Measuring Cultural Competence in Mental Healthcare: 
An Organisational Needs Analysis

Abstract

Background: Cultural competence is based on the premise that culturally appropriate care aids the recovery process for ethnic groups; the training of mental health practitioners has become pivotal to the development of cultural competence in organisations. This article presents an analysis of cultural competence in the East London NHS Foundation Trust (ELFT).

Methods: A mixed methods multilevel design study, comprising a staff survey with semi-structured interviews and questionnaires. The sample included strategic managers and clinical staff.

Results: Clinical staff are engaged in culturally competent activities and that there is a growing awareness of cultural competence amongst staff in general, with many having attended training. Strategic plans and procedures that promote cultural competence tend not to be well communicated to frontline staff; whilst there is little understanding at corporate level of culturally competent practices implemented by clinical staff. The Trust had commenced a targeted recruitment campaign with the explicit aim of recruiting staff from underrepresented groups, and had taken significant steps in developing collaborative working patterns with service users.

Conclusion: There is evidence to show that the Trust has taken tentative steps towards building cultural capability in the organisation. However, further work is needed to embed cultural competence principles and practices at every level of the organisation, and to put in place monitoring systems that enable the Trust to benchmark its performance and measure its cultural capability.

Background

Since passage of the Race Relations (Amendment) Act (2000), public authorities have been placed under a statutory duty to promote race equality. Legislation outlaws any discrimination (direct and indirect); and promotes equality of opportunity and good relations between people of different racial groups. Disparities in mental health care and ethnic inequalities in service experience and outcome are well documented; with much research being undertaken into race differences and ethnic or cultural predispositions to mental illness. The case for promoting race equality in mental health services was strengthened when David 'Rocky' Bennett died while being restrained in a psychiatric ward in 1998; this tragic incident raised important questions about race equality in the NHS. Seven years later, the government published Delivering Race Equality (DRE) in Mental Health Care (2005), in response to the Bennett inquiry; which
contained an action plan for reducing inequalities in black and minority ethnic (BME) patients' access to, experience of, and outcomes from mental health services.

Staff training is strongly advocated in the DRE and Race Relations (Amendment) Act (2000) and has become the mainstay in building cultural capability in public authorities. Mental health services have been slow to implement the action plan; the lack of progress being the source of much controversy and national debate between leading experts in cultural competence and government agencies. The commitment of the government and the NHS to the race equality agenda was called into question.

Service user surveys and research have shown that Black and Minority Ethnic (BME) groups fear and mistrust mental health services, and that BME groups feel alienated and generally misunderstood. BME service users are less likely to attend their GP and more likely to be placed on compulsory treatment orders. Another area of disparity has manifested itself through pathways into mental health care; with black service users more likely to be admitted via the criminal justice system. Misdiagnosis, and in particular over diagnosis of schizophrenia among Black service users has also been well documented. These disparities demand an explanation.

The relationship between ethnicity and mental health has been the focus of much debate and dispute in the UK for many years, and a wealth of research has been undertaken in this area. A large number of studies have focused on ethnic differences in relation to diagnosis, inpatient admission, pathways into care and compulsory detention. (e.g., Mohan et al. 2006; Bhui et al. 2003; Leese et al. 2006; Fearon et al. 2006). Another group of studies examines racial discrimination and mental ill health (e.g., Bhui et al. 2005; Karlsen et al. 2005; Bhugra & Aynrinde, 2001). A smaller set of studies has focused on acculturation and mental ill health. (e.g., Bhui et al. 2005; Berry, 1988, 1997).

Only a relative handful of studies address organisational assessment of cultural competence or performance management (e.g., Siegel et al. 2003; Stork et al. 2001). Studies reflecting service user based assessment of benefit remain uncharted territory. The scarcity of information on the organisational infrastructure (e.g. Trust Board diversity, community & organisational assessment, and the collection of race and ethnicity data) is regrettable, since there is evidence to support the notion that there is a relationship between the cultural competence of health practitioners and the organisations where they work. Health practitioners that are culturally motivated and rank cultural competence highly in their repertoire are more likely to work in culturally competent organisations (Paez et al. 2007). It would seem that this sort of evidence could be useful to directors and strategic leaders in organisations when designing workforce strategy.

The concept of cultural competence

Cultural competence begins with understanding the strengths and weaknesses of the healthcare organisation and the unique needs of the population being served. Cross et al. (1989) defined cultural competency as "a set of congruent behaviours, attitudes, and policies that come
The concept of cultural competence has evolved as multicultural societies have grown and mental health services are required to respond to a range of cultural needs from the communities that they serve. Cultural competence is based on the premise that culturally appropriate care aids the recovery process; therefore, the training of mental health practitioners has become central to the development of cultural competence in organisations. Cultural competence is developed over time through training, experience, guidance and self evaluation. Attitudes, policy and practice must come together in a congruent whole called cultural competence. Attitudes may be cultivated through training and experience. Policy evolves through research, and practice grows with information, training and the development of new alternatives.

In the UK cultural competence has developed within the diversity framework and was initially applied within health and social care systems. It is suggested that the term came into use because it fit in with work based competencies framework and was consistent with thinking about good professional practice. There are numerous models of cultural competence. Davis (1997) postulated that at an operational level cultural competence is the ability to integrate knowledge about individuals and groups into specific standards, policies, practices and attitudes, which are used to improve the quality of health care and ultimately produce better outcomes. Cross et al’s (1989) model identifies a continuum of cultural competence from cultural proficiency at one end through to cultural destructiveness at the other. It is a process of increasing proficiency gained from informal and formal cross-cultural experiences rather than an endpoint that is achieved.

The diversity framework explains cultural differences as the cause of racial inequality. Cultural competence is the accepted approach in the Government's Delivering Race Equality (2005) action plan; however it fails to acknowledge the role that individual and institutional racism play in racial inequality. Bhui (2002) describes the concept of cultural capability; which underpins the publication Inside Outside (NIHME, 2003). Cultural capability emphasises not just the competence of mental health practitioners but the capability of the workforce. It is a framework for service delivery characterised by a multicultural and multiracial workforce that have received training in cultural competence. Cultural competence not only addresses cultural interventions in the clinical setting, but across organisational systems in general. It is argued that cultural competence ought to be integral to policy making, administrative practices and service delivery, and should be informed through service user and community involvement.

Aim

The purpose of this study was to perform a multiple level organisational needs analysis that examines the embeddedness of cultural competence principles in the East London NHS Foundation Trust.

Objectives
➢ To explore ELFT strategic leaders’ understanding of and commitment to cultural competence (corporate level).
➢ To explore the extent to which cultural competence is incorporated into ELFT strategic planning (corporate level).
➢ To assess the degree of cultural competence among managers (operational level).
➢ To assess the degree of cultural competence of clinical staff (direct care level).
➢ To assess the concordance between corporate, operational and direct care levels in relation to culturally competent practice.

About East London NHS Foundation Trust

The East London areas served by the Trust are the most culturally diverse and deprived areas in England and therefore provide significant challenges for the provision of mental health services. The Trust’s local services are provided to a population of 710,000 in East London and the Trust’s forensic services are provided to a population of 1.5 million in North East London. The Trust was awarded Foundation Trust status in November 2007.

Methods

Study design

The strategy of inquiry used in this study was mixed methods concurrent approach. The study comprised an organisational needs analysis of the East London NHS Foundation Trust. Cultural competence assessment tools were used to collect quantitative and qualitative data. The concept of cultural competence and strategic planning was explored through a series of semi-structured interviews; whilst a large scale staff survey using closed questions examined cultural competence in clinical practice. Qualitative data was validated by quantitative data collected from clinical staff across the Trust in the staff survey. Mixed methods allowed for comparison of data sets to explore convergence, divergence and contradiction - a process of crystallisation. Both qualitative and quantitative data were collected concurrently during the study and the information integrated into the interpretation of the overall results. Primarily the design was quantitative in nature with nested qualitative data used to augment the description of the direct care participants. The strategies employed in this study have included the nesting of one method into another to provide insight into different levels of analysis; combined with the collection of data from multiple levels across ELFT to increase the power of inferences drawn from the data. Tashakkori & Teddlie (1998) described this approach as a multilevel design.

Participants

Stratified samples were taken from the Trust workforce for the staff survey. The sample was selected so that direct care disciplines i.e. nurses, doctors, occupational therapists, psychologists, social therapists and healthcare support workers appeared in numbers proportional to their percentage size of the Trust workforce. Within each discipline participants
were selected on a random basis. A total of 336 clinical staff were selected; nurses made up two thirds of the sample. A purposive sample was taken for the operational level and corporate level participants. Borough Nurses, Senior Managers and Modern Matrons across the Trust were identified; in total thirty operational level staff were selected. For the corporate level sample, heads of department and directors were selected, representative of the key functions of the Trust; including Human Resources, Information Management & Technology, Training & Development, Equality & Diversity, Nursing and Medicine. In total six corporate level staff were selected.

**Data collection**

Qualitative and quantitative data were collected concurrently. The survey was supported by the Trust and the questionnaire was made available via the Trust intranet. Questionnaires complete with participant information sheet, were emailed to the sample, and the researcher made three on site visits to collect data to maximise the response rate. Most data were collected electronically via email. Semi-structured interviews were undertaken by the researcher, handwritten notes were taken as a record of the interview. In each case ethics and confidentiality were explained. The data collection period spanned six weeks.

**Data analysis**

Descriptive statistics were used to analyse the survey results; whilst the framework approach was utilised to analyse the semi structured interviews. The framework approach was developed by the National Centre for Social Research in the UK. It is both inductive and deductive in nature. The analytical process is well structured and is informed by prior reasoning related to the aims and objectives of the study. This approach borrows from quantitative procedures in so far as it is more systematic and transparent than conventional qualitative methodology.

**Consent for the Study**

The process for obtaining authorisation involved the submission of the project proposal with copies of the questionnaires and the participant information sheet to the Trust Ethics Committee. The Trust Ethics Committees’ function is to consider applications for non-research projects to be undertaken in the Trust. Projects are generally placed into three categories; these include research, service evaluation and audit. This study fell into the category of service evaluation. Concerns raised by the ethics committee related to the use of Americanised terminology and the perceived sensitivity of some questions. The necessary amendments were made and the assessment tool was piloted prior to the large scale staff survey.

**Cultural competence assessment tool**

An assessment tool was developed based on a cultural competence conceptual framework
designed by Siegel et al (2000). Siegel’s project involved the selection and benchmarking of performance measures in behavioural health care provision. The project synthesises identified areas of concern into six domains including needs assessment, information exchange, services, human resources, policies/procedures, and cultural competence outcomes. Culturally competent activities in these domains were hypothesised to lead to positive outcomes for multicultural and multiracial clients. The domains are defined as:

- **Needs Assessment** – availability of information on characteristics of population in treatment, i.e. demography, socioeconomic status, languages spoken, literacy levels, cultural beliefs & practices.

- **Information Exchange** – Exchange of information between local communities & the Trust, i.e. concerns of multicultural and multiracial groups and information from the organisation to the community re: services offered.

- **Human Resources** – Cultural competence training; recruitment of cultures representative of the community and who speak the languages of the target population of the area. Performance appraisal framework incorporates cultural competence principles.

- **Services** – Service user and carer involvement in the development of services. Services are responsive to cultural needs.

- **Policies/Procedures** – Trustwide cultural competence plan should be formulated with representation from local community then disseminated to all sites.

- **Cultural Competence Outcomes** – Desirable outcomes for service users are evidenced by clinical change, increased social functioning and recovery.

Three questionnaires were devised based on these six domains; two questionnaires were identical for operational and direct care levels respectively. The third questionnaire asked similar questions in an open-ended style to allow exploration of issues for the semi-structured interviews with strategic leaders. A participant information sheet was incorporated into the tool outlining the participant’s right to withdraw with ethical considerations such as confidentiality and anonymity. For validity purposes the concept of ‘cultural competence’ was defined and explained. The cultural competence definition was withheld from the semi-structured interview respondents, to avoid bias in the answers. Direct care respondents were asked to provide their gender, ethnicity, job title and work location.
Results

Direct care level characteristics
Seventy three (22%) staff from the direct care sample responded to the questionnaire. Two thirds of the respondents were nurses, mostly of Black African ethnic origin; which was proportional to the size of the nursing sample. White British and Black Africans represented 82% of all respondents. Participating staff included 49 nurses, 6 doctors, 5 healthcare support workers, 4 occupational therapists, 3 social therapists, 3 social workers and 3 psychologists (Table 1).

Operational level characteristics
Fourteen (39%) staff from the operational sample responded to the questionnaire. The sample comprised 5 modern matrons, 1 borough nurse, 5 community team managers and 3 senior managers. Almost half respondents were White British and the remainder were from BME groups (Table 1).

Table 1
Operational & direct care level sample characteristics, \( n=87 \)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>( n (%) )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>51 (59)</td>
</tr>
<tr>
<td>Male</td>
<td>36 (41)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>33 (38)</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Black African</td>
<td>36 (41)</td>
</tr>
<tr>
<td>Asian</td>
<td>8 (9)</td>
</tr>
<tr>
<td>Indo Caribbean</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>3 (4)</td>
</tr>
<tr>
<td>Discipline</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>55 (63)</td>
</tr>
<tr>
<td>Doctor</td>
<td>6 (7)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Social worker</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Social therapist</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Healthcare support worker</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Manager</td>
<td>8 (9)</td>
</tr>
</tbody>
</table>
**Needs assessment domain:** Both managers and clinical staff were agreed on the collection of ethnicity data and languages spoken by service users. However there was less agreement as to whether socioeconomic status was routinely collected; this finding was consistent across the direct care and operational samples. Seventy nine per cent of clinical staff reported that literacy levels were not assessed or recorded (Table 2). The ability to collect data about literacy was compounded by the fact that English cannot be recorded as a spoken or written language on the Trust’s patient information database.

**Exchange of information domain:** Managers and clinical staff were divided on how the exchange of information between local communities & the Trust is facilitated. Managers frequently reported the presence of service user and faith led fora; whereas the response of clinical staff was inconclusive in this area. Clinical staff showed greater consistency in reporting the absence of ethnic specific and joint working groups in their localities.

**Human resources domain:** Two thirds of clinical staff reported that their staff teams were more or less representative of the communities that they served; whilst less than half of managers thought that this was the case; this maybe indicative of an increased level of awareness in clinical staff about the cultural characteristics of the client group they work with, in comparison to managers that do not have direct patient contact. More than two thirds of clinical staff and managers were aware of the Trust’s cultural competence training programme, however just over a third of each group had attended training either in the Trust or elsewhere. Approximately one third of clinical staff and managers gave an ambiguous response in stating they didn’t know whether they had attended cultural competence training or not. This ambiguity may be accounted for by the proliferation of cultural competence focused training available in the UK; commonly known by other names such as equality & diversity, race equality, racism awareness, cultural awareness/diversity etc. Hence, it might be possible that people had attended cultural competence training, but hadn’t thought of it as such.

**Services domain:** Fifty seven per cent of managers reported the involvement of service users in service planning; a similar amount of clinical staff concurred on this matter. There was a tendency though for clinical staff that did not respond positively to respond with uncertainty; whilst managers were more likely to respond either positively or negatively. These results are consistent with the existence of joint working groups that are convened at a senior level in the Trust, and are unlikely to involve clinical staff; but rather, would involve managers.

**Policies & procedures domain:** The Trust had not developed a strategic plan for cultural competence; therefore issues of relevance to any potential plan were explored through the semi-structured interviews. Ninety three per cent of managers indicated that the Trust vision statement made reference to cultural competence; clinical staff were less certain about this; in fact the Trust vision statement makes no reference to cultural competence. In the absence of performance measures, it was not possible to assess the clinical outcomes domain. Remarkably, most clinical staff were unaware of the existence of lead personnel for cultural competence
across the Trust; which may indicate that messages about cultural competence are not filtering through to front line staff.

Table 2

Direct care level n=73
Operational level n=14

<table>
<thead>
<tr>
<th>Question</th>
<th>Direct care yes (%)</th>
<th>Operational yes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural/spiritual needs assessed</td>
<td>79.4</td>
<td>78.5</td>
</tr>
<tr>
<td>Services advertised</td>
<td>57.5</td>
<td>42.8</td>
</tr>
<tr>
<td>Service info available in languages</td>
<td>65.7</td>
<td>50.0</td>
</tr>
<tr>
<td>Cultural competence training available</td>
<td>72.6</td>
<td>71.4</td>
</tr>
<tr>
<td>Cultural competence training attended</td>
<td>35.6</td>
<td>35.7</td>
</tr>
<tr>
<td>Staff representative of communities</td>
<td>67.1</td>
<td>42.8</td>
</tr>
<tr>
<td>Performance appraisal reflect cultural competence</td>
<td>61.6</td>
<td>57.1</td>
</tr>
<tr>
<td>Engaging of service users in service planning</td>
<td>56.1</td>
<td>57.1</td>
</tr>
<tr>
<td>Person responsible for cultural competence</td>
<td>24.6</td>
<td>57.1</td>
</tr>
<tr>
<td>Language assistance available</td>
<td>76.7</td>
<td>78.5</td>
</tr>
<tr>
<td>Bilingual staff members in team</td>
<td>94.5</td>
<td>100</td>
</tr>
<tr>
<td>Cultural competence in Trust mission statement</td>
<td>67.1</td>
<td>92.8</td>
</tr>
</tbody>
</table>

Direct care level = clinical staff
Operational level= managers

Corporate level characteristics
The semi structured interviews with the corporate sample comprised four males and two females, all were strategic leaders for key functions of the organisation. Three participants were White British, one Black African, one Black Caribbean and one Mixed Race.

Analytic Process
Interviews were analysed using the framework approach (Miles & Huberman 1984). This approach is based on matrix based methods of analysis, and it is both inductive and deductive in nature. The analytic process is linked to the aims and objectives of the study; whilst also
being rooted in the original accounts and observations of the people studied. The researcher acquired an intimate knowledge of the raw data. The process of *familiarisation* with the data began on conducting the semi structured interviews. The collection of data and the analysis of data were not entirely discrete activities, since themes began to emerge during the data collection phase. The analysis moved iteratively through stages of data management, description and explanation. A list of emerging themes were noted and then categorised into sub groups and coded for easy retrieval; these were further refined to the point where several broad themes were conceptualised under these headings:

- The quality of patient information held by the Trust;
- Trust ownership of the cultural competence agenda;
- How the Trust fares in the delivery of race equality;
- How cultural competence is perceived by strategic leaders;
- Equality and the workforce;
- Structures in place to facilitate community engagement;
- Linguistic capacity of the Trust;
- Strengths and weaknesses of the Trust.

These themes conveyed the key ideas and formed the *thematic framework*. The themes were numbered and named using short descriptive text. Distilled summaries were taken from the original data and charted onto an Excel spreadsheet, according to the appropriate part of the thematic framework to which they related. The process of mapping and interpretation of the data was influenced by the original research objectives as well as the themes that emerged from the data itself.

Participants had a tendency to describe cultural competence in terms of *understanding differences* in the cultural context, and the ability to change and adapt clinical practice to meet the client’s cultural needs. The need to be aware of one’s own prejudices and biases was seen as prerequisite for that change to take place. Views expressed supported the idea that cultural competence training is not transferable; but rather, that it should be contextual and relevant to the type of service being delivered.

Collectively, participant discourse mainly focused on the individual practitioner’s responsibility for cultural competence practice, with the organisational responsibility largely ignored. The trust had recently implemented a race equality cultural competence (RECC) programme; which is mandatory for all clinical staff. This is in addition to the equality & diversity training that all new staff receive on the induction programme. Themes related to *equality in the workforce* centred on underrepresentation of BME staff in senior management and at board level; targeted recruitment to redress the balance, the mediocrity of workforce data and the management of staff performance; all of which are traditional human resource functions. Ongoing initiatives involve the training of career advisors as a resource for Trust employees and promoting programmes for staff seeking promotion into senior management and director level positions.
The Trust owns a substantial amount of service user data. ‘Patient information’ is collected through the Care Programme Approach (CPA) and the recently introduced patient information database (RIO). There is inconsistency between data that has been collected on paper and data that is collected electronically; plus there was a lack of understanding about RIO and the data held on it. There were disparate accounts about how patient data might be used; it was apparent that participants’ views about utilisation of data were consistent with statutory legislation requirements to improve ethnicity data. No comparisons had been made of the representativeness of BME inpatients in relation to local population statistics, although relevant data is available for such analysis to take place. The ‘Count Me In’ survey; a national inpatient survey, provides a baseline for measuring the ethnicity of all inpatients, and is intended to help service providers to develop accurate and sustainable procedures for capturing ethnicity information. There was evidence though, that the Trust had commissioned a report with predictive data for age, ethnicity & religion up until 2011 to enable strategic planning of services that meet the needs of multicultural and multiracial communities.

Delivering Race Equality is a theme which encapsulates a multitude of activities that emanate from statute, and which are pivotal for the reform of mental health services. Many change initiatives such as training, equality impact assessments of policies, monitoring of seclusion rates and MHA section rates were mentioned. Less was known about the duties levied by the Race Relations (Amendment) Act (2000). On the topic of race equality there was a tendency to defer to staff appointed by the Trust that lead on equality & diversity. Accountability for race equality was not seen to be a shared responsibility, but was articulated as the domain of specialist staff.

The Trust has made a significant investment in service user participation. The empowerment of service users has manifestations in strategic appointments in the Trust, service user involvement on interview panels and the delivery of training. There were numerous innovations and appointments in the Trust that strengthen community engagement principles such as joint working groups, locality based partnership boards, carers forums; MELLOW - a Trust funded African Caribbean project; the Members Council; People Participation Leads and Equality & Diversity Co-ordinators.

Linguistic capacity is about the ability of the Trust to respond to the linguistic needs of its service users. Until recently, the linguistic capacity of the Trust had until recently been an area that had been largely neglected. There are no historical data to assess the quality of linguistic services. The Trust was working to develop service level agreements with preferred providers and interpreters who are skilled in the context of the psychiatric assessment and competent in language assistance in the clinical process; little was known about the project. People were better informed about the availability of patient information in languages other than English. The Trust does employ bilingual support workers that have an explicit role in providing language assistance; however there are numerous staff who are bilingual but whom are not employed for their bilingual ability; and whom the Trust rely on to provide bilingual assistance.
on an ad hoc basis.

**Trust strengths and weaknesses:** The Trust experience of cross cultural care was seen as a particular strength. Greater ethnic diversity amongst senior clinical staff, especially consultant psychiatrists and the targeted recruitment of underrepresented groups; coupled with equality & diversity road shows were identified as significant steps towards developing a culturally competent workforce. Cultural competence was not seen to be mainstreamed in the Trust; it was still seen in some quarters as a topic for enthusiasts. It was suggested that for cultural competence to blend in it needed to be treated as a process and not an outcome. Management of patient and workforce data is seen as particularly problematic, poor quality data impairs the ability to analyse service utilisation trends. There was a strongly expressed opinion that the Trust needed to benchmark its performance to really understand how well it was doing. It was suggested that Human Resource practices lacked consistency; in a way that did not always promote equality. In particular, it was thought necessary to standardise interview procedures.

**Discussion**

Findings indicate that the Trust have taken several definite steps towards building the cultural capacity of the organisation. The Human Resources and Equality and Diversity departments are taking the lead in addressing issues around recruitment & retention, improving data, engaging faith communities, training, challenging stigma, impact assessing policies and systems; much of this work is ongoing. The findings indicate that the Trust has been slow to embrace the cultural competence agenda, and has yet to embed cultural competence principles at all levels of the organisation.

It was apparent that there was greater convergence between strategic leaders and operational managers than strategic leaders and clinical staff, where there was discordance. Strategists were less well informed about cultural competence initiatives happening in clinical practice. For example, most strategic leaders interviewed had little idea of what culturally appropriate services were available or how such services were advertised. The knowledge gap at the strategic level of the organisation was evident amongst front line staff too. Strategic plans for cultural competence were described with aplomb at the strategic level. Yet, clinical staff showed little knowledge of these initiatives. In addition, clinical staff were largely unaware of the existence of Trust employees leading on cultural competence. There was evidence too that at corporate level there is a tendency to defer to the Equality & Diversity lead on matters of cultural competence, in a way that places the responsibility for cultural competence with one or two individuals, and which conveyed a lack of ownership.

The Trust sets out its vision in the annual plan and it appears on the website. Cultural competence is not referred to explicitly; yet strategic objectives outline the development of a culturally capable workforce, the need for culturally sensitive services and recruitment of staff that are locally representative. Regrettably, the Trust Board is not representative of the cultural
and racial diversity of East London, nor is the senior management team. Race Equality and Cultural Competence (RECC) training is mandatory for all clinical staff, however the same does not apply to senior managers and directors. It has been suggested that RECC training does not adequately meet the needs of senior managers and directors; recent reports indicate that managers would benefit from training with an interpersonal focus on managing BME staff. Interviewees described cultural competence in the context of understanding cultural differences and shared a narrow interpretation of cultural competence. This finding is consistent with literature that shows that cultural competence training has tended to focus on understanding difference, rather than inequalities that affect BME groups. Little attention was paid to how culture impacts upon clinical presentation and the acceptability of specific interventions.

**Relevance of North American research to UK**

Since much of the research on cultural competence has taken place in North America, it might be reasonable to question the relevance of findings to the UK setting. There are apparent parallels evidenced in the increasing diversity of the populace; the similarity in ethnic health inequalities and the growing demand for cultural competence in health care systems. Ethnic and racial disparities in health care form the basis for developing culturally competent practice and in recent years have come to the forefront of healthcare policy and research. These inequities are well documented in the literature, and were strongly reflected in the literature reviewed in this study. All of the studies with the exception of one were North American; the nature of health inequalities experienced in health care, nevertheless, are not dissimilar from those experienced in the UK. Shared characteristics of racial inequality in mental health care between the US and UK include issues of access, over-representation in inpatient services and misdiagnosis; all of this against a background of an increasingly diverse population.

The context in which health care is delivered differs in the UK due to the welfare system and in particular the NHS; which is free at the point of delivery. In the US, healthcare is largely privatised and ‘managed care’ functions to gate keep healthcare services; hence health care provision is a mercenary affair that has nothing to do with need but rather more to do with affordability. So whilst universally, health inequalities are related to socioeconomic status and ethnicity; it is fair to say that in the US disparities in health care will inevitably be influenced by the privatisation of their health care system.

**Strengths and limitations of study**

The use of mixed methods in this study has produced a greater yield over and above a qualitative study or quantitative study undertaken independently. The interviews with strategic leaders in the organisation allowed for richer and deeper insights into attitudes towards cultural competence; and most crucially offered insight into the sense of ownership felt by influential individuals. The meaning attached to this study needs to be understood in the context of
organisational politics. The researcher worked in the Equality & Diversity department of the Trust; there has been resistance to delivering the reforms outlined in the DRE (2005) and Government agencies including mental health Trusts around the UK have been criticised for their tardiness and unwillingness to change. It is against this background that sensitivities are heightened, given the nature of this study. The tone of the discourse was very much about what we should be doing to develop cultural competence and what we need to achieve to meet race equality legislation. There was a sense of ‘ticking the boxes’ as opposed to genuine commitment to cultural competence and with it, high quality care for all service users.

Limitations of the study may include the fact that the cultural competence assessment tool was modelled on performance measures developed in North America where health care systems are characteristically different from the UK; therefore, the validity of the tool may be compromised. The corporate sample was small and interviews were not conducted in depth, therefore it was difficult to generalise results to all employees in the Trust. Purposive sampling can decrease the generalisability of the findings, and lastly, the researcher had a working relationship with the interviewees and this may have created demand characteristics.

Conclusion

It would seem that ELFT provides services with the express philosophy of being unbiased. It functions with the belief that race or culture are immaterial and that all people are the same. Cross et al (1989) defined organisations presenting with such characteristics as ‘culturally blind’. Culturally blind organisations are characterised by the belief that helping approaches traditionally used by the dominant culture are universally applicable. The belief that prevails is if the organisation was functioning as it should be, then everyone would be served with equal effectiveness. This view reflects well intended liberalism; however it renders the services provided virtually useless to almost everyone except those who are most assimilated. Such organisations ignore cultural strengths, encourage assimilation and blame the victim for their problems. Outcomes are usually measured in terms of how closely the client approximates to being middle class.

Prevalence of institutional racism curtails BME access to professional training and staff promotion. Eligibility for services is usually ethnocentric. For example, BME access to psychological therapies has historically been limited for several reasons: below average referral rates; low uptake by BME service users; practitioners lacking cultural competence; the perception that only white middle class or well assimilated BME people can benefit from talking therapies. Culturally blind agencies also suffer from a deficit of ethnicity data for their workforce and service users. Whilst such organisations often view themselves as unbiased and responsive to BME needs, their ethnocentrism is reflected in attitude, policy, and practice. It must be remembered that change occurs in a complex interplay between practice and policy set in the context of politics and the culture of the system. Cultural competence is a developmental process and takes time, commitment and sustained effort at each level of the organisation. In
recent years, the Trust has progressed in putting in place infrastructure to enhance its cultural capability; however, in terms of strategic planning for cultural competence the organisation is stunted.

**Recommendations**

1) Community engagement is crucial; the Trust has recently gained Foundation Trust (FT) status and should capitalise on the opportunity of partnership working with local communities. The racial and cultural diversity, plus community expertise of the Members Council, should be harnessed to study and address issues of local communities, with the specific aim of building culturally appropriate services.

2) The Trust needs to examine patterns in staff banding, appraisals, disciplinaries, grievances, and uptake in training, by ethnicity. Publication of the same is necessary in keeping with race equality legislation.

3) The Trust should set standards for cultural competence. The Trust Board may develop standards it expects its employees to follow. Standards should be set through self-assessment and community input.

4) Cultural competence training should form part of a wider framework for reducing race inequality and address the needs of the organisation and its staff. Training should be linked to the organisation’s Race Equality Scheme (RES) action plan and address the inequalities that affect BME people; i.e. compulsory detention, diagnosis, seclusion rates, reducing fear etc. rather than a generic focus on cultural difference or diversity.

5) It is not enough to require employees to undergo cultural competence training. The Trust Board and Senior Management Team must educate itself to the dynamics of difference, and develop some cultural knowledge in order to make decisions and take actions that are not ethnocentric.

6) Race equality should be embedded in the Trust assurance systems and standards monitored in accordance with the Trust’s RES action plan.

7) The Trust should find ways of making use of faith healers and natural networks of the BME communities. Through written agreements, systematic communication, and sustained contact, the organisation can encourage access to natural helping networks in the community.

8) The Trust should build on the five year business plan by developing a comprehensive plan to develop culturally competent services. As Trust policies are impact assessed and revised; positive changes are incorporated systematically and cultural competence becomes embedded in the structures of the organisation.

9) The Trust vision statement and values need to be revised to make explicit the commitment to cultural competence. It is at the strategic level that the commitment to a culturally competent system of care must be embraced. By accepting this commitment and communicating this to staff in organisational goals and objectives, strategists provide credence and direction to develop the cultural capability in the organisation.

10) The organisation will need to know if their staff and Trust Board are representative of
the local population; the Trust should determine the demographic makeup of its service area and define the client population. A comparison of actual client population and community demographics gives some indication of BME inequalities and provides direction for service planning.

11) The Trust should ensure that data regarding services to BME clients are collected and used in planning and evaluating activities. This data should be made available to the community in a special or annual report.

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