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Editorial

Rethinking cultural competence

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In recent years, cultural competence has become a popular term for a variety of strategies to address the challenge of cultural diversity in mental health services. This issue of *Transcultural Psychiatry* presents papers from the McGill Advanced Study Institute in Cultural Psychiatry on "Rethinking Cultural Competence from International Perspectives," which was held in Montreal, April 27 and 28, 2010. Selected papers from the meeting have been supplemented with other contributions to the journal that fit the theme. Taken together, these papers show how conceptual analysis and critique of cultural competence can point toward ways to improve the cultural responsiveness, appropriateness and effectiveness of clinical services, and in doing so contribute to reducing health disparities.

Cultural diversity poses challenges to mental health services for many reasons. Culture influences the experience, expression, course and outcome of mental health problems, help-seeking and the response to health promotion, prevention or treatment interventions. The clinical encounter is shaped by differences between patient and clinician in social position and power, which are associated with differences in cultural knowledge and identity, language, religion and other aspects of cultural identity. Specific ethnocultural or racialized groups may suffer health disparities and social disadvantage as a result of the meanings and material consequences of their socially constructed identities. In some instances, cultural processes may create or constitute unique social and psychological problems or predicaments that deserve clinical attention. In culturally diverse societies, the dominant culture, which is expressed through social institutions, including the health care system, regulates what sorts of problems are recognized and what kinds of social or cultural differences are viewed as worthy of attention.

A large literature shows the importance of social determinants of health including social status, employment, education, wealth and social support

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(Wilkinson & Pickett, 2009). These social factors cannot be understood without taking culture into account (Corin, 1994; Gone & Kirmayer, 2010). For example, the meaning of poverty is different in a culture or community where social status and esteem are not centred on monetary or material wealth. Similarly, the meanings of unemployment are entirely different in a community where a valued social role and contribution to the community is unrelated to wage earning. Social inequality itself is a major determinant of health and is configured in ways that reflect local histories that are normalized, justified or rendered invisible through cultural frameworks of identity and commonsense.

The social determinants of health are based on universal processes but they take unique form in each society based on its cultural history, politics and economy. Similarly, the ways that human problems are understood and the particular forms of help that are available reflect the cultural knowledge and practices of specific systems of medicine and healing. These are embedded in larger social contexts that define health and well-being as well as restitution and recovery. Hence, the goals and pathways of healing, rather than being entirely dictated by scientific explanations of psychopathology, depend on cultural worldviews, values and concepts of personhood through which people articulate their own life projects, goals and aspirations (Gone & Kirmayer, 2010).

There is wide recognition that health services and mental health promotion must consider culture to be ethically sound and clinically effective (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Brach & Fraserirector, 2000). In the US and other countries, this has been approached in terms of the need for "cultural competence" among health professionals, organizations and institutions (Allen, 2008; Betancourt, Green, Carillo, & Ananeh-Firempong, 2003). Models of cultural competence developed in the US have been widely promoted through textbooks and training materials as strategies to improve the skills of clinicians, health care services and systems to address ethnocultural diversity (Qureshi, Collazos, Ramos, & Casas, 2008).

Despite this attention to culture, models of mental health services, guidelines for clinical practice, and therapeutic interventions tend to be presented in a decontextualized way that ignores the fact that the basic concepts used to frame human problems and solutions have emerged from a particular cultural history or tradition and continue to bear the traces of that history. Moreover, the models and metaphors of psychiatry also reflect specific cultural concepts of personhood as well as current social and political contexts. Ironically, this extends to efforts to address culture itself in health services. For example, the definitions of culture at play in the US reflect a particular history and politics of identity and therefore do not map neatly onto the distinctions among groups made in other countries. Cultural competence, therefore, needs to be critically assessed and re-thought to identify alternative models and metaphors that may better fit the needs of patients and providers working in specific health care settings across nations, regions and communities.

Cultural competence

Cultural competence aims to make health care services more accessible, acceptable and effective for people from diverse ethnocultural communities. Cultural competence has been defined variously as:

- "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. iv).
- "the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt et al., 2003, p. v).

Cultural competence can be addressed at the levels of the organization of health systems and institutions, the training and composition of the health workforce, and the specific models of care or types of intervention (Table 1). There is evidence that attention to cultural competence at each of these levels can reduce health disparities (Betancourt, Green, Carillo, & Park, 2005; Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Brach & Fraserirector, 2000; Smedley, Stith, Nelson, et al., 2003).

At the level of health care systems and institutions, several broad domains of cultural competence have been described by the U.S. Department of Health and Human Services (1997, p. 17): (i) organizational values; (ii) governance; (iii) planning and monitoring/evaluation; (iv) communication; (v) staff development; (vi) organizational infrastructure; and (vii) services and interventions. A variety of measures for these and related domains have been developed (Gozu et al., 2007; Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009; Siegel et al., 2000).

In some cases, it is assumed that cultural competence can be achieved by a type of ethnocultural matching. As Weinfeld (1991) has pointed out, ethnic matching can occur at different levels, including: the governance of organizations and institutions; the identities of practitioners themselves; and the type of clinical service or intervention. The research literature suggests that these different levels of matching can have quite different consequences for different groups or individuals depending on the way that culture figures in their specific health problems. At the level of the institution or service this might mean providing mental health services in community settings to reduce the stigma attached to psychiatric institutions. At the level of the practitioner, cultural competence might be achieved through ethnic matching of health care provider and patient. In terms of technique, clinicians may modify their mode of interaction with patients, develop culturally adapted interventions, or offer patients interventions drawn from their own cultural traditions. Each of these approaches has potential benefits and drawbacks (see Table 1). Moreover, the implications of matching at each of these levels may differ markedly for different ethnocultural groups, communities and individuals (Flaskerud, 1986; Flaskerud & Hu, 1994; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). For example, for a patient

Table 1. Levels of cultural competence

	Institution	Practitioner	Technique
Strategy	Organizational cultural competence	Clinical cultural competence	Cultural adaptation of interventions
Examples	Institutional policies of equity, anti-racism, cultural diversity awareness Insuring that administration and staff are representative of ethnocultural composition of communities served Engaging communities in policy making, planning, and regulation of services	Ethnic matching of clinician and patient Training of professionals in specific and generic cultural knowledge, skills and attitudes Referral to other professionals and helpers in the community Use of culture-brokers or mediators	Adjusting style of interaction and communication to patient Matching intervention to patient Cultural adaptation of interventions Adoption of new interventions Referral to other sources of help or healing
Benefits	Can organize systems and services in ways that are responsive to needs of specific groups Can address issues of power and discrimination, empowering community and resulting in greater equity, safety and trust in institution Can improve access and acceptability through community relationship to the institution and through design of specific programs	Can facilitate initial trust Linguistic match facilitates communication Shared cultural background knowledge facilitates mutual understanding Can provide role modeling of successful or resilient individuals from similar background	Can tailor intervention to take into account specific psychological or social issues and processes May improve acceptability of intervention Can mobilize personal and community cultural resources for resilience and recovery Can identify culture-specific goals and outcomes that require alternative therapeutic approaches

(continued)

Table 1. Continued

	Institution	Practitioner	Technique
Limitations	If focus is primarily on representativeness of governance and staff, actual delivery of services may be conventional Institutional policies may not result in actual changes in behaviours of staff Ethnospecific services may constitute a form of social segregation and fail to transform the general health care system	Match may be crude or approximate (owing to differences in ethnicity, subculture, social class, education, dialect, etc.) Clinician may not know how to apply their own tacit cultural knowledge to clinical care Clinicians may be feel typecast, professionally limited or marginalized Patients may feel singled out, racially categorized, stereotyped Patients may feel exposed to scrutiny by their own community and may wish for the psychological distance or privacy associated with meeting a cultural 'outsider'	Adaptation may be superficial or purely cosmetic May lose elements essential for efficacy Culturally-grounded methods may not address issues related to cultural hybridity or culture change Culture-specific or traditional methods may be socially conservative and do not allow patients opportunity to escape from culturally mediated or rationalized forms of oppression Interventions may not be familiar or appealing to patients who eschew tradition and value other ("modern", scientific) approaches

who speaks only a foreign language, matching at the level of the person by finding a clinician (or an interpreter or culture broker) who shares that language may be crucial; for someone from a racialized group that faces systematic discrimination, matching at the level of the person may convey a sense of safety or the likelihood that one's social predicament will be understood – but it may also raise the concern that one is being singled out in a way that reflects racial prejudice; for a person from a marginalized community, responsiveness at the level of the institution may represent an important step toward engagement and empowerment.

Cultural competence is increasingly recognized as an essential skill set for all mental health professionals, especially those working in multicultural milieus or with ethnocultural minorities (Sue, Zane, Nagayama Hall, & Berger, 2009). Training materials and approaches have been developed to enhance the cultural competence of physicians, mental health practitioners and staff, and there are resources available in print and on the Internet to address these issues (Betancourt, 2006; Ring, Nyquist, & Mitchell, 2008; Tseng & Streltzer, 2004; Warren, 2000).[1] In Canada, for example, specific curriculum and materials have been developed by the Indigenous Physicians Association of Canada and the Royal College of Physicians of Canada (2009) to train psychiatric residents in culturally competent indigenous mental health, and the Transcultural Section of the Canada Psychiatric Association has developed guidelines for training in cultural psychiatry more broadly (Kirmayer et al., 2012). However, there is substantial variation in programs and evaluation of the impact of cultural competence training remains limited (Beach et al., 2005; Crosson, Deng, Brazeau, Boyd, & Soto-Greene, 2004; Green et al., 2007; Lim, Luo, Suo, & Hales, 2008; Price et al., 2005).

Unpacking cultural competence

Cultural competence emerged as a framework for addressing diversity and inequality in the US in the 1980s, and the social history of the US is crucial for understanding how the notions of culture and competence have been configured. "Culture" in the US has been framed largely in terms of five major ethnoracial blocs (Hollinger, 1995): African American, Asian American and Pacific Islanders, Latino, American Indian and Alaska Native, and White. The definitions of these blocs conflate language, geographic origin, ethnicity and race. They were created by the U.S. Census and have persisted because they serve the political function of identifying people with similar social predicaments who have made common cause to address some of the major inequities of U.S. society. At the same time, when the census has allowed multiple choices, it is clear these categories do not capture the diversity of the society and the rapidly growing numbers of people who define themselves in hybrid ways that cut across these categories or escape them entirely. These categories also do not capture the identities of new immigrants, who may be forced to fit themselves into this framework in their interactions with health services. For example, recent African immigrants do not easily fit into the category of "African American," which is part of the legacy of slavery. Even people from the

Caribbean, who share similar histories of colonial violence and slavery, come from quite different societies with corresponding differences in their culture and identity.

In actual practice, cultural competence in the US has been largely approached through sensitization of clinicians to the social predicaments of these ethnoracial blocs or through efforts at ethnic matching of patient and practitioner (Good, Willen, Hannah, Vickery, & Park, 2011). The cultural competence literature tends to treat culture as a matter of group membership (whether self-assigned or ascribed). This assumes that members of a group share certain cultural ''traits,'' values, beliefs and attitudes that strongly influence or determine clinically relevant behaviour. Unfortunately, this approach tends to reify and essentialize cultures as consisting of more or less fixed sets of characteristics that can be described independently of any individual's life history or social context – hence the plethora of textbooks with chapters on specific ethnocultural groups. This is an old-fashioned view, now largely abandoned by anthropology.

Contemporary anthropology emphasizes that culture is not a fixed, homogeneous, intrinsic characteristic of individuals or groups (Guarnaccia & Rodriguez, 1996). Instead, culture involves a flexible, ongoing process of transmitting and using knowledge that depends on dynamics both within communities and at the interface between ethnocultural communities and institutions of the larger society, like the health care system, as well as global networks (Modood, 2007; Phillips, 2007). As a result, cultures are often hybrid, mixed, and undergoing constant flux and change (Burke, 2009; Kraidy, 2005). Nevertheless, because culture provides the concepts through which individuals and communities interpret the world and construct their hierarchies of goals and values, cultural processes remain central to the ethics and pragmatics of health promotion and health delivery.

An approach to cultural competence based on this more contemporary view of culture must consider how to meld recognition of, and respect for, the identity of individuals and communities with attention to the dynamic, contested, and often highly politicized nature of individuals' interactions with collectivities, both local and global. The cultural identity of an individual must be understood in terms of ongoing interactions within multiple networks or communities; similarly, the culture of an ethnic community can only be understood in terms of its interaction with the larger society. Each struggles to define, position, constrain and exploit the other. This view of culture foregrounds issues of power and the politics of identity and otherness (Modood, 2007). Recognition of cultural diversity coupled with analysis of the structural sources of inequality offers us the best way to understand and redress the inequities and injustices that are ignored, or even aggravated, by culturally-blind health care (Fraser & Honneth, 2003).

Competence and epistemic communities

''Competence'' is the latest iteration of the emphasis on technical expertise in a scientifically-based medicine that was central to the professionalization of biomedicine and the reform of medical training following Flexner in the 1920s (Carraccio, Wolfsthal, Englander, Ferentz, & Martin, 2002). Science remains the touchstone of

technically competent practice in current efforts to develop evidenced-based practice in the health professions (Whitley, Rousseau, Carpenter-Song, & Kirmayer, 2011). This has close parallels in the development of clinical psychology, with the notion of the scientist–practitioner. Far from criticizing this central role for science, we should recognize it as an essential though unfinished project, but distinguish the unique value of scientific research and reasoning from ''scientism'' — the invocation of science as an article of faith or rhetorical flourish to foreclose critical analysis and debate.

Certainly, clinical and professional competence are highly desirable qualities. Indeed, some version of competence (the ability to do things well, to achieve desired goals, and to act appropriately for the context) is widely desired and respected across very different traditions, professions and domains. Judgements of competence may not only reflect evidence on outcomes (which, of course, are hard for individuals to judge and prone to bias), but on the ability to act in ways that are viewed as (culturally) appropriate for the case in context. Emphasis on this attention to protocol, appropriateness and other forms of cultural authority is sometimes viewed as an alternative to the epistemology of science. Thus, traditional healing is said to work because ''it has stood the test of time,'' it fits with deeply held ontologies that explain illness and healing, it is authorized by social institutions that are among the pillars of collective identity, or simply because it is sacred and ineffable and, hence, beyond any critique.

Whatever the merits of arguments that traditional medicine lies outside the epistemological frame of biomedicine, practitioners must still meet some shared criteria of safety and competence. There are inept practitioners and ineffective or inappropriate practices in every health care system or healing practice. Appeals to tradition do not vouchsafe the clinical efficacy or ethical integrity of any health practice or practitioner. Traditionally, healers were members of local communities so that their ethical conduct and effectiveness could be monitored by others close at hand. However, the modes of regulating practice that worked in small-scale societies will not suffice in the global agora, where every form of knowledge and medicine is commodified, and superficial appeals to cultural tradition are used to market treatments. Pluralistic health care systems raise complex ethical and pragmatic issues and simply decrying the hegemony of biomedicine does not take us very far toward resolving the problems created by a naïve embrace of anything labelled ''non-Western'' or ''traditional'' as being inherently good and beyond critical appraisal.

Despite this caution, it is important to recognize that the institutionalization of competence within the mental health professions also serves political and economic processes of boundary marking, domination and legitimation. Professionals who are competent arrogate the right to designate others as less competent (or frankly incompetent) and to regulate and control the delivery of health services. The ingredients of competence, in terms of knowledge, skills and attitudes, may be quite distinct from the mechanisms by which competence is certified and maintained – and both the content and the process of defining competence in different medical

systems deserve critical analysis. We need to diversify our notion of competence itself, not to encourage the indiscriminate embrace of any treatment that is labelled traditional but to broaden our notions of efficacy and outcome to assess practitioners and treatments in diverse systems of healing and intervention.

Alternatives to cultural competence

While it is essential that professionals be technically competent and, in the case of clinicians, this competence includes interpersonal skills, ethical commitments, and the ability to effectively refine and use one's empathic capacity, an emphasis on professional competence in the domain of culture risks reifying appropriating rather than respecting and engaging the other's lifeworld. For this reason, some have advocated alternative concepts through metaphors such as "cultural responsiveness" (Sue et al., 1991), "cultural humility" (Tervalon & Murray-Garcia, 1998), or "cultural safety" (Papps & Ramsden, 1996).

The notion of cultural safety was developed in the 1980s in New Zealand in response to Maori discontent with medical care (Papps & Ramsden, 1996; Koptie, 2009). In contrast to the emphasis in cultural competence on practitioners' skills, cultural safety "moves beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health care" (National Aboriginal Health Organization, 2008, p. 3). In Canada, cultural safety has been recognized by the National Aboriginal Health Organization (NAHO), other Aboriginal organizations and the Mental Health Commission of Canada, as a preferred approach to guide efforts to improve the cultural responsiveness and appropriateness of health care. Nursing educators and practitioners have led the development of the concept of cultural safety in New Zealand and in Canada (Aboriginal Nurses Association of Canada, 2009; Smye, Josewski, & Kendall, 2010; Stout & Downey, 2006).

> Cultural safety is a powerful means of conveying the idea that cultural factors critically influence the relationship between carer and patient. Cultural safety focuses on the potential differences between health providers and patients that have an impact on care and aims to minimize any assault on the patient's cultural identity. Specifically, the objectives of cultural safety in nursing and midwifery training are to educate students to examine their own realities and attitudes they bring to clinical care, to educate them to be open-minded towards people who are different from themselves, to educate them not to blame the victims of historical and social processes for their current plight, and to produce a workforce of well-educated and self-aware health professionals who are culturally safe to practice as defined by the people they serve. (Crampton, Dowell, Parkin, & Thompson, 2003, p. 596)

Cultural safety in indigenous contexts means that professionals and institutions, whether indigenous or not, work to create a safe space for an encounter with

patients that is sensitive and responsive to their social, political, linguistic, economic, and spiritual realities. Culturally unsafe practices involve "any actions that diminish, demean or disempower the cultural identity and well-being of an individual" (Nursing Council of New Zealand, 2002, p. 7, cited in Polaschek, 1998).

In Canada, the National Aboriginal Health Organization (NAHO, 2008; Brascoupé & Waters, 2009) has advocated principles of cultural safety that are grounded in recognizing the historical context of Aboriginal experience. This includes recognizing the diversity of populations, understanding power issues in health care worker–patient relationships, and raising awareness of cultural, social and historical issues in organizations and institutions. In the training of health care providers and professionals, cultural safety involves attention to issues of communication, power sharing and decision making, working toward understanding and addressing misunderstandings, and recognizing and respecting fundamental cultural beliefs.

Although there is overlap between concepts of cultural safety and cultural competence, the metaphors have different connotations and the constructs emphasize distinct approaches to social and cultural dimensions of care. Cultural safety does not emphasize developing "competence" through knowledge about the cultures with which professionals are working. Instead, cultural safety emphasizes recognizing the social, historical, political and economic circumstances that create power differences and inequalities in health and the clinical encounter (Anderson, Perry, et al., 2003; Anderson, Scrimshaw, et al., 2003). Cultural safety has some overlap with concepts such as "cultural sensitivity," cultural responsiveness and "cultural humility" – that is, with a willingness and ability to listen and learn from patients. Openness, respect and attentiveness are pre-requisites for cultural safety but, by themselves, are not sufficient. "Sensitivity can be thought of as the first step towards learning about oneself within the context of one's interaction or relationship with people of a different culture" (NAHO, 2008a, p. 27). The self-reflexivity of practitioners and systems opens the door to reorganizing the delivery of services and the conduct of clinical work in ways that share power and control over health care but the details of how this is achieved must be worked out for specific contexts.

The concept of cultural safety has also received some criticism, both for its ambiguities and its narrow readings of the social determinants of health and the politics of the clinical encounter. Johnstone and Kanitsaki (2007) provide a critique from an Australian perspective. They note that cultural safety developed in the bicultural political context of New Zealand and it is not clear how well the construct applies to the multicultural context of Australia. There has been relatively little research on cultural safety and, in particular, the links between cultural safety and positive outcomes (in training or practice) have not been clearly demonstrated. As metaphor or model, cultural safety is not a transparent concept but, like cultural competence, requires unpacking and further specification in terms of its implications for training, health systems and clinical practice. Discussions of cultural safety tend to frame the clinical encounter as a situation

fraught with risk and vulnerability, and locate all the power and potential for aggression and harm on the side of the clinician. As a result, cultural safety tends to approach culture in terms of vulnerabilities rather than strengths. By implying that the cultural "other" is vulnerable, cultural safety may also contribute to essentializing and stereotyping ethnocultural groups.

To explore the significance of some of these criticisms, Johnstone and Kanitsaki (2007) conducted a focus group and key informant study of how practitioners, patients, consumers and ethnic minority organizations in Australia understand cultural safety. Providers interpreted cultural safety as not imposing their own cultural values on patients in areas that were of vital importance, or as exhibiting "racial respect" and explicitly anti-racist perspectives. The key threats to cultural safety identified by patients included: inability to communicate with service providers; poor attitudes by staff resulting in not being treated with respect (for example, patients being treated as if they were stupid, subjected to stereotypes and prejudice); not being able to have their families present; not being listened to; not being given clear explanations; being forced to comply with unfamiliar forms of care or treatment; being powerless or unable to take action to help themselves or their loved ones; overall inflexibility of the system; feeling isolated because no one around them shared their culture or language); not having access to appropriate interpreter services. It is these sorts of violations of clinical trust and power imbalances that attention to cultural safety is meant to remedy. A wide range of strategies have been proposed to counteract these barriers to work toward an open, collaborative and safe space in clinical services and systems (Brascoupé & Waters, 2009). The framework of cultural safety can be used to critique health policy and practice (Josewksi, 2011).

Many other metaphors may be helpful in rethinking how best to address cultural difference and diversity in health care. The language chosen serves particular rhetorical purposes in social contexts, but also directs thinking along particular lines. In our own work, the emphasis has been on the cultural critique of psychiatry. Appreciating the cultural underpinnings of psychiatric science and clinical practice opens a space to consider alternative perspectives and negotiate common ground. One key notion has been the view of culture that comes from contemporary social studies of science that focuses on the networks that individual actors use to make sense of their experience, and which begins with a cultural analysis of the production of scientific knowledge in psychiatry (Gone & Kirmayer 2010). A second key concern has been with what might be called the politics of alterity: the social conditions that frame people or groups as other; and the moral stance that allows us to recognize, respect and value diversity as a positive resource for individuals and society – without shying away from the ways in which culture and difference are used to stereotype and oppress people or divert attention from various forms of structural violence (Kirmayer, 2011; Shaw, 2005). The politics of identity and alterity have reflections in the microdynamics of the clinical encounter where they provide the backdrop to efforts to achieve mutual recognition, dialogue and collaboration (Kirmayer, 2008).

Conclusion

Cultural competence has emerged as an important counter-balance to the movement for evidence-based mental health care, which tends to lead to a ''one-size-fits-all'' approach (Whitley, 2007). Efforts within heath care systems to develop cultural competence or other modes of responding to diversity represent potential sites of resistance to the homogenizing forces of assimilation and marginalization of minority groups. However, current approaches to cultural competence have been criticized for essentializing, commodifying and appropriating culture, leading to stereotyping and further disempowerment of patients (Fuller, 2002; Kleinman & Benson, 2006; Taylor, 2003). Various alternative approaches to addressing cultural diversity have been proposed, including the constructs of cultural safety (Papps & Ramsden, 1996) and cultural humility (Tervalon & Murray-Garcia, 1998). These approaches focus on issues of power and aim to move both health care institutions and the clinical encounter toward greater dialogue and accountability.

Each of these metaphors draws attention to certain dimensions of intercultural work while downplaying or obscuring others. Each perspective is rooted in particular constructions of cultural identity and difference that have social origins. Approaches to cultural competence have been dominated by work in the US, which configures cultural difference in specific ways that reflect its history, demography, and politics. In New Zealand, *cultural safety* has been promoted as a term that draws attention to issues of power and vulnerability resulting from the history of colonization. Work in other countries has favoured other models and metaphors to address diversity. No one construct is likely to be sufficient to cover the range of issues that need to be addressed to transform mental health systems to address the high levels of diversity found in cities around the world. And each metaphor or construct must be elaborated in ways that take into account the local histories and politics that give rise to health disparities and that mark off some groups as different while assimilating or simply ignoring others.

While there are good reasons to transform institutions, service systems, programs and interventions to make them culturally safe, responsive, competent and appropriate, the evidence that this actually results in improved effectiveness remains limited. In fact, in some instances, cultural adaptation may reduce the benefits of a program if essential elements are eliminated. For this reason, there is a great need for research on the processes of implementation, clinical effectiveness, wider social impact and outcomes of culturally competent services and interventions. The comparative study of models of mental health care in different societies provides a unique opportunity for critical reflection and creative rethinking of current practices.

Note

1. Web-based resources include the National Centre for Cultural Competence (http://nccc.georgetown.edu/), the Victorian Transcultural Psychiatry Unit (www.vtpu.org.au/), Diversity Rx (www.diversityrxconference.org), and the Multicultural Mental Health Resource Centre (www.mmhrc.ca). The Canadian Psychiatric Association has recently

published guidelines for training in cultural psychiatry that include attention to cultural competence and safety.

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