Toward a Culturally Responsive Approach to Child and Youth Mental Health Practice: Integrating the Perspectives of Service Users and Providers

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ABSTRACT

An increased awareness of barriers facing visible minority populations in Canada has prompted the growth of "cultural competence" research to inform service provision with these groups (Este, 2007; Thomas Bernard & Moriah, 2007). Overwhelmingly, this literature is rooted in the perspectives of practitioners and/or academics who view cultural competence as the process of acquiring knowledge and skills to work with

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"others." In this paper, we summarize findings from an empirical study aimed at understanding the complex meanings and practices of working across cultures, from service user and practitioner perspectives. We conclude that drawing upon a "cultural *responsive*" approach to pedagogy (Gay, 2000; Villegas & Lucas, 2002) can enrich the way we work across difference with diverse families.

Keywords: service provision, cultural responsiveness, race, child and youth mental health

In 2006, immigration became the main driver of Canada's population growth (Centre for Addiction and Mental Health, 2009; Statistics Canada, 2006). Here in Ontario, 28% of the population are immigrants (the highest percentage in the country), and of those between newborn and 18 years of age 37% are immigrants, 4% are francophone, and 2.5% are Aboriginal (Lam & Cipparrone, 2008). Research has shown that marginalized groups (including newcomers and those identifying as visible minorities) experience a greater number of barriers to health and well-being than mainstream Canadians (e.g., Brach & Fraser, 2000; Raphael, 2004). While the Canada Health Act (1984) promises universal and accessible health services for all Canadians, our health and mental health systems are currently ill-equipped to adequately meet the increasingly diverse needs of consumers (Shah & Zakus, 2004).

In recent years, mainstream social service agencies have experienced pressure to create culturally appropriate and relevant services to meet the needs of all children, youth, and families, including those from diverse ethnoracial and cultural groups (Herberg, 1993; Sue, 2001a, 2001b). The result is a growing body of literature focusing on understanding "cultural competence" (Este, 2007; Thomas Bernard & Moriah, 2007). Service provision is considered culturally competent when service providers use particular strategies to increase self-awareness, knowledge, and skills when working with members of diverse groups (Lum, 1999; Williams, 2006; Yan & Wong, 2005). Developing cultural competence is seen as *necessary* for service providers engaging with diverse clients in multicultural environments, particularly when working with children, youth, and families living with mental health issues.

In this paper, we review current understandings of the concept of cultural competence and attend to the relational aspects of this practice. We begin by describing the unique challenges faced by members of ethnoracial and cultural groups living in North America, and discuss how cultural competence has emerged as a strategy used to manage these challenges. We then review models of cultural competence, and summarize their strengths and limits. Based on this critique, we then describe the goals, findings, and implications of a small pilot study aimed at understanding the meaning of race/ethnicity/culture for young people who currently receive or who in the past have received mental health services, and for the practitioners who work with them. We conclude by suggesting that the challenges of working across cultural difference may be somewhat mediated by drawing upon the cultural *responsiveness* approach used in education, which attends to issues related to oppression in the relationship between students and teachers in an educational setting, and emphasizes how critical these processes are for learning to occur (Villegas & Lucas, 2002).

CULTURAL COMPETENCE: AN APPROACH FOR WORKING ACROSS DIFFERENCE

Here in North America, a number of studies suggest that visible minority status is linked with higher levels of psychological distress and disorder (Trujillo, 2001). In addition to the stress of the migration process (e.g., trauma, loss of social supports, homesickness, and uncertainty), racism and perceptions of discrimination can contribute to the experience of mental health problems in diverse populations (Qureshi & Collazos, 2008; Snowden, Martinez, & Morris, 2000). Risk factors for mental illness in ethnoracial and cultural groups are further compounded by immigration status, geography, and access to financial and social resources (Reese & Vera, 2007). Of particular concern are research findings arguing that while members of visible minority groups tend to bear a disproportionate burden of mental illness, they are less likely to access and receive necessary services, and are more likely to receive poorer quality service when these supports are used (Carpenter-Song & Schwallie, 2007; Dogra & Vostanis, 2007).

In response, there has been considerable debate about whether culturally "competent" practice is the best way to respond to diversity (Este, 2007; Thomas Bernard & Moriah, 2007). By using the language of competence, organizations situate the problems of accessing and receiving adequate services within the profession and the individual practitioner's capacity to function effectively (Anderson & Scrimshaw, 2007; Cross, 1989). The goal of cultural competence is therefore to increase the self-awareness, knowledge, and skills of predominantly white professionals who are working with non-white members of diverse groups in order to promote quality and client-centred care (Cross, 1989; Killion, 2007; Vega & Lopez, 2001; Williams, 2006; Yan & Wong, 2005). Cultural competence is defined as a set of strategies used by those in helping professions to manage the effects of increased diversity on the health and mental health systems.[1] Specifically, it is the "delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs and values" (Whaley & Longoria, 2008, p. 169).

A review of literature from mental health–related fields (e.g., medicine, nursing, psychology, and social work) suggests that cultural competence consists of four main elements. First, an *emotional component* focuses on the way one thinks about difference, and the feelings that accompany that perspective. According to Eunyoung (2004), the goal of cultural competence training is to help practitioners become aware of how they feel and react to people based on ethnoracial and cultural characteristics, and to promote practice that is sensitive to and respectful of cultural diversity. Second, the *knowledge component* focuses on understanding the world views of people who are different from us (ethnically, culturally, and racially), and promoting self-awareness, which involves understanding our own beliefs, values, and attitudes that shape the way we view and interact with others (Bhui & Warfa, 2007; Yan & Wong, 2005). This includes an examination of race, racism, and prejudice. The third is a *skills component*, which focuses on developing tools that can be used to provide effective services to those across different groups (e.g., assessment, intervention, communication; Sue, 2001a, 2000b). Finally, the *behavioural component* (typically the final stage of achieving cultural competence) focuses on creating responses, or developing appropriate interventions based on an awareness of the emotional, knowledge, and skills elements (Allen, 2007). Cultural competence, then, is "not simply the memorization of a list of ethnic facts but the ability to modify care plans to incorporate (client) and family perspectives" (Chrisman & Zimmer, 2000, p. 65), as well as to recognize and challenge oppression that creates the disparities in health and well-being discussed earlier (Kumaş-Tan & Beagan, 2007).

LIMITATIONS OF THE CONCEPT OF "CULTURAL COMPETENCE" AND RATIONALE FOR THE CURRENT PROJECT

While much has been done to develop the notion of cultural competence, a number of authors remain quite critical of this concept (e.g., Pon, 2009; Yee & Dumbrill, 2003). The first critique comes from observing that the language of culture has enabled practitioners and researchers to conflate race, culture, and ethnicity (Carpenter-Song & Schwallie, 2007), and to avoid difficult and often politically challenging discussions of race in favour of the more neutral language of culture (Pon, 2009; Williams, 2006). When researchers and practitioners avoid such discussions (and the accompanying discomfort), the historical and contemporary harms of racism go unaddressed (Pon, 2009), and "culture" becomes a "catch-all" term that conjures up less distress while offering a number of superficial methods to deal with difference. The goal of writing on cultural competence then becomes to develop clinical guidelines or to describe specific groups in detail to be used as shorthand for practitioners rather than addressing power differences, inequity, and the impact of racism in the lives of people from diverse backgrounds. The second challenge is that training in cultural competence is rooted in an understanding of people's identities as coherent and stable, which is particularly problematic when working with many racially and culturally diverse youth who understand themselves in biracial, bigenerational, and/or bicultural terms (Keddell, 2009). Finally, concerns have been raised that there is little empirical evidence that links cultural competence of service providers and improved health outcomes for clients (Vega & Lopez, 2001).

There is a need, then, for an alternative approach to working across difference that incorporates the positive aspects of contemporary models of cultural competence, but that addresses a number of the critiques described above. Keeping these concerns in mind, we conceived of a pilot project that empirically focuses on the meaning of race/culture/ethnicity for young people who currently receive or who in the past have received mental health services, and the practitioners who work with them. Through a series of focus group interviews, this work sought to understand the particular ways that racialized youth experience the mental health system, as well as service providers' perspectives on the challenges and opportunities in working with these young people. By foregrounding race, culture, and ethnicity in discussions with youth and practitioners, we hoped to establish a safe space for discussions of the experiences of prejudice, discrimination, and racism from both service users' and providers' perspectives.

METHODS

The goal of this pilot study was to gather preliminary, in-depth data on how young people from diverse ethnoracial backgrounds talk about their experiences of receiving mental health–related services, and practitioners' perspectives on providing those supports. This information will be used to provide the foundation from which to design a larger, more comprehensive, mixed-methods study to explore themes in more depth. In the present project, we used a qualitative methodology, as our focus was on understanding how participants make sense of their experiences (Alvesson & Sköldberg, 2000; Berg, 2004; Patton, 2002). We conducted four focus group interviews (two with youth, two with practitioners) in order to address the following research questions:

1. Are current notions of cultural competence relevant to ethnoracially diverse youth who currently use or who have used mental health services?
2. How do ethnoracially diverse youth, and the practitioners who work with them, view mental health and illness?
3. What do youth and service providers consider "culturally competent services"?
4. What are concrete ways that practitioners can best support youth from diverse ethnoracial and cultural backgrounds who seek/use mental health services?

Study Participants

Study participants were convenience samples drawn from existing groups affiliated with organizations in the province of Ontario, and connected professionally to one or more of the authors. Ethics approval was obtained from all three institutions with which authors are affiliated (i.e., the Children's Hospital of Eastern Ontario, Carleton University, and Kinark Child and Family Services).

Youth participants were 5 young women and 8 young men between 16 and 20 years of age. All youth (with the exception of one young man) identified as members of visible minority groups. While 85% of youth were born in Canada, 29% identified themselves nationally as either "Canadian" or hyphenated-Canadian (e.g., Iranian-Canadian), and the majority identified with other nationalities (e.g., Ethiopian, Iraqi). In terms of religious affiliation, most youth were Muslim, while 2 identified as Christian and 1 indicated no religious attachment. Eighty-six percent of youth spoke at least two languages (identifying English as their first language), and all youth were either in high school or had just begun university. While most youth reported living in nuclear families, 2 youth also reported having extended family members in their home.

Practitioner participants were 10 women and 2 men between 24 and 62 years of age in a range of professions related to mental health work with children and youth (e.g., youth worker, manager, therapist, social worker, community worker). Fifty-three percent were born in Canada, and 47% were born in "countries of colour" (e.g., the Caribbean, India, and Tanzania) and identified themselves as members of racialized groups; most (80%) used the label "Canadian" or hyphenated-Canadian to identify themselves nationally. Linguistically and religiously, practitioners were a more diverse group than the youth. For example, 25% identified themselves as Christians, 13% were Hindu, 13% were Muslim, and 1 service provider practiced Sikhism. While 6 members of the practitioner group spoke only English, the remaining half of participants spoke two or more languages.

Data Collection and Analysis

Our goal was to begin to gather data to generate a number of themes that would be used to develop insights about service provision across ethnoracial and cultural boundaries. Subsequently, this information could be used to develop a larger study using a combination of qualitative and quantitative methods, and featuring a more geographically diverse sample. In focus group interviews, participants are typically a group of people with some common characteristic(s) who reflect on a topic in a context that includes the views of others (Patton, 2002). Data were analyzed using a method consistent with the grounded theory approach,

and open coding procedures were used to identify common themes across interviews. Using the method of constant comparison (Strauss & Corbin, 1998), new textual material was compared with established codes in order to either confirm those already existing or establish new codes. This process continued until each category of codes was determined to be independent of other categories, and no new themes seemed likely to emerge. An audit trail (Patton, 2002) was used throughout coding in order to ensure the credibility of the data, and illustrative quotations[2] have been used to describe participants' experiences where appropriate.

KEY FINDINGS AND DISCUSSION

Research questions 2, 3, and 4 described above guided the focus group discussions, which took place with ethnoracially diverse youth and with child and youth mental health practitioners. In particular, we were interested in understanding how these youth and the service providers who work with them view mental health and illness, and how they talk about "culturally competent services." Our questions were also aimed at gaining insight into concrete ways that practitioners can best support youth from diverse ethnoracial and cultural backgrounds. Below we describe three key themes that emerged from these discussions: identity and mental health/illness, race/ethnicity/culture and its role in service provision, and qualities of the client-practitioner relationship. These findings form the basis of the model that we present in the following section.

Identity and Mental Health/Illness

Participants often presented their identities as multidimensional (including race, culture, religious background, gender, sexual orientation, and status within the family). Not surprisingly, these identities shift across time, place, generations, and relationships, a finding that is consistent with previous work in this area (e.g., Sundar, 2008). For example, according to these participants,

> Here everybody else considers me being Black. But then my own people, people who are Ethiopian and stuff wouldn't consider me being Ethiopian. They think I'm Spanish and stuff [because I don't look "typically" Ethiopian]. (Samira)

> I'm a girl. I'm 19 so I consider myself a Canadian. I guess … young in the eyes of society but at the same time old enough that my opinions have enough value and merit behind them that I think I should be heard and taken into account. I consider myself Black. Most people don't consider me Black [because my skin is light]. Oh well, too bad for them. (Jain)

> I went to Dubai for four years and here in Canada, [in] Ottawa, I was too Arab to be Canadian.… I'm always considered an Arab. When I went there I was too Canadian to be Arab because I wasn't [speaking Arabic] so I was Canadian and not Arab. And it's weird because I am [both] Arab and Canadian. I'm not "either/or." It's just confusing sometimes. I don't know how to describe myself. I'm just me. (Youssef)

Youths' multiple identities are related to one another in complex ways. In this study, youth discussed being both connected and disconnected from their historical roots and from their "Canadian" present, which can have an impact on their mental health. For one participant, prior to coming out to his friends and family, his struggle with his sexual orientation was embedded both in a mainstream Canadian context that views homosexuality in diverse progressive ways and in his parents' culture that tends to view this issue in a decidedly negative way:

> I went to a mostly [white] school. So I was this brown kid who hung out with the white kids because I felt more comfortable there because personally I think I have the eyes or like the marks of a white kid. So when I see, like, a Black kid or when I see a group of Black people, I don't feel like I belong there. When I see Arabs, I don't feel like I belong there either… I did grow up in the Muslim community so I do know Arabs and I never felt close to them. Now thinking about it, I never thought about it before, but I think it was because I was maybe a homosexual. At that time I wasn't sure. But they just called me "girl"; they called me "fag"; so I just felt I was addressed [this way] because of my culture in general. So now when I see Arabs I just feel like rebelling. I feel pushed away. I feel like the only healthy community is the white community where they're open-minded and because I live here and I know they're my friends…. I don't associate myself with that religion or culture anymore. I still say I'm Iraqi. I'd say being Muslim, I just don't believe I'm religious any more. I believe in spirituality. I believe in God. I don't believe in set rules. So if I'm a good person, I don't lie, cheat or steal, I live my life honestly, do good for people and karma, that's actually having it there is a heaven. If not, I'm happy in my life, and I had a good life. And even though I disagree with half my culture [that views homosexuality as unacceptable], I don't completely go and disregard it and go against it. (Youssef)

The tension for him, then, was around trying to reconcile his identity as a gay, Canadian male with his Iraqi cultural roots. Issues related to sexuality, culture, and religion are clearly connected and influence one another in complex ways. Given the challenges associated with teasing out these varied elements and finding a comfortable way to negotiate his sense of self through all of this, Youssef experienced various mental health problems for which he sought support.

For another youth, her ethnicity became a source of depression. In this instance, the challenges associated with being a young person are compounded by "being different" based on ethnicity. The result can sometimes be an internalization of these negative messages, which then leads to mental health problems. With proper supports, however, these circumstances can present opportunities for growth.

> Sometimes I just feel different [from the kids I go to school with] which made me feel down because I wanted to fit in, and just being ethnic [makes you different]. Because I hear it sometimes and so when you hear it so much you say it to yourself. And the more you say it, the more you hate yourself. So I went through a little depression phase when I was younger. I wouldn't look in the mirror for years at a time. I just hated myself, hated everything about myself. But then when I started having supportive friends … just a community that was different from what I grew up with, that's when I started realizing I'm who I am and I have to accept it and I have to grow from it and be proud of it. (Vanita)

Practitioners' identities are also multifaceted. For example, in the quotes that follow, we see how service providers are often *themselves* working to determine when, where, and how to express various aspects of their identities. Clearly, their ethnoracial and cultural backgrounds (along with age, gender, etc.) are also at play and likely influence the practice relationship.

> We are Hindu but we still have a Christmas tree … because you … want your kids to feel that they have assimilated … you know, within different cultures and different languages. (Rani)

> I believe that again, going back to the roots, because my identity is so strong, I am very happy [wearing many different types of clothing].… I have a big walk-in closet with both sides of clothing. I think having a strong ethnic identity means that you are ready to assimilate in another country as well. (Jayanthi)

Views of mental health and illness, as well as appropriate responses to mental health problems, are clearly influenced by one's identities, context, and cultural beliefs and values. While youth participants never

actually used the term "cultural competence," it was clear that they saw a link between culture, mental health, and service provision. For example, Youssef's experience of coming out to his family required that supports needed to acknowledge the role both ethnoracial identities played in his life at the time:

> [My] dad is not pro-gay at all. I was raised in [his] household … [so] I totally understand his mindset. This is the reason why he had a priest call me. The reason why he's trying to "help" me to be straight is because he cares and that's his value… because he was taught to be anti-gay.… [When I was coming out] I first ran away from home and got my own apartment and trying to come out was really hard. So I was referred to a multicultural guidance counsellor who was [also Muslim] and she helped me write my coming out letter … and she helped me get it translated into Arabic so my parents would fully understand it. It was me who wrote it but it was her who got me the resources to help translate it and … she gave me advice on how to do it safely. She never told me do it or don't do it. She supported my own idea but she gave me all the pros and cons to it. (Youssef)

The fluidity of both youths' and practitioners' identities means that the needs of young people from diverse ethnoracial backgrounds who are experiencing mental health problems cannot be generalized and learned in advance of a specific practice relationship. Culture and identity and the way these are played out in the service relationship are never fixed and stable, therefore it is impossible to ever become completely "competent" at working across difference. Given this, writings on cultural competence are limited in terms of providing effective guidelines that can be used by all service providers to meet the needs of all youth from particular ethnoracial and cultural backgrounds.

Ethnicity/Race/Culture and Service Provision

As described above, youths' identities are critically linked to the mental health challenges they have encountered or continue to struggle with. For the youth in this study, help-seeking behaviour appeared to be multifaceted, and the role of the service provider varied from situation to situation. Some youth sought help only from peers or adults with whom they have had a previous relationship (to ensure trust and understanding), while other youth purposely sought support outside of the community to ensure confidentiality and privacy. Simply training mainstream service providers to be "culturally competent," then, does not mean marginalized communities will see them as the most appropriate people to provide help. In some cases, a traditional client-practitioner relationship may work well, while at other times the most "culturally competent practice" is one done through a person's family, peer group, or community. The role of the practitioner in such cases, then, is less traditional and involves providing information and assistance to support this process:

> It depends how serious [the mental health problem] is. Like if it's a certain illness where you need to go to the doctor to get pills or something like that and that you can deal with it mainstream I guess. But if it's something like drug addiction or stuff like that, you would deal with it like more like religiously I guess. Like try to bring them back to their religion and stuff like that.… You take them to the mosque, have the imam talk to them.… The community actually prays for them as well. (Shafreen)

According to participants, the foundation of the client-practitioner relationship must be based on mutual openness, respect, careful curiosity, and ongoing reflection on one's own culture, race, and ethnicity. The practitioner need not share the youth's ethnoracial, cultural, and religious background, but must have a general awareness of the young person's culture and an appreciation for its role in her/his life. Therefore,

cultural competence (i.e., as specific knowledge about different ethnoracial and cultural groups) is a *necessary but not sufficient* characteristic of a service relationship. In the words of one practitioner participant,

> Originally what I thought [cultural competence] was … understanding that culture completely so you can best serve that culture, right? But now I've learned that there is no one blueprint for any culture and there is no such thing as cultural competency. You just learn as you go and always learn to ask more questions. (Sylvia)

While cultural competence training tends to be focused on knowledge acquisition and skill development, practitioners in this project spoke about working across difference in *relational* terms. While knowledge and skills are important, the quality of the connection between service user and practitioner determines the extent to which knowledge and skills result in positive outcomes for youth. These findings led us to consider a model of cultural competence that attends to the relational dynamics and those factors that facilitate or impede empowerment, mutuality, and empathy. Participants in this study understood these factors as more significant in shaping effective practice than a particular body of knowledge about "others" or a knowable set of skills. For those in our study, then, the practice of cultural competence was more uncertain, with successes and challenges being determined largely by the quality of the relationship between young person and practitioner.

Qualities of the Client-Practitioner Relationship

We concluded focus group interviews by asking participants to think back to a time when they were experiencing a mental health problem that they sought support for (or in the case of practitioners, a time when they were providing support to a young person with diverse ethnoracial roots), and to tell us both helpful and unhelpful characteristics of that experience. As described above, ethnoracially specific knowledge and related skills, while important, are capable of addressing the complex needs of diverse youth only to a limited degree; it is the *quality* of the service relationship that is critical in determining the mental health outcomes for youth and their experiences with the mental health system. Specifically, participants talked about events or factors that either threatened or strengthened the therapeutic relationship.

Relationship barriers. The most common barrier to establishing a positive, productive service relationship stemmed from making assumptions and being closed-minded. While having general knowledge about different ethnoracial groups was helpful, practitioners believed that relying on those as "scripts" when interacting with young people was inappropriate. According to one practitioner, it's important to "ask lots of questions.… Don't assume … be curious … don't stereotype … and above all, respect the differences. Everybody's different—don't assume they're right or wrong … they're just different" (Jayanthi).

Youth also talked about practitioner inflexibility and fixed thinking as threats to the service relationship. For these youth, service providers who were fixed in their views of either the young person or her/his challenge and were inflexible in terms of potential solutions were unhelpful. For example,

> I had seen a counsellor like twice, but not by choice.… [She used to be my teacher for art] but now she turned into a counsellor and I think that was really bad because she already knew me and she goes to me, "Oh, you were such a nice boy. You were so happy. Why are you doing this now?" I didn't like that at all. Plus I also said, "I don't want you calling my parents," and she called my parents and said everything that I said. (Dev)

Finally, perhaps the most critical barrier cited by youth was a lack of mutual empathy and empowerment. A lack of patience on the part of practitioners, and the absence of a secure therapeutic space in which confidentiality and anonymity would be ensured prevented youth from feeling comfortable about sharing their experiences. They came away from these sessions feeling ill-equipped to deal with their challenges.

> [The guidance counsellors at my school] started a new program [where you get together with a group of eight other students] … and they want you to tell them, like they want you to explain your whole life and everything.… I just went to miss class…. They were asking really personal questions that I didn't want to [answer] … and then nobody kept anything confidential. The teachers talked to each other, the students talked to each other… (Walleed)

Relationship facilitators. In addition to discussing unhelpful aspects of a service relationship, youth and service providers spoke at length about helpful factors that facilitated the relationship. Not surprisingly, given that making assumptions and engaging in stereotypical thinking were identified as relationship barriers, participants identified expressing a thoughtful curiosity as critical in the therapeutic process. This curiosity was not unidirectional; rather youth and practitioners felt that *both* parties should be comfortable to ask questions of one another, provided that this is done in a respectful way. Simply creating conditions in which this is a possibility can help to open and enrich the relationship. One practitioner said that she always invites questions from the young people she works with: "You may be wondering about me.… Do you have any questions?" (Sylvia).

Related to this is the notion of flexibility and openness. For youth in particular, simply having an appointment with a counsellor does not necessarily result in youth sharing what's on their mind. Youth were more inclined to talk to practitioners who were open, engaged, and willing to follow the young person's lead in terms of the level of sharing that might take place in a given session.

> I think every person goes to a guidance counsellor to see them one time or another. So when you see them, like when you're talking to them, it would be like, "Okay, so how is everything else with you, you know, your family? Are you good?" And then, yeah, maybe you'll talk, maybe you won't. (Vanita)

Participants also discussed the importance of continuous learning. While practitioners considered it necessary to possess appropriate skills and knowledge, they cautioned against becoming fixed in these ways of thinking and working. Ongoing learning about the needs and experiences of newcomers, as well as second and third generation families from diverse ethnoracial and cultural backgrounds is critical in order to stay relevant and provide appropriate support. According to this practitioner,

> I think … there will be progression because as the second generation and third generation are growing up, there is assimilation of cultures and, you know, new kind of a very rich culture is [emerging].… There are also new immigrants coming into Canada all the time. It's a continuous process so … there will always be a need to understand the new immigrants as they keep on coming into the country.… We'll have to keep on raising awareness and [being] educated about the various cultures. (Rani)

Not surprisingly, participants felt that mutual empathy and empowerment were essential ingredients for creating a positive service relationship. Youth in particular felt that having something in common with the therapist was helpful in ensuring mutual empathy. Whether related to cultural background, other aspects of identity (e.g., gender, sexuality), or even common interests, sharing something with one another can help youth and practitioners to feel a kinship with one another. This in turn can enable youth to feel more empowered

to problem solve around their mental health challenges, and implement solutions that are generated within that relationship. According to one young person, this type of relationship can be similar to a friendship:

> If I don't know [a person], I won't tell them anything.… [With friends], they know your background and everything so they won't, like, tell you to tell the story, like the whole story from the beginning. They just take up where you left off.… They know who you are better than anybody else.… They help you.… Their advice is kind of comforting [and you're more likely to take it]. (Sheela)

Finally, youth in particular spoke about engaging in realistic problem solving as a key component of the service relationship. According to youth participants, practitioners need to listen to what youth say about what is likely and unlikely to work in solving their mental health challenges. While the role of the practitioner is to suggest possible options, these need to be realistic, and consistent with the lived experiences and opportunities of youth.

> [They need to] give me choices to do that reflect my own values. Don't tell me to do something that … is not accepted by my culture or that I personally haven't grown up with. They need to understand my background to give me proper choices. (Shafreen)

> I don't want them giving advice that's going to get me in more problems with my family. Give me both options and then try to help me decide which one would be okay with my culture. (Youssef)

Toward a Culturally Responsive Model of Mental Health Practice With Youth

Given the key findings summarized above, current writing in the area of "cultural responsiveness" can be a helpful framework for interpreting the findings from our project, and may contribute to a richer understanding of service provision within diverse contexts. This approach originates in the education literature, and focuses on relationships between the school and community, educator(s) and students. Here, five key characteristics of such connections are emphasized: a sociocultural consciousness of the relations of oppression, an affirming attitude to people from all backgrounds, a commitment to being agents of change, a constructivist perspective on clinical relationships and change, and an understanding of relationships as involving mutual learning (Villegas & Lucas, 2002). By drawing on this perspective, our attention shifts from a focus on professional competence to the service *relationship* and flexibility that was found to be so important in our study (Villegas & Lucas, 2002). What becomes central is the overall relationship between client and practitioner; the flexibility of people's identities and the role this plays in shaping the experience of mental health/illness and potential solutions to challenges; and the integration of people's identities, contexts, and other factors that shape the service relationship.

By drawing on a culturally responsive model that has been developed in educational literature, we align with existing research that challenges the idea that working across cultures is solely about developing appropriate techniques, skills, or specific knowledge about "others." Instead, we focus on how helpers and clients can rework our organizations. As professionals, we must challenge ourselves to move out into the community rather than always demanding that communities come to us (Wlodowski & Ginsberg, 1995).

This shift reflects what our participants understood as centrally important to practice across cultures: the *relationship* between client and practitioner. In a culturally responsive model, this relationship is viewed as being shaped by broader structures that require we organize ourselves as agents in broader attempts at

change. This means changing not only the way we work interpersonally, but also how we situate our organizations in relation to ethnoracially and culturally diverse communities (Wlodowski & Ginsberg, 1995). Emphasizing the quality of the relationship between the service provider and the client ensures that *both* parties experience caring, respect, validation, empathy, and empowerment.

Although originating in education, such an approach is readily applicable to the provision of mental health services, and has the advantage of not being accompanied by the same baggage and limitations that are associated with the concept of cultural competence. It is not a replacement, but can be used as a complementary framework that addresses the limitations of cultural competence. Even with the language of the approach, the core focus shifts to "responsiveness" between a worker and a client rather than professional aptitude.

Within this model, then, people's identities, the surrounding context, and various factors that can either facilitate or hinder the helping relationship are represented as interrelated and exerting influence upon one another. At the same time, a culturally responsive approach has self-reflection and exploration at its core (Gay & Kirkland, 2003). Thus the process of being culturally responsive demands ongoing internal work and change along with shifting how we move and respond to the external environment.

In summary, we see a culturally responsive framework as helping to address some of the key limits of the cultural competence model. In taking a relationship-focused, constructivist approach, we can attend to the flexible and situated nature of identities; they are no longer understood as fixed. It also turns our attention away from a focus on skill and technique to self-reflection, the relationship, and a commitment to changing the contexts in which we work and live. These are not additions, or attempts to rework difference; they are at the core of the culturally responsive approach.

LIMITATIONS OF THE PRESENT WORK AND DIRECTIONS FOR THE FUTURE

The present study has several limitations, most of which relate to the convenience sample used for focus groups. The total number of participants was small ($n = 25$), and they were primarily from two urban regions in Ontario. Each of the focus groups was relatively homogenous (e.g., primarily Somali youth, primarily South Asian service providers) since we tapped into existing groups. While the use of existing groups facilitated the flow and openness in discussing a potentially sensitive topic involving culture and racism, a larger, more diverse sample would likely have contributed to more robust findings. For example, potential participants' perspectives may vary depending on time since arrival in Canada, education levels, religious affiliations, urban versus rural lifestyles, and length or type of experience with the mental health system in Canada versus country of origin.

A second limitation of the present study is the lack of perspectives of ethnoracially diverse parents of children with mental health difficulties who have used mental health services. Parents and caregivers are key partners in the delivery of mental health services, and while attempts were made to access this particular group, logistical barriers prevented their views from being adequately reflected in this study.

Finally, while we were able to discuss the issues under study with youth who have historical and/or current experience with the child and youth mental health system, we did not outreach specifically to potential participants (i.e., parents and youth) who are considering accessing the system, or who have made attempts

to access the system without success. Views on what constitutes culturally relevant and appropriate services may differ significantly among members of this group.

Future empirical work that involves a larger sampling frame with participants reflecting various perspectives and that uses a mixed-methods approach would be useful in order to test the model proposed in this study. Further investigation of the bidirectional nature of influence between service providers and service users can also enrich the extant literature that focuses on service providers as influencing clients, and clients as mere receivers rather than active agents in the delivery of "culturally competent" services. Finally, additional study to investigate the key elements of a culturally responsive approach can potentially enrich what we currently understand as helpful aspects of cultural competence, while filling a number of the limitations associated with this concept.

CONCLUSION

The field of child and youth mental health, along with other social services, is working hard to provide appropriate, relevant supports to clients from all ethnoracial and cultural backgrounds. In this project, we sought to add to the growing body of literature on social work across cultures, and address a number of the limitations inherent in the popular concept of cultural competence. Specifically, through focus group interviews with youth and practitioners, we worked to create an environment in which participants could have frank discussions about race and its role in service provision. We sought to address the problem of viewing youths' (and practitioners') ethnocultural and racial identities as fixed and unchanging by using a qualitative methodology that allowed us to capture the more complex, constantly evolving nature of people's selves. We propose bringing forward a culturally responsive approach through which to understand work across difference in child and youth mental health, and suggest that future research in this area might bring to bear ideas and strategies that can complement current understandings about cultural competence. Finally, we added to the small but growing empirical base of evidence upon which education and training related to social work with clients with diverse racial/ethnic/cultural backgrounds is typically shaped, and notably, incorporated the views of service users into this body of work.

NOTES

1. While writing on cultural competence is found in a range of fields, including business and management, our focus in this paper is on cultural competence as it relates to health and mental health service provision in the fields of medicine, nursing, psychology, and social work.
2. All participant names that accompany quotations are pseudonyms.

RÉSUMÉ

Les préoccupations croissantes que suscitent les obstacles auxquels font face les Canadiens membres de minorités visibles ont conduit à la réalisation de plus en plus de recherches, dans le domaine du savoir-faire culturel, qui analysent la prestation des services offerts à ces groupes (Este, 2007 ; Thomas, Bernard et Moriah, 2007). Dans la très grande majorité des cas, ces travaux s'appuient sur le point de vue de praticiens ou de chercheurs qui considèrent le savoir-faire culturel comme un ensemble de connaissances et de

compétences nécessaires pour travailler avec les « autres ». Dans cet article, nous résumons les conclusions d'une étude empirique dont l'objectif était de nous permettre de mieux comprendre la complexité du travail avec des gens de différentes cultures, selon le point de vue d'utilisateurs de services et de praticiens. Nous montrons que l'utilisation d'une approche pédagogique « sensible aux cultures » (Gay, 2000 ; Villegas et Lucas, 2002) peut contribuer à améliorer la compréhension des différences ainsi que les pratiques qu'impliquent les interventions avec des familles d'origines diverses.

Mots clés : prestation de services, sensibilité culturelle, race, santé mentale des enfants et des adolescents

REFERENCES

Allen, J. (2007). A multicultural assessment supervision model to guide research and practice. *Professional Psychology: Research and Practice, 38*(3), 248-258.

Alvesson, M., & Sköldberg, K. (2000). Reflexive methodology: New vistas for qualitative research. Thousand Oaks, CA: Sage Publications.

Anderson, L., & Scrimshaw, S. (2007). Culturally competent healthcare systems: A systematic review. *American Journal of Preventative Medicine, 24*(3), 68-79.

Berg, B. (2004). *Qualitative research methods for the social sciences* (5th ed.). Boston, MA: Pearson Education.

Bhui, K., & Warfa, N. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research, 7,* 15.

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*(1), 181-217.

Carpenter-Song, E., & Schwallie, M. (2007). Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services, 58*(10), 1362-1365.

Centre for Addiction and Mental Health. (2009). *Understanding the issues, best practice and options for service development to meet the needs of ethno-cultural groups, immigrants, refugees, and racialized groups.* Ottawa, ON: Author.

Chrisman, N., & Zimmer, P. (2000). Cultural competence in adult primary care. In P. Meredith & N. Horan (Eds.), *Adult primary care* (pp. 65-75). Philadelphia, PA: W.B. Saunders Company.

Cross, T. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed.* Washington: National Institute of Mental Health, Child and Adolescent Service System Program.

Dogra, N., & Vostanis, P. (2007). Child mental health services: Cultural diversity training and its impact on practice. *Clinical Child Psychology and Psychiatry, 12*(1), 137-142.

Este, D. (2007). Cultural competency and social work practice in Canada: A retrospective examination. *Canadian Social Work Review, 24*(1), 93-104.

Eunyoung, E. (2004). The model of cultural competence through an evolutionary concept analysis. *Journal of Transcultural Nursing, 15*(2), 93-102.

Gay, G. (2000). *Culturally responsive teaching: Theory, research, & practice.* New York: Teachers College Press.

Gay, G., & Kirkland, K. (2003). Developing cultural critical consciousness and self-reflection in pre-service teacher education. *Theory Into Practice, 42*(3), 181-187.

Herberg, D. (1993). *Frameworks for cultural and racial diversity: Teaching and learning for practitioners.* Toronto, ON: Canadian Scholars' Press.

Keddell, E. (2009). Narrative as identity: Postmodernism, multiple ethnicities and narrative practice approaches in social work. *Journal of Ethnic and Cultural Diversity in Social Work 18,* 221-241.

Killion, C. (2007). Patient-centered culturally sensitive health care: Trend or major thrust in health care delivery? *The Counseling Psychologist, 35*(5), 726-734.

Kumaş-Tan, Z., & Beagan, B. (2007). Measures of cultural competence: Examining hidden assumptions. *Academic Medicine, 82*(6), 548-557.

Lam, R., & Cipparrone, B. (2008). *Achieving cultural competence: A diversity toolkit for residential care settings.* Ministry of Children and Youth Services, Ontario.

Lum, D. (1999). *Culturally competent practice: A framework for growth and action*. Pacific Grove, CA: Brooks/Cole.

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.
Pon, G. (2009). Cultural competence as new racism: An ontology of forgetting. *Journal of Progressive Human Services, 20,* 59-71.
Qureshi, A., & Collazos, F. (2008). Cultural competency training in psychiatry. *European Psychiatry, 23*, S49-S58.
Raphael, D. (Ed.). (2004). *Social determinants of health – Canadian perspectives.* Toronto, ON: Canadian Scholars' Press.
Reese, L., & Vera, E. (2007). Culturally relevant prevention: The scientific and practical considerations of community-based programs. *The Counseling Psychologist, 35*(6), 763-778.
Shah, A., & Zakus, D. (2004). The future of healthcare in Canada: Diagnosing the needs of immigrants. *University of Toronto Medical Journal, 82*(1), 21-23.
Snowden, L., Martinez, M., & Morris, A. (2000). Community psychology and ethnic populations. In J. Rappaport & F. Seidman (Eds.), *Handbook of community psychology* (pp. 833-855). New York, NY: Klewer Academic/Plenum Press.
Statistics Canada. (2006). 2006 Census. Retrieved from http://www.census2006.ca/census-recensement/2006/dp-pd/prof/92-591/index.cfm?Lang=E
Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage Publications.
Sue, D. (2001a). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29*(6), 790-821.
Sue, D. (2001b). The superordinate nature of cultural competence. *The Counseling Psychologist, 29*(6), 850-857.
Sundar, P. (2008). To 'brown it up' or to 'bring down the brown': Identity and strategy in second-generation, South Asian-Canadian youth. *Journal of Ethnic and Cultural Diversity in Social Work, 17*(3), 251-278.
Thomas Bernard, W., & Moriah, J. (2007). Cultural competency: An individual or institutional responsibility? *Canadian Social Work Review, 24*(1), 81-92.
Trujillo, M. (2001). Culture and the organization of psychiatric care. *Cultural Psychiatry: International Perspectives*, *24*(3), 539-552.
Vega, W., & Lopez, S. (2001). Priority issues in Latino mental health services research. *Mental Health Services Research, 3*(4), 189-200.
Villegas, A., & Lucas, T. (2002). *Educating culturally responsive teachers*. Albany, NY: State University of New York Press.
Whaley, A., & Longoria, R. (2008). Assessing cultural competence readiness in community mental health centers: A multidimensional scaling analysis. *Psychological Services, 5*(2), 169-183.
Williams, C. (2006). The epistemology of cultural competence. *Families in Society, 87*(2), 209-220.
Wlodowski, R. J., & Ginsberg, M. B. (1995). *Diversity and motivation: Culturally responsive teaching.* San Francisco: Jossey-Bass.
Yan, M., & Wong, Y. (2005). Rethinking self-awareness in cultural competence: Toward a dialogic self in cross-cultural social work. *Families in Society, 86*(2), 181-188.
Yee, J., & Dumbrill, G. (2003). Whiteout: Looking for race in Canadian social work practice. In A. Al-Krenawi & J. Graham (Eds.), *Multicultural social work in Canada: Working with diverse ethno-racial communities* (pp. 98-121). Don Mills, ON: Oxford University Press.