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Briefing Sheet 06

An Introduction to Cultural Competence

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Originating in America in the late 1980's, Cultural Competency as a concept for supporting both organisational and individual change has gained increasing recognition over the last two decades. Whilst historically, the focus has been on the transformation and delivery of healthcare services to diverse populations, the conceptual frameworks, models, guiding values and principles are equally applicable across all forms of service delivery.

Within Scotland, inclusion of cultural competency as a specific mandate within policy, can be traced back to a Scottish Executive Health Department letter issued in June 2002[1]. Numerous references are now to be found in a cross section of Scottish and local government policy and strategies. Broader equalities legislation has provided additional impetus both in terms of understanding and implementation.

What is Cultural Competency?

It is important to note that there is not one universally accepted definition of cultural competency although literature searches and research demonstrate that Cross *et al's*[2] definition is widely adopted:

"Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations."

Similar definitions include:

"Cultural competence comprises behaviours, attitudes and policies that can come together on a continuum that will ensure that a system, agency, programme, or individual can function effectively and appropriately in diverse cultural interaction and settings. It ensures an understanding, appreciation and respect of cultural differences and similarities within, among and between groups. Cultural competency is a goal that a system, agency, programme or individual continually aspires to achieve."[3]

"A culturally competent service is defined as a service which recognises and meets the diverse needs of people of different cultural backgrounds. This applies to every individual with a healthcare need. It includes, but is not limited to, making provision for religious and cultural beliefs such as worship, diet and hygiene requirements, catering for communication and language diversity and involving users in service development. A key part of cultural competence is ensuring that discrimination on the basis of culture, belief, race, nationality or colour has no role in the delivery of services."[4]

The definition developed by the Child Welfare League of America extends the definition to include sexual orientation and socio economic circumstances and reinforces the transferability and relevance of cultural competency across all marginalised groups.

[1] Scottish Executive (2002) *'Fair for All: Working Together Towards Culturally Competent Services'* NHS HDL (2002) 51

[2] Cross T., Bazron, B., Dennis, K., & Isaacs, M. (1989) *Towards a culturally competent system of care, volume I.* Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center

[3] Cited in Cultural Competency Definitions (2008) London Deanery School of Cultural Competence

[4] Scottish Executive (2002) *ibid*

"Cultural Competence: The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations and faiths or religions in a manner that recognises, affirms and values the worth of individuals, families, tribes and communities and protects and preserves the dignity of each. Cultural competence is a vehicle used to broaden our knowledge and understanding of individuals and communities through a continuous process of learning about the cultural strengths of others and integrating their unique abilities and perspectives into our lives."[5]

Davis's[6] later definition focuses on cultural competency within an operational context:

"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."

From the numerous definitions available, it is evident that a common set of 'ingredients' can be identified. Cultural competence can be seen as a dynamic process involving individual and organisational learning, attitudinal and behavioural change, systems and process development, commitment and leadership.

The Role of Culture in Achieving Cultural Competence

Understanding what is meant by culture is essential in working towards a culturally competent organisation. Culture can be defined as:

"… the distinctive way of life of the group, race, class, community or nation to which the individual belongs. It is the first and most important frame of reference from which one's sense of identity evolves."[7]

Similarly:

"It is a shared set of values, assumptions, perceptions and conventions, based on a shared history and language, which enable members of a group or community to function together. Our culture vitally affects every aspect of our daily life, how we think and behave and the judgements and decisions we make. It is like a set of lenses through which we look at the world and which defines both what we see and how we interpret it."[8]

Culture can manifest itself both visibly and invisibly. Visible forms of culture, such as food, clothes, the 'Arts' and architecture, are by their very nature more easily identifiable and recognisable. Invisible forms of culture can be harder to quantify but permeate every aspect of daily living. They include belief systems, customs, norms, and morality and affect the way individuals experience the world. These unwritten rules, values and assumptions are more powerful because they are seldom questioned until something is experienced that differs from our expectations. This is particularly true of majority cultures where any deviation can be perceived as different, difficult, strange or 'other'. This, in turn, can lead to judgements which influence how individuals and organisations see and interact with other cultures leading to disadvantage and marginalisation.

The influence and tenacity of cultural stereotyping must also be taken into account. For example, the belief that Minority Ethnic communities 'prefer to look after their own' is still prevalent but research demonstrates that family structures which historically underpinned this are gradually being eroded due to a wide range of demographic, socio-economic and cultural factors.

[5] London Deanery School of Cultural Competence (2008) *ibid*
[6] Davis, K. (1997). *Exploring the intersection between cultural competency and managed behavioural health care policy: Implications for state and county mental health agencies.* Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.
[7] O'Hagan K (2001) *Cultural Competence in the Caring Professions* Jessica Kingsley Publications
[8] Henley A & Schott J (1999) *Culture, Religion and Patient Care in a Multi-Ethnic Society* Age Concern

Organisations also have distinctive cultures. An organisation's culture, through its tradition, history and structure, beliefs, norms, values, and language largely determine the way in which things are done. It is argued that mainstream organisations tend to mirror the cultural norms and values of the majority culture. For example, health and social care services are premised on the needs of the majority community and it is argued, have a euro-centric focus to the detriment of Minority Ethnic communities.

Cross et al argue that a culturally competent system of care must "*acknowledge and incorporate 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*".[9]

Dimensions of Cultural Competency

Cultural competency has traditionally focused on the individual but the concept has been broadened to include a systems wide approach that incorporates organisational, professional and systemic cultural competencies.[10]

Drawing on the work of Eisenbruch, Gallegos[11] defines individual, professional and organisational cultural competency as:

Individual cultural competency relates to knowledge, attitudes, values and behaviours that impact on the ability of an individual to actively engage with clients, communities and colleagues from different cultural backgrounds.

Professional cultural competency is where cultural competence is identified as important and integrated as a component of education, training and professional development. The profession provides standards to guide the working lives of individuals.

Organisational cultural competency is the capacity to provide access to high quality services across diverse cultural backgrounds. It encompasses an approach which facilitates the development of: culturally safe physical and linguistic environments; meaningful data collection; diverse work teams and leadership; service delivery systems that are flexible and adaptable; policies, procedures and strategies that have incorporation of cultural diversity as a central tenet.

Why is Culturally Competent Care Important?

Even before figures from the 2011 census are published, it is abundantly clear that Scotland is becoming increasingly ethnically diverse. In addition to new migration, notably from the A8 Countries, Scotland has a growing settled Minority Ethnic population.

As communities expand and age, increasing demands will be made on health and social care services. A considerable body of research already exists which evidences the poorer overall health status of Minority Ethnic communities and lower levels of access to, and satisfaction with, health and social care services generally[12] [13].

[9] Cross T L (1988) *Cultural Competence Continuum* Focal Point Bulletin The Research and Training Centre on Family Support and Children's Mental Health Portland State University

[10] Eisenbruch M (2004) *Optimising clinical practice in cancer genetics with cultural competence: lessons to be learned from ethnographic research with Chinese-Australians* Social Science and Medicine, 59 (2), 235-48

[11] Gallegos Danielle Dr (2006) Reproduced from *Cultural Competencies Discussion Paper* Centre for Social and Community Research Murdoch University Perth Australia

[12] MECOPP (2012) *The Health of Scotland's Black and Minority Ethnic Communities* www.mecopp.org.uk

[13] MECOPP (2012) *Informal Caring within Scotland's Black and Minority Ethnic Communities* ibid

The rationale for developing culturally competent services can be summarised as follows:

- Everyone has the right to health and social care services that meet their needs;
- Disparities in health and social care status can be addressed or mitigated leading to improved outcomes for individuals and communities;
- It can assist in initiating and maintaining contact with all sections of the local population;
- It improves the quality of health and social care services for all by driving up standards;
- Statutory bodies have a legal duty to ensure equality of access for all sections of the population;
- It can enhance current practice and provide opportunities for transferable learning across all equality strands;
- It can be more cost effective in the longer term; and,
- It is a mainstream issue and not one that is solely the premise or responsibility of special interest groups.

Schyve[14] summarises the above as meeting the shared goals of effectiveness, safety, efficiency and equity.

Achieving Cultural Competence

Cultural competence recognises that there are barriers which prevent or inhibit Minority Ethnic communities accessing appropriate supports and services. Achieving cultural competency can present many challenges both for individual practitioners and service providers/organisations. The extent to which an individual or service can be culturally competent may be influenced by factors as diverse as individual prejudice, inexperience due to a lack of interaction with Minority Ethnic communities, unmet training and support needs, resourcing issues or a lack of vision and leadership.

The absence of cultural competence may also indicate broader issues of structural discrimination which are embedded within the service and/or organisational culture.

As a framework for development, cultural competence requires the individual practitioner and the organisation to:

- Value diversity;
- Recognise and effectively manage the dimensions of cultural difference; and,
- Adapt and respond to the cultural diversity of the communities served.

Cross and other commentators highlight the importance of the dynamic nature of achieving cultural competence and warn against expectations of a linear or 'step by step' approach. Models which have been developed frame cultural competence as a continuum whereby systems, teams and organisations may be at different stages at different times with different populations.

Cultural Competency Models

Numerous models of cultural competence have been developed based on the original work of Cross *et al*. For example, Mason's[15] model identifies 5 key stages: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence and cultural competence. Similarly, Purnell[16] identifies 4 stages: unconscious incompetence, conscious incompetence, conscious competence and unconscious competence. Papadopoulos, Tilki and Taylor's[17] model has 4 stages of cultural awareness, knowledge, sensitivity and cultural competence.

Cross *et al's* model has been reproduced below.

[14] Schyve P (2006) *In Search of Actionable Models of Cultural Competency* The Commonwealth Fund htpp:/www.commonwealthfund.org/Publications/.Commentaries/2006
[15] Mason, J. L (1993) *Cultural competence self-assessment questionnaire* Portland State University Multicultural Initiative Project.
[16] Purnell L & Paulanka B (1998) *Transcultural health care: A culturally competent approach* Philadelphia: F. A. Davis.
[17] Papadopoulos I, Tilki M & Taylor G (1998) *Transcultural Care: A guide for Health Care Professionals* Quay Books Wiltshire (ISBN 1-85642-051 5)

Cultural Competence Continuum[18]

Stage	Description
1. Cultural Destructiveness	Systems and organisations characterised by: • attitudes, policies and practices which are destructive to cultures and consequently to the individuals within the culture. The most extreme example of this orientation are programmes which actively participate in cultural genocide (the purposeful destruction of a culture)
2. Cultural Incapacity	Systems and/or agencies do not intentionally seek to be destructive but lack the capacity to respond effectively to the needs, interests and preferences of culturally and linguistically diverse groups. Characteristics include: • institutional or systematic bias (recruitment, promotion, resourcing); and, • subtle messaging to different ethnic groups of being under-valued and unwelcome.
3. Cultural Blindness	Culturally blind systems/organisations are dominated by the needs and preferences of the majority culture. Characteristics include: • the belief that helping approaches traditionally used by the dominant culture are universally applicable; • undervaluing or not recognising cultural strengths; and, • blaming individuals/communities for their circumstances.
4. Cultural Pre-competence	Organisations have an awareness of their strengths and areas for growth in responding to the needs of culturally and linguistically diverse groups. Characteristics include: • respect for difference; • on-going self-assessment; • continuous expansion of cultural knowledge and resources; and, the adaptation of existing models of service delivery to meet the needs of minority populations.
5. Cultural Competence	Systems and organisations demonstrate value and respect for cultural differences. Characteristics include: • strong leadership with organisational commitment to cultural and linguistic competence; • policies and procedures which integrate competency into core functions at all levels of the organisation; • development of inclusive structures and strategies to support and promote community participation in the planning, delivery and evaluation of services/functions; • collection and analysis of data that has a meaningful impact on minority groups; • policies to recruit and maintain a diverse workforce; and, • the reciprocal transfer of knowledge and skills between all partners and key stakeholders.
6. Cultural Proficiency	Systems and organisations that demonstrably value culture and cultural diversity and which use this as the basis for their work. Characteristics include: • on-going development of knowledge base to inform new services and approaches; • dissemination of good practice to support transferable learning; • mentoring of other organisations on the continuum; • development of cultural competence 'champions'; and, • advocating with and on behalf of under/un-served minority populations.

[18] Cross T., Bazron, B., Dennis, K., & Isaacs, M. (1989) *ibid*

Critiques of Cultural Competence

Criticisms of cultural competency have emerged from both an anthropological and critical race theory perspective.

Anthropological critiques argue that cultural competency theory frequently presents 'culture' as static and as subject matter to be taught rather than acknowledging it as a dynamic process which is constantly evolving in response to human interaction. It is also suggested that such an approach does not recognise diversity within cultural groups, conflates culture with ethnicity and race, may inadvertently place blame on an individual's culture and can over emphasise cultural differences thereby obscuring structural power imbalances.

It is argued that the failure of cultural competency models and programmes to capture the dynamic and fluid nature of culture and self-identity may result in a 'one size fits all' approach to the acquisition and implementation of cultural knowledge which may be to the detriment of the individual and the practitioner.

Critical race theorists argue that by focussing on the transformation of individual attitudes and organisational practice, systematic and institutionalised oppression are not addressed. By emphasising the culture of individuals, cultural competency often fails to recognise that health and social care systems are themselves cultural constructs which need to be considered within a historical context.