition of cultural competency as defined by Arthur Evans (2003), Deputy Commissioner of the Connecticut Department of Mental Health and Addiction Services, is simply:

“Outcomes + Client Satisfaction = Cultural Competence” (p. 6).

This definition reflects a somewhat different approach to cultural competency in which culturally competent services are not independently identified by their attributes but are identified by their effectiveness and their outcomes. While emphasising client perception, the lack of defining specific therapeutic attributes and processes has been criticized as flawed (Ridley et al., 2001), and as leading to crude measures of competency (Leong, 1998) (see F. Evaluation Research: Brief Overview of Research on Cultural Competence Intervention).
An evidence-based definition of cultural competence emphasizing process and the client-clinician relationship in addition to outcomes comes from the field of nursing:

Cultural competence is an important skill for mental healthcare providers to incorporate within their practices to improve access, treatment, and outcomes for clients. Cultural competence is a circular process that flows from nurses' respect and understanding of the importance of culture in persons' lives and use of culturally-specific knowledge and approaches grounded in client needs. Such understanding and knowledge form the basis for the effective communication and interaction between a nurse and client. (Warren, 2002, p. 209)

Clinical Cultural Competence Practice Components/ Competencies

Therapeutic cross-cultural competencies refer to the set of knowledge, skills and awareness that a clinician must have in order to provide effective interventions for problems of clients from diverse backgrounds (Leong, 1998). This set of competencies involves the effect of culture on diagnosis, aetiology, presentation, and definition of psychopathology, client/clinician conceptualization of health/well-being/illness and the treatment process itself (Leong, 1998).

Arthur Kleinman's (1988) work, linking anthropology and psychiatry, has been very influential particularly with regard to the development of the cultural formulation of the DSM-IV and Explanatory Model of Illness/Health as a framework for assessment and treatment. However, much of the literature on cross-cultural practice stems from the field of counselling psychology. In fact, multiculturalism has been referred to as psychology's “fourth force”; the “third force” being humanism. Multiculturalism is seen as the “hottest topic” in the counseling profession (Sue, Arredondo, & McDavis, 1992). Not surprisingly then, is it that the most widely used framework for understanding, training and researching culturally competent care across disciplines is the model developed by Sue and colleagues (1992) which has formed the basis of most standardized measures of culturally competent care developed to date (Miyake Geron, 2002).

The Association for Multicultural Counseling and Development (AMCD) adopted this model with some revisions in 1996 (Arredondo et al., 1996). For example, Arredondo and colleagues (1996) distinguished the terms multicultural and diversity as follows: "Multiculturalism focuses on ethnicity, race, and culture. Diversity refers to other individual, people differences including age, gender, sexual orientation, religion, physical ability or disability, and other characteristics which someone may prefer to self-define" (p. 44).

In their original formulation, Sue et al. (1992) developed a tripartite framework with the domains: (1) Awareness of attitudes, beliefs, and values (or affective domain), (2) Knowledge (or cognitive domain) and (3) Skills (or behavioural domain). This review revealed a fourth domain -- **Power/Relationship Issues** based on the research of Sodowsky et al. (1994) that identified it as important for cross-cultural counselling. While not explicitly defined as a fourth domain, cross-cultural competencies identified across the disciplines examined in this review in addition to the training programs addressed the **Power/Relationship Issues** domain. Though these competencies are organized into four distinct domains there is considerable overlap among them. In Tables 1 and 2, practice domains and components for clinical cultural competence are organized according to the original tripartite framework developed by Sue et al. (1992) plus the added domain of **Power/Relationship Issues** (Sodowsky et al., 1994) and according to the lens for examination used in this review.

The following is a description of these domains and their components including some examples of specific competencies (See Table 2 for specific competencies identified across disciplines).
(1) Awareness of attitudes, beliefs, and values
This domain can be organized under the two components: I. Counsellor Awareness of Own Cultural Values and Biases and II. Counsellor Awareness of Client Worldview.

I. Counsellor Awareness of Own Cultural Values and Biases.
There is a general consensus that the starting point in culturally competent practice and training begins with the exploration of the cultural conditioning of the perspectives, biases, values, and prejudices of the clinician. This reflexive attitude begins with a process of critical self-reflection and evaluation that situates oneself within one's own cultural milieu of values, beliefs, and customs (O'Byrne, Undated). An awareness of how one's own cultural values, assumptions and beliefs influence the process of care and are shaped by social relationships and the contexts in which one works and lives is critical to cultural competence (Gompertz, 1997; Like, Steiner, & Rubel, 1996; Williams, 2002).

II. Counsellor Awareness of Client's Worldview.
This level of awareness is aimed at cognitive restructuring to generate a worldview or paradigm shift in order to understand, respect and validate “the other’s” position (Reynolds, 1997; O’Byrne, Undated).

(2) Knowledge
This domain involves understanding theory, research, and cross-paradigmatic approaches of multicultural counseling (Gompertz, 1997). It can be divided into the two components: I. Culture-Specific Knowledge (Emic) and II. Culture-Generic Knowledge (Etic) (O'Byrne, Undated).

I. Culture-Specific Knowledge
Intervention is focused on normative values/beliefs about health and illness, help-seeking behaviour, cultural-bound syndromes, idioms of distress, socio-political functioning, preferred modes of interaction, acculturation processes, family and community systems, and migration history, of specific ethnoracial or cultural groups with which one is working (Gompertz, 1997).

II. Culture-Generic Knowledge
Intervention focuses on knowledge required in any cross-cultural therapeutic encounter, working contextually and regarding every interaction as cultural. In this perspective, it is suggested that there are universals from theories of counseling/therapy, such as establishing the therapeutic alliance, conveying authenticity, and empathy for example, that can be applied in cross-cultural contexts (Williams, 2002). However, Williams (2002) points out that use of these basic clinical skills does not preclude the importance of sensitivity to cultural differences and the need to appreciate multiple worldviews. This level includes knowledge of: a) institutional barriers that prevent some diverse clients from using mental health services, b) history, experience and consequences of oppression, prejudice, discrimination, racism, and structural inequalities, c) the heterogeneity that exists within and across cultural groups and the need to avoid overgeneralization and negative stereotyping.

(3) Skills
Skills refer to the behavioural level of cultural competence but require competency in the domains of awareness and knowledge. This domain is related to the “knowing how” to conduct counselling sessions with clients from diverse groups whereas the knowledge domain refers to “knowing that” (Gompertz, 1997, p. 35). Competencies were organized under the added categories of: Pre-Engagement, Engagement, and Closure, based on Lo & Fung (2003), to clearly illustrate the application to practice across disciplines. These three phases of the treatment process are particularly important for cross-cultural work where empathy and establishment of the therapeutic alliance, for example, are especially significant in the clinical encounter. Lo & Fung (2003) have systematically examined generic and specific cultural competence in psychotherapy according to the competencies required in the various phases of therapy: pre-engagement, engagement, assessment/feedback,
treatment/intervention and closure/discharge. There is overlap of competencies among these phases with some phases occurring simultaneously.

I. Pre-Engagement
Lo & Fung (2003) point out that there are factors that may influence clinical outcomes even before the clinician sees the client. Help-seeking pathways can impact clinical outcome. They state that positive recommendations from a community elder, for example, may be more conducive to promoting therapeutic alliance than a perfunctory referral from a hospital emergency department. Important therapist skills in cultural sensitivity such as curiosity, perceptiveness and respect are highlighted in this phase (Lo & Fung, 2003).

II. Engagement
This initial phase of contact is very important for establishing the therapeutic alliance and develops simultaneously with the assessment/feedback phase (Lo & Fung, 2003). Lo & Fung (2003) report that research has documented high dropout rates of minority patients from the mental health care system which underscores the critical importance of this phase of therapy. The importance of eliciting the client’s explanatory model also is important for establishing the therapeutic alliance (College of Nurses of Ontario, 2003; Srivastava, 2004). Ability to inspire hope, maintain a strengths perspective focussing on resilience are also crucial attributes (Sue & Sue, 2003).

The Awareness of Own Cultural Values and Biases component which includes such competencies as an awareness of one’s own background/experiences, values and biases and how they influence psychological processes and affect clients, is important for facilitating the engagement process (College of Nurses of Ontario, 2003).

III. Assessment/Feedback
Assessment/Feedback is particularly important for maintaining the therapeutic alliance (Lo & Fung, 2003). “Attempts to understand patient problems should begin with what the patient deems important” (Lo & Fung, 2003, p. 163). Thus, eliciting the client’s explanatory model is necessary. It is in this phase that the components of Awareness of Client’s Worldview and Culture-Specific Knowledge including an exploration of the client’s cultural identity (which is not static) are very important (Lo & Fung, 2003).

IV. Treatment/Intervention
Collaboration between therapist and client in establishing goals and the tasks/interventions required to meet those goals is emphasised throughout the cultural competence literature across disciplines and is integral to engagement or establishing a therapeutic alliance (College of Nurses of Ontario, 2003; Hayes, 2001; Lo & Fung, 2003; Tsang, 2003; Sue & Sue, 2003). Cross-cultural communication and negotiation skills are also highly significant for successful cross-cultural therapeutic encounters (Lo & Fung, 2003; Leininger, 1995; Srivastava, 2003; Williams 2001). Another very important part of this phase requires the clinician to be flexible, negotiate interventions based on indigenous as well as mainstream perspectives and strategies and consult with traditional healers or religious/spiritual leaders and practitioners in treatment of culturally diverse clients (Leininger, 1995; Tsang, 2003; Sue & Sue, 2003).

V. Closure/Discharge
Lo & Fung (2003) acknowledge the importance of this phase for ethnic patients and their families, in particular, who may need to maintain contact after discharge due to a lack of community support and due to different understandings of relationships which are rarely terminated artificially. They indicate that therapists may maintain links with patients and their families by reconsulting in appropriate circumstances or if this is not possible refer patients for continued support to other hospitals or community agencies.
(4) Power Issues/Relationship

I. Client-Therapist Dyad (Micro Level)
This micro level refers to the dynamics of the clinician-client relationship including an examination of the therapeutic relationship between clinicians and clients with similar and different cultural values, racial identity attitudes and issues of power, control, and oppression. Power Relationship/Issues is particularly salient, as in many cases the clinician will represent the dominant group in society.

II. Client-System (Macro Level)
This review identified a macro-level of the Power Issues/Relationship domain to be client-system in addition to the client-clinician level. Client-system level focuses on the impacts of systemic oppression, discrimination and racism at the sociocultural, institutional, and political levels on psychosocial, political, and economic development. Thus, this involves an expansion of the clinician role from one-to-one therapy to alternative helping roles such as —consultant, change agent, teacher and advocate.

Table 1 is a global comparison of clinical practice domains and components of cultural competence among the disciplines of psychology, social work, nursing, and psychiatry. These competencies have been gleaned from the literature on cross-cultural clinical care across the four disciplines as shown in the sources section of Table 2. One can see at a glance from Table 1 that these disciplines are almost identical in the acknowledgement of practice competencies.

Table 2 shows the specific competencies identified across disciplines. Differences exist primarily with regard to emphasis placed on particular competencies. For example, the practitioner role of system advocacy as a cultural competency appears more often in the psychology and social work literature (APA, 1990; Arredondo & Arciniega, 2001; CPA, 2001; Dean, 2001; Hayes, 2001; NASW, 2002; Tsang & George, 1998; Sue & Sue, 2003) but it is gradually emerging in the psychiatry literature (Center for Linguistic and Cultural Competence in Health Care, 2002; Hayes, 2001). The analysis of cultural implications of basic and fundamental theoretical constructs and practice approaches tends to be emphasised in the social work, psychology and psychiatry literature (Center for Linguistic and Cultural Competence in Health Care, 2002; Hayes, 2001; Lo & Fung, 2003; Lu, Lim, & Mezzich, 1995; Sue & Sue, 2003).

This review revealed that, interestingly, clinician confidence in one's ability to provide cross-cultural care was identified as a specific competency only by the nursing field (Salimbene, 1999). A tentative finding which would underline the significance of clinician confidence as a specific competency comes from a qualitative research in-progress project in which the researcher reported that a prominent theme appears to be that one of the challenges for providing culturally competent care identified by clinicians she interviewed (from the fields of OT, Nursing and Social Work) is a lack of confidence and “fear of doing it wrong” (Srivastava, April 2004). Obviously, this emerging finding has important implications for cultural competence training/education programs.

Other competencies most notable in the social work and psychology literature are 1) recognition of the importance of valuing and respecting practitioner self-care and 2) ability to inspire hope, maintaining a strengths perspective focusing on resilience of the client and 3) ability to help clients determine whether a “problem” stems from racism or bias in others (concept of healthy paranoia) so that clients do not inappropriately blame themselves (CPA, 2001; Sue et al., 1992; Sue & Sue, 2003; Tsang, 2004).
Table 1  Clinical Cultural Competence Practice Components

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Psychology</th>
<th>Social Work</th>
<th>Nursing</th>
<th>Psychiatry</th>
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<tr>
<td>Client worldview</td>
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<tr>
<td>Culture specific</td>
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<td>Culture generic</td>
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<td>Pre-engagement</td>
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<td>Engagement</td>
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<td>Assessment</td>
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<td>Treatment/ Intervention</td>
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<tr>
<td>Closure/ Discharge</td>
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<tr>
<td>Research &amp; Education</td>
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<tr>
<td>Power/ Relationship</td>
<td>Client-Therapist</td>
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<td>Client-System</td>
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Table 2   Clinical Cultural Competence Practice Components / Competencies

<table>
<thead>
<tr>
<th>Awareness of Values/ Attitudes</th>
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<tr>
<td><strong>Awareness of Own Cultural Values and Biases</strong></td>
</tr>
<tr>
<td>- Aware of and sensitive to own cultural heritage and self-identity with relation to ethnic and cultural definitions</td>
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<tr>
<td>- Aware of own background/experiences, values and biases and how they influence psychological processes and affect clients</td>
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<tr>
<td>- Able to recognize the limits of own multicultural competency and expertise</td>
</tr>
<tr>
<td>- Acknowledges and is aware of own racist, sexist, heterosexist, or other detrimental attitudes, beliefs, and feelings</td>
</tr>
<tr>
<td>- Aware of differences between self and clients in terms of race, gender, sexual orientation and other sociodemographic variables</td>
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<tr>
<td>- Aware of cultural transference and counter-transference and defensive reactions</td>
</tr>
<tr>
<td>- Engage in critical self-reflection regarding personal identity and attitudes to other groups, self-monitoring, and self-correction</td>
</tr>
<tr>
<td>- Understanding of how oppression and discrimination personally affect oneself and one's work</td>
</tr>
<tr>
<td>- Values and respects helper wellness, self-care and self-awareness</td>
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<tr>
<td>- Valuing and respecting humility and willingness to learn from others; open-mindedness</td>
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<tr>
<th>Awareness of Client’s Worldview</th>
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<tr>
<td>- Values/respects differences, diversity among and within a cultural group</td>
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<td>- Respects religious and/or spiritual beliefs of others</td>
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<td>- Respects indigenous helping practices and community networks</td>
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<tr>
<td>- Values bilingualism</td>
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<td>- Can be non-judgemental</td>
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<th>Knowledge</th>
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<tr>
<td><strong>Culture-Specific (Emic)</strong></td>
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<tr>
<td>- Possesses specific knowledge of normative values/beliefs about illness, normality/ abnormality, help-seeking behaviour, culturally unique symptoms and interventions, interactional styles, and worldview of main cultural groups with which one is working</td>
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<td>- Possesses specific knowledge about cultures one serves to anticipate barriers to access</td>
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<tr>
<td>- Possesses enough knowledge about cultures one serves to avoid breaching client’s taboos, health care beliefs, or rules of interaction</td>
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<tr>
<td>- Knowledge of service resources for culturally-appropriate care</td>
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<th>Culture-Generic (Etic)</th>
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<tr>
<td>- Aware of institutional barriers that prevent some diverse clients from using mental health services</td>
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<tr>
<td>- Knowledge of history, experience and consequences of oppression, prejudice, discrimination, racism, and structural inequalities</td>
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<tr>
<td>- Understands culture-bound, class-bound, and linguistic features of psychological help/interventions</td>
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<tr>
<td>- Knowledge of the heterogeneity that exists within &amp; across cultural groups and the need to avoid overgeneralization and negative stereotyping</td>
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<tr>
<td>- Good understanding of sociopolitical system and its treatment of marginalized groups in society, immigration, poverty, powerlessness, etc.</td>
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<td>- Knows how discriminatory practices operate at a community level.</td>
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<tr>
<td>- Knowledge of own social impact and communication styles</td>
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<tr>
<td>- Knowledge about personal dynamics of acculturation, ethnic identity development and cultural identification</td>
</tr>
<tr>
<td>- Understanding the process by which clients internalize oppression, how process is manifested, and how it results in surplus powerlessness</td>
</tr>
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## Skills

### Pre-Engagement
- Understanding help-seeking pathways

### Engagement
- Establishing rapport and therapeutic alliance in culturally congruent way considering culture-bound interpretations of verbal and nonverbal cues, personal space, and eye contact
- Educates clients in the nature of one’s practice
- Cultural empathy
- Establish goals collaboratively
- Ability to inspire hope, maintain a strengths perspective focusing on resilience.

### Assessment/Feedback
- Ability to assess issues as client's level of acculturation, acculturative stress, and stage of gay or lesbian identity development
- Ability to modify standardized tests/assessment tools and qualify conclusions appropriately (incl. Empirical support where available) for use with identified groups, with consideration of their inherent cultural biases
- Conduct assessments through open-ended questions to elicit client's perceptions and beliefs, concepts/definitions of health, disease, health care utilization and healing; Elicit Explanatory Model of Illness (Kleinman)
- Integrate physical, psychological, social, cultural, and spiritual dimensions in assessing problems and strengths
- Use of cultural consultant
- Assessment of family dynamics and support systems
- Ability to help clients determine whether a “problem” stems from racism or bias in others (concept of healthy paranoia) so that clients do not inappropriately blame themselves
- Knowledge of culture-specific diagnostic categories, “idioms of distress”, culture-bound syndromes
- Ability to ascertain effects of therapist-client language difference (incl. Use of translators) on assessment and intervention

### Treatment/Intervention
- Ability to use cross-cultural communication skills—send and receive and generate a wide variety of verbal and nonverbal responses, use patience, listening and tolerance of silence to leave space for client
- Ability to problem-solve based on client perspective
- Can seek consultation with traditional healers or religious/spiritual leaders and practitioners in treatment of culturally diverse clients
- Ability to work with interpreters
- Ability to exercise institutional skills on behalf of client; this involves out-of-office strategies (outreach, consultant, change agent, facilitator of indigenous support systems) that discard the intra-psychic counselling model and view problems/barriers as residing outside the minority client
- Support clients in identity pride, building on strengths and encouraging self-definition
- Ability to empower client and families through community-based organizations
- Confidence in one's ability to provide quality care to patients of diverse cultures
- Ability to negotiate interventions based on indigenous and mainstream perspectives and strategies
- Advocate for client-centred care

### Closure/Discharge
- Ability to define appropriate circumstances in which should re-consult with client and family members

### Power/Relationship Issues

#### Client-therapist Dyad (Micro-Level)
- Knowledge about cultural differences and power dynamics that affect cross-cultural interactions
- Set goals, develop treatment plans and choose interventions collaboratively with clients
- Sensitivity to issues of power, trust/mistrust, respect and intimacy in practitioner-client relationship
- Managing rather than masking emotional response

#### Client-System (Macro-Level)
- Social justice orientation and recognition of power issues in relationships
- Ability to engage in systemic advocacy impacting societal levels—may involve out-of-office strategies that discard intrapsychic model and view problems/barriers as residing outside the client. (E.g. Outreach, consultant, change agent, ombudsman roles)

### Practitioner-Oriented Research and Knowledge Development
- Systematic process-outcome research
- Seeks out ongoing educational, consultative, and multicultural training experiences

### Sources

#### Psychology
1. Sue (2001)
2. Sue & Zane (1987)
5. Gopaul-McNicol (1997)
6. Arredondo et al. (1996)
7. Sue et al. (1992)
9. Sodowsky et al. (1997)
10. American Psychological Association (1990)
11. Canadian Psychological Association (2001)

#### Social Work
4. Cross et al. (1989)
5. Williams (2001)
9. NASW (2001)

#### Nursing
1. Srivastava (November 2002)
5. Salimbene (1999)

#### Psychiatry
5. Like et al. (1996)
6. Carrillo et al. (1999)
8. Foulks et al. (1998)
9. Lu et al. (1995)
B. Professional Colleges and Association—Standards & Guidelines for Cultural Competence

Introduction
Although in the last two decades an abundance of writing and training in the area of cultural competence can be seen there is a lack of national standards and guidelines for cultural competence among the various professional colleges and associations. Table 4 shows the associations and colleges for which standards and guidelines for Cultural Competence could be found and reveals global similarities and differences. These Colleges/Associations are: the American Psychological Association (APA), the National Association of Social Workers (NASW) (United States), the College of Nurses of Ontario, and the Canadian Psychological Association (CPA). While the CPA refers to the guidelines as Guidelines for Non-discriminatory Practice, the content is consistent with culturally competent practice.

No standards and guidelines could be found for the following Associations and Colleges:

- College of Physicians & Surgeons (Canada)
- Canadian Psychiatric Association (CPA)
- Canadian Association of Social Work (CASW)
- Ontario Association of Social Workers and Social Service Workers (OASW)
- Canadian Association of Occupational Therapy (CAOT)
- College of Occupational Therapists of Ontario (COTO)
- American Occupational Therapy Association (AOTA)

COTO has no separate guidelines that outline cultural competency however there is reference throughout the guidelines for professional practice, ethics and competency around consideration and regard for cultural needs, values and beliefs of clients and communities. Similarly, the AOTA (1998) has included one standard regarding knowledge of legislative, political, social, cultural, and reimbursement issues that affect clients and the practice of occupational therapy. In addition, in the AOTA (2000) Occupational Therapy Code of Ethics, one of the principles states: “Occupational therapy personnel shall provide services in a fair and equitable manner. They shall recognize and appreciate the cultural components of economics, geography, race, ethnicity, religious and political factors, marital status, sexual orientation, and disability of all recipients of their services”.

Table 3  
Comparison of College and Association Standards & Guidelines for Culturally Competent Practice

<table>
<thead>
<tr>
<th></th>
<th>APA</th>
<th>NASW</th>
<th>CNO</th>
<th>CPA</th>
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<tr>
<td><strong>Awareness</strong></td>
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<td>Self</td>
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<td>Client worldview</td>
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<td><strong>Knowledge</strong></td>
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<td>Culture specific</td>
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<td>Culture generic</td>
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<td>Pre-engagement</td>
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<td>Engagement</td>
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<td><strong>Skills</strong></td>
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<td>Assessment</td>
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<td>Treatment/Intervention</td>
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<td>Closure/Discharge</td>
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<td>Research &amp; Education</td>
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<td><strong>Power/Relationship</strong></td>
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<td>Client-Therapist</td>
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<td>Client-System</td>
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Comparison

In Tables 3 and 4, the standards and guidelines were analysed and organized according to the lens for examination to facilitate comparison among the professional colleges and associations. In terms of a more global comparison, Table 3 shows at a glance that there are more commonalities than differences. For example, all colleges and association standards and guidelines do not address Skills--Pre-engagement, and all address the following areas: Awareness—I. Own Cultural Values and Biases and II. Client Worldview, Knowledge—I. Culture-Specific and II. Culture-Generic, and Skills-Treatment/Intervention. NASW is the only association that does not address Skills--Assessment, CNO the only college that does not address Skills--Research and Education, APA the only college that does not cover Closure/Discharge and finally, APA and NASW standards and guidelines do not address Power/Relationship Issues-- Client-Therapist Dyad. More specifically, in Table 4, we can see that the CNO is the only college that does not explicitly link client problems to socio-cultural, political and economic contexts.
Table 4  Detailed Comparison of Colleges and Association Standards & Guidelines for Culturally Competent Practice

<table>
<thead>
<tr>
<th>College / Association</th>
<th>Philosophical Underpinning</th>
<th>Goals &amp; Objectives</th>
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<tbody>
<tr>
<td>AMERICAN PSYCHOLOGICAL ASSOCIATION (August 1990)</td>
<td>Unstated</td>
<td>The specific goals of the standards are to:</td>
</tr>
<tr>
<td>NATIONAL ASSOCIATION OF SOCIAL WORK (June 2001) [United States]</td>
<td>Integrated Emic/Etic Approach to Practice</td>
<td>1. maintain and improve the quality of culturally competent services provided by social workers, and programs delivered by social service agencies;</td>
</tr>
<tr>
<td>COLLEGE OF NURSES OF ONTARIO (2003)</td>
<td>Unstated</td>
<td>2. establish professional expectations so social workers can monitor and evaluate their culturally competent practice;</td>
</tr>
<tr>
<td>CANADIAN PSYCHOLOGICAL ASSOCIATION (2001)</td>
<td>Unstated</td>
<td>3. provide a framework for social workers to assess culturally competent practice;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. inform consumers, governmental regulatory bodies, and others, such as insurance carriers, about the profession's standards for culturally competent practice;</td>
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<td>5. establish specific ethical guidelines for culturally competent social work practice in agency or private practice settings;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. provide documentation of professional expectations for agencies, peer review committees, state regulatory bodies, insurance carriers, and others.</td>
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</table>

Guidelines were developed to: |
1. gain an awareness for the need for non-discriminatory practice. |
2. promote non-discriminatory practice among psychologists. |
3. provide guidelines for self-evaluation |

Philosophical Underpinning: Unstated for all associations except for the National Association of Social Work which has an integrated Emic/Etic Approach to Practice.

Goals & Objectives: The specific goals of the standards are to maintain and improve the quality of culturally competent services provided by social workers, and programs delivered by social service agencies; establish professional expectations so social workers can monitor and evaluate their culturally competent practice; provide a framework for social workers to assess culturally competent practice; inform consumers, governmental regulatory bodies, and others, such as insurance carriers, about the profession's standards for culturally competent practice; establish specific ethical guidelines for culturally competent social work practice in agency or private practice settings; provide documentation of professional expectations for agencies, peer review committees, state regulatory bodies, insurance carriers, and others.

To support nurses in problem solving in commonly encountered situations to enable nurses to provide culturally sensitive care.
<table>
<thead>
<tr>
<th>College / Association</th>
<th>Definitions</th>
</tr>
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<tbody>
<tr>
<td>AMERICAN PSYCHOLOGICAL ASSOCIATION (August 1990)</td>
<td>Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each. Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations (Cross, 1989). Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (Davis &amp; Donald, 1997). Competence in cross-cultural functioning means learning new patterns of behavior and effectively applying them in appropriate settings. Gallegos (1982) provided one of the first conceptualizations of ethnic competence as “a set of procedures and activities to be used in acquiring culturally relevant insights into the problems of minority clients and the means of applying such insights to the development of intervention strategies that are culturally appropriate for these clients.” (p. 4). This kind of sophisticated cultural competence does not come naturally to any social worker and requires a high level of professionalism and knowledge.</td>
</tr>
<tr>
<td>NATIONAL ASSOCIATION OF SOCIAL WORK (June 2001) [United States]</td>
<td>None</td>
</tr>
<tr>
<td>COLLEGE OF NURSES OF ONTARIO (2003)</td>
<td>None</td>
</tr>
<tr>
<td>CANADIAN PSYCHOLOGICAL ASSOCIATION (2001)</td>
<td>None</td>
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<tr>
<td>Culture</td>
<td>Broadly defined. &quot; 'Culture' is defined as the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, care taking practices, media, educational systems) and organizations. Inherent in this definition is the acknowledgment that all individuals are cultural beings and have a cultural, ethnic, and racial heritage. Culture has been described as the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions. It also encompasses a way of living informed by the historical, economic, ecological, and political forces on a group. These definitions suggest that culture is fluid and dynamic, and that there are both cultural universal phenomena as well as culturally specific or relative constructs. (p.9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guidelines / Standards</th>
<th>Summary of Guidelines intended for service delivery not limited to clinical or counselling; clients may also be organizations, government and/or community agencies. (from Sadowsky et al., 1997, p. 6-7)</th>
<th>Standards for Social Workers</th>
<th>Guidelines for Nurses for Providing Culturally Sensitive Care</th>
<th>Guidelines for Non-Discriminatory Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td>Own Cultural Values and Biases</td>
<td>Own Cultural Values and Biases</td>
<td>Own Cultural Values and Biases</td>
<td>Own Cultural Values and Biases</td>
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<td></td>
<td>• recognition of the limits of psychologist competencies and expertise</td>
<td>• seek to develop an understanding of their own personal, cultural values and beliefs as one way of appreciating the importance of multicultural identities in the lives of people.</td>
<td>• Engage in ongoing reflection regarding cultural sensitivity and learning about different cultures.</td>
<td>• Be aware of one's own cultural, moral, and social beliefs, and be sensitive to how they may enhance one's interactions with others or may interfere with promoting the welfare of others.</td>
</tr>
<tr>
<td></td>
<td>• recognize ethnicity and culture as significant parameters in understanding psychological processes. This requires an awareness of how own cultural background, experiences, attitudes, values, and biases influence psychological processes and therapeutic interventions.</td>
<td>• function in accordance with the values, ethics, and standards of the profession, recognizing how personal and professional values may conflict with or accommodate the needs of diverse clients.</td>
<td></td>
<td>• Constantly reevaluate one's competence, attitudes, and effectiveness in working with diverse populations.</td>
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|                        | | | | • Acknowledge one's own vulnerabilities and care for oneself outside of relationships as psychologists.
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<tr>
<td><strong>Client Worldview</strong></td>
<td><strong>Awareness of how client’s cultural background, experiences, attitudes, values, and biases influence psychological processes and therapeutic interventions.</strong>&lt;br&gt;<strong>Respect the roles of family members and community structures, hierarchies, values, and belief systems within the client’s culture.</strong>&lt;br&gt;<strong>Respect clients’ religious and /or spiritual beliefs and values, including attributions and taboos, because they affect worldview, psychosocial functioning, and expressions of distress.</strong></td>
<td><strong>Understanding about the history, traditions, values, family systems, and artistic expressions of major client groups that they serve.</strong>&lt;br&gt;<strong>Be non-judgemental.</strong></td>
<td><strong>Recognize inherent worth of all human beings regardless of how different they may be from oneself.</strong></td>
<td></td>
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<tr>
<td><strong>Knowledge</strong></td>
<td><strong>Culture Specific</strong>&lt;br&gt;- are cognizant of relevant research and practice issues as related to the population being served&lt;br&gt;- familiarity with indigenous beliefs and practices**&lt;br&gt;<strong>Culture Generic</strong>&lt;br&gt;- acknowledgement that ethnicity and culture affect the behaviour of clients&lt;br&gt;- cognizant of relevant discriminatory practices at the social and community level&lt;br&gt;- know that culture, ethnicity, race, and socioeconomic and political factors have a significant impact on the psychosocial, political, and economic development of ethnic and culturally diverse groups&lt;br&gt;- understand the interaction of culture, gender, and social orientation on client behaviors and needs.</td>
<td><strong>Culture Specific</strong>&lt;br&gt;- have and continue to develop specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expressions of major client groups that they serve.&lt;br&gt;- have a knowledge base of their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups (Ethical Standard 1.05b)</td>
<td><strong>Culture-Specific</strong>&lt;br&gt;- Study group or cultural norms in order to recognize individual differences within the larger context.</td>
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<td><strong>Culture Specific</strong>&lt;br&gt;- obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability. (Ethical Standard 1.05c)&lt;br&gt;- understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures. (Ethical Standard 1.05a)</td>
<td><strong>Culture Generic</strong>&lt;br&gt;- Broaden understanding of cultural concepts and issues.</td>
<td><strong>Culture Generic</strong>&lt;br&gt;- Be aware that theories or precepts developed to describe people from the dominant culture may apply differently to people from non-dominant cultures.</td>
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<tr>
<td>Skills</td>
<td>Pre-Engagement N/A</td>
<td>Pre-Engagement N/A</td>
<td>Pre-Engagement N/A</td>
<td>Pre-Engagement N/A</td>
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<tr>
<td></td>
<td>Engagement</td>
<td>use appropriate methodological approaches, skills, and techniques that reflect the workers’ understanding of the role of culture in the helping process.</td>
<td>Advocating for client-centred care Facilitate client choice in goals for treatment.</td>
<td>Respect, listen and learn from clients who are different from oneself in order to understand what is in their best interests.</td>
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<td></td>
<td>Assessment</td>
<td>Conduct assessments through open-ended questions to elicit the client’s perceptions and beliefs (Kleinman et al., 1978).</td>
<td>Assessment</td>
<td>Assess accurately the source of difficulties, apportioning causality appropriately between individual, situational, and cultural factors.</td>
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<td></td>
<td>Treatment/Intervention</td>
<td>Incorporate religious/spiritual leaders/practitioners relevant to the client’s cultural and belief systems into psychological interventions. Interact in the language requested by the client and, if not feasible, make appropriate referral. Document culturally relevant factors in client records. These may include, but are not limited to, factors associated with client’s acculturation, extent of family support, level of education, and intimate relationships with people of different backgrounds. Facilitate clients’ understanding, resolution, and maintenance of their own sociocultural identifications.</td>
<td>Make efforts to accommodate cultural preferences in whatever way possible that does not compromise client safety. Recognize the need to sometimes involve non-traditional health team members such as interpreters (linguistic and cultural), spiritual leaders/counsellors and other individuals identified by the client. Strategies for working effectively with interpreters. Ability to use non-verbal communication strategies. Ability to negotiate, validate, and restructure interventions based on indigenous and mainstream perspectives and strategies. Develop formal and informal networks related to culture-specific care.</td>
<td>Use inclusive and respectful language. Consult with others who may be more familiar with diversity in order to provide competent services.</td>
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<td></td>
<td>Closure/Discharge</td>
<td>be knowledgeable about and skilful in the use of services available in the community and broader society and be able to make appropriate referrals for their diverse clients</td>
<td>Closure/Discharge</td>
<td>Be knowledgeable of community resources available for diverse populations.</td>
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<td></td>
<td>Research &amp; Education</td>
<td>seeking educational and training experiences to enhance understanding of minority clients.</td>
<td>Research &amp; Education</td>
<td>Research &amp; Education</td>
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<tr>
<td></td>
<td></td>
<td>advocate for and participate in educational and training programs that help advance cultural competence within the profession.</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Other</td>
<td>Diverse Workforce—support and advocate for recruitment, admissions and hiring, and retention efforts in social work programs and agencies that ensure diversity within the profession. Cross-Cultural Leadership—be able to communicate information about diverse client groups to other professionals.</td>
<td>Other</td>
<td>Other</td>
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A Review of Clinical Cultural Competence
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<tr>
<td><strong>Power/Relationship Issues</strong></td>
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<td><strong>Client-System (Macro-Level)</strong></td>
<td><strong>Client-System (Macro-Level)</strong></td>
<td><strong>Client-System (Macro-Level)</strong></td>
<td><strong>Client-Therapist Dyad (Micro-Level)</strong></td>
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<tr>
<td>Attend to as well as work to eliminate biases, prejudices and discriminatory practices assuming an advocacy role.</td>
<td>Empower &amp; advocate by being aware of the effect of social policies and programs on diverse client populations, advocating for and with clients whenever appropriate.</td>
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<td>Recognize the power differential between oneself and others in order to diminish the differences, and to use power for the advantage of others rather than unwittingly abuse it.</td>
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<td><strong>Client-Therapist Dyad</strong></td>
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<td>Share all relevant decision making with clients including goals of the interaction and the nature of proposed interventions in order to serve their best interests.</td>
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<tr>
<td>- Be sensitive to issues of power, trust, respect and intimacy.</td>
<td>- Ensure that consent is truly informed, keeping in mind diversity issues and cultural differences.</td>
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<td>- Establishment of mutual goals.</td>
<td>- Be especially careful to be open, honest, and straightforward, remembering that persons who are oppressed may be distrustful or overly trustful of those in authority.</td>
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<td>- Respect privacy and confidentiality according to the wishes of clients, and explain fully any limitations on confidentiality that may exist.</td>
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<td>- Make competent services available to disadvantaged groups by offering services at a lower cost in proportion to client income for a proportion of one's caseload.</td>
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<td>- To the extent that individuals and groups without power suffer oppression in society, psychologists have an ethical responsibility to use their knowledge and power to contribute to social change.</td>
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<td>- Recognize that in addition to personal coping skills, empowerment of vulnerable persons so that they have equal opportunities in mainstream society, requires political and social changes.</td>
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<td>- Recognize the reality, variety, and implications of all forms of oppression in society, and facilitate clients' examination of options in dealing with such experiences.</td>
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<td>- Recognize that those who are subjected to physical or sexual assault are victims of crime and that those who assault are guilty of crimes.</td>
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<tr>
<td></td>
<td>- Choose ways in which one can contribute to the making of a society that is respectful and caring of all its citizens.</td>
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In terms of more detailed comparison, we can see from Table 4, varying objectives for the standards and guidelines among all the colleges and associations. For APA, the goal is to provide a sociocultural framework for diversity issues and knowledge and skills. Similarly, the objectives for NASW standards are to provide a framework for social workers to assess culturally competent practice and this is also an objective for the CPA. However, as mentioned previously, the term used throughout the guidelines for the CPA is “Non-Discriminatory Practice”; the term “cultural competence” is never used. The CNO consist of guidelines for problem solving to enable nurses to provide culturally competent care. All colleges and associations define culture broadly to be diversity-inclusive, (i.e. to include the diversities of gender, sexual orientation, language, religious/spiritual beliefs, visible and invisible disability, socioeconomic class, and immigrant status, in addition to race, ethnicity, and Country of Origin). Only the NASW includes a definition of cultural competence. Only the APA contains a standard under Skills—Intervention/Treatment for documentation of culturally relevant factors in client records. The NASW, APA, and CPA contain standards under Power/Relationship Issues—Client-System that promote an advocacy role linking client problems to sociocultural, political and economic contexts. Only the CPA acknowledges the importance of practitioner self-care under Awareness—Own Cultural Values and Biases. In addition, the CPA contains many more guidelines under both levels of Power/Relationship Issues—Client Therapist Dyad and Client-System than other colleges and associations. In fact, interestingly, most of the guidelines fall under this domain. In addition, only the CPA addresses issues of informed consent and making competent services available to disadvantaged groups by adjusting fees in proportion to client income. Furthermore, this association explicitly states in its guidelines the need for psychologists to: "Recognize that those who are subjected to physical or sexual assault are victims of crime and that those who assault are guilty of crimes".

C. National and International Standards and Mandates for Culturally Competent Clinical Care

In her review of cross-cultural training programs, O’Byrne (Undated) reports that it was difficult to collect a complete list of cross-national training programs. It is pointed out that although an abundance of local initiatives that are evolving in this area can be found on the Internet, there is a lack of a clear, coordinated national framework for training models.

Canada

A lack of coordination in cultural competence training models and standards can also be seen in Canada. O’ Bryne (Undated) notes

"... cross-cultural training in mental health in Canada within major institutional structures is a rare occurrence and what has been implemented is ill-defined, undocumented, and un-researched. There are informal training structures in place, largely in community organizations, which do not necessarily interact or overlap with government, university or hospital settings" (p. 18).

The United States

Similarly, while the U.S. is moving towards a consensus on many major points of what constitutes cultural competence in primary health care much less work has been done in the area of culturally competent mental health care and what has been done is aimed at the organizational level (O’ Byrne, Undated). The National Standards for Culturally and Linguistically Appropriate Services in Health Care
published by the U. S. Department of Health and Human Services—Office of Minority Health (March 2001) target the organizational level of cultural competence. The United States Department of Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA) (January 2001) has published Clinical Standards and Implementation Guidelines for Cultural Competence Standards in Managed Care Mental Health Services which also focus only on the organizational level of cultural competence.

**Australia**

As with the United States, in Australia there is a lot of activity with regard to multicultural training and research but there seems to be a more coordinated effort with regard to the clinical level of cultural competence in mental health. In fact, Multicultural Mental Health Australia (MMHA) links a wide range of state and territory mental health specialists and services, advocacy groups and tertiary institutions to promote the mental health and well being of Australia's diverse communities. A major initiative undertaken by MMHA is the development, in conjunction with the Australian Health Ministers Advisory Committee National Mental Health Working Group, of a national policy statement and framework for action to identify priorities for national initiatives in multicultural mental health and guide decisions about national project activity expected to be complete by Spring 2004. The MMHA website, a 'network of networks' tracks and offers ongoing training seminars, interpreter training, and training manuals in cross-cultural mental health across the country. It has also published an online introductory training tool kit for cultural competence (MMHA, 2002).

**International Standards**

Internationally, the ICD-9 Classification of Mental and behavioural Disorders of the World Health Organization (1992), incorporated major methodological developments such as a phenomenological organization of nosology, use of more specific definitions for diagnostic categories, the development of an international psychiatric glossary that contains descriptions of culture-bound syndromes and an international casebook (Lu, Lim, & Mezzich, 1995). However, there are no published standards or guidelines for culturally competent clinical care.

**D. Training**

**Introduction**

Standard 3 of the National Standards for Culturally and Linguistically Appropriate Services in Health Care developed by the United States Department of Health and Human Services, Office of Minority Health (2001) states: “Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically competent service delivery” (p. 7). In the Recommended National Standards for Culturally and Linguistically Appropriate Health Care Services it stated: “This [standard] may be the single most important element of assuring the cultural competence of an organization, and one of the elements most directly related to clinical care and outcomes” (p. 5).

One of the main rationales for the development of these national standards is that, as the report points out, while definitions, resources, training programs, curricula and purveyors of cultural competence proliferate, there were, at the time of the report, no comprehensive standards of cultural or linguistic competence in health care service delivery developed by any national body. In addition, there is no consensus on the definition of what constitutes a culturally competent health professional and no standard curriculum or universally accepted certification or credentialing.
This section contains representative material that has been compiled from the vast array and quantity of information and resources related to training in cultural competence clinical care, as well as from the consultations with cultural competence trainers from various programs/hospitals in Toronto.

Outside academic settings, continuing education courses, workshops, and courses designed for individual organizations or groups of staff range from a few hours to a few days. As reported by the Office of Minority Health (OMH) (2001), many consultants and trainers are teaching cultural competence to health professionals. Their credentials range from no formal training to previous experience in human resources diversity training to doctoral level research and academic training experience in cross cultural issues. There is much variation in content and teaching approaches among trainers.

Philosophical Underpinnings

Literature reviews across disciplines reveal that cultural competence training is implemented across a continuum of philosophies ranging from generic approaches to culture-specific approaches (Gompertz, 1997; O’Byrne, Undated; Williams, 2002). More recently, these two approaches are being integrated (Gompertz, 1997; Lo & Fung, 2003). However, the literature does not present empirical findings comparing the effectiveness of these models in ensuring cultural competence of trainees (Gompertz, 1997).

Generic or Etic Approach

This approach to cross-cultural practice, sometimes also referred to as the “universal” approach, emphasizes commonalities shared by all humans. Advocates of this philosophy, suggest that there are universals from theories that can be applied in cross-cultural contexts. For example, basic therapeutic skills in the area of establishing a therapeutic alliance, conveying authenticity, empathy and warmth are considered to be also good tools for cross-cultural practice (Tsang, 2004; Williams, 2002). Etic constructs have been criticized largely for ignoring Eurocentric biases inherent in mainstream assessment and research and overlooking political disparities among racial, ethnic and other minority groups (Sodowsky et al., 1997).

Culture-Specific or Emic Approach

The culture-specific or emic approach to practice means founding practice on the specific values, behaviours and experiences of a specific cultural group. Cultural norms, values, and worldviews affect the expression, meaning, and definition of disorder (Sue & Sue, 2003). Thus, problems and interventions are conceptualized in culture-specific ways. Culture-bound syndromes, anthropological descriptions, and indigenous concepts and explanations characterize emic assessment and intervention (Sodowsky, Kuo-Jackson, & Loya, 1997). For example, a wide variety of interventions may be based on indigenous healing practices. However, due to past criticisms of the tendency of this approach to essentialize, oversimplify and stereotype the experience of cultural groups, there has been a shift away from an emphasis on “expert knowledge” to recognition of within-group differences and changing political and social contexts which influence culture (Williams, 2002). The Emic approach has been described as being best utilized when working for extended periods with a small number of specific ethnoracial and ethnicultural groups (Sodowsky et al., 1997; Williams, 2002).

Increasingly, however, practitioners, researchers, and trainers are using both emic and etic data to make assessment and interventions more comprehensive (Allibhai, 2004; Betancourt et al., 2003; Sodowsky et al., 1997; Srivastava, 2004). Sue and Sue (2003) also point out that, " Few mental health professionals today embrace the extremes of either position, though most gravitate toward one or the other" (p. 5).
**Integrated Emi-Etic Approach**
This approach to cultural competence can be described as a balance between etic and emic perspectives (Williams, 2002). In this approach, specific multicultural constructs (e.g. acculturation, racial/ethnic identity, worldview) are applied in work with all clients, regardless of specific cultural background (Sodowsky et al., 1997). In this sense, universal practices are used to reveal unique aspects of individuals and groups. This approach, also referred to as an “imposed etic”, involves hypothesis-testing and a collaborative exploration with the client to discover ways in which the client experiences her or his culture-- the personal meaning derived from affiliation/connection with one or more cultural groups, and the best ways to conceptualize problems and interventions for individuals (Dyche & Zayas, 2001; Williams, 2002). The major assumption is that all hunches about a client based on prior culture-specific knowledge must be considered tentative until the clinician obtains the information directly from the client. Williams (2002) says that integrated or idiographic practices have been adopted as the standard for the National Association of Social Workers (NASW) in the U. S. The idiographic approach, however, has been criticized as perpetuating the dominance of Western models as a norm against which all other models of practice are measured (Williams, 2002).

**Learning Goals/ Objectives**
Ridley et al. (1994) underscore the importance of articulating clear learning objectives that reflect congruence of the training philosophy/conceptual framework. Ridley and colleagues have described, what they believe to be, ten of the most important, though not definitive, multicultural training objectives collated from the literature. This list represents different aspects of cross-cultural care philosophy and illustrates a continuum of conceptual developments found in the literature from basic operationalizations to theoretical concepts:

1. displaying culturally responsive behaviours;
2. [expanding] ethical knowledge and practice pertaining to multicultural issues;
3. [cultivating] cultural empathy;
4. [developing the] ability to critique existing counseling theories for cultural relevance;
5. development of an individualized theoretical orientation that is culturally relevant;
6. obtaining knowledge of normative characteristics of cultural groups;
7. [developing] cultural self-awareness;
8. obtaining knowledge of within-group cultural differences;
9. learning about multicultural counseling concepts and issues;
10. respecting cultural differences. (p.251)

Ridley and colleagues also stress the need to operationalize each objective in measurable terms. This is important for evaluation of the effectiveness of the training program. Tsang (2004) from the University of Toronto's School of Social Work, also reiterates these points.

**Conceptual Training Models**
O’Byrne (Undated), in her review of cross-cultural training in mental health, has outlined four main conceptual training models:

1. Cultural/Anthropological
2. Clinical under which are subsumed 5 subtypes:

I. Culture Broker
II. Cultural Competence
III. Ethnopsychiatry
IV. Clinical-Anthropological
V. Developmental

3. Cultural Epidemiology & Sociology

4. Anti-Racism or Anti-Oppression Training

These models have been delineated according to underlying conceptualizations of cross-cultural issues in mental health and to the context of training of which are mostly university departments of psychiatry and anthropology and/or hospitals under residency curricula or clinical psychology programs. There is some divergence with regard to the emphasis of philosophical underpinnings of these models (i.e. culture-specific vs. culture-general approaches) (Kirmayer et al., undated). However, many of the identified concepts and/or topics included in the various cross-cultural training models are similar and overlapping. This section will focus on Clinical—Cultural Competence and Anti-racism or Anti-Oppression Training Models, as these are the models underlying the training programs reviewed in this paper. Many of the models are compatible. In fact, four of the six training modules examined in this review adopt both Clinical-Cultural Competence and Anti-racism/Anti-Oppression training models. Other training models are described briefly in Appendix A.

Clinical
Clinical training models, most common in the United States and Australia, are programs typically considered to be a “patient-based” approach and are often attached to hospitals under residency curricula or clinical psychology programs (O’Byrne, Undated). The emphasis of training is on topics such as: the cultural formulation, use of interpreters, developing cultural sensitivity and awareness, communication issues, counter-transference issues, and knowledge about specific cultures and populations, including epidemiological information (Carrillo et al., 1999; O’Byrne, Undated).

Clinical—Cultural Competence
Clinical-cultural competence can be characterized as a specific clinical model (O’Byrne, Undated). It is also a general model, however, in the sense that it addresses cultural competence at organizational and policy levels in addition to individual (clinical) levels. On a clinical level, cultural competence approaches to training are organized under three main domains: 1) Awareness of attitudes, beliefs, and values, 2) Knowledge, and 3) Skills (Miyaake Geron, 2002; O’Byrne, undated; Williams, 2002). Each of these domains contains strategic guidelines or competencies in an attempt to address change at the behavioural level by developing specific skills necessary for working across cultural difference.

Pure clinical cultural competence training models originally tended to be based implicitly or explicitly on emic or culture-specific philosophical underpinnings (O’Byrne, undated). However, a review of the literature (Gompertz, 1997) and current clinical cultural competence training models in place at various mental health programs reveal an increasing trend to adopt an integrated approach utilizing both emic or culture-specific and etic or culture-generic information. The extent of emphasis on emic or etic approaches to training appears to be largely influenced by the context of the training. Emic approaches are considered more useful when working for extended periods in settings with a small number of specific, definable ethnoracial/cultural groups (Williams, 2002).

Anti-Racist/Anti-Oppression
The anti-racist or anti-oppression theoretical framework places cross cultural clinical practice within the broader systemic context of current structural inequalities, racial politics, histories of colonization and slavery, and other forms of oppression and emphasizes the dominance of western sociocultural
values in diagnosis and treatment and the power differential between professionals and service users (O’Byrne, Undated). These perspectives are widespread in Britain and have been making some progress in the United States and Canada as well (Williams, 2002).

The main goals of anti-racist and anti-oppression training are to: 1) increase understanding of how the socio-political systems impact people outside of dominant identity groups (i.e. people who have been marginalized by one or more of the following identities: gender, race, age, physical or mental ability, gender identity, sexual orientation, religion/faith, family status, language ability, literacy, socio-economic status, immigration/refugee status and country of origin) particularly with regard to health and well being and how these systems privilege dominant groups (however, anti-racist training tends to focus on the impact on race or People of Colour in particular); 2) develop critical awareness of the implications for clinical practice; 3) question western-based assumptions in medicine and reorient the clinician to consider other value systems and paradigms of health and health care (Tsang & George, 1998; O’Byrne, Undated); and 4) actively promote systemic social change and social justice (Gordon, 2004; Tsang & George, 1998).

Williams (2001b) points out that one of the main differences between anti-racist and multiculturalist approaches is that anti-racist models assume that society is resistant to the goals of organizing against racism, inequity, and injustice.

The main distinction between anti-racist and anti-oppression approaches to training is that an anti-racist approach puts racism at the centre of analysis whereas anti-oppression approaches focus on marginalization based on other identities in addition to race, such as gender, sexual orientation, and ability for example (Gordon, 2004).

Tripartite Framework of Practice Components/ Competencies for Training Programs

In general, most cultural competence training programs are based on a tripartite framework with the domains: (1) Awareness of attitudes, beliefs, and values, (2) Knowledge and (3) Skills, described elsewhere in this report (Chapter 3, Section A, Clinical Cultural Competence Practice Components/Competencies). This model, attributed to Sue and colleagues (1992), is reportedly the most widely used framework for training and researching culturally competent practice across disciplines and has formed the basis of most standardized measures of culturally competent care developed to date (Miyake Geron, 2002).

Pedagogical Strategies & Tools

While there is little consensus about the most effective strategies and approaches to teaching about multiculturalism and diversity, most practitioners and researchers agree that competency-based teaching is essential (Arredondo & Arciniega, 2001). Williams (2002) in her review of training models indicates that there is a paucity of research evaluating educational interventions for cultural competence and, as with other educational evaluations, problematic research designs allow for only tentative conclusions regarding the effectiveness of specific interventions (See Section F2 for a more in-depth discussion on evaluation research). She notes, however, that while mostly theoretical, the literature on “multicultural training” has identified some key components. She further notes that many of these strategies are the same as those utilized for conventional professional training based on adult education principles. The following is a brief overview of some of the strategies and tools identified in this literature.

*Content-based vs. Process-based Training*

O’Bryne (undated) in her review of cross-cultural mental health training programs, notes that training can be regarded according to the emphasis placed on content or process. Training based on content
tends toward didactic instruction and culture-specific information whereas training approaches that focus on process, emphasize experiential learning and self-exploration. Process-based training tends to place more emphasis on culture-generic information. In this review, it was found that most training modules and programs employ a mix of content- and process-based learning strategies.

**Activity-based Learning**
A conclusion that seems supportable from multiple sources of information is that activity-based learning is more successful in generating behavioural change than education focused on didactic sessions and knowledge transfer (Williams, 2002). Furthermore, single group pre-test/post-test designs have validated the effectiveness of training that involves critical incident exercises, case analysis, interviewing, ethics training in combination with cultural issues, cross-cultural contact before and during training and small group processes. However, these findings must be interpreted with the knowledge that single group pre-/post- testing cannot account for other explanations of change such as maturation or testing effects (Williams, 2002).

**Varied Instructional Strategies**
An important component of training programs that is identified in the literature on cultural competence training for university multicultural counselling programs is a diversity of teaching strategies and procedures that utilize both cooperative learning and individual achievement approaches (Ponterotto, 1997; Leach & Carlton, 1997). Dr. Rohini Anand (2003), a specialist in diversity training and organizational change strategies, reiterates the importance of presenting material using a variety of mediums to meet the needs of the diverse learning styles of participants. Williams (2002) also found that learners valued the variety of instructional stimuli that included written materials, videos, and lectures and recommends varying instructional methods.

**Case-Based Learning**
Williams (2002) in her evaluation study reconfirmed the finding that active case-based learning was associated with superior gains in cultural competence training than other types of training such as lecture. However, the cases must be relevant to the learner’s needs. Learners in this study indicated that one of the strengths of the program was that the “…case material was realistic and similar to issues addressed in practice” (p.135). Williams notes that this reaction is consistent with reports from the adult education literature that underlines the importance of learning that integrates real life situations and job-specific tasks that contribute to transfer of skills. Anand (2003) also asserts that case studies based on actual incidents that participants have encountered in the workplace are a particularly powerful tool for practicing the skills taught in the training. Williams (2002) contends that this finding tends to lend support to discipline-specific training.

In addition to providing an effective tool for skills-training, small group learning with case studies and simulations is enjoyable for learners and an effective strategy for teaching values related to professional practice as demonstrated through post-intervention and in-process evaluations with learners (Williams, 2002).

**Role-play and Modelling**
Role-play and case studies are valuable training tools particularly when structured evaluations of audiotaped and videotaped role-play practice are incorporated (Tsang, 2004; Williams, 2002). Furthermore, culturally competent practices can be modelled and practiced with opportunities for self-reflection and constructive feedback. (Usually executed through practice of clinical supervision and highly dependent on the cultural competence of the supervisor.) Williams (2002) reports that studies using one-group pre-/post-test designs provide descriptive evidence that training based on simulations can result in acquisition of transferable skills.

**Opportunities to transfer learning to practice situations**
Gompertz (1997), in her review of the literature on training evaluation for multicultural counseling, found it is important that skill development using experiential and exploratory exercises move to
direct application with actual clients to enable evaluation of the impact and use of learning competencies. Consistent with this finding is Williams’ (2002) conclusion that longitudinal educational strategies that include opportunities to intersperse learning with occasions for practice are also more successful at transferring skills learned in training to practice situations.

Peer supervision and coaching
Williams (2002) notes that an important aspect of the development of cross-cultural practice is supervision. However, she points out that due to institutional constraints this is not always possible. The group activities in her training program provided participants an opportunity to share experiences and consult with each other as well as gain an appreciation of each other’s perspective and expertise in addressing cross-cultural practice. An interesting finding of Williams’ (2002) study was that the peer supervision and coaching that had started in the training program was continuing in the follow-up period. Many participants commented on the immense support they experienced from this supervision to improve cultural competence.

Critical self-reflection and self-exploratory exercises
The two major competencies under the domain of Awareness i.e. (1) Awareness of Own Cultural Values and Biases and (2) Awareness of Client Worldview require cognitive restructuring and paradigm shifts. Reynolds (1997) points out, “...that these worldview or paradigm shifts demand more intensive, interactive, or experiential interventions that move beyond content about various cultural groups...Often these efforts focus more on process, with the goal of challenging an individual’s underlying cultural assumptions or beliefs” (p.217). Williams (2002) points out that cross-cultural practice requires a level of flexibility and self-awareness that can be compared to the ‘reflection-in-action’ that is desirable in clinical practice in general but requires specific considerations of power, difference and personal bias. Others have also underlined the importance for critical self-reflection of the service provider in promoting empowerment approaches to mental health care (Clark & Krupa, 2002). Thus the use of self-exploratory and experiential exercises is a critical component of cultural competence training (Wun Jung, 1995).

Small group activity is also useful for structuring discussions that can elicit multiple perspectives on an issue (Williams, 2002) and result in self-reflection. As mentioned previously, modelling and practicing culturally competent practices can build in opportunities for self-reflection and feedback. Case-based learning as described previously, can also promote self-reflection. In order for these exercises to be effective it is essential that a safe environment be fostered where discussion of cultural and racial difference and self-reflection can be conducted with openness and sensitivity (Anand, 2003; Williams, 2002).

Importance of a safe environment
Training in cultural competence and difference must be conducted in a supportive environment where participants feel safe to express their feelings, beliefs, and attitudes openly and freely without negative repercussions (Ptak, Cooper, & Brislin, 1995; Srivastava, 2004; Williams, 2001a). Williams’ (2002) study revealed that participants’ “sense of being in a safe environment” was extremely important (p.139). She contends that creating safety in the learning environment is dependent on the composition of the learning group and the skills and attributes of the facilitator. Similarities of gender, practice speciality, organizational context and professional discipline of the participants, she concludes, likely contributed to perceptions of homogeneity and safety. Others have also pointed to the necessity of participants being able to take risks in a safe setting to ensure success of the training (Ptak et al., 1995).

Discipline-Specific vs. Multidisciplinary
There is very little written in the academic literature on cultural competence and the advantages/disadvantages of training programs geared for discipline-specific or multidisciplinary participants. This is probably due to the fact that most of the literature is confined to its own field and many of the training programs described are within university departments of psychiatry and
anthropology and/or hospitals under residency curricula or clinical psychology programs and therefore are geared to one discipline. However, training programs developed by community organizations and mental health agencies tend to be targeting mental health professionals in general and participants from a variety of disciplines are trained together. Unfortunately, literature evaluating the effectiveness of a multidisciplinary or discipline-specific approaches based on these trainings has yet not been published.

Nevertheless, some experts in cultural competence training have identified advantages and disadvantages to both approaches to training. For example, Williams (2002) tends to advocate discipline-specific training based on her evaluation of a cultural competence training program for social workers. She argues that because of varied roles of different disciplines, training is enhanced when discipline-specific. She adds that the unique roles of social work such as the incorporation of work at both micro-levels (individuals, families and groups) and macro-levels (organization, community, and system) lends support for discipline-specific training. In her study, another advantage to this approach is the perception of homogeneity of the group that promoted an atmosphere of trust, understanding, and mutual respect. Williams (2002) writes: “It seems that a foundation of similarity must be in place before difference can be discussed safely” (p. 159). Therefore, she adds, designs for educational intervention need to build in explicit strategies for establishing social homogeneity. Others in the field of cultural competence training have reiterated this point (Andermann, 2004, Spiteri DeBonis, 2004). When discipline-specific training is not possible, Williams (2002) suggests that group cohesion based on multidisciplinary team or organization-based learning is preferable to external learning events.

Opportunities to incorporate homogeneity may be present with identity affiliations, professional experience, history with the organization, and program in addition to discipline. Srivastava (2004) advocates program-based multidisciplinary training to provide the opportunity for: 1) increased understanding and appreciation of roles/disciplines, 2) teambuilding, 3) knowledge-sharing or -transfer, 4) breaking down stereotypes of disciplines/roles and 5) reducing isolation. She also points to the fact that in multidisciplinary team care, many of the duties/tasks are not discipline-specific (for example, care plans and assessments are centre-wide). Similarly, Tsang (2004) states that discipline-specific approaches to training depend on the goals of the training. If, for example, the main goals are teambuilding and organizational development, then program-specific training is more beneficial. However, if the goals are primarily training of specific skills tied closely to professional/clinical roles, then discipline-specific training is more effective.

E. Comparison of Training Modules

Introduction
The following six modules that are included in this review and analysis are shown in Tables 5, 6, and 7. These modules were selected for review, as the trainers were available for consultation with the exception of the Culture of Emotions Cultural Competence Training Program. Furthermore, other training programs outside of Ontario were contacted (See Appendix B) but either program manuals were unavailable for public distribution or the programs did not respond to inquiries. Table 6 reveals global differences and similarities. Table 7 is a detailed outline of programs.

Introduction to Diversity at CAMH
The Introduction to Diversity at CAMH training module is a 6-hour introduction to diversity intended for clinical and non-clinical CAMH staff. Therefore, some sections of the lens for examination that deal specifically with clinical care are not relevant to this particular module (E.g. pre-engagement skills). This training model is not defined as a cultural competence approach as it is an introduction
and not a skills-based training (Mawhinney, 2004) but it is included in this review to establish a point of departure for the Level II Diversity Training for Culturally Competent Clinical Care (See Table 5).
### Table 5  
**Introduction to Diversity Training at CAMH**

<table>
<thead>
<tr>
<th><strong>Intended Audience</strong></th>
<th>CAMH staff: clinical and non-clinical</th>
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<tr>
<td><strong>Time Frame</strong></td>
<td>6 hours</td>
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<tr>
<td><strong>Conceptual Training Models</strong></td>
<td>Anti-Oppression</td>
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<tr>
<td><strong>Philosophical Underpinning</strong></td>
<td>Integrated Emic-Etic Approach</td>
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**Definitions**

**Cultural Competence**

Not defined as a CC Approach

Designated Groups: “...refers to members of our community who have been marginalized by one or more of the following identities: gender, race, age, physical or mental ability, gender identity, sexual orientation, religion/faith, family status, language ability, literacy, socio-economic status, immigration/refugee status and country of origin.”

**Goals and Objectives**

Objectives:
1. Increase level of understanding and awareness about Diversity.
2. Recognize Diversity as a multifaceted process with personal, professional and institutional implications & responsibilities.
3. Develop capacity as an agent of change and leader in CAMH Diversity Plan.
4. Become acquainted with tools, strategies and ideas for discussing and implementing Diversity with colleagues.
5. To provide the experience of modelling or practicing respectful dialogue about challenging diversity issues in the workplace, and knowledge transfer/sharing among colleagues.

**Pedagogical / Strategies / Tools**

Developmental: 6-hour Introduction to Diversity with mix of content & and process-based activities.

Didactic instruction & population-specific information: --Video- Village of 100 people from The Global Village.

- Statistics warm-up
- CAMH Diversity Video

Experiential learning and self-exploration: -Power Flower Exercise
- Values, Beliefs, & Assumptions Exercise
- Case Studies Small Group Discussion
- Large Group
- Discussion

Diversity Snapshot in My Workplace
Short survey to assess own workplace using diversity lens

**Competencies**

**Awareness of Attitudes, Beliefs, & Values**

- Increase awareness about self and others’ views, attitudes and knowledge about diversity as related to service and workplace culture issues.
- Increase awareness of own social location, position of power & privilege and identities.
- Increase awareness of self in own workplace using diversity lens.

**Knowledge**

- Introduction of some statistics on designated group inequity in the local and global contexts.
- Introduction to CAMH Diversity Plan.
- Brief overview of main results of KPMG study at CAMH.
- Diversity Policy, selected initiatives including Cultural Interpretation Services, Employee Related Harassment and Discrimination Policy, population specific services, manual ( P. 79-83).

**Clinical Skills Training**

N/A

**Intervention/ Treatment**

Case study: Scenarios 8, 9, & 10

**Assessment**

Case Study: Scenario 1

**Power / Relationship Issues**

**Client-therapist (micro-level)**

- Values, Beliefs & Assumptions Exercise also implicitly introduces power issues in individual (clinical) and organizational (workplace) contexts.
- Power Flower Exercise -self-exploration of OWN location in terms of power and privilege and culture/diverse identities.

**Client-system (macro-level)**

- Provides brief information on concentration of power and influence, unequal access to resources, entrenchment of dominant group standards or norms, and equity.
**Culture of Emotions Cultural Competence Training Program**
A 58-minute video with accompanying guide, this training program is designed to introduce cultural competence and diversity skills to psychiatrists and mental health professionals, working in academic, community mental health, or managed care settings. Produced for the Office of Minority Health’s Center for Linguistic and cultural Competence in Health Care, U. S. Department of Health and Human Services, this program is aimed primarily at psychiatrists and residents but is a relevant training tool also for practitioners in the fields of psychology, social work, counselling, medicine and nursing.

**Cultural Competence for Social Workers—C. Williams (CAMH)**
This training module, developed by Charmaine Williams for Social Work staff at CAMH as part of a pilot project, is a skill-focused cultural competence education program delivered in four weekly 3-hour sessions.

**Working in Culturally Diverse Health Care Environments—R. Srivastava**
This diversity training module, targeting various mental health professionals, was developed by Rani Srivastava, Deputy Chief of Nursing Practice at CAMH, as a 1-day training. While not skills training-based, there is a strong self-exploration component with introduction of important cross-cultural communication and cross-cultural encounter strategies.

**Cross-Cultural Mental Health: Perceptions, Assessment & Health Approaches—Gulshan Allibhai [Canadian Mental Health Association (CMHA)—Toronto Branch]**
A 1-day workshop based on participant needs, this training program is aimed at such diverse groups as mental health case workers, ACT team workers, Nurses, Occupational Therapists, Social Workers, hostel staff and Toronto Community Housing Authority staff. While containing a hands-on component, this program is primarily theoretical.

**An Integrative Model of Clinical Practice with Diversity—A. Ka Tat Tsang (University of Toronto)**
Developed by Dr. A. Ka Tat Tsang, a leader in the field of diversity education, training, and research, this multidisciplinary training program consists of three levels ranging from introductory (1 Day) to Advanced (6 Days) and offers a substantial skills-training component.
**Comparison of Training Modules**

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**Comparison**

All training programs acknowledge the necessity for specific cross-cultural skills in order to be clinically competent. However, while all training programs introduce required cross-cultural skills only two of the six modules reviewed (Williams and Tsang) include a skills-training component in which opportunities for practicing specific skills through role-play and/or modelling are provided. Allibhai's module does devote a segment to role-play practice for working with families. In Table 6, these components are shown according to the categories: I. Skill-Presentation and II. Skill-Training.

With the exception of Williams' training, all the training modules are targeting multidisciplinary participants. The major differences lie in whether or not the objectives of the training/education have a skills-based component and this determines the length and content of the trainings (See Table 7). For example, Tsang's module is the only one which includes intensive skills training with AV recording, analysis and feedback. In addition, this module is the only one that covers the clinical change process, consideration of self-disclosure, and professional self-care. Only, Srivistava's training contains a component exploring professional culture. Both Tsang and Allibhai's modules devote a large section of the training to awareness of internalized culture. Allibhai's training is the only one that contains an explicit anti-racist objective: "To recognize the impact racism has had on shaping mental illness diagnosis, assessment and treatment".
All trainings:

1. address the tripartite framework of cultural competencies in addition to both client-clinician and client-system levels of the fourth domain of **Power/Relationship Issues**
2. are based on an integrated culture-specific and culture-generic philosophical underpinning
3. define ‘culture’ broadly to be diversity-inclusive; i.e. not limited to an ethnicity-based conceptualization
4. base training on both clinical cultural competence and anti-racist/anti-oppression conceptual models with the exception of the Culture of Emotions module which does not specify an anti-racist/anti-oppression perspective
5. consist of activities and presentation of theory to raise awareness of own attitudes, beliefs, biases and worldviews and client worldviews
6. employ self-exploration/experiential activities
7. introduce skills for eliciting the client’s Explanatory Model of Illness (Kleinman, 1988) with the exception of the Introduction to Diversity at CAMH training
8. introduce skills required for cross-cultural work even if they don’t have a skills-training component
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<tr>
<td><strong>Time Frame</strong></td>
<td>58-Minute Video Training Program</td>
<td>4 Weekly (3-hour) Sessions</td>
<td>1 Day</td>
<td>1 Day</td>
<td>1 Day (introductory) 3 Days or 20 hours (foundation) 6 Days or 40 hours (advanced)</td>
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<tr>
<td><strong>Conceptual Training Models</strong></td>
<td>Clinical—Cultural Competence</td>
<td>Clinical—Cultural Competence</td>
<td>Clinical—Cultural Competence</td>
<td>Anti-Racist/Anti-Oppression</td>
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<td>Anti-Racist/Anti-Oppression</td>
<td>Anti-Racist/Anti-Oppression</td>
<td>Anti-Racist/Anti-Oppression</td>
<td>Clinical—Cultural Competence</td>
<td>Integrative Clinical—Cultural Competence Managing multiple contingencies (Implied—Personal Communication)</td>
</tr>
<tr>
<td><strong>Definitions</strong></td>
<td>Culture broadly defined, not limited to ethnicity-based</td>
<td>Culture broadly defined, not limited to ethnicity-based</td>
<td>Culture broadly defined, not limited to ethnicity-based</td>
<td>“Who we are; how we think; how we relate to one another.” “Culture is the sum total of the way people live.” “All cultures are alive and changing. They are not fixed.” EXTERNAL CULTURE - Behaviour, Beliefs - Explicitly learned - Conscious - Easily changed - Objective knowledge INTERNAL CULTURE - Values &amp; Thought Patterns - Implicitly learned - Unconscious - Difficult to change - Subjective knowledge*</td>
<td>Culture broadly/globally defined, not limited to ethnicity-based</td>
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<tr>
<td><strong>Definitions</strong></td>
<td><strong>Cultural Competence</strong></td>
<td>- begins with an understanding of own personal, professional and organizational culture</td>
<td>- requires understanding of concepts such as trust, equity and power.</td>
<td>- means acknowledging differences, becoming a mind-shifter (own &amp; others), becoming a master learner &amp; broker, and developing the ability to see patterns, connections, and relationships between seemingly diverse perspectives.”</td>
<td>- “culturally congruent care” which “preserves/validates key values and beliefs” of client.</td>
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<td>- as a composite concept (together with diversity, social justice, multiple contingencies)</td>
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A Review of Clinical Cultural Competence
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<tr>
<td><strong>Goals/ Objectives</strong></td>
<td>Unstated</td>
<td>Module 1 - Foundations of Cultural Competence 1. Explore connections between culture and social work. 2. Learn frameworks commonly used to support understanding of cross-cultural interactions in practice. 3. Apply knowledge, values, skills, and self-awareness from social work and cultural competence models to practice situations. 4. Reflect on personal development in cultural competence. Module 2 - Culturally Competent Assessment 1. Integrate and apply social work and cultural competence knowledge 2. Learn guidelines for culturally competent assessment of individuals, families, and communities 3. Practice interview techniques for integrating cultural information into problem formulation. Module 3 - Culturally Competent Intervention 1. Integrate and apply social work &amp; cultural competence knowledge. 2. Explore guidelines for negotiating intervention in cross-cultural situations. 3. Practice interview techniques for integrating cultural competence skills in assessment &amp; intervention. Module 4 - Building Cultural Competence 1. Integrate race, ethnicity, and cultural analysis with analysis of other identities. 2. Apply cultural competence skills to professional and organizational issues. 3. Explore specific goals for building cultural competence.</td>
<td>1. Identify different approaches to Diversity and increase understanding of personal views on diversity 2. Describe myths &amp; misconceptions about Culture and how they relate to the health-care environment. 3. Strengthen insight into own personal and professional culture. 4. Describe the key elements necessary to provide culturally appropriate care. 5. Discuss approaches (from assessment to intervention) to bridge the gap between cultures. 6. Develop Cross Cultural Communication Strategies to integrate culture into practice.</td>
<td>1. To learn and apply key skills in becoming a culturally competent mental health worker. 2. To recognize the importance of being culturally self-aware, and how it plays a role in successful intercultural relations. 3. To recognize the impact racism has had on shaping mental illness diagnosis, assessment, and treatment. 4. To develop understanding of cross-cultural mental health assessment and healing approaches.</td>
<td>1. Introductory Program: Awareness, sensitivity, basic orientation, basic competence 2. Foundation: Competence in managing diversity in day-to-day practice 3. Advanced: Sophisticated mastery of attitude, knowledge, and skills related to diversity,</td>
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- Tripartite Model based on developing 1) Awareness of Attitudes, Beliefs, Values; 2) Knowledge; and 3) Skills  
- Emphasis on professional context and self-care |
| Pedagogical/Strategies/Tools | Mostly Content Based (Didactic Instruction)  
- Video: The Culture of Emotions with guide  
- Skill-focused & Developmental  
- Peer supported Learning  
- Presentation of Material Immediately Applicable in Practice  
- Video Simulations of Interviewing  
- Warm Up Exercises  
- Self-exploration Exercises  
- Case studies using strengths/challenges analysis  
- Role Play  
- Simulations & Modelling based on real-life situations | Mix of content (didactic lecture) and process-based activities  
Experiential and self-exploration activities:  
The 10 lenses questionnaire Values exploration activities Childhood Experience  
Small Group Discussion on experience of diversity in the workplace | Mix of content and process-based activities  
Experiential and self-exploration activities:  
Name Game  
Group Exercises  
Small Group Discussions  
Role Play: How to work with families  
Self-Assessment Checklist for promoting cultural competency | Mix of content (didactic instruction) and process-based activities, especially in foundation and advanced programs  
Experiential and self-exploration activities (not in introductory program)  
Small Group Discussions  
Use of video recording and playback/analysis (foundation and advanced programs) |
| Competencies | Awareness of Attitudes, Beliefs, & Values | Own Values/ Biases  
Self-reflection on /assessment of OWN and CLIENT cultural identity, worldview (Key Ideas 3 -- Hayes, 2001) | Own Values/ Biases  
Structured self-reflection on OWN and CLIENT cultural identity, worldview, value systems, relevant skills and knowledge & gaps. | Own Values/ Biases  
Structured self-reflection on OWN culture, biases/prejudices, values/beliefs | Own Values/ Biases  
Structured self-reflection on OWN culture, biases/prejudices, values/beliefs  
Brief Encounters Exercise (ISAP) | Own Values/ Biases  
- Structured critical self-reflection on OWN culture, biases/prejudices, values/beliefs  
- Cultural transference and Countertransference  
- Commitment to justice and equity |
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<tr>
<th>Competencies</th>
<th>Knowledge</th>
<th>Culture-Generic</th>
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<tr>
<td>Client Worldview Ethnocultural Transference and Countertransference</td>
<td>Client Worldview Cultural Transference and Countertransference</td>
<td>Experiential and self-exploration activities: Self-Awareness Questionnaire to guide the Exploration of Cross-Cultural Issues Identity Dimensions Exercise Identify individual strengths and limitations for working cross-culturally Case-based Learning</td>
<td>Experiential and self-exploration activities: The 10 lenses questionnaire Values vine “How would you spend $1000.00? Childhood experience—“what would you teach your kids?” Small Group Discussion on experience of diversity in work setting.</td>
<td>Experiential and self-exploration activities: Worldviews of Mental Health - How do people across cultures understand mental illness and mental health? - Impact of racism on psychiatry and mental health - Witch doctors and psychiatrist exercise (Torrey, 1972)</td>
<td>- Valuing difference - Openness to cultural difference - Readiness to learn from the client/patient</td>
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<tr>
<td>Knowledge</td>
<td>Culture-Generic</td>
<td>- Concepts of Race, Culture, &amp; Ethnicity</td>
<td>Introduction to Dimensions of Culture Care Framework</td>
<td>Concepts of Culture, Ethnicity</td>
<td>- Understanding culture - What is culture - Models for understanding culture - Group exercise - Value systems</td>
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<tr>
<td>Video and Companion Guide: Outline for DSM IV Cultural Formulation</td>
<td>- Model for 3 major dimensions influencing worldview</td>
<td>- Racial Identity Development Stages</td>
<td>- Understanding professional, organizational Culture - Understanding OWN culture, e.g. biases/prejudices, values/beliefs</td>
<td>Understanding culture - What is culture - Models for understanding culture - Group exercise - Value systems</td>
<td>Non-western approaches - Introduction of alternative conceptions of health/illness - Types/characteristics of healing approaches - Integrated healing approaches: Buddhism, Ayurveda, Chinese medicine</td>
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<tr>
<td>Cultural Identity of the Individual</td>
<td>- Modification of Herberg's (1993) Acculturative Framework</td>
<td>- Integrating social work and cultural competence knowledge</td>
<td>- Integrating analysis of other identities with race, ethnicity and culture</td>
<td>- Understanding Culture Sensitivity</td>
<td>- Introducing and systematic understanding of culture, e.g. Race, Ethnicity, Culture</td>
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<tr>
<td>Cultural Explanations of Individual's Illness</td>
<td>- Integrating social work and cultural competence knowledge</td>
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<td>- Integrating analysis of other identities with race, ethnicity and culture</td>
<td>- Understanding Culture Sensitivity</td>
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<td>- Integrating analysis of other identities with race, ethnicity and culture</td>
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<td>- Integrating analysis of other identities with race, ethnicity and culture</td>
<td>- Understanding Culture Sensitivity</td>
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<td>- Cultural Elements of the Relationship Between Individual and Clinician</td>
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<td>- Integrating analysis of other identities with race, ethnicity and culture</td>
<td>- Understanding Culture Sensitivity</td>
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<td>- Overall Cultural Assessment for Diagnosis and Care</td>
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<td>- Integrating analysis of other identities with race, ethnicity and culture</td>
<td>- Understanding Culture Sensitivity</td>
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<td>- Integrating analysis of other identities with race, ethnicity and culture</td>
<td>- Understanding Culture Sensitivity</td>
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<tr>
<td>Training Module</td>
<td>PSYCHIATRY (Culture of Emotions, 2002)</td>
<td>SOCIAL WORK (Williams, June 2001)</td>
<td>NURSING / Multidisciplinary (Rani Srivastava 2003)</td>
<td>MULTIDI SCPLI NARY (Canadian Mental Health Association, December 2003)</td>
<td>MULTIDI SCPLI NARY (Tsang, 2004)</td>
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<td>Competencies</td>
<td><strong>Culture-Specific</strong>&lt;br&gt;Culture-specific knowledge introduced&lt;br&gt;Glossary of Culture-Bound Syndromes&lt;br&gt;*The following information is presented in the Companion Guide Only</td>
<td><strong>Culture-Specific</strong>&lt;br&gt;No culture-specific knowledge introduced</td>
<td><strong>Culture-Specific</strong>&lt;br&gt;No culture-specific knowledge introduced</td>
<td><strong>Culture-Specific</strong>&lt;br&gt;No Culture-specific information</td>
<td><strong>Culture-Specific</strong>&lt;br&gt;Individual uniqueness and White privilege</td>
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<tr>
<td>Skills: Pre-engagement</td>
<td>Help-seeking pathways</td>
<td>Help-seeking pathways</td>
<td>N/A</td>
<td>Help-seeking behaviour&lt;br&gt;Effects of culture and stigma on seeking help</td>
<td>Pathways to help – research-based understanding of clinical change processes</td>
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<tr>
<td>Skills: Engagement</td>
<td>Guidelines for Establishing Respect and Rapport (Key Ideas 5—Hayes, 2001)</td>
<td>Issues for the working alliance</td>
<td>Commitment to relationships&lt;br&gt;Expectations for relationships&lt;br&gt;Strategies to develop relationships</td>
<td>Emphasis on how to engage with and understand cultural difference in a systematic and methodical manner instead of culture-specific information</td>
<td>Structural Analysis of Narratives (Kleinman and beyond)&lt;br&gt;Assessment as dia-gnosis (knowing across/through)&lt;br&gt;Sense-making and negotiation of meaning&lt;br&gt;Clinical formulation and goal setting connected to client/patient reality</td>
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<tr>
<td>Skills: Assessment / Feedback</td>
<td>Elicit Explanatory Model (Kleinman)&lt;br&gt;DSM IV Cultural Formulation&lt;br&gt;Examples of Questions for HOPE Approach to Spiritual Assessment&lt;br&gt;Migration History</td>
<td>Elicit Explanatory Model (Kleinman)&lt;br&gt;DSM IV Cultural Formulation&lt;br&gt;Guidelines for culturally competent assessment for individuals, families, &amp; communities&lt;br&gt;Tools for integrating cultural issues into problem formulation&lt;br&gt;Interviewing techniques for eliciting relevant information</td>
<td>Elicit Explanatory model&lt;br&gt;(Kleinman)&lt;br&gt;Incidence/Prevalence/Risk&lt;br&gt;Biologic Variations&lt;br&gt;Impact of Life Events-immigration/settlement /racism</td>
<td>Guided by an understanding of the overall clinical change sequence&lt;br&gt;Accessing the heart of the matter – cutting through cultural barriers&lt;br&gt;Intersecting diversity and multiple contingency&lt;br&gt;Dynamics of cross-cultural communication and understanding&lt;br&gt;Authority and “directedness” versus (?) partnership and collaboration&lt;br&gt;The politics of language spoken and written&lt;br&gt;Talking, doing, and living – Narrative, script and action&lt;br&gt;Self-disclosure – reciprocal consideration of means and ends&lt;br&gt;Specific change strategies&lt;br&gt;Negotiation&lt;br&gt;Unique treatment methods and solutions (e.g. fengshui/geomancy, fortune telling, charms)&lt;br&gt;Psychotherapy systems with specific cultural features (e.g. Dao/Taoist, Morita)&lt;br&gt;Application of western systems that are culturally relevant</td>
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<tr>
<td>Skills: Treatment / Intervention</td>
<td>Implementing Culturally Responsive Interventions*&lt;br&gt;(Key Ideas 9—Hayes, 2001)—Set goals, develop treatment plans, and choose interventions in collaboration with clients.&lt;br&gt;*Guidelines for working with Interpreters (Exhibit 6.1—Hayes, 2001)</td>
<td>Collaborative treatment planning&lt;br&gt;General Skills for Cross-cultural communication&lt;br&gt;Defining the social/cultural context&lt;br&gt;Defining the problem&lt;br&gt;Interviewing Guidelines: Interviewing and Negotiating from Explanatory Models&lt;br&gt;Guidelines for working with Cultural &amp; Language Interpreters</td>
<td>Collaborative Goal-setting &amp; Treatment Planning: Three modes of Action/Decision—&lt;br&gt;1. Culture Care preservation/Maintenance (Validation)&lt;br&gt;2. Accommodation (Negotiation)&lt;br&gt;3. Reframing/Repatterning (Restructuring)&lt;br&gt;Cross-cultural communication strategies&lt;br&gt;Model of cross-cultural encounters&lt;br&gt;Culture Resources (Internal/External)&lt;br&gt; - Interpreters/Brokers&lt;br&gt; - Access to information&lt;br&gt; - Practice Expectations&lt;br&gt; - Organizational Systems</td>
<td>Cross-cultural communication strategies&lt;br&gt;Non-Western healing approaches&lt;br&gt; - Unique/indigenous treatment methods and solutions (acupuncture, etc.)&lt;br&gt; - Integrated healing approaches: Buddhism, Ayurveda, Chinese medicine&lt;br&gt;Culturally responsive workers&lt;br&gt;Goal-setting&lt;br&gt;Completion and positive outcome – multiple perspectives&lt;br&gt;Guided by an understanding of the overall clinical change sequence&lt;br&gt;Accessing the heart of the matter – cutting through cultural barriers&lt;br&gt;Intersecting diversity and multiple contingency&lt;br&gt;Dynamics of cross-cultural communication and understanding&lt;br&gt;Authority and “directedness” versus (?) partnership and collaboration&lt;br&gt;The politics of language spoken and written&lt;br&gt;Talking, doing, and living – Narrative, script and action&lt;br&gt;Self-disclosure – reciprocal consideration of means and ends&lt;br&gt;Specific change strategies&lt;br&gt;Negotiation&lt;br&gt;Unique treatment methods and solutions (e.g. fengshui/geomancy, fortune telling, charms)&lt;br&gt;Psychotherapy systems with specific cultural features (e.g. Dao/Taoist, Morita)&lt;br&gt;Application of western systems that are culturally relevant</td>
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<td>Competencies</td>
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<td>Skills: Closure / Discharge</td>
<td>N/A</td>
<td>Continuum of sites for Service Provision: Mainstream-Multicultural-Ethnospecific-Indigenous</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<td>Clinical Skills - Training</td>
<td>N/A</td>
<td>Case Studies and Role play Practice Simulations</td>
<td>N/A</td>
<td>N/A</td>
<td>Intensive training with AV recording/analysis/feedback Other Components-- Professional self-care The &quot;sub-versions&quot; of clinical discourse: spirituality, Eros, creativity, etc.</td>
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<td>Power / Relationship Issues</td>
<td>Client-Therapist Dyad</td>
<td>Recognition of Power &amp; Privilege in helping professions Collaboration between clinician and client</td>
<td>Client-Therapist Dyad</td>
<td>Examine Issues of Power &amp; Privilege in helping professions Collaboration between clinician and client</td>
<td>Client-Therapist Dyad</td>
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<td>Client-System</td>
<td>Awareness of systems of privilege and oppression (racism, sexism, classism, heterosexism, ableism, ageism, and colonialism). Intervene at sociocultural, institutional, and political levels when appropriate and possible. (From Key Ideas 9--Hayes, 2001)</td>
<td>Client-System</td>
<td>History and manifestation of oppression, prejudice, and discrimination in North America and their psychological sequelae Knowledge of sociopolitical influences (poverty, stereotyping, stigmatization and marginalization) that impact the lives of identified groups.</td>
<td>Client-System</td>
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<td>Client-System</td>
<td>Examine barriers, power structures</td>
<td>Client-System</td>
<td>Examine barriers, power structures Impact of racism on psychiatry and mental health system</td>
<td>Client-System</td>
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*Culturally Responsive Interventions can be defined as observable behaviours that incorporate cultural factors relevant to professional interactions in a manner that is beneficial to the service user or others in the professional setting (Williams, 2002). Hays (2001) describes culturally responsive therapy as an approach which “…requires therapists to think about therapy in new ways and to intervene in ways that may not fit mainstream conceptualizations but that will benefit people of both minority and dominant groups” (p.155).*
F. Evaluation Research

Brief Overview of Research on Cultural Competence (CC) Intervention

While the specification of awareness, knowledge, and skills in cultural competence has been widely discussed in the mental health professions and testing attempts have been made, more empirical research is necessary before conclusions can be drawn about specific competencies (Lo & Fung, 2003; Williams, 2002). Most efforts in operationalization and measurement of CC focus on organizational level not individual level and contribute to a lack of validated comprehensive measure of CC for research or training (Lo & Fung, 2003).

In Notes from the U. S. Department of Health and Human Services- SAMHSA Roundtable on Conceptualizing and Measuring Cultural Competence, Leong (1998) remarks that research and theoretical advances that have focused on the individual level of CC have focused on interpersonal cross-cultural competencies as opposed to therapeutic cross-cultural competencies. He adds further that very few studies have helped delineate what therapeutic processes are most effective in cross-cultural counselling beyond initial sessions. Most of these studies have not been based on clinical field studies with real clients being treated by practicing counsellors and therapists (Leong, 1998; Pope-Davis et al., 2002). Therefore, Leong (1998) points out, relevant elements of the counselling process have not been identified and current measurements of cross-cultural counselling skills are quite rudimentary and of unknown predictive validity in relation to counselling outcomes.

Paucity of rigorous research (clinical trials)

There is a paucity of research, especially rigorous research such as clinical trials, on treatment outcomes for ethnic minority groups on which to base intervention models (Sue, 2003). The Consumer Operated Services Program Multi-site Research Initiative (COSPMRI) (Undated), reports that the lack of culturally competent instruments to measure the outcomes of mental health services is problematic resulting in inappropriate or misunderstood research questions. Therefore, some researchers advocate for the development of separate instruments among culturally diverse groups while others propose methods for developing instruments with cross-cultural validity or equivalence (COSPMRI, Undated).

The SGR supplement (2001) reports that while “many models of cultural competence have been proposed, few if any have been subject to empirical test. No empirical data are yet available as to what the key ingredients of cultural competence are and what influence, if any, they have on clinical outcomes for racial and ethnic minorities” (p.36).

Lack of research on consumer perceptions

There is a need for measures of CC to include the client or care recipient’s evaluation of the cultural competency of the care received. Little research has been conducted to learn whether clients experience interactions as culturally appropriate or inappropriate (Miyake Geron, 2002). Miyake Geron (2002) points out that one notable exception is a recent qualitative study by Pope-Davis and colleagues (2002), which examines client perspectives on cross-cultural clinical encounters. It seems telling that a research-in-progress report of a qualitative study being conducted with mental health clinicians found that one of the indicators of cultural competence being reported by clinicians is “client feedback” (Srivastava, 2004).

Use of qualitative methods for inquiry

Ponterotto et al. (1994) in their review of current methods used to assess multicultural counselling competence suggest that the development of qualitative methods of assessment would facilitate understanding of competence. Other researchers in the field of multicultural psychology also contend that research methodology in this area lends itself to qualitative evaluative research rather than quantitative research efforts in naturalistic settings due to the interdependence between contextual
meaning and understanding the multidimensional process of the influence of individuals on and by societal structures (Parks & Holloway, 2002; Shorter-Gooden, 2002).

Shorter-Gooden (2002) has outlined six core values of multicultural psychology that she claims converge with the assumptions underlying qualitative research strategies. Therefore she proposes multicultural psychology is more suited to qualitative investigations than quantitative. These core values are:

1. Diversity as normative
2. The creation of new models and understandings
3. The illumination of cultural meanings
4. An ecological view of the person
5. A diversity of ways of knowing
6. Culturally sensitive and empathic relationships (p.126)

Problems with self-report questionnaires and social desirability factors (Williams, 2002) and weaknesses of researcher-defined measures (researchers often being from dominant culture group) could also be avoided with a qualitative component to research (Ridely et al., 1994).

**Brief Overview of Research on Cultural Competence Training/ Education**

**Lack of Empirical Research**

Although there has been an increase in proposed cross-cultural training models and strategies, there is a lack of published empirical research evaluating the effectiveness of these training programs (Crandall et al., 2003; Lo & Fung, 2003; Pope-Davis et al., 1994; Reynolds, 1997;). Empirical evidence that is published is based primarily on post-test only or single group pre-test/post-test evaluations of knowledge and attitudes. Williams (2002) reports that one group pre-test/post-test designs have validated the effectiveness of training that involves critical incident exercises, case analysis, interviewing, and small group processes. She adds, however, that this design cannot account for other explanations for changes such as maturation or testing effects. These studies do not reveal whether new competencies have been developed and are being applied in practice (Williams, 2002).

With current research available it is difficult to assess if positive outcomes can be attributed specifically to programs. Neither true experimental data nor qualitative data are available to make that link (Ridley et al., 1994; Williams, 2002). Few studies can support evidence-based choices of educational strategies and content thus most programs are using untested cross-cultural training methods (Williams, 2002; Reynolds, 1997; Ridley et al., 1994; Gompertz, 1997).

Srivastava (2002) reports that the research on cultural competency training has not yet identified the components that are effective in promoting culturally competent health care and that sustain the benefits over time. This is probably due to the fact that much of the research on cultural competence acquisition focuses on self-report of cultural competence awareness/attitudes and knowledge (Gompertz, 1997).

**Training Evaluation Focussing on Self-Report**

A study of multicultural competencies of doctoral interns at university counselling centers conducted by Pope-Davis et al. (1994) found that educational variables accounted for a significant amount of variance of self-reported multicultural counselling competencies. The researchers report that, not
surprisingly, interns who had received multicultural counselling supervision, had completed more multicultural workshop hours, or had taken a greater amount of multicultural course work reported greater multicultural Knowledge-Skills than did interns who had no supervision, fewer workshop hours, or less course work. The authors point to the need for further study of factors influencing intern’s Awareness both in terms of specific educational experiences that are helpful in developing greater awareness and in terms of how awareness is best conceptualized in general. Impediments or aids to increasing awareness in varied educational formats such as course work or supervision could be the focus of future research. The researchers also assert the need for examination of multicultural competencies as assessed by observational methods in addition to self-report. Further research in which various methods of multicultural education and training are evaluated is needed to understand the influences on acquisition of multicultural competencies for interns and mental health professionals.

An interesting finding of Williams’ (2002) mixed method evaluation study of a cultural competence training program for social workers was that after the training, even though they perceived challenges in their work due to a broad cultural diversity of potential clients, participants reported that they, “…felt more confident about their ability to address that diversity” (p. 134).

**Organizational Support**

An important finding of Lefley (1986b) was that administrative participation in mental health training facilitates transfer of clinical training skills as well as optimal implementation of action plans. The importance of administrative support for clinical cultural competence training is well documented (Srivastava, 2001; Tsang & George, 1998). Williams’ (2002) research also corroborated this finding. Her study reinforces the existing empirical literature suggesting that cultural competence training can promote positive outcomes if it is designed systematically, with attention to adult education principles and strategies and with institutionalized support for applying newly developed skills and knowledge. Williams points out that her study replicated the findings of other research that indicates the importance of organizational support for time and space to apply culturally competent practice.

**Levels of Cultural Competence Training**

One of the findings from the qualitative analysis of Williams’ (2002) study was the importance to some learners of dividing courses into introductory, intermediate and advanced levels of cultural competence. Williams reports that this finding reinforces the quantitative finding of her study that past exposure to cultural competence training is associated with self-perceptions of higher levels of cultural competence. However, she points out that, although cultural competence is understood to exist along a continuum within which capacity is regularly being developed, there has been no validation of any tools that can accurately assess learners for training. Furthermore, using previous education in cultural competence as criteria to separate learners into beginning to advanced levels may be partly helpful but, Williams cautions that research has indicated previous diversity education is often not recalled or used by practising social workers and is not a reliable indicator of advanced development of cultural competence.

**Summary of General Findings**

The following list contains some general findings in the cultural competence training literature.

1. There is a lack of consensus on appropriate, reliable, and valid measures for evaluating patient outcomes (Ridley et al., 1994; Williams, 2002).

2. Little has been written linking different types of instructional strategies, content of knowledge components of training, and actual knowledge obtained and length of time retained (Pope-Davis et al., 1994; Ridley et al., 1994).

3. Most evaluation research has focused on awareness and knowledge with little attention directed toward specific skill development and evaluation (Gompertz, 1997).
4. Subjective evaluation methods have questionable validity, provide little insight into the specific effects of training on trainee's actual competence and the narrow focus of these evaluation efforts disregards the complex interaction of behaviours, attitudes, cognitive abilities and knowledge that have been identified as outcomes of training (Ridley, et al., 1994).

5. There is a lack of available measures to assess the effects of multicultural training and the emphasis is on quantitative as opposed to qualitative methodologies (APA, 2002).
A. Training

While more research is needed before definitive conclusions can be made with regard to training and education in the area of clinical cultural competence in mental health care, the literature has contributed some helpful strategies for training in the area of cultural competence. The following are some tentative recommendations based on this literature and on consultations with trainers.

1. As the critical issue in all professional education is the transfer of training to practice, an integral component of training models should involve development of a comprehensive evaluation (Lefley, 1986). Evaluation should be built in at the start of training development in order to inform decisions such as length of training to ensure that enough training takes place so that transfer of training can be observed and measured in terms of more skilful performance of clinicians and greater responsiveness of clients (Lefley, 1986; Tsang, 2003).

2. Extract core skills and competencies specific to the professional role based on a detailed analysis of workplace expectations and job requirements. This strategy is based on the instructional system design approach (Williams, 2002).


4. Provide ongoing training with follow-up sessions (Greater Vancouver Mental Health Service, 1999; Lefley, 1986; Salimbene; 1999).

5. Schedule training sessions to allow for time between sessions to apply new learning to practice (Williams, 2002).

6. Provide organizational support in terms of: a) allowing space, time, and other resources for clinicians to apply new skills to practice (Srivastava, 2001; Williams, 2002). Examples of these are equipment and materials required for practice, interpreter services and training on how to work with interpreters (Srivastava, 2001); b) implementation of centre-wide assessment tools, policies, and practice guidelines (Srivastava, 2001); c) recruitment of clinicians with diverse language skills and cultural backgrounds, facilitating examination of processes through which clinician’s own values and beliefs influence care, and enabling inclusive participation and opportunities for dialogue in which alternative perspectives are encouraged are all critical aspects of organizational support for clinical cultural competence at the individual level (Srivastava, 2001; Williams, 2002).

Pedagogical Strategies/Tools

1. Role-play and case studies (relevant to the learner’s needs) are valuable training tools (Williams, 2002).

2. Structured evaluation of audiotaped and videotaped Cultural Competence role-play practice (peer supervision and coaching) is helpful for transfer of learning to practice (Tsang, 2004; Tsang et al., 2003; Williams, 2003).

3. Provide modelling and role-play practice with opportunities for self-reflection and constructive feedback (Tsang, 2004; Williams, 2002).

4. Provide activity-based learning as it has been shown to be more successful in generating behavioural change than education focused on didactic sessions and knowledge transfer.
5. Williams’ (2002) study revealed that participants’ “sense of being in a safe environment” was extremely important (p.139). Others have also pointed to the necessity of participants being able to take risks in a safe setting to ensure success of the training (Ptak, Cooper, & Brislin, 1995).

B. Implications for Future Research

Very few studies on cultural competence training employ qualitative methodology (Pope-Davis et al., 2002). There are strong indications that gaps in the research on cultural competence intervention and training related to identifying specific elements of the client-therapist relationship and therapeutic processes in addition to outcomes, for example, could be obtained from qualitative inquiry or studies with mixed methods. Williams (2002), in her evaluation research of cultural competence training for social workers found that the data provided by the qualitative methods was able to broaden the perspective on how the training program contributed to outcomes. She notes, “The identification of outcomes in the areas of awareness, knowledge, practices and anticipated practices is unprecedented in the empirical studies addressing professional training for cultural competence” (p. 127).

Furthermore, there has been little focus on understanding cultural competence from the perspective of clients (Pope-Davis et al., 2002). Qualitative inquiries are most suited to gaining this kind of information as they allow for generating new forms of knowledge and theory in addition to giving voice to minority clients through allowing space for self-expression of research participants in their own words. Moreover, this kind of methodology promotes a more egalitarian relationship between researcher and participant.

While the specification of awareness, knowledge, and skills in cultural competence has been widely discussed in the mental health professions and testing attempts have been made, more empirical research is necessary before conclusions can be drawn about specific competencies, measures/indicators and/or training approaches. More research is needed which employs:

1. Mixed methods (qualitative & quantitative) for evaluating clinical interventions and training to eliminate problems with social desirability factors and researcher-defined measures
2. Research on client perceptions of interventions
3. Process research on client-therapist dyads to identify or delineate specific clinical cultural competencies/indicators
4. Outcome studies examining context using qualitative methodologies.

C. Conclusion

An essential first step for developing clinical cultural competency training programs in mental health care is to clarify conceptualizations of the term cultural competence across disciplines. This review revealed that key components of clinical cultural competence and many of the same practice competencies are being identified across the disciplines of psychology, social work, nursing and psychiatry with divergence occurring more in the areas of emphasis. Furthermore, global as opposed to ethnicity-based definitions of culture are cited across disciplines in the professional standards and in the training modules examined in this review. Interestingly, all training modules in this review were based either explicitly or implicitly on an idiographic or integrated emic-
etic philosophical underpinning and combined clinical cultural competence and anti-racist/anti-oppression conceptual training models.

This review also revealed the usefulness and applicability across disciplines for a quadripartite framework (i.e. awareness, knowledge, skills and power/relationship issues) for enhancing understanding and training in clinical cultural competence. In addition to the client-clinician dyad or micro-level of the Power/Relationship Issues domain originally identified by Sodowsky and colleagues (1994), a macro-level of this domain, client-system, was found to be relevant. This level focuses on the impacts of systemic oppression, discrimination, racism and deprivation at the sociocultural, institutional, and political levels on psychosocial, political, and economic development and underlines the expansion of clinician roles to include change agent and advocate. While not explicitly defined as a fourth domain, cross-cultural competencies identified across disciplines in addition to the training programs and professional standards examined in this review all addressed the Power/Relationship Issues domain.

Currently, systematic training evaluation research is limited and training programs are using methods that have not been empirically tested. To increase clinicians’ confidence in cross-cultural practice it is important to provide evidence-based training to help equip them with knowledge, tools, and skills to better understand and manage sociocultural issues in the clinical encounter. Our primary goal is to provide the highest quality care for all clients. Consequently, more research efforts are needed to explore the effects of specific cultural competence training models/approaches on development of clinician competencies and ultimately on clients.
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Appendix A - Brief Description of Conceptual Training Models

Cultural/Anthropological
These training programs are typically attached to university environments within departments of psychiatry and anthropology and are based on the work of Arthur Kleinman (1988), which established a link between anthropology and psychiatry. In this model, the conceptualizations of mental health and illness are examined within the cultural context. One of the main contributions of this model is the “Explanatory Model of Health and Illness” in which the patient’s perception of cause, meaning, conceptualization and care of the condition are explored in relation to norms of the cultural reference group and are part of the Cultural Formulation now used in applying DSM-IV criteria in a multicultural environment. Cultural explanatory models inform emotional, physical and psychological experience.

Clinical Ethnopsychiatry
This training model, a subtype of the clinical training models, is promoting a patient-based approach and is intended for hospital residency curricula or clinical psychology programs. Furthermore, as with most clinical models, the emphasis of training is on topics such as cultural formulation, developing cultural sensitivity and awareness, communication issues, culture-specific knowledge, counter-transference issues, and use of interpreters. Consideration of cultural identity is considered as important as the psychic function within a person (O’Bryne, Undated). The first category of the DSM–IV Outline for Cultural Formulation is the cultural identity of the individual.

Clinical Culture Broker
The culture broker, a concept borrowed from anthropology, is a member of a specific cultural community who acts as a trainer or clinical mediator/consultant between clinician and a client belonging to that particular cultural group (O’Bryne, Undated).

Clinical Developmental
In this model, training emphasises stages of learning in the process of attaining cultural awareness (O’Bryne, Undated). There are several multicultural education models that adhere to a developmental perspective of cultural competence (Anand, 2003). According to most developmental perspectives, typically the person moves along a continuum from cultural incompetence through stages of development where conscientiousness begins to develop and progresses to “cultural integrity” in which cross-cultural training is incorporated into the didactic and clinical components of a training program (O’Bryne, Undated). Cross (1989) describes a six-point continuum applicable to individuals and organizations ranging from cultural destructiveness to cultural proficiency.

Cultural Epidemiology & Sociological Models
This model, combining epidemiology and anthropology, focuses on patterns of mental illness and resilience in the context of migration, immigration and refugee populations (O’Bryne, Undated). The impact of culture on illness experience, meaning and behaviour and cultural determinants in course
and outcome are explored. The EMIC instrument, developed by Mitchell Wiess and colleagues at the Swiss Tropical Institute, is a tool developed to gain an understanding of “the insider’s point of view and narrative accounts” (O’Bryne, Undated).
Appendix B - Brief Descriptions of Training Programs Contacted that did not respond

1) Soma Ganesan, M.D is Clinical Professor and Director of the Cross-Cultural Program, Department of Psychiatry, University of British Columbia and Medical Director of Psychiatry at Vancouver Hospital and Health Sciences Centre. He is a member of the Ministers Advisory Council on Mental Health. He participated in setting up the Multicultural Liaison Worker program at Vancouver Community Mental Health Services and is a founding member of the Vancouver Association of Survivors of Torture. He maintains a high level of involvement in the development of clinical services, policy and research in refugee and cross-cultural mental health.

2) Multicultural Mental Health Resource Data-base: Greg Turner, Managing Cultural Diversity in Mental Health. Eight one-day Train-the-Trainer program covering Cultural Factors in Mental Health Illness; Language Matters in Mental Health Care; Transcultural Assessment and Diagnosis; Transcultural Treatment Issues; Migration and Settlement Issues and Mental Health; Developing Culturally Responsive Mental Health Services; Acculturative Stress, Trauma and Mental Health and Transcultural Issues in Child and Youth Mental Health. (Brisbane, Australia)

3) Miriam Delphin, An Integrated Approach to Cultural Competency Training: Incorporating Consumer Voices and Recovery Principles, An integrative approach to cultural competency training for mental health and substance abuse service providers in which consumer story-telling and perspectives were an integral part of the program development and training process. In addition, recovery-oriented values and principles emphasizing person-centred care, strengths, and assets and spirituality as a cultural resource were incorporated throughout the training. These concepts build on and further enhance traditional cultural competency principles, and together served as the conceptual underpinnings of the training curriculum. The inclusion of consumer story-telling and recovery oriented approaches to care enhance traditional training and provide participants with a framework to understand the value and utility of culturally competent mental health treatment.

4) Hardin Coleman, Ph. D., Department of Psychology, University of Wisconsin-Madison. His area of research are (a) assessment of multicultural and school counsellor competence and (b) cultural diversity. He is involved in the preparation of community mental health counsellors to work with culturally diverse populations.

5) Since 1974, Intercultural Institute of Montreal has been offering intercultural training programs to professionals of various institutions and community workers. These training programs are designed to respond to the needs and concerns of these social agents who are confronted with social diversity and to help them serve their culturally diverse clientele adequately.

The goals of these training programs are: to help participants develop skills to understand persons from various cultural and racial backgrounds and develop intercultural competence to work in a multicultural context. These programs also aim at inciting these social agents to seek alternatives for social change. The pedagogical approach to these training programs involves a synergy between theory and practice. It brings participants to recognize and integrate the knowledge of various cultures into their professional practices.