Establishing Standards for Culturally Competent Mental Health Care

The past 2 decades have witnessed a sharp increase in the global migration of health care providers, along with an increasingly diverse patient population. Since culture fundamentally influences all health-related behaviors, an understanding of patient perspectives, values, beliefs, and approaches to health and well-being is critical to ensuring the best possible health outcomes. In addition, providers must be willing to work within these diverse frameworks. When culture is ignored, the results are disparities in outcomes and unequal distribution of mental illness burden. Much work still needs to be done to identify and apply standards for cultural competence in all health care settings where mental health services are provided. Given the multilingual, multiracial, and multicultural needs of an expanding diverse population in the United States, cultural competence is a relevant component to reducing disparities in health care and health outcomes (Echeverri, Brookover, & Kennedy, 2010).

Moreover, clinical skills need to be extended to incorporate awareness of health statistics that highlight mental health disparities, training, and cross-cultural health care delivery at the individual and system levels (Núñez & Robertson, 2003). Cross-cultural expertise is the ability to work within several cultural systems (i.e., different patients, populations, providers, organizations, community systems) that generate and promulgate their own culture. Cross-cultural expertise also enables one to compare, integrate, and differentiate these cultural systems according to patient goals and needs. Notably, cross-cultural expertise is a vital component to delivering quality mental health care and services, especially in two essential areas: (a) establishing standards for culturally competent mental health care and (b) proposing a global model of cultural competence for mental health providers.

ESTABLISHING STANDARDS FOR CULTURALLY COMPETENT MENTAL HEALTH CARE

Developing culturally competent mental health providers is essential. Standards can be implemented, but to be effective, providers first need to know how to adapt their practice to successfully manage elements associated with culture and health and, second, to effectively deliver patient-centered care. Further, culturally competent mental health providers must negotiate care to “bridge cultural beliefs and practices” and adapt care provided to specific contexts (Park, Chesla, Rehm, & Chun, 2011, p. 2373). Standards must therefore be reflective of regional, national, and international policies and provisions that effectively address health needs of their population and professional/mental health standards, regardless of geographical location. As a result, these providers will create a workforce and health care delivery system that is able to provide exemplary care to every patient despite differences such as adeptness to language, ethnicity, race, or culture.

An additional factor that can be a conundrum when examining standards for culturally competent mental health care is the lack of uniformity in educating mental health providers about cultural competence and inconsistencies in how cultural competence is defined. Prescriptive and descriptive approaches have been suggested to address this issue (Park et al., 2011). From this stance, prescriptive approaches would focus mental health cultural norms and distinctive attributes of diverse groups. These factors are relevant, but caution by providers is warranted. Since portrayals of cultural groups tend to stem from their culture of origin, a broadened lens is needed to better understand change that has occurred resulting from engagement with a new cultural context (e.g., individuals of Mexican descent and exposure to American cultural traditions). Thus, skill and experience with Mexican culture alone is not adequate to understand perspectives of Mexican Americans, particularly individuals born in the United States.

Descriptive approaches tend to categorize features of culturally competent care and its context. Unfavorable misperceptions may arise if care is not taken to prevent stereotyping or making assumptions about groups (e.g., mental health providers who have values and attitudes similar to individuals they work with are more effective than those who are of the same ethnic background). Complexities in how one practices can surface at this point. While standards tend to be based on evidence-based research, culturally competent clinicians are aware that they need to evaluate how these provisions operate in real life. Thus, practice-based evidence (e.g., evidence based on everyday clinical practices) is critical to: (a) recognize problems in daily practice that produce dissonance between recommended and actual care, (b) examine whether treatments with proven efficacy are actually useful and sustainable in the context of real life, and (c) examine how structural and organizational factors may be shaped. As clinicians work with the many culturally diverse patients they encounter, cultural perspectives are exchanged and negotiated. Importantly, this process can support the cross-cultur-
Standards to guide the education and training of mental health providers facilitate a more equitable distribution of mental health services, as a larger pool of patients would be assured a certain level of cultural competence by their providers. This need for more equitable access to competent care in all areas has become more recognized in the United States due to the passage of The Patient Protection and Affordable Care Act (2010).

- Mental health care services have become increasingly complex, requiring a higher level of cross-cultural skills in providers who work with an increasingly diverse patient population.

- The global migration of health care providers is increasing, and international nurse recruitment is a ubiquitous phenomenon with no regulatory oversight. Therefore, teaching and using standards in mental health care assessment, treatment, and evaluation can provide more stability and reliability of services.

The United Nations (2008) member nations first published the Declaration of Human Rights in 1948. The most basic of these is safety, which includes the right to be free from physical, mental, social, political, and cultural harm (incorporating the concept of cultural safety). Next, the right to shelter and sanitation (including clean water), access to health care when sick, and self-determination (incorporating the right to be free from enslavement and human trafficking). These globally recognized rights form the basis for developing a framework of assumptions, depicted in the process model of culturally competent mental health care delivery. This model depicts the filtering process that all mental health care undergoes in order to reach the point of care. The point of care might be at the face-to-face provider-patient level in a home, school, hospital, business, or street, or at other politically, economically, geographically, or socially mandated locations of delivery globally. The model (Figure) is guided by these basic principles:

- Culturally competent mental health care is provided by various disciplines and professions of the mental health care field, including, for example, psychiatrists, advanced practice psychiatric nurses, nursing services, psychologists, and social service workers, as well as culture-specific health care workers, such as shamans, midwives (unlicensed), and doulas. The services they provide are filtered through interactive layers to the point of care—the center of the bull’s-eye. The layers are not hierarchical, but rather filter services through a transactional and dialectical process to the actual point of care represented at the center of the model.

- Culturally competent mental health care delivery includes access to resources such as health care education (including education specific to mental health care) and health care information. Providers must consider access to all of these needed resources when designing and delivering services.

- Culturally competent mental health care uses the economic practices and occupations of each nation and culture to deliver targeted services. For example, a cultural group or patient population may want services filtered through, or approved by, their council.
of elders, and the provider must incorporate such provisions into the design and delivery of services.

- Culturally competent mental health care is continually affected and transformed by the geography, housing, community structures, communication practices, and transportation of the nations, states, commonwealths, and cultures at the point of delivery. For instance, due to lack of access to mental health care providers in certain rural areas, telepsychiatry is increasingly being considered as a valid delivery system for mental health education, supportive services, and counseling/therapy.

- Delivery of services is also filtered through the providers’ culturally based values, beliefs, and behaviors, as well as their recognition of and respect for those of their patient populations.

- Lastly, all of these interrelated factors are affected by political systems, which mental health care providers must identify, understand, and work within to safely and legally provide culturally competent services. Although this is the last point, it is the critical reality that frames the delivery of culturally competent mental health care. Political realities will not only shape the funding of services but determine the availability of certain treatments and services, and even dictate the delivery method. For example, knowing where hijab (head covering) is required on women will help providers keep both their patients and themselves safe.

CONCLUSION

The report on the future of nursing (Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, Institute of Medicine, 2011) emphasizes the need to provide patient-centered care based on a careful incorporation of the culture of patients. While there has been an increased awareness of the need for cultural competence among all health care providers within the past few decades, this core provider skill is still poorly understood, irregularly demonstrated, and haphazardly taught.

Providers of mental health care in all settings are under increased pressure to incorporate cultural competence as a guiding force within their practice. While there is increased appreciation for this concept within individual practitioners and health care organizations, there is still more work to be done to raise the standard of cultural competence for those providing mental health care.

The challenge moving forward is to establish policies and procedures that will ensure this outcome. A first step is to support formalized inclusion of cultural knowledge, skills, and education as it relates to the cultures served within one’s practice. This can be done by individual nurse practitioners or by mental health care organizations providing service to diverse populations. Examples of strategies to improve enhanced cultural competence skills and increased organizational cultural awareness include mandatory educational inservices or required continued education credits specifically directed toward enhancing cultural competency skills. We advocate (a) continued development and measurement of policies and practice standards that will integrate culturally competent mental health care, disease prevention, and treatment for patients and within the workplace, (b) examination of “best practice” initiatives for cultural awareness and improving mental health literacy, and (c) implementation of evolving federal and state policies regarding more equitable health care delivery, with increased activism related to providing mental health. In addition, professional health care organizations must find a way of supporting mental health research related to the provision of culturally competent care and interventions.

More work must be done to raise the standard of cultural competence. Since culture is fundamental to health-related behavior, it is important to attend to cultural differences and build skills necessary for cross-cultural expertise when providing care. If culture is ignored, the differential outcomes and unequal distribution of disease burden noted today will be perpetuated and exacerbated. To mitigate this outcome, inclusion of cultural knowledge, skills, and education must be formalized within mental health care delivery and mental health provider services.

REFERENCES


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