Cultural Competence: A Literature Review and Conceptual Model for Mental Health Services

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This article presents a conceptual model of organizational cultural competence for use in mental health services that resulted from a comprehensive review of the research literature. The model identifies four factors associated with cultural competence in mental health services (community context, cultural characteristics of local populations, organizational infrastructure, and direct service support) and redefines cultural competence as the degree of compatibility among these factors. A strength of this model of organizational cultural competence is that it facilitates future research and practice in psychiatric services settings and links culturally competent practices to service parity. (*Psychiatric Services* 60:1046–1050, 2009)

Among individuals who are in need of mental health services, members of many U.S. racial-ethnic minority groups face significant disparities compared with Americans with European origins (1). For instance, compared with European Americans with co-occurring depression and substance abuse, African Americans and Latinos with the same co-occurrence tend to have less access to selective serotonin reuptake inhibitors (2), which are often recommended as a first-line treatment for individuals with co-occurring depression and substance use disorder (3). Even when services are available to members of U.S. racial-ethnic minority groups, they often are not accessible to large subsets of those populations. For example, compared with their English-proficient counterparts, Asians, Pacific Islanders, and Latinos with a mental health need and limited English proficiency tend to be less likely to receive services (4). Given the limited English proficiency of a large proportion of Asians, Pacific Islanders, and Latinos, their limited ability to access mental health services may contribute to overall racial-ethnic disparities in mental health services (4).

It often has been suggested that increasing cultural competence in providing psychiatric services can contribute to the reduction of existing mental health service disparities (5,6). According to one popular definition, cultural competence in mental health services occurs when a set of congruent behaviors, attitudes, and policies come together in a system, an agency, or among professionals to enable effective cross-cultural work (7). Although the proposition that increased cultural competence in providing psychiatric services can reduce existing disparities is appealing, cultural competence lacks a clear means of operationalization that can direct research and practice (8–10).

This article summarizes a model for cultural competence in mental health services. The model has emerged from research that seeks to operationalize cultural competence in order to facilitate its understanding and implementation in behavioral health organizations (11). The model organizes the findings from a literature review that examined over 1,100 articles on the topic of cultural competence in mental health services for racially and ethnically diverse groups in the United States. The goal of the review was to identify and describe measurable factors associated with cultural competence in mental health services and the relations among these factors (11,12). This review was part of a larger study that focused on identifying organizational practices to operationalize cultural competence and reduce mental health service disparities by improving service accessibility (13). A full description of the study methodology can be obtained from source materials and by direct inquiry to the authors.

The model

The available literature suggests that disparities in delivery of mental health services are driven by incompatibility

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between available services and the culture and social context of the communities being served. Indeed, results of the literature review led to redefining cultural competence in mental health services as the degree of compatibility between the cultural and linguistic characteristics of a community and the manner in which the combined policies, structures, and processes underlying local mental health services seek to make these services available, accessible, and utilized (11).

The model arising from our review of the literature suggests that cultural competence occurs when there is compatibility among four important factors: community context, cultural characteristics of local populations, organizational infrastructure, and direct service support (11). These factors and their role in ensuring culturally competent mental health services are described below.

Community context

Community context provides an overall background for understanding psychiatric service organizations and their target populations. Organizations function within larger community, city, county, state, and national environments that affect their efforts to serve their local community (12). Individuals' responses to mental health issues also occur within the framework of the larger social environment (14). Because of this system, community context affects the manner in which racially and ethnically diverse individuals come into contact with services (14). For example, when compared with their European-American peers, African-American adolescents are more likely to enter mental health services through involuntary commitment, such as juvenile justice (14–18). Similarly, compared with their European-American peers, Native-American adolescents are more likely to be removed from their homes in order to receive services and are overall less likely to receive services. These differing service pathways are influenced by family choices, cultural factors, and by the interaction between contextual and organizational factors, including service availability and the availability of social networks that provide referrals to services (14).

Cultural characteristics of local populations

Culture has a pervasive influence over important aspects of people's everyday experience, including their perceptions of, and interactions with, mental health services (14,19,20). For instance, cultural differences influence mental health help-seeking strategies, affecting variables such as problem identification, problem definition, and treatment or provider choices (14). Simply stated, culture influences what gets defined as a problem, how the problem is understood, and which solutions to the problem are acceptable. Culture also affects mental health services when there are cultural differences between providers and individuals receiving services. When unacknowledged and unaddressed, these differences have been found to perpetuate disparities through misdiagnosis and mistreatment (19–22). Culturally competent mental health services are to a great extent tied to a service organization's ability to appropriately understand and respond to the cultural characteristics of the community it serves (11).

One important caveat when providing services to communities in which there is inequitable distribution of social capital across cultural groups, as is the case for many U.S. communities, is to avoid confusing the influences of culture with those of socioeconomic status (14), particularly because socioeconomic status also influences important service factors. Individuals with lower socioeconomic status tend to face significantly more service access barriers, including a lack of insurance, time constraints, and transportation limitations (23). These patterns underscore the importance of attending to both the joint and the independent effects of socioeconomic status and culture (24).

In summary, a community's cultural characteristics meaningfully influence many factors associated with mental health service disparities. To overcome these disparities, providers must be attentive and responsive to these cultural characteristics and their effects and consider them in the context of other powerful contextual factors, including socioeconomic status (11,24).

Organizational infrastructure

There are two service domains that should be considered when attempting to develop culturally competent mental health services, and as explained below, such services reflect compatibility between and within these service domains. The first domain, organizational infrastructure, includes eight interrelated components of psychiatric services organizations. Each component and its relevance to culturally competent service delivery are introduced below.

Values. Values are reflected in service organizations' mission and vision statements, documentation, the stated beliefs of administrative and direct service personnel, and the documented manner in which an organization acts on these beliefs (25,26). In culturally competent service organizations, these value markers articulate the importance of cultural competence and reflect the organization's commitment to culturally competent services and the manner in which these services will be provided (27).

Communication. Communication refers to the exchange of information between a service organization and the community, among partner organizations, and within one organization (28). Culturally competent communication practices foster learning and direct exchanges of information both within the organization and between the organization and the community it serves (29).

Community participation. This component refers to the level of engagement between a service organization and the community (30). Culturally competent service organizations move beyond community outreach and into strategies that involve community members in providing a large degree of input into the variety of and manner in which services are provided (25,31,32).

Governance. Governance refers to the processes through which a service organization acts to institute policies, procedures, and goals (27,33). Organizations that provide culturally competent services typically have in place rules and plans to guide the provision of these services (31,34).

Planning and evaluation. The methods and procedures for an organization's systematic data collection regarding its target community are called

planning and evaluation (25,31,35). Common planning and evaluation tools include assessments of community needs and an organization's self-assessment of cultural competence levels (27,34). Culturally competent organizations tend to include communities as fully contributing partners in planning and evaluation processes and to implement data collection approaches that reflect the relation between the community context and the services being provided (27).

Human resources. Human resource practices facilitate culturally competent services by ensuring that the organization's employees have the requisite knowledge and skills to deliver these services (27). This includes recruiting and hiring personnel versed in the languages and cultures that prevail in the community (36,37), providing comprehensive opportunities for cultural competence training (32,35,36), and reflecting the importance of cultural competence through performance incentives, in personnel evaluations, and in the criteria for personnel retention and promotion (34).

Service array. Culturally competent service organizations adapt their service array in response to a community's needs and practices (11). For instance, some service organizations increase their multilingual and multicultural capacity in order to ensure provision of consistently high-quality services in culturally and linguistically heterogeneous communities (27,34). Other organizations incorporate informal supports into their service array in order to increase accessibility to and adequacy of services (34). Informal supports are naturally existing agents that are accessed by community members in times of need and can include family, friends, religious organizations, cultural healers, and other human services. *Technical support.* To ensure cultural competence, service organizations must ensure the availability of assets or supplies necessary to the community. These include financial supports, staffing, linkages, and technology (25,27).

Direct service support

Direct service support, the second organizational domain to be considered when attempting to develop culturally competent mental health services, groups together three interrelated organizational functions: service availability, service accessibility, and service utilization (11,12). Each function and its relevance to culturally competent service delivery are introduced below.

Availability. Cultural competence in service availability involves ensuring that the range and capacity of available services adequately reflects the needs of the community being served (11).

Accessibility. Accessibility involves facilitating individuals' ability to successfully enter, navigate, and exit needed services and supports (11). Examples of adaptations that service organizations can make to increase cultural competence in service accessibility include providing and promoting services at times and locations that are convenient to the community, such as at community events or through home-based services (38,39); ensuring that services and supporting materials are available in the languages used by the community (5,31); and incorporating cultural healing traditions into the service array (29).

Utilization. As an organizational process, utilization involves the promotion of service use in the community and the facilitation of organizational accountability by tracking service use patterns (11). Examples of adaptations that increase cultural competence in service use include providing reminder calls for appointments and providing transportation to services (40–42). Patterns tracked by culturally competent service organizations include the length of time in service, client retention rates, client dropout rates, and rates of client return (41,43,44).

Compatibility issues

As underscored by the model's revised definition of cultural competence, the available literature highlights the importance of creating compatibility among service domains and community characteristics in order to reduce existing disparities (5,6,11). In one striking illustration of the importance of ensuring compatibility, results of a meta-analysis of 76 published studies found that services adapted to ensure compatibility with the cultural characteristics of specific communities were four times more effective than services broadly adapted for individuals from a variety of cultural backgrounds (45).

An example of the need for compatibility among service factors is as follows: An organization decides to increase service access by developing a one-stop family services center. However, a failure to clearly articulate and operationalize cultural competence values prevents community participation in service planning and development. In turn, this lack of input prevents the identification of a need for the availability of bilingual services and increases community mistrust of the service organization. Ultimately, the community's lack of opportunity to provide input and its growing mistrust drive service utilization levels far below expectations and contribute to the perpetuation of disparities in psychiatric and mental health services.

Tracking parity: organizational cultural competence outcomes

The available literature suggests that increased cultural competence in mental health services leads to reduced mental health disparities (43,46). However, disparities can exist across a wide variety of outcomes associated with mental health and mental health services (47). For this reason, in order to track disparities, outcomes should be measured at multiple levels. Organization-level outcomes include rates of access, client retention, and client no-shows (41–43). At the population level, a primary outcome is service use, which includes attending to overall rates of use across community subgroups and to potential disproportionalities in use of specific types of services (14). At the service-recipient level, outcomes include satisfaction with services, clinical outcomes, social functioning, and client empowerment (28,48,49).

An applied example

African American Family Services (AAFS), a Minneapolis, Minnesota, agency focused on the mental health needs of African Americans, provides a useful example of organizational cultural competence in mental health services. Regarding the first service domain, infrastructure, AAFS values and principles define their target com-

munity, espouse a commitment to culturally specific services, and enable the achievement of culturally specific services. Planning and evaluation at AAFS feature open meetings with their target communities where community issues and ways in which these issues could be addressed by AAFS are discussed. By emphasizing hiring from within the community, AAFS human resources practices have led to a staff that is racially and ethnically representative of the community. AAFS fosters culturally competent community participation and communication by contributing to community events and fairs, developing partnerships with other local organizations, supporting staff involvement in local and regional councils and committees, and interacting closely with community media. AAFS offers a broad service array, including cultural adaptations of traditional mental health practices and additional services based on programs developed and supported by the community. Technical support for culturally competent services is evident through ongoing training of existing staff, reflecting the organization's assumption that culturally specific services result from deliberate efforts and are not necessarily achieved by focusing solely on demographic representation of the service population.

In terms of the second service domain, direct service support, AAFS ensures that service availability corresponds to community needs through ongoing data collection and service development. For instance, a needs-monitoring exercise with local family courts led to domestic violence services. AAFS facilitates access by allowing walk-in appointments, placing its offices within the community, providing expanded hours (evenings and weekends), and delivering services in a variety of settings already frequented by the community, including primary care offices, schools, other organizations' service delivery sites, and religious institutions that are important in the community. After identifying utilization gaps among adolescents and individuals with chronic and severe mental health problems, AAFS implemented an incentive program that rewards participation with gift certificates and other appropriate inducements.

Conclusions

Based on the available research literature, the model described in this article directly addresses a common criticism of cultural competence as a response to mental health service disparities by setting the foundation for a measurable approach to the pursuit of cultural competence in mental health care. It should be noted that this model places previous conceptualizations of cultural competence, such as characteristics of individual practitioners (6) or of specific service practices (5), within the broader context of the organization in which they exist. By doing so, the success of efforts to develop a culturally competent psychiatric practitioner community or to disseminate culturally competent psychiatric service practices may be meaningfully influenced by the overall ability of the service organization to recognize, value, and respond to the needs of the particular cultural communities being served.

In contrast to other models' focus on broad cultural values, the model described here highlights that cultural competence is demonstrated by understanding and responding to local communities' culturally influenced values, needs, and attitudes toward service. In doing so, the model expands the scope of cultural competence in two important ways. First, it facilitates culturally competent services in contexts often overlooked by overly broad approaches (for example, small ethnic communities and subcultures within larger ethnic groups). Second, it highlights cultural competence as an inherent aspect of all organizations providing mental health services, not only those serving racial and ethnic minority groups. In this sense, the model avoids a common tendency to exoticize culture by considering it only as a factor affecting the care of racial-ethnic minority populations rather than as a dynamic set of factors that have a pervasive influence on important aspects of all individuals' everyday experience (50).

Although the model described identifies measurable factors associated with culturally competent services, further work must determine the best approaches to measuring these factors, thereby facilitating research

and organizational practice. In particular, research is needed to examine the frequent suggestion that increased cultural competence in mental health services can reduce disparities in delivery of existing services. Ultimately, the model's value will depend on the results and relevance of such efforts. Nevertheless, the model provides direction for future work aimed at ensuring that the mental health needs of large segments of the U.S. population are no longer misunderstood and unmet.

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