WPA POSITION STATEMENT ON CULTURAL COMPETENCY IN MENTAL HEALTH CARE

Patients who need help with their mental ill-health require services which are able to take their cultural experiences and expectations into account. Similarly healthcare professionals have to be aware of their own cultural values and nuances. This therapeutic interaction is further complicated by micro-identities of the participants in the therapeutic encounters. Micro-identities include religion, gender, and sexual orientation, place of training and actual place where therapeutic interventions are being delivered. Cultural competence is at a minimum good clinical practice where the patient is at the centre of therapeutic interaction and the clinician is able to take into account various socio-cultural factors of the patient and of the clinician themselves.

Defining Culture

Culture is conceptualised as the behaviour patterns and lifestyle shared by a group of people which are unique to that group. It is about shared meanings. These go on to influence individual's world-view and cognitive and social development. These include the totality of knowledge, customs, beliefs, norms, values, and more importantly, shared meanings. Culture can guide one's thinking, emotions, decisions, actions, and ways of life in patterned ways, influencing an individual's worldview and cognitive and social development.

Culture should be seen as life style in contrast with ethnicity which refers to individual group of people self-ascribed, shared ancestry and history. People are not born with culture but into culture. These learned,

shared and transmitted values, beliefs, norms and life ways of a particular group that guide their thinking, decisions, and actions in patterned ways. Culture is common heritage or set of beliefs, norms, and values, shared attributes of one group and has a system of shared meanings. The term 'culture' is applicable to everyone. Cultures are further influenced by people having multiple micro-identities related to gender, sexual orientation, religion etc. it must be recognised that culture is not static but dynamic and changes in response to various factors and individuals influence cultures and in turn are affected by cultures. Cultural identity of the individual and their beliefs and valuesIt is defined as an ability to understand and be aware of cultural factors in the therapeutic interaction between the therapist and the patient. These include awareness of social, cultural, religious factors, attitudes, behaviours, models and explanations. This should be applicable to all patients and all therapeutic interactions. The concept of culture also applies to health professionals who treat them.

Culture affects mental illness in a number of ways: these include pathogenic (causes symptoms); pathoselective (affects groups of people in specific ways); pathoplastic (modifies symptom presentation); pathoelaborating (elaborates symptoms); pathofacilitative (exists across but more common in certain cultures) and pathoreactive (modifies beliefs and their reactions). Cultures affect threshold for seeking help and where help is sought from.

It is important to remember that not all psychiatric conditions per se are affected by cultures, only their presentation. Any temptation to blame cultures for pathology should be avoided. Cultures also have similarities which need recognition. For example, educational status may bring about more similarities than dissimilarities according to cultures.

Consequently, cultural competence is a complex, multifaceted, and essential clinical skill for all health professionals. This includes the professional's ability to recognize the limitations of their own cultural

interpretations, to understand and become aware of cultural factors in the therapeutic interaction between the therapist and the patient, and to be flexible in working with individuals from cultures different from their own, including interpreting and understanding behaviours and intentions of people from other cultures non-judgementally and without bias, as well as modifying, adapting, and collaboratively facilitating culturally appropriate interventions. Cultural competency encompasses concepts articulated by cultural humility, cultural sensitivity, cultural safety, cultural knowledge, cultural insight, cultural empathy, and culturally appropriate behaviours and interventions. Cultural competence should be considered at both the individual/clinical level (micro) as well as at the institutional level (meso) and the systems/societal level (macro).

The clinicians need to understand the concept of culture and how it can influence individual behaviour in the context of their culture, how that behaviour is interpreted and evaluated and must also demonstrate an openness/willingness to identify and explore their own cultural values, beliefs and attitudes. They should be able to understand emotions and thoughts generated by intercultural interactions and demonstrate an openness/willingness to explore the same things from the perspective of people from diverse cultures. The clinicians who are culturally competent should also be able to demonstrate the ability to identify useful and culturally appropriate strategies for working with people from diverse cultural backgrounds. Cultural competence is the ability to establish a relationship and interaction between the therapist and the patient focusing on cultural similarities and differences. The clinicians should also be able to manage ethnic/race/culturally related transference and countertransference.

A culturally competent healthcare system or institution needs equitable policies and procedures; programs and practice support; as well as commitment and resources, so that clinicians can develop, plan, and deliver

services which are accessible and meet the needs of the patients, their families, and their carers, taking into account socio-cultural and language differences.

During clinical assessment, the clinician should aim to understand the presentation and symptoms in their socio-cultural context. This includes examining their relationship with the environment and various perpetuating and protective factors. Sometimes, distress may arise from cultural perceptions and explanations of the patients and their families regarding mental health symptoms. Patients may bring with them possible explanations of causation, which will vary across cultures and may not conform to biomedical explanations. They may identify external factors causing their distress and the locus of control may be therefore perceived as internal or external. The latter may include beliefs in supernatural, natural, or social whereas the former may include medical, genetic, or psychological causation. Distress caused by wider systemic issues, including oppression, racism, discrimination, and other systemic inequities, may be overlooked by clinicians who are overly focused on internal factors. Ultimately, clinicians need to work towards a shared integrated understanding of the problems and a shared plan for addressing them, while attending to the power differences inherent in the therapeutic relationship. The clinicians who are culturally competent should be able to demonstrate the ability to identify useful and culturally appropriate strategies and interventions for working collaboratively with people from diverse cultural backgrounds.

At the micro level, clinicians need to understand basic concepts about culture, how it can influence individual behaviour in various socio-cultural contexts, and how behaviour is culturally interpreted and evaluated. The clinicians must demonstrate an openness and willingness to identify and

explore their own cultural values, beliefs, attitudes, and assumptions. This includes acknowledging and suspending preconceptions, biases, and stereotypes, as patients may well differ from other members of their cultural groups. They must produce a shared understanding of the problems and a shared plan for addressing the problems. Patients will bring with them the possible explanations of causation which will vary across cultures. They may see external factors causing their distress and the locus of control may be therefore internal or external. The latter may include beliefs in supernatural, natural or social whereas the former may include biological or medical, genetic or psychological causation. Verbal and non-verbal communications should be taken into account in the therapeutic interactions as these will vary across cultures. The clinician must suspend preconceptions as patients may well differ from other members of their cultural group.

Psychotherapies: Most Western psychotherapies are ego based and may not work very well across all cultures. Other therapies such as behavioural and cognitive behaviour therapies are easily adaptable across cultures. It may be possible to use and adapt indigenous therapies according to the need of patients. The therapist must therefore, check reality for the group, differences in cultures and cultural expectations. In addition to cultural factors, social class, economic status, age and previous experiences will also affect help-seeking and subsequent therapeutic engagement. Clinicians need to be aware of their own prejudices, likes, dislikes, beliefs and stereotypes. They should take into account their own cultural identity and ability to be neutral and open-minded; ability to learn about other cultures and have an awareness that there are differences. Some therapists may tend to idealise one or other cultures but it is important that they are aware of strengths and weaknesses of own/other cultures.

Pharmacotherapy: When commencing medication the clinicians must be aware of pharmacokinetics of drugs i.e. how biological organism affects the

fate and distribution of drugs-absorption, its distribution; metabolism and excretion as well as pharmacodynamics i.e. how drug affects a person. Demographic factors such as age, gender and ethnicity along with pharmacogenetic factors will influence responses to medication. Pharmacokinetic factors are also likely to be influenced by various factors such as religious and dietary taboos, special foods and environmental factors such as smoking, complementary and alternative medicines. Many cultural groups prefer medication in injections, others prefer syrups or capsules. Colour of the tablets and its size also affects compliance. These must be explored in the assessment. Low adherence to medication in many groups is affected by a number of these factors. Among many groups, higher blood levels of anti-psychotics may be seen creating higher levels of side effects and poor adherence. Differences in diet, nutrition, body mass and use of legal and illegal substances may also play a role. Prior to commencing pharmacotherapy the clinicians must check the diet, religious taboos, smoking, alcohol and drug use along with the use of complementary and alternative medicines and attitudes as well as expectations of the medication. It is essential to start the medication at lower dose and the clinician must have a low threshold for identifying side effects. Once medication has been started, compliance must be ascertained with close monitoring of side effects.

WPA through its member societies urges that all clinicians are:

1. Trained in cultural competency and are aware of diversity of the populations they serve. They must have a training in developing cultural formulation. Medical/psychiatric curricula at all levels - undergraduate, post-graduate and continuing education – need to include cultural competence training. This should include training in: conducting culturally competent assessments; developing cultural formulation; and

providing cultural competent treatment including pharmacotherapy and psychotherapy.

2. Have diverse staff reflecting the populations they serve. Clinicians need to collaboratively provide culturally competent assessments, and develop care plans that are culturally sensitive and appropriate.
3. If needed have culture-brokers or cultural mediators who link between communities and psychiatric teams.
4. Provide access to services through information leaflets, through social media in appropriate languages.
5. Have easy access to interpreters when needed and are trained in the use of interpreters.
6. Develop care plans which are culturally sensitive and appropriate.
7. Have regular evaluation of services focusing on the patient and illness outcomes.
8. Curricula at all levels-undergraduate, post-graduate and continuing education reflect the needs for cultural competence and training.
9. Clear information about medication, therapies and resources should be available.
10. Specialist or generalist services need to be developed according to the local needs of populations and available resources.
11. Cultural training for ALL health professionals is a must.

All researchers must

1. Take into account cultural diversity of the populations being studied. Considerations of diversity and cultural identities need to be explicitly addressed as part of the research protocols.
2. All research should take into account cultural diversity of the populations being studied.

For Policy Makers:

1. There should be clear policies taking into account housing, employment and physical and mental health needs of population psychiatric healthcare systems serve. Therefore appropriate resources must be made available to meet the service and training needs.

2. Adequate resources are also needed to ensure that accurate data and outcomes are collected.

3. Some cultural groups are more susceptible to mental illness, which may be related to their minority or marginalised status hence public mental health and public education about cultural groups and their needs and obligations must be part of the policies to ensure equity and eliminate social and health disparities.

4. Public mental health and education should be culturally appropriate.

For service providers

1. Services should be linguistically, culturally, geographically and emotionally accessible. All staff should be trained in the use of interpreters and should have easy access to interpreters when needed.
2. Cultural-brokers or cultural mediators should also be made available to facilitate communication, understanding, and collaboration between communities and psychiatric teams.
3. Programs and institutions should provide equitable access to cultural competent services. Information about such services should be provided

through information leaflets, websites, or social media in multiple languages.

4. Programs and institutions should have regular evaluation of services focusing on patient and illness outcomes, especially for underserved, minority, or diverse populations.
5. Separate or mainstream services for vulnerable groups should be decided according to local need.
6. Cultural competence and diversity training should be an integral part of induction processes as well as ongoing training.
7. Local needs to be determined regularly.
8. Regular cycles of audit of services and outcomes should be set up and changes made in services accordingly.
9. There may be requirements to develop cultural mediation, culture broker or other models.

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