TOWARDS A CULTURALLY COMPETENT SYSTEM OF CARE

A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed

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March, 1989

This project is funded by the National Institute of Mental Health, Child and Adolescent Service System Program (CASSP)

Available from:

CASSP Technical Assistance Center
Georgetown University Child Development Center
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CHAPTER II: THE CULTURAL COMPETENCE CONTINUUM

(Substantial portions of this chapter have been reprinted from *Focal Point*, vol. 3, #1, Fall, 1988 issue).

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. The word "culture" is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates--at all levels--the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs.

Certainly this description of cultural competence seems idealistic. How can a system accomplish all of these things? How can it achieve this set of behaviors, attitudes, and policies? Cultural competence may be viewed as a goal towards which agencies can strive. Accordingly, becoming culturally competent is a developmental process. No matter how proficient an agency may become, there will always be room for growth. It is a process in which the system of care can measure its progress according to the agency's achievement of specific developmental tasks. As the tasks are defined, the system will be guided toward progressively more culturally competent services. First, it is important for an agency to internally assess its level of cultural competence.

To better understand where one is in the process of becoming more culturally competent, it is useful to think of the possible ways of responding to cultural differences. Imagine a continuum that ranges from cultural destructiveness to cultural proficiency. There are a variety of possibilities between these two extremes. The six points along the continuum and the characteristics that might be exhibited at each position are as follows:

Cultural Destructiveness

The most negative end of the continuum is represented by attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture. The most extreme examples of this orientation are programs/agencies/institutions that actively participate in cultural genocide--the purposeful destruction of a culture. For example, the Exclusion Laws of 1885-1965 (Hune, 1977) prohibited Asians from bringing spouses to this country, immigration quotas restricted their migration, and laws denied basic human rights on the state and federal level. Another example of cultural genocide is the systematically attempted destruction of Native American culture by the very services set up to "help" Indians, i.e., boarding schools (Wilkinson, 1980). Equally destructive is the process of dehumanizing or subhumanizing minority clients. Historically, some agencies have been actively involved in services that have denied people of color access to their natural helpers or healers, removed children of color from their families on the basis of race, or purposely risked the well-being of minority individuals in social or medical experiments without their knowledge or consent.

One area peculiar to Native Americans is the Indian Child Welfare Act. This act is an example of a legislative response to culturally-destructive practices. The Act sets up requirements for states regarding placement procedures for Indian children. These requirements are designed to protect children's rights to their heritage and to protect children as the most valuable resource of Indian people. States must deal with Indian tribes on a government-to-government basis.

While not many examples of cultural destructiveness are currently seen in the mental health system, it provides a reference point for understanding the various possible responses to minority communities. A system which adheres to this extreme assumes that one race is superior and should eradicate "lesser" cultures because of their perceived subhuman position. Bigotry coupled with vast power differentials allows the dominant group to disenfranchise, control, exploit, or systematically destroy the minority population.

Cultural Incapacity

The next position on the continuum is one at which the system or agencies do not intentionally seek to be culturally destructive but rather lack the capacity to help minority clients or communities. The system remains extremely biased, believes in the racial superiority of the dominant group, and assumes a paternal posture towards "lesser" races. These agencies may disproportionately apply resources, discriminate against people of color on the basis of whether they "know their place," and believe in the supremacy of dominant culture helpers. Such agencies may support segregation as a desirable policy. They may act as agents of oppression by enforcing racist policies and maintaining stereotypes. Such agencies are often characterized by ignorance and an unrealistic fear of people of color. The characteristics of cultural incapacity include: discriminatory hiring practices, subtle messages to people of color that they are not valued or welcome, and generally lower expectations of minority clients.

Cultural Blindness

At the midpoint on the continuum, the system and its agencies provide services with the express philosophy of being unbiased. They function with the belief that color or culture make no difference and that all people are the same. Culturally-blind agencies are characterized by the belief that helping approaches traditionally used by the dominant culture are universally applicable; if the system worked as it should, all people--regardless of race or culture--would be served with equal effectiveness. This view reflects a well-intended liberal philosophy; however, the consequences of such a belief are to make services so ethnocentric as to render them virtually useless to all but the most assimilated people of color.

Such services ignore cultural strengths, encourage assimilation, and blame the victim for their problems. Members of minority communities are viewed from the cultural deprivation model which asserts that problems are the result of inadequate cultural resources. Outcome is usually measured by how closely the client approximates a middle class, non-minority existence. Institutional racism restricts minority access to professional training, staff positions, and services.

Eligibility for services is often ethnocentric. For example, foster care licensing standards in many states restrict licensure of extended family systems occupying one home. These agencies may participate in special projects with minority populations when monies are specifically available or with the intent of "rescuing" people of color. Unfortunately, such minority projects are often conducted without community guidance and are the first casualties when funds run short. These agencies occasionally hire minority staff, but tend to be motivated more by their own needs than by an understanding of the needs of the client population. Such hiring drains valuable resources from the minority community.

Culturally-blind agencies suffer from a deficit of information and often lack the avenues through which they can obtain needed information. While these agencies often view themselves as unbiased and responsive to minority needs, their ethnocentrism is reflected in attitude, policy, and practice.

Cultural Pre-Competence

As agencies move toward the positive end of the scale they reach a position called cultural pre-competence. This term was chosen because it implies movement. The pre-competent agency realizes its weaknesses in serving minorities and attempts to improve some aspect of their services to a specific population. Such agencies try experiments, hire minority staff, explore how to reach people of color in their service area, initiate training for their workers on cultural sensitivity, enter into needs assessments concerning minority communities, and recruit minority individuals for their boards of directors or advisory committees. Pre-competent agencies are characterized by the desire to deliver quality services and a commitment to civil rights. They respond to minority communities' cry for improved services by asking, "What can we do?" One danger at this level is a false sense of accomplishment or of failure that prevents the agency from moving forward along the continuum. An agency may believe that the accomplishment of one goal or activity fulfills their obligation to minority communities or they may undertake an activity that fails and are therefore reluctant to try again.

Another danger is tokenism. Agencies sometimes hire one or more (usually assimilated) minority workers and feel they are then equipped to meet the need. While hiring minority staff is very important, it is no guarantee that services, access, or sensitivity will be improved. Because minority professionals are trained in the dominant society's frame of reference, they may only be a little more competent in cross-cultural practice than their co-

workers. Minority professionals, like all other professionals, need training on the function of culture and its impact on client populations. The pre-competent agency, however, has begun the process of becoming culturally competent and often only lacks information on what is possible and how to proceed.

Cultural Competence

Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations. Such agencies view minority groups as distinctly different from one another and as having numerous subgroups, each with important cultural characteristics. Culturally competent agencies work to hire unbiased employees, seek advice and consultation from the minority community, and actively decide what they are and are not capable of providing to minority clients. Culturally competent agencies seek minority staff whose self-analysis of their role has left them committed to their community and capable of negotiating a bicultural world. These agencies provide support for staff to become comfortable working in cross-cultural situations. Further, culturally competent agencies understand the interplay between policy and practice, and are committed to policies that enhance services to diverse clientele.

Cultural Proficiency

The most positive end of the scale is advanced cultural competence or proficiency. This point on the continuum is characterized by holding culture in high esteem. Culturally proficient agencies seek to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects. Culturally proficient agencies hire staff who are specialists in culturally competent practice. Such agencies advocate for cultural competence throughout the system and for improved relations between cultures throughout society.

In conclusion, the degree of cultural competence agencies achieve is not dependent on any one factor. Attitudes, policies, and practices are three major arenas wherein development can and must occur if agencies are to move toward cultural competence. Attitudes change to become less ethnocentric and biased. Policies change to become more flexible and

culturally impartial. Practices become more congruent with the culture of the client from initial contact through termination. Positive movement along the continuum results from an aggregate of factors at various levels of an agency's structure. Every level of an agency (board members, policymakers, administrators, practitioners, and consumers) can and must participate in the process. At each level the principles of valuing difference, self-assessment, understanding dynamics, building cultural knowledge, and practice adaptations can be applied. When, at each level, progress is made in implementing the principles, and as attitudes, policies, and practices change in the desired direction, an agency becomes more culturally competent.

CHAPTER III: THE CULTURALLY COMPETENT SYSTEM OF CARE

(Portions of this chapter have been adapted from *Focal Point*, vol. 2, #4, Summer, 1988 issue).

The culturally competent system of care is made up of culturally competent institutions, agencies, and professionals. Five essential elements contribute to a system's, institution's, or agency's ability to become more culturally competent. The culturally competent system values diversity, has the capacity for cultural self-assessment, is conscious of the dynamics inherent when cultures interact, has institutionalized cultural knowledge, and has developed adaptations to diversity. Further, each of these five elements must function at every level of the system. Attitudes, policies, and practices must be congruent within all levels of the system. Practice must be based on accurate perceptions of behavior, policies must be impartial, and attitudes should be unbiased. As mentioned earlier, unbiased does not mean color blind; rather it means acceptance of the difference of another.

VALUING DIVERSITY

To value diversity is to see and respect its worth. A system of care is strengthened when it accepts that the people it serves are from very different backgrounds and will make different choices based on culture. While all people share common basic needs, there are vast differences in how people of various cultures go about meeting those needs. These differences are as important as the similarities. Acceptance of the fact that each culture finds some behaviors, interactions, or values more important or desirable than others can help the system of care interact more successfully with differing cultures. In the system of care, awareness and acceptance of differences in communication, life view, and definition of health and family are critical to the successful delivery of services.

CULTURAL SELF-ASSESSMENT

The system of care must be able to assess itself and have a sense of its own culture. When planners and administrators understand how that system is shaped by culture, then it is easier for them to assess how the system interfaces with other cultures. System leaders can then choose courses of action that minimize cross-cultural barriers. For example, if "family" refers to nuclear families in one culture and in another culture "family" denotes

extended family, then concepts such as "family involvement" will require some adjustment or they simply will not work. Only by better knowing the culture of the existing system of care can the complexities of cross-cultural interfacing be understood.

DYNAMICS OF DIFFERENCE

What occurs in cross-cultural system interactions might be called the "dynamics of difference." When a system of one culture interacts with a population from another, both may misjudge the other's actions based on learned expectations. Each brings to the relationship unique histories with the other group and the influence of current political relationships between the two groups. Both will bring culturally-prescribed patterns of communication, etiquette, and problem solving. Both may bring stereotypes or underlying feelings about serving or being served by someone who is "different." The minority population may exhibit behaviors expressing tension and frustration that the system is uncomfortable with. It is important to remember this creative energy, caused by tension, is a natural part of cross-cultural relations, especially when one of the cultures is in a politically dominant position. The system of care must be constantly vigilant over the dynamics of misinterpretation and misjudgment. Historic distrust is one such dynamic that can occur between a helper of the dominant society and a client of a minority community (Lockart, 1981; Good Tracks, 1973). Part of what they bring to the helping relationship is the history of the relationship between their peoples.

Without an understanding of cross-cultural dynamics, misinterpretation and misjudgment are likely to occur. It is important to note that this misunderstanding is a two way process--thus the label "dynamics of difference." These dynamics give cross-cultural relations a unique character that strongly influences the effectiveness of the system. By incorporating an understanding of these dynamics and their origins into the system, the chances for productive cross-cultural interventions are enhanced. When people of any culture violate the norms of another there are consequences. A range of examples are provided in the practice and service adaptation sections of this monograph.

INSTITUTIONALIZATION OF CULTURAL KNOWLEDGE

The system of care must sanction and in some cases mandate the incorporation of cultural knowledge into the service delivery framework. Every level of the system needs accurate information or access to it. The practitioner must be able to know the client's concepts of

health and family as well as be able to effectively communicate. The supervisor must know how to provide cross-cultural supervision. The administrator must know the character of the population the agency serves and how to make services accessible. The board member or bureau head must be able to form links with minority community leaders so as not to plan ill-fated interventions. Mechanisms must be developed within the system to secure the knowledge it requires. The development of knowledge through research and demonstration projects must be made possible. Networks must be built, lines of communication must be opened, and the structure and process of the system must adapt to better respond to the needs of all children. The system must provide cultural knowledge to the practitioner. Information about family systems, values, history, and etiquette are important. However, the avenues to such knowledge are as important as the knowledge itself. The practitioner must have available to them community contacts and consultants to answer their culturally-related questions.

ADAPTATION TO DIVERSITY

Each element described here builds a context for a cross-culturally competent system of care. The system's approach may be adapted to create a better fit between the needs of minority groups and services available. Styles of management, definitions of who is included in "family," and service goals are but a few of the things that can be changed to meet cultural needs. Agencies understanding the impact of oppression on mental health can develop empowering interventions. For example, minority children repeatedly receive negative messages from the media about their cultural group. Programs can be developed that incorporate alternative, culturally-enriching experiences and that teach origins of stereotypes and prejudices. By creating such programs, the system can begin to institutionalize cultural interventions as a legitimate helping approach. Only as professionals examine their practice and articulate effective helping approaches will practice improve. Agencies engaging in these efforts add to the knowledge base.

Becoming culturally competent is a developmental process for the individual and for the system. It is not something that happens because one reads a book, or attends a workshop, or happens to be a member of a minority group. It is a process born of a commitment to provide quality services to all and a willingness to risk.