Synthesizing Culture and Power in Community Mental Health: An Emerging Framework

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ABSTRACT

Mental health services in western English-speaking countries are struggling to respond to growing cultural and racial diversity. The overall purpose of the Community University Research Alliance (CURA) study was to explore, develop, pilot, and evaluate how best to provide community-based mental health supports that are effective for people from culturally diverse backgrounds. Using a participatory action research

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approach within a multimethod design, the study partnership has developed an emerging framework that synthesizes the ideals of previous culture-oriented and power-oriented models. The emerging framework has 3 main components: *values* that guide concrete *actions* that in turn produce desired *outcomes*. Central to the emerging framework is the need for reciprocal collaboration between the mental health system and cultural-linguistic communities.

Mental health services in western English-speaking countries are struggling to respond to growing cultural and racial diversity (Ingleby & Watters, 2005; de Jong & van Ommeren, 2005). Western-trained service providers and program planners often do not understand the culturally specific meanings and customs attached to mental health, mental illness, and associated stigma (James & Prilleltensky, 2003; Kim, Brenner, Liang, & Asay, 2003). A range of structural barriers deters cultural-linguistic minorities from seeking mental health services. Barriers include a lack of linguistic capacity within mental health organizations, limited diversity among professional staff and in organizational governance structures, undeveloped relationships with cultural-linguistic communities to identify how best to serve them, and a lack of accountability to cultural-linguistic communities about the quality of service provided (Murphy, Ndegwa, Kanani, Rojas-Jaimes, & Webster, 2002; Nadeau & Measham, 2005). As a consequence, many cultural-linguistic minority groups receive inadequate diagnosis and treatment (Cuellar & Paniagua, 2000; Gagnon, 2002), experience services that are demeaning (Bowl, 2007; Shahsiah & Yee, 2006), or find it difficult to access appropriate mental health services (Williams, 2001).

Mental health practice has attempted to adapt to the reality of cultural pluralism (e.g., California Dept. of Mental Health, 2002; Canadian Mental Health Association, 2002; Kirmayer, Groleau, Busder, Blake, & Jarvis, 2003), but these attempts have been limited and remain largely ineffective and fragmented (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Toronto-Peel Mental Health Implementation Task Force, 2002). Most of these attempts have not been based on systematic investigations or analyses (Beiser, 2003), nor have they been inductively developed or rigorously evaluated from the perspectives of the recipients of care (Wells, Miranda, Bruce, Alegria, & Wallerstein, 2004). It is true that there have been ethno-specific and disorder-specific efforts to understand culturally relevant mental health concepts and practice (e.g., Ito & Maramba, 2002; Karasz, 2005). However, no known efforts have comprehensively examined and synthesized (a) understandings of mental health and mental illness among people from globally diverse cultural backgrounds, (b) the range of help-seeking strategies among marginalized cultural-linguistic groups, and (c) the development of evidence-based, multicultural best practices that have been implemented and evaluated collaboratively by mental health practitioners/planners and members of diverse cultural-linguistic communities.

This article reports on the progress of a 5-year community-based study that attempts to address these gaps. The study has issued an invitation for leading mental health practitioners, cultural-linguistic community leaders, and academics to collaborate in innovating mental health policy and practice. One intended outcome of this study is to develop a theoretical framework useful for guiding mental health policy and practice in multicultural contexts. The process of framework development began with a preliminary review of multi-disciplinary literature chronicling the historical progression of how the helping professions have responded

to cultural diversity. While we elaborate on these trends elsewhere (Janzen, Ochocka, & the "Taking Culture Seriously" Partners, 2007), the review generally revealed two streams of response: theoretical models that emphasize *culture* and those that emphasize *power*.

Following World War II, culture models minimized the notion of culture either by suggesting that diversity did not exist (*universalism*) or by ignoring culture and treating service users the same regardless of their differences (*culture blind*). Later, *cultural sensitivity* recognized culture as an essential component of a service user's identity and behaviour. Practitioners were advised to be aware of similarities and differences between cultural communities, but not to assign values to those cultural differences. Most recently, *cultural competence* perspectives have acknowledged that change is required of practitioners who need new attitudes, knowledge, and skills to respond to the cultures of others (*cultural literacy*), and who need to critically reflect on their own cultural values and beliefs (*experiential-phenomenological reflexivity*; Al-Krenawi & Graham, 2003).

In addition to these culture-oriented models, power-oriented models have also guided social and health practice (McKenzie & Harpham, 2006). *Anti-oppressive* models build on *anti-racist* models by being aware not only of "whiteness" as a social privilege, but also of the privilege inherent in other forms of identity and diversity. Some recent anti-oppressive models acknowledge the intersection between multiple forms of identity-based discrimination, with oppression experienced in varying configurations and in varying degrees of intensity (Sokoloff & Dupont, 2005). These power-oriented models imply that social privilege should be acknowledged and that interventions work against the systemic basis of this advantage ("power").

Reflecting on this literature review, the study partners concluded that a framework that adequately synthesized the ideals of both the culture-oriented and the power-oriented streams was missing. Such a framework should be applicable to the full range of cultural diversity, not simply to a select few cultures. It should be developed collaboratively by mental health practitioners, academics, and cultural-linguistic communities. A new framework not only should be useful to the practitioner/client interaction (i.e., at the individual or relational level), but also should serve to inform mental health policy and service design (i.e., at the systems or structural level). Our objective was therefore to build theory for practice (Shadish, Cook, & Leviton, 1991), primarily relevant to the mental health field but potentially to other fields as well. The purpose of this article is to describe this emerging framework.

OVERVIEW OF THE STUDY

The overall purpose of the Community University Research Alliance (CURA) study is to explore, develop, pilot, and evaluate how best to provide community-based mental health services and supports that are effective for people from culturally diverse backgrounds. This research initiative has brought together over 40 partners in two regions of Ontario, Canada: Toronto and Waterloo. With these two sites, our study offers built-in contextual comparisons in scale and services.

The study involves three phases. In the first phase (2005–2006), academic and community researchers used multiple research methods and considered multiple perspectives to explore diverse conceptualizations of mental health problems and practice. In phase 2 (2007), the partners drew on their learnings to develop a number of multiculturally responsive demonstration projects at both study sites. These demonstration projects were piloted and evaluated in phase 3 (2008–2009).

The study has used a participatory action research (PAR) approach (Kemmis & McTaggart, 2005) that sought to meaningfully involve stakeholders throughout the research process, and that emphasized producing useful results for positive change (Ochocka, Janzen, & Nelson, 2002). Our commitment to PAR values (Nelson, Ochocka, Griffin, & Lord, 1998) led us to develop a structure that ensured participation and oversight by the various stakeholders. Stakeholders included members of five cultural-linguistic groups: Punjabi Sikh, Mandarin Chinese, Somali, Spanish Latin American, and Polish; service providers within the community mental health system; provincial umbrella organizations in both the mental health and immigrant settlement sectors; and members of a multidisciplinary, multiuniversity research team.

The governance structure consisted of a Partnership Group with open representation from all partner organizations, and two local Steering Committees consisting of representatives from the cultural-linguistic communities, practitioners, and researchers that guided research activities within the two study sites. The research team included graduate students, community researchers (two from each of the five cultural-linguistic communities), and seven professional researchers from a number of different disciplines. A more complete description of the project structure and the mechanisms used to implement the PAR approach has been reported elsewhere (Ochocka & Janzen, 2007).

RESEARCH METHODS AND DATA ANALYSIS

The framework presented below emerged through the analysis of data collected during the study's first phase. Main research questions posed during this phase included the following: (a) What are the culturally diverse understandings of mental health and mental illness? (b) What help-seeking strategies do people from diverse cultural-linguistic communities use to support individuals toward mental health? (c) How well is the Canadian mental health system responding to cultural diversity? and (d) How can members of culturally diverse communities be better supported in their mental health?

Four primary data collection methods were used to answer these questions: literature review, key informant interviews, focus groups, and a survey. Case studies of 10 cultural-linguistic community members who struggled with their mental health were also collected but for the purpose of illustration rather than theory formation. A subcommittee devoted to each of these methods met throughout the life of the particular method; their work included planning, data gathering, data analysis, and writing. The research began with a comprehensive review to identify what the extant literature said about community mental health theory, policy, and practice (knowledge and skills, or interventions) in relation to cultural diversity. The collaborators produced an annotated bibliography of 225 articles and developed an analytical framework consisting of six categories: context, problem analysis, proposed solutions/intervention goals, methods, transformational process/how change happens, and proposed outcomes.

Next, key informant interviews, focus groups, and service provider surveys were conducted in parallel (Tashakkori & Teddlie, 1998). The purpose of the *key informant interviews* was to gain an overview of the major issues related to mental health and cultural diversity in the province and in Canada, what the mental health system in Ontario was doing well with regard to cultural diversity, where it was failing, and what steps should be taken to remedy its shortcomings. A total of 22 key informants—individuals with a "balcony" view of mental health and cultural diversity—participated in interviews, including policy-makers, consumer/

survivors, families, multicultural leaders, researchers, service providers, and umbrella organizations concerned with mental health or cultural diversity.

The purpose of the third method, *focus groups*, was to understand culturally diverse conceptualizations of mental health problems and to obtain community perspectives about necessary services. Trained community researchers facilitated the group discussions in the language of participants' choice. In total, 21 focus groups were held with 185 participants from the five participating cultural-linguistic communities. Along with being members of a specific ethnic group and residing in Canada for at least 5 years, participants were recruited with the following range of attributes in mind: gender, education/social status, age, regional representation, and interest in mental health.

The fourth method, a *service provider online survey*, was exploratory in nature, gathering data about how responsive community mental health organizations perceived themselves to be with regard to the service needs of people from diverse cultural-linguistic groups. Questions on the survey were both closed and open-ended and grouped into three sections: demographics, current practices, and challenges and preferred changes. The survey was sent to executive directors or program heads of all 348 mental health-related services in Ontario through the electronic membership listings of four provincial umbrella organizations. One follow-up reminder was sent, and people from 111 organizations (32% of organizations) responded.

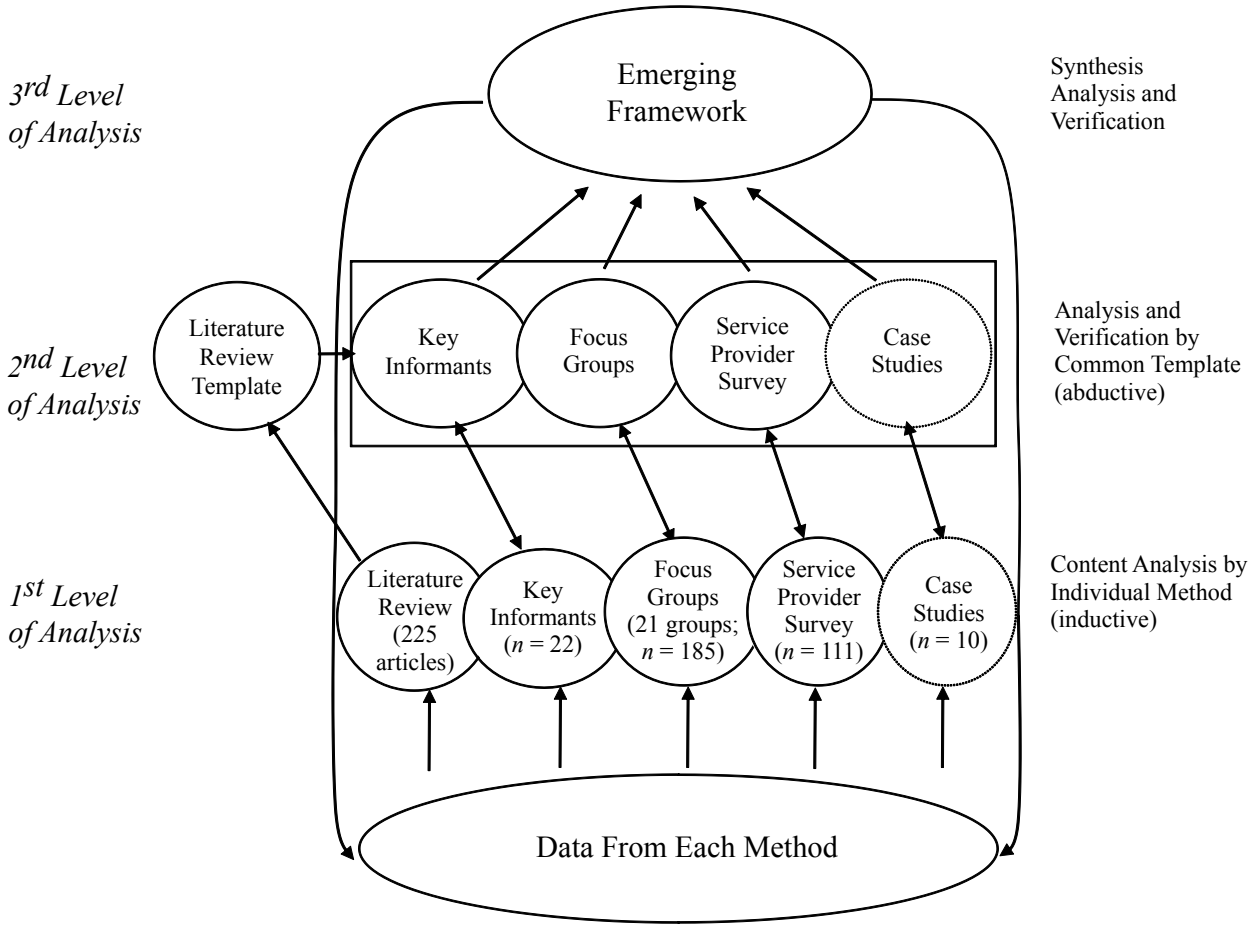
The first-level analysis of each of these three empirical methods was inductive, following a grounded theory approach (Charmaz, 2006). The second level of analysis was abductive (Thagard & Shelley, 1997) with the findings of each method fitted into the six categories of the analytic framework developed through the literature review. To complete the third level of analysis, a theory-building committee of seven multidisciplinary researchers was formed as an umbrella group across methods. This group met over a period of 2 years to reflect on the data analysis process and to synthesize a theoretical framework based on the first- and second-level analyses of data from each method. The ongoing discussions within this group helped to maintain consistency in data analytical approaches and to sharpen the group's thinking about the emerging framework (see Figure 1 for a summary of methods and data analyses). Members of the theory-building group are the primary authors of this paper. This paper was then vetted through the two steering committees for further refinement (see Westhues et al., 2008, for a detailed description of methods and theory-building process).

OVERVIEW OF MAIN FINDINGS

In general, cultural linguistic communities articulated their opinions about mental health, mental illness, help-seeking strategies, and the Canadian mental health system according to what was valued within their own cultural community. So, for example, "good mental health" among Latin American participants was often connected to a collective sense of community and strong families, while a combination of mental and spiritual strength was emphasized in the Somali community. Mental illness, by contrast, was more difficult to concretely define, but included such notions as failing to meet family or community responsibilities (often cited by Punjabi participants), and the inability to function within social norms (all communities). Employment worries (unemployment, underemployment, and a lack of education and credential recognition), as well as the constant negotiation between two cultures were viewed as particularly stress-inducing (see Simich, Maiter, Moorlag, & Ochocka, 2009, for more detailed opinions of cultural linguistic community members).

Figure 1

Overview of Methods and Data Analysis Progression



With regard to help-seeking strategies, data from all methods pointed to the pervasiveness of mental health stigma and the barrier that this caused in reaching out for support. As one key informant stated, "I think there has been the whole traditional stigma around mental health, which is still pervasive. It is not always safe for people to admit that they have had a mental health … issue." One Chinese participant said, "We don't take mental health seriously in our culture." When people did seek out support, they tended to turn to natural and informal supports such as family and friends. In cultural-linguistic communities that highly valued religion (e.g., Polish, Somali, Punjabi), people also turned to their religious leaders. This reliance on natural supports proved problematic for many recent immigrants, who often had left family members and friends behind.

When speaking of the Canadian mental health system, participants from all five communities often expressed distrust or conveyed a general lack of knowledge about the nature and existence of mental health services. Key informants said the mental health system has its own distinct culture: one that displays a narrow focus on the biomedical, an impersonal approach, disorganization, and an overall lack of consideration of the social determinants of poor mental health. While systemic barriers to accessing services exist for all Canadians, these barriers were seen to intensify when the culture of the mental health system clashed with the cultures of those from diverse backgrounds. As one key informant stated,

> Well, the assessment is white, the language is white, the person is white. It is about Eurocentrism. It doesn't take into awareness any knowledge that families are raised with different norms and practices outside of Canada.… So, they assess immigrants based on their [own Eurocentric] values.

Participants did note some positive changes. In particular, deinstitutionalization, the recovery model, the creation of Assertive Community Treatment teams, an overall move toward community-based services, as well as some emerging culturally responsive practices (e.g., greater diversity of service providers, increased language flexibility, more cultural competence training, and more partnerships with cultural-linguistic communities) were mentioned as positive developments. However, participants did not claim that these changes were comprehensive, organized, or broadly implemented throughout the mental health system.

It is interesting to note that these findings generally clash with the intent of government policy to create a cohesive society in which culturally diverse people feel a sense of belonging and attachment to Canada (Fleras & Elliott, 2003). While the sociopolitical context is one that is intended to bring culturally diverse people together to collaborate in nation building, the experiential reality is often one of disconnection. Most notable is the cultural disconnection between cultural-linguistic minorities and a mental health system mandated to serve the entire community.

THE EMERGING FRAMEWORK

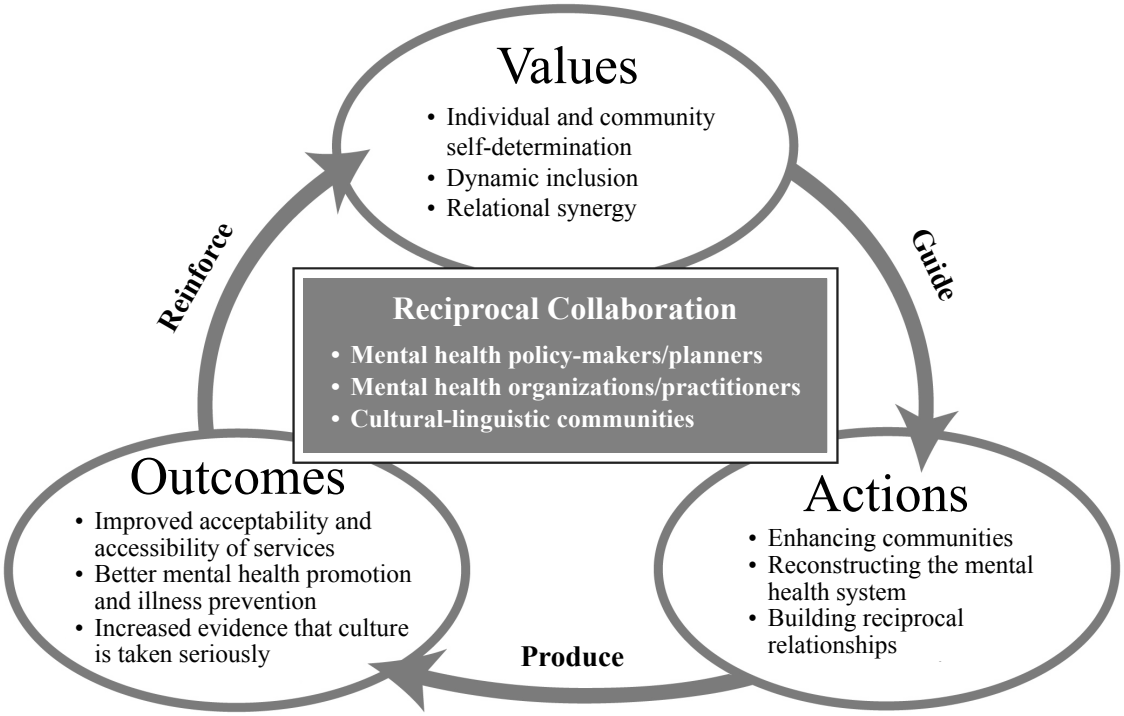
In an attempt to address this cultural disconnection, we proceeded to develop a framework that could guide future mental health policy and practice. The emerging framework includes three main components: *values* that guide concrete *action* that in turn produces desired *outcomes* that serve to reinforce the stated values (Figure 2). Central to the framework is the active involvement of mental health policy-makers/system planners, mental health organizations/practitioners, and cultural-linguistic communities. Their collaboration in innovating mental health policy and practice is characterized by reciprocity in which the benefits and responsibilities of collaboration are shared (Maiter, Simich, Jacobson, & Wise, 2008).

Values

Value 1: Individual and community self-determination

> We need self-support.… I am wondering whether the government could give us a place, and we could try to help each other first. If we couldn't deal with some cases, we would go to see doctors and counsellors.… We should depend on ourselves. (focus group participant)

Figure 2
Overview of the Emerging Framework



The first value foregrounds the need for self-determination—that people from culturally diverse backgrounds, individually and collectively, should direct the formation and implementation of culturally responsive services and supports that promote their well-being. This value is oriented to issues of power in that it attempts to address existing structural inequities between the mental health system and cultural-linguistic communities. It recognizes that access to existing mental health services is limited by structural barriers.

Value 2: Dynamic inclusion

> If you are going to be in the business of providing mental health services in a racially and ethnically diverse community, you have got to make a commitment to learn about other cultures and to be able to help people make choices about the kind of treatment and support they want. (key informant)

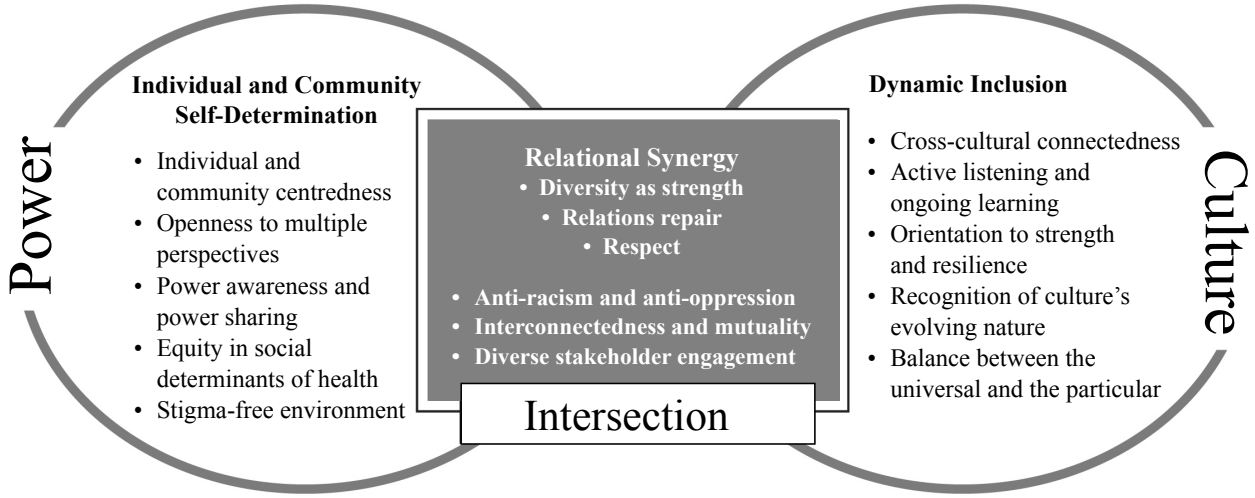
The second value stresses the importance of culture and the need for people to improve culturally responsive attitudes, knowledge, and skills. We called this value *dynamic inclusion* because it emphasizes, on the one hand, the need to ensure that people from all cultural-linguistic backgrounds have a sense of belonging to and participation in mainstream society (inclusion). The dynamic element is added because striving for inclusiveness is not always a straightforward matter, as both the notion of culture and our response to it are fluid and circumstantial.

Value 3: Relational synergy

> I think we [service providers] have to look at who we serve and we have to respond to our community and our service has to reflect our community. (key informant)

The final and pre-eminent value we named relational synergy. Here power and culture intersect through the process of seeking new, mutually respectful, and beneficial connections between cultural-linguistic communities and the mental health system. The diversity inherent within such collaboration holds the potential to spur innovation beyond what each stakeholder group could create in isolation (see Figure 3).

Figure 3
Guiding Values of the Emerging Framework



Actions

Action 1: Enhancing cultural-linguistic communities

> It would [be] important to train mental health promoters. Among us, there are people with a great desire to help others, besides the knowledge, skills, and motivation. Then why not train members of the Latino community as mental health promoters? (focus group participant)

Community enhancement refers to activities that strengthen cultural-linguistic communities. Implicit is an acknowledgement that activities build on and augment existing strengths inherent in cultural-linguistic communities. Equally important is recognizing the need to equip cultural-linguistic communities with resources to more fully realize well-being.

Action 2: Reconstructing the mental health system

> [We need] more equitable allocation of resources to the communities we work with. More balanced resources to different components of our continuum of services—currently there is a heavy focus on "illness." A balance [is needed] on prevention, promotion, and rehabilitation. (web survey respondent)

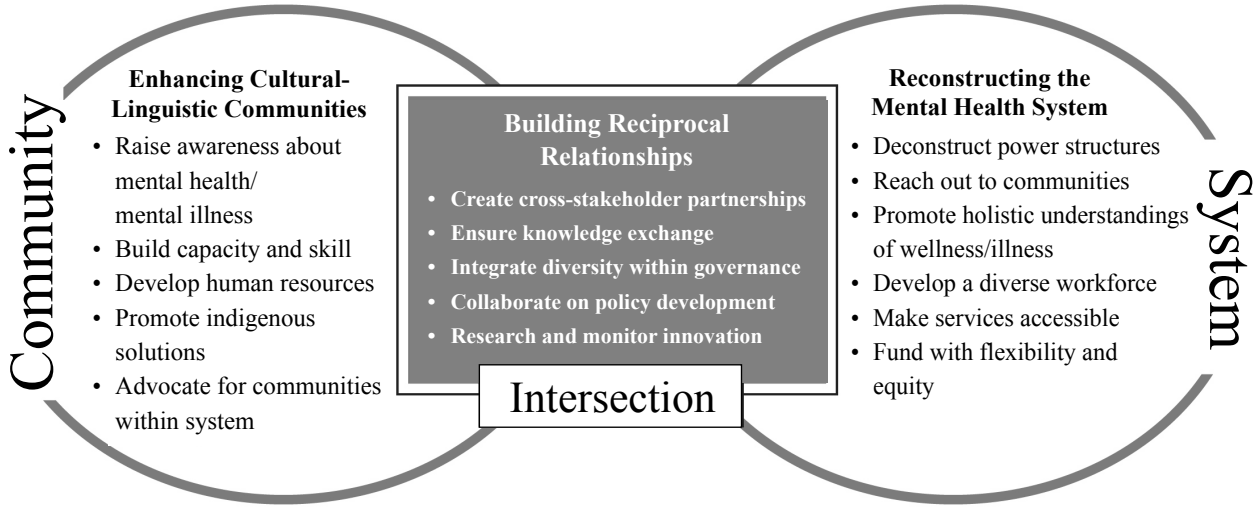
The second group of activities targets the mental health system. These activities work to make mental health policy, system planning, organizations, and individual practitioners more responsive to the cultural diversity around them. This requires a reconstruction or rebuilding of a mental health system that in many ways is currently dysfunctional.

Action 3: Building reciprocal relationships

> [We need to] work jointly with ethno-specific agencies in the delivery of resources and services. (web survey respondent)

In the spirit of reciprocal collaboration, the third group of actions is the most important in that it brings together cultural-linguistic communities and the various parts of the mental health system. Here the value of "relational synergy" is acted out, as communities and the system find innovative expressions of collaboration and build relationships that allow each to influence and shape the other. These relationships are reciprocal because the responsibilities and benefits of the collaboration are mutual (see Figure 4).

Figure 4
Actions of the Emerging Framework



Outcomes

Outcome 1: Reciprocal relationships

As shown in Figure 5, the starting point of observable change is the new and stronger reciprocal relationships that are developed among cultural-linguistic community members and the various components of the mental health system. From this foundation all other outcomes flow, as reciprocal relationships are the gateway to subsequent levels of change. These reciprocal relationships remind us that it is through interdependence—among those who work in mental health system policy and planning, those who run mental health organizations or deliver front-line services, and those who belong to diverse cultural-linguistic communities—that people make improvements to mental health care. This outcome stresses that people from each group have expertise and experience that is valuable to the others, and that this "value-added" contribution is mutually sought out.

Outcome 2: Changes within stakeholder groups

A second level of outcomes identifies changes that occur within specific stakeholder groups. *Cultural-linguistic communities* are expected to change in ways related to both culture and power. Leaders and members of cultural-linguistic communities will have greater mental health competency; they will be more open (change of attitudes), better informed and equipped (change in knowledge), and more effective (change in skills) in dealing with distress and in seeking appropriate support. They will also become more empowered, enabling them to more effectively promote culturally responsive mental health policy, planning, and service delivery.

> I think it will be very effective … if the mental health institutions in Canada would go back to the communities and empower them with knowledge. And these people can … advocate and … bring awareness of the issues, and give confidence to where they are going. (focus group participant)

The emerging framework suggests that the *mental health system* will also change in relation to culture and power. Specifically, mental health policy-makers, planners, and practitioners will be more culturally competent—more open, better informed and equipped, and more effective in responding to the needs of diverse cultural-linguistic community members. This means that members of the mental health system, like cultural-linguistic community members, will develop new attitudes, knowledge, and skills.

The mental health system will also change in a way that balances its previous power advantage. The result will be that mental health policy-makers and planners will establish the procedures, standards, and funding necessary to facilitate system/community collaborations (better process) and to ensure more culturally responsive mental health services and supports (better outcomes).

> [We need] standards on practices and indicators for what would be outcomes to satisfy the organization, [to ensure] that we are meeting our objectives to have a diverse staff with an accepting culture and that we are responsive to diverse populations. (web survey respondent)

Outcome 3: Longer-term changes in mental health services

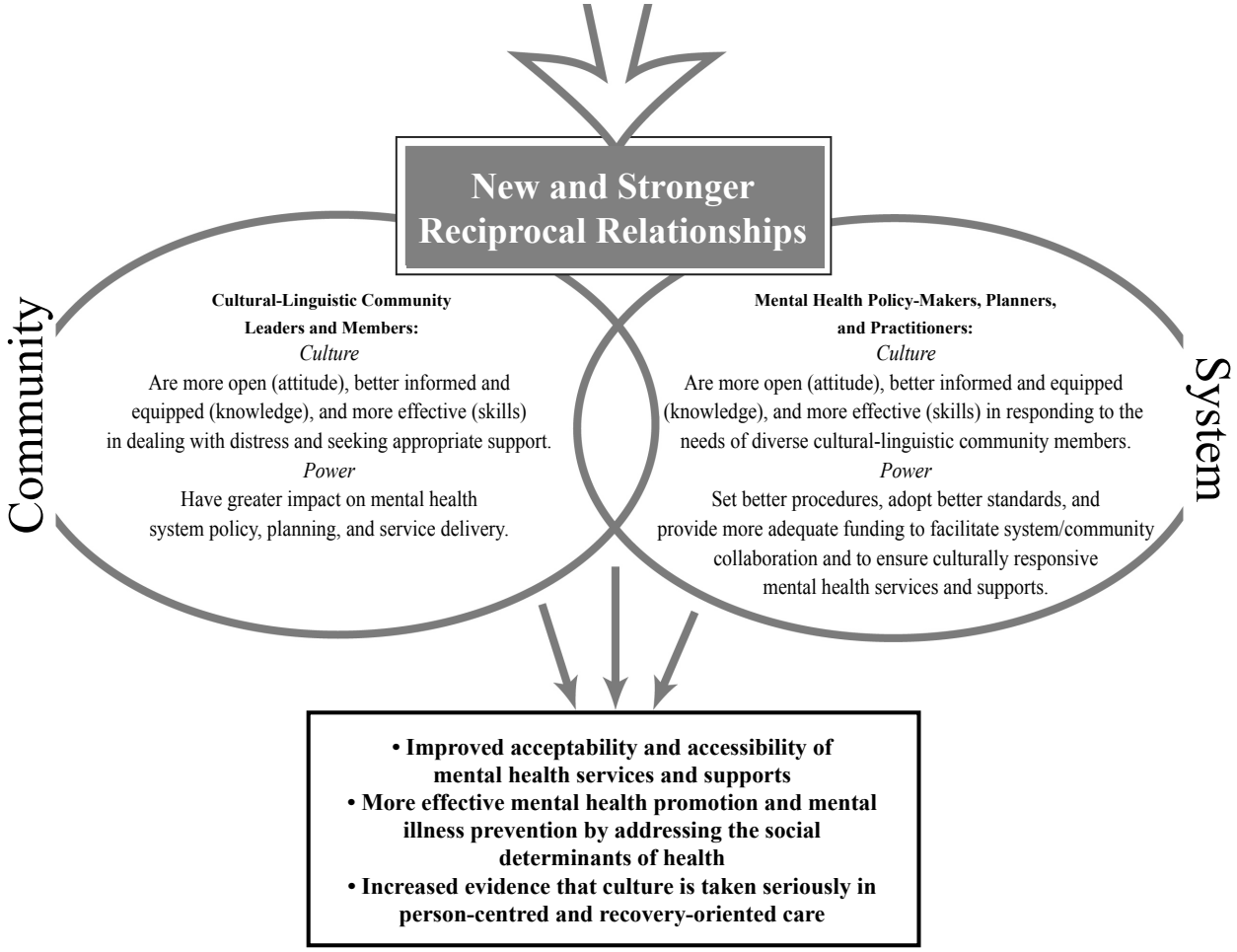
The third level of outcomes flow from those mentioned above, being longer-term in nature. The three groups of outcomes include (a) improved acceptability and accessibility of mental health services and supports,

(b) better mental health promotion and mental illness prevention by addressing the social determinants of health, and (c) increased evidence that culture is taken seriously in person-centred and recovery-oriented care.

These outcomes acknowledge that changes are needed in how mental health interventions are provided (more accessible and acceptable), in what these services address (a stronger emphasis on mental health promotion, social determinants of health, and upstream prevention), and in how services are evaluated. The evidence should show that interventions are actually making an impact (consistent with contemporary mental health discourse on person-centred and recovery-oriented care).

Figure 5

Outcomes of the Emerging Framework



SITUATING THE EMERGING FRAMEWORK IN CONTEXT

While grounded in theory and in empirical data, this emerging framework has not yet been fully tested in practice. In an effort to address this limitation, study partners (and interested others) have clustered into subgroups to develop a series of demonstration projects. To date 12 demonstration projects (5 in Toronto, 6 in Waterloo, and 1 provincewide) have been developed, and of these, 6 have received funding and are presently being implemented. Each project was developed as a collaborative effort to examine both power and culture in practice, and to take action to advance reciprocal relationship building between the mental health system and cultural-linguistic communities. While no one project will illustrate the entire framework, collectively the projects aspire to promote innovation at multiple levels of intervention.

It should be noted that each of the 12 demonstration projects was designed by a specific cluster of partners committed to addressing their own unique challenges. In this way, the demonstration projects are taking context seriously. We believe that this is important to do as people exist in social contexts created by distinct intersecting systems of power. The demonstration projects should therefore consider the textured structural layers within a setting (Sokoloff & Dupont, 2005).

We will illustrate the importance of context by highlighting two case examples. One of the funded demonstration projects in Toronto is being led by the Punjabi Community Health Centre. The purpose of this project is to provide culturally appropriate case management, outreach, and support services to the Punjabi community in mental health and addictions. To meet the goals of this project, the Punjabi community will also establish stronger relations with mainstream mental health organizations to facilitate referrals and a holistic approach to working with clients and their families. Through involvement with the CURA study, the community was able to leverage financial resources from the local health funding body and initiate its own project. Demonstrating the value of community self-determination, this project will be carried out with a family-oriented approach consistent with Punjabi cultural norms. In the past, Punjabi community members seldom used the formal mental health system. With this demonstration project the Punjabi community is now the leader of an innovative partnership—a partnership that involves mainstream mental health providers as junior, yet complementary, partners.

A second illustration is a funded demonstration project located in Waterloo. Consistent with this region's penchant for developing multicultural (as opposed to ethno-specific) supports, this demonstration involves all five CURA cultural-linguistic communities, plus the Afghani and Sudanese communities. Over 200 members identified the need to initiate this project at a joint community forum organized by the CURA project. The purpose of this project is to train and then employ "mental health navigators" from each cultural-linguistic community to promote mental health within their respective communities and to link people to formal mental health services. These navigators will also be trained to better understand the Canadian mental health system and then to participate in the governing bodies of local organizations as agents of change. As a demonstration of the value of relational synergy (i.e., relations repair), the cultural communities invited a local multicultural community health centre to be the administrative lead for this project on their behalf. Other local mental health organizations are actively involved in the training of mental health navigators, and are possible recipients of these navigators as future members of their boards of directors.

These are but two examples of how demonstration projects are attempting to live out the ideals of the emerging framework in practice. Each project demonstrates some level of reciprocal collaboration and does so in a way that acknowledges the uniqueness of the specific context while addressing its unique challenges.

CONCLUSION

While the emerging framework is a work in progress, at this juncture we believe its contribution has been twofold. The first contribution relates to the process of theory development. The emerging framework was developed using a mixed method design and a participatory action research approach that stressed the involvement of diverse stakeholders and built on the considerable past efforts of the many study partners. Combined with a collaborative process of analysis and writing, this approach allowed us to synthesize and generate theory in way that was credible and plausible (Krefting, 1991) and also met Charmaz's (2005) criteria of originality and usefulness (see Westhues et al., 2008, for details on how these criteria were met). This reciprocal collaboration in framework development therefore mirrors a core transformational process (reciprocity) being proposed in the framework itself.

The second, more substantial, contribution relates to content. Our study participants affirmed what our literature review had revealed: the need to develop a conceptual framework that synthesizes notions of culture and power if improvements to mental health policy and practice are to be made. Such a position resonates with recent mental health discourse that, on the one hand, has pointed out the detrimental effects of power abuse in the mental health system and the need for critical voices to keep that power in-check and to remain consumer centred (Everett, 2000). On the other hand are growing calls to take culture seriously and develop competencies toward more effective mental health policy and practice in increasingly cross-cultural settings (Cross, Bazron, Dennis, & Isaacs, 1989). By synthesizing both culture and power, our framework stresses that improving the responsiveness of community mental health services to diversity rests as much in naming and addressing privilege and socioeconomic inequalities as it does in understanding and managing cultural differences (Maitra, 2008).

It is the reciprocal collaboration between the mental health system and cultural-linguistic communities that is the gateway to this desired change. The emerging framework emphasizes that it is through deepened reciprocal relationship building across stakeholders that power differentials can be acknowledged and re-negotiated (building on anti-oppressive models), and that an effective response to cultural diversity can be mutually identified (building on cultural competence models). In other words, it is by bringing together the mental health system with the diverse people that it is to serve that innovation is catalyzed. A strong commitment is needed from public policy to reinforce this collective responsibility to build more accessible and culturally responsive mental health supports (Muntaner, Borrell, & Chung, 2008).

An obvious limitation of the emerging framework is that it has not yet been fully evaluated in practice. Such an evaluation was incorporated into our original study plan (phase 3). Study partners have already developed and begun implementing a common evaluation framework for application across the numerous demonstration projects. It is our expectation such evaluation will deepen our collective understanding of how community mental health services can do a better job of taking culture seriously.

RÉSUMÉ

Les services de santé mentale des pays anglophones de l'Occident se démènent pour répondre à une diversité culturelle et raciale grandissante. Le but général de l'étude de l'Alliance de recherche université-communauté (ARUC) était d'explorer, de développer, de piloter et d'évaluer la meilleure façon de fournir des services de santé mentale communautaires pour les gens provenant de divers milieux culturels. Utilisant une approche de recherche-action participative au sein d'un plan multi-méthodes, l'association d'étude a développé une structure émergente qui rassemble les idéaux des modèles précédents qui s'orientaient vers la culture et le pouvoir. Cette structure émergente comprend 3 composantes principales: des *valeurs* menant à des *actions* concrètes qui à leur tour engendrent les *résultats* désirés. Le pivot de cette structure émergente est le besoin de collaboration réciproque entre les communautés culturelles-linguistiques et le système de santé mentale.

REFERENCES

Al-Krenawi, A., & Graham, J.R. (2003). *Multicultural social work in Canada: Working with diverse ethno-racial communities*. Oxford: Oxford University Press.

Beiser, M. (2003). Why should researchers care about culture? *Canadian Journal of Psychiatry, 48,* 154-160.

Bhui, K., Warfa, N., Edonya, P., McKenzie K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research*, *7*. Retrieved from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1800843

Bowl, R. (2007). The need for change in UK mental health services: South Asian service users' views. *Ethnicity and Health, 12*(1), 1-19.

California Dept. of Mental Health. (2002). *Plan for culturally competent specialty mental health services*. Retrieved from http://www.dmh.cahwnet.gov/DMHDocs?docs/notices02/02-03_Enclosure.pdf

Canadian Mental Health Association National Office. (2002). *Creating a culturally inclusive organization: A resource action guide.* Retrieved from http://www.cmha.ca/english/advocacy/images/diversity_guide.pdf

Charmaz, K. (2005). Grounded theory in the 21st century: Applications for advancing social justice studies. In N.K. Denzin & Y.S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 507-536). Thousand Oaks: Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.

Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). *Towards a culturally competent system of care: A monograph for effective services for minority children who are severely emotionally disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Cuellar, I., & Paniagua, F. (2000). *Handbook of multicultural health.* London, UK: Academic Press.

de Jong, J., & van Ommeren, M. (2005). Mental health services in a multicultural society: Interculturalization and its quality surveillance. *Transcultural Psychiatry, 42*(3), 437-456.

Everett, B. (2000). *A fragile revolution: Consumers and psychiatric survivors confront the power of the mental health system.* Waterloo, ON: Wilfrid Laurier University Press.

Fleras, A., & Elliott, J.L. (2003). *Unequal relations*. Toronto: Prentice Hall.

Gagnon, A.J. (2002). *Responsiveness of the Canadian health care system towards new comers.* Discussion Paper No. 40, Commission on the Future of Health Care in Canada. Retrieved from http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/40_Gagnon_E.pdf

Ingleby, D., & Watters, C. (2005). Mental health and social care for asylum seekers and refugees. In D. Ingleby (Ed.), *Forced migration and mental health: Rethinking the care of refugees and displaced persons* (pp. 191-210). New York: Springer.

Ito, K.L., & Maramba, G.G. (2002). Therapeutic beliefs of Asian American therapists: Views from an ethnic-specific clinic. *Transcultural Psychiatry, 39*(1), 33-73.

Janzen, R., Ochocka, J., & the "Taking Culture Seriously" Partners. (2007). The road toward cultural empowerment: An invitation to inclusion. In D. Zinga (Ed.), *Navigating multiculturalism negotiating change* (pp. 58-70). Newcastle, UK: Cambridge Scholars Press.

James, S., & Prilleltensky, I. (2003). Cultural diversity and mental health: Towards integrative practice. *Clinical Psychology Review, 22,* 1133-1154.

Karasz, A. (2005). Cultural differences in conceptual models of depression. *Social Science and Medicine, 60*, 1625-1625.

Kemmis, S., & McTaggart, R. (2005). Participatory action research: Communicative action in the public sphere. In N.K. Denzin and Y.S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 559-603). Thousand Oaks, CA: Sage Publications.

Kim, B.S.K., Brenner, B.R., Liang, C.T.H., & Asay, P.A. (2003). A qualitative study of adaptation experiences of 1.5-generation Asian Americans. *Cultural Diversity & Ethnic Minority Psychology, 9*, 165-170.

Kirmayer, L., Groleau, D., Busder, J., Blake, C., & Jarvis, E. (2003). Cultural consultation: A model of mental health service for multicultural societies. *Canadian Journal of Psychiatry, 48*(3), 145-153.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy, 45*(3), 214-222.

Maiter, S., Simich, L., Jacobson, N., & Wise, J. (2008). Reciprocity: An ethic for participatory action research with culturally diverse communities. *Action Research, 6*(3), 305-325.

Maitra, B. (2008). Postcolonial psychiatry: The empire strikes back? Or, the untapped promise of multiculturalism. In C. Cohen & S. Timimi (Eds.), *Liberatory psychiatry, philosophy, politics and mental health* (pp.183-204). New York: Cambridge University Press.

McKenzie, K., & Harpham, T. (2006). *Social capital and mental health*. London: Jessica Kingsley Publishers.

Muntaner, C., Borrell, C., & Chung, H. (2008). Class exploitation and psychiatric disorders, from status syndrome to capitalist syndrome. In C. Cohen & S. Timimi (Eds.), *Liberatory psychiatry, philosophy, politics and mental health* (pp. 131-146). New York: Cambridge University Press.

Murphy, D., Ndegwa, D., Kanani, A., Rojas-Jaimes, C., & Webster, A. (2002). Mental health of refugees in inner-London. *Psychiatric Bulletin, 26*, 222-224.

Nadeau, L., & Measham, T. (2005). Immigrants and mental health services: Increasing collaboration with other service providers. *Canadian Child and Adolescent Psychiatry Review, 14*(3), 73-76.

Nelson, G., Ochocka, J., Griffin, K., & Lord, J. (1998). Nothing about me, without me: Participatory action research with self-help/mutual aid organizations for psychiatric consumer/survivors. *American Journal of Community Psychology, 26*, 881-912.

Ochocka, J., & Janzen R. (2007). Blending commitment, passion and structure: Engaging cultural linguistic communities in collaborative research. In A. Williamson & R. DeSouza (Eds.), *Researching with communities* (pp. 323-338). Waitakere City, New Zealand: Wairua Press.

Ochocka, J., Janzen, R., & Nelson, G. (2002). Sharing power and knowledge: Professional and mental health consumer/survivor researchers working together in a participatory action research project. *Psychiatric Rehabilitation Journal, 25*(4), 379-387.

Shadish, W.R., Jr., Cook, T.D., & Leviton, L.C. (1991). *Foundations of program evaluation: Theories of practice*. Newbury, CA: Sage.

Shahsiah, S., & Yee, J.Y. (2006). Striving for best practices and equitable mental health care access for racialized communities in Toronto. Retrieved from www.accessalliance.ca

Simich, L., Maiter, S., Moorlag, E., & Ochocka, J. (2009). Taking culture seriously: Ethnolinguistic community perspectives on mental health. *Psychiatric Rehabilitation Journal, 32*(3), 208-214.

Sokoloff, N.J., & Dupont, I. (2005). Domestic violence theories: Intersections of race, class, sexual orientation, and gender. In N.J. Sokoloff (Ed.), *Domestic violence in the margins: Readings on race, class, gender and culture* (pp. 25-38). New Brunswick, NJ: Rutgers University Press.

Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Thousand Oaks, CA: Sage.

Thagard, P., & Shelley, C. (1997). Abductive reasoning: Logic, visual thinking and coherence. University of Waterloo, Ontario. Retrieved from http://cogsci.uwaterloo.ca/Articles/Pages/%7FAbductive.html

Toronto-Peel Mental Health Implementation Task Force. (2002). *The time has come: Make it happen – An action plan for Toronto and Peel.* Toronto: Ontario Ministry of Health and Long-Term Care.

Wells, K., Miranda, J., Bruce, M.L., Alegria, M., & Wallerstein, N. (2004). Bridging community intervention and mental health services research. *American Journal of Psychiatry, 161*(6), 955-963.

Westhues, A., Ochocka, J., Jacobson, N., Simich, L., Maiter, S., Janzen, R., & Fleras, A. (2008). Developing theory from complexity: Reflections on a collaborative mixed method participatory action research study. *Qualitative Health Research, 18*(5), 701-717.

Williams, C. (2001). Increasing access and building equity into mental health services: An examination of the potential for change. *Canadian Journal of Community Mental Health, 20,* 37-51.