

CULTURAL COMPETENCE IN MENTAL HEALTH SERVICES:
LEARNING FROM CLIENT EXPERIENCES

by

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TABLE OF CONTENTS

LIST OF TABLES	v
ABSTRACT	vi
LIST OF ABBREVIATIONS USED	vii
ACKNOWLEDGEMENTS	viii
CHAPTER ONE: INTRODUCTION	1
Mental Health in Vancouver: Background and Issues	3
Purpose of Thesis	7
Theoretical Framework: Cultural Competence and Anti-Oppressive Practice	9
CHAPTER TWO: LITERATURE REVIEW	13
A Closer Look at Mental Health Services in Vancouver	13
Mental Health Client Experiences	19
Cultural Competence, Anti-Oppressive Practice, and Mental Health Services ...	25
CHAPTER THREE: METHODOLOGY	32
Research Objectives	32
Study Design	33
Sampling	33
Data Collection	35
Data Analysis	35
Strengths and Limitations	37
Ethical Considerations	40

CHAPTER FOUR: FINDINGS	43
Participant Profile	43
Themes and Sub-themes Identified	49
Cultural Competence in the Programs Offered	50
Cultural Competence as Work with Members of Marginalized Groups	54
Cultural Competence as Representation of Marginalized Groups	58
Cultural Competence in the Qualities Exhibited by Staff	63
Cultural Competence as “Having All My Needs Looked After”	69
Cultural Competence is “A Lack of Discrimination”	76
CHAPTER FIVE: DATA ANALYSIS	84
Cultural Competence Operates on Different Levels	85
The Roles and Expectations of Staff Members	86
The Piecemeal Configuration of Services	88
Clients’ Intersecting Social Categories have Compounding Effects	89
Cultural Safety versus Culturally-Specific Spaces	90
Cultural Competence is a Moving Target	91
Implications for Mental Health Policy	92
Implications for Mental Health Services	96
Implications for Social Work Practice	98

CHAPTER SIX: CONCLUSION	101
Summary	101
Strengths and Limitations	103
Areas for Further Exploration	104
Final Reflections	105
REFERENCES	106
APPENDIX A: Letter of Approval	112
APPENDIX B: Recruitment Flyer	113
APPENDIX C: Permission to Post and Distribute Recruitment Materials Form	114
APPENDIX D: Informed Consent Form	115
APPENDIX E: Demographics Survey	119
APPENDIX F: Interview Guide	121
APPENDIX G: List of Mental Health Services in Vancouver	122

LIST OF TABLES

Table 1: Participant Profile	44
Table 2: Study Participants' Age, Gender Identity, and Sexual Orientation	45
Table 3: Study Participants' Highest Levels of Education	46
Table 4: Study Participants' Main Sources of Income	46
Table 5: Study Participants' Racial and/or Ethnic Backgrounds	46
Table 6: Study Participants' Religious Backgrounds	47
Table 7: Study Participants' Mental Health Diagnoses	47
Table 8: Study Participants' Health Comorbidities and/or (dis)Abilities	47
Table 9: Study Participants' Other Social Categories	48
Table 10: Study Participants' Utilization of Services	48
Table 11: Document Review	49
Table 12: Client Involvement in Mental Health Services	61

ABSTRACT

Despite the introduction of cultural competence models in mental health services, individuals from marginalized backgrounds with severe mental health (dis)abilities continue to face health and mental health inequities attributable to the social determinants of health. Through an anti-oppressive practice lens, this qualitative study explored clients' experiences with cultural competence in mental health services in Vancouver and the implications of these experiences on the development of such services.

The study finds that understandings and experiences of cultural competence differ across contexts. The subsequent interventions taken and resulting outcomes are influenced by these varying definitions and are also constrained by the sociopolitical context. The study findings identify considerations for cultural competence in mental health policy and services, as well as anti-oppressive social work practice. The intersectionality of clients' social categories are intricate and complex, and the personal stories shared here are a reflection of clients' strength, resistance, and resilience.

LIST OF ABBREVIATIONS USED

ACT	Assertive Community Treatment
ADHD	Attention deficit hyperactivity disorder
BC	British Columbia
CAP	Canada Assistance Plan
CHST	Canada Health and Social Transfer
CPP	Canadian Pension Plan
DSM-V	Diagnostic and Statistics Manual of Mental Disorders, Fifth Edition
HIV/AIDS	Human immunodeficiency virus/Acquired immune deficiency syndrome
ICM	Intensive Case Management
PHSA	Provincial Health Services Authority
PSR	Psychosocial rehabilitation
PTSD	Post-traumatic stress disorder
PWD	Persons with Disabilities
SAMI	Severe Addictions and/or Mental Illness
SRO	Single room occupancy
VCHA	Vancouver Coastal Health Authority

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CHAPTER ONE: INTRODUCTION

This introductory chapter lays the foundation for the thesis and offers a context for situating the research topic. It will include a history of Vancouver's mental health system, as well as a summary of mental health services and crises in recent years. The purposes of this thesis will also be discussed and an overview of anti-oppressive social work practice, the theoretical framework for this study, will be provided.

In British Columbia, one in every five individuals experiences significant mental health issues in their lifetime (Ministry of Health, 2010; City of Vancouver, 2014). Approximately 130,000 adults, or 3% of the province's population, experience the most severe and complex forms of mental illness such as schizophrenia, major depression, and bi-polar disorder (Ministry of Health 2010); about 20,400 of those individuals reside in the city of Vancouver (Vancouver Coastal Health, 2013; City of Vancouver, 2014). In comparison to the general population, these individuals are more likely to experience other forms of marginalization and stigma associated with their social location (Ministry of Health, 2010; Ministry of Health, 2013; VCH, 2013, City of Vancouver, 2014).

Demographic information collected from individuals with severe mental illness supports the correlation between the social determinants of health and mental health status (Krausz, Clarkson, Strehlau, Torchalla, Li, & Schuetz, 2013; Currie, 2010; Dow, 2011; Ministry of Health, 2013; VCH, 2013; MHCC, 2014). The social determinants of health can be understood as processes whereby members of marginalized groups, who as a result of inequalities embedded within sociopolitical structures, come to experience poorer health outcomes in comparison to the general population (Raphael, 2006). One's disadvantaged position in social categories such as level of education and income,

employment status, quality of housing, social exclusion, physical and social environments, availability of health services and a social safety net, food security, early life experiences, Aboriginal or minority status, and other considerations related to their social location are linked with higher rates of mental illness (Raphael, 2006; Travers, 2008; Dow, 2011; Ministry of Health, 2010). Policy makers and health care providers are recognizing the significance of the social determinants of health that can impact on one's health and quality of life, and the need for more responsive approaches to providing mental health care to society's most vulnerable citizens (Gansean & Janzé, 2005; Raphael, 2006; Capell, Veenstra, & Dean 2007; Ministry of Health, 2010; VCH, 2013).

Cultural competence has gained popularity as a service model that allows practitioners to work with diverse and often marginalized populations in ways that are effective and equitable (Abrams & Moio, 2009; Williams, 2006; Cross & Singh, 2012). With the rise in mental health crises and the persistence of health disparities in Vancouver in recent years, however, it is apparent that despite collaborative efforts by government and health officials to take a more integrated approach to mental health services, services currently in place are not adequately meeting the needs of clients (Vancouver Police Department, 2013; VCH, 2013).

Through the perspectives of mental health clients who identify as members of marginalized groups, this thesis seeks to learn more about their experiences with cultural competence in mental health services in Vancouver, and the implications of these experiences on the development of culturally competent mental health services. The theoretical foundation of this work is grounded in anti-oppressive social work practice, utilizing qualitative methodologies with thematic analysis as its method of inquiry.

This first chapter will provide an introduction to the thesis, the next chapter will be a review of the literature pertaining to the research topic, and the third chapter will outline the research design and methodology used to carry out this study. Chapter four will discuss the findings of the research, and chapter five will offer an analysis of those findings. A conclusion in summary of the thesis will be provided in chapter six.

Mental Health in Vancouver: Background and Issues

The beginnings of a formal system of mental health care in British Columbia took shape in 1850 with the first reported case of insanity (British Columbia Mental Health and Substance Use Services, 2009). Prior to the opening of Riverview Hospital in 1913, those with mental health issues were either incarcerated, committed to one of two overcrowded asylums in the province, or sent abroad (BCMHSUS, 2009). The establishment of Riverview Hospital marked the first provincial institution for mental health. This asylum model of mental health care was based on the belief that mental health patients required ongoing treatment in a peaceful location isolated from the rest of society (BCMHSUS, 2009).

Riverview Hospital was an inpatient psychiatric hospital made up of several buildings on the Riverview grounds. Located outside of Vancouver, at its peak, it housed over 4,000 patients (BCMHSUS, 2009). With new advances in psychotropic medications, changing societal views of how mental health patients should be treated, and increased pressure to implement cost-cutting measures, the government shifted their focus to deinstitutionalization. Riverview Hospital was phased out over three decades and officially closed in 2012. Today, parts of the grounds remain open to tertiary mental health and substance use programs (BCMHSUS, 2009).

The majority of individuals with severe mental illness in Vancouver currently reside in the community (City of Vancouver, 2014). These individuals experience higher rates of concurrent disorders, chronic health conditions and/or (dis)Abilities, homelessness, unemployment, and other forms of marginalization. They are more likely to be overrepresented in emergency departments and hospital admissions, and have greater involvement with the criminal justice system both as offenders and victims. (Ministry of Health, 2010; VPD, 2013; VCH, 2013; Krausz et al., 2013). The high prevalence of mental illness among this small segment of Vancouver's population has significant personal and socioeconomic impacts, with an estimated cost of \$100 million to the health and criminal justice systems annually (City of Vancouver, 2014).

Culturally competent mental health services that have been put in place recognize the need to improve health outcomes for this group who has long been underserved by the mental health system (Ministry of Health, 2010; VCH, 2013; Elliott & Masters, 2009; Raphael, 2006). Other contributing factors to the current service framework include the changing demographics and complexities within society, health disparities that continue to persist between members of marginalized groups and the general population, and recognition that mainstream treatment approaches have not been effective for everyone, especially those with complex intersections of marginalization (Ministry of Health, 2010; VCH, 2013; VPD, 2013; Clarke, Dusome, & Hughes, 2007; Elliott & Masters, 2009; Bernard & Moriah, 2007).

Mental health services in British Columbia are governed by the Mental Health Act (RSBC, 1996), which delegates the provision of mental health treatment to five regional health authorities and one Provincial Health Services Authority (PHSA).

Vancouver Coastal Health Authority (VCHA) is primarily responsible for the delivery of mental health and substance use services in the city of Vancouver, in collaboration with various levels of government, service providers, and community organizations. A population health approach, which aims to address the needs of groups rather than individuals, has been adopted to target those with severe addiction and/or mental illness (SAMI) (VPD, 2013; VCH, 2013; Krausz et al., 2013; Ganesan & Janzé, 2005; Raphael, 2006; Capell, Veenstra, & Dean, 2007; Ministry of Health, 2010). As a result of the high prevalence of individuals with concurrent disorders in the province, substance use services have merged with mental health services over the years (BCMHSUS, 2009).

Mental health services in Vancouver fall along a continuum of care made up of acute care beds, primary care, and specialized inpatient and outpatient services for specific populations such as youth, older adults, First Nations communities, etc. There are programs available according to treatment needs including eating disorders, concurrent disorders, neuropsychiatry, psychosis, mood disorders, developmental (dis)Abilities, and forensics. Tertiary care programs include acute, rehabilitation-focused, and long-term specialized residential care. In the community, there are eight mental health teams across the city, Intensive Case Management (ICM) and Assertive Community Treatment (ACT) teams, outreach and mobile responders, cross-cultural liaisons, and various levels of residential services. There are also drop-in centres, advocacy services, rehabilitation and employment programs, consumer-run and family support services, referral and crisis telephone lines, and health promotion programs. The spectrum of substance use and concurrent disorders services includes withdrawal management, specialized clinical

services, day and outpatient programs, residential treatment and supported housing, and harm reduction initiatives (Ministry of Health, n.d.; VCH, 2013).

In September 2013, the Vancouver Police Department (VPD) released Vancouver's Mental Health Crisis: An Update Report, with alarming concerns of an increase in mental health crises in Vancouver. This report was preceded by two other reports published in January 2008 and September 2010, both noting an increase in police incidents involving people with severe mental illness in light of changes to the manner in which mental health services are provided to this population. Mental health crises continue to rise and the demand for supports for those with severe mental health and substance use issues far exceeds the capacity of the mental health system (VPD, 2013).

From 2008 to 2013, Vancouver has seen a 43% increase in individuals at downtown Vancouver's St. Paul's Hospital presenting with severe mental health and substance use-related issues, an 18% increase in apprehensions under the Mental Health Act (RSBC, 1996) between 2010 and 2013, and 25% of police time being allocated to mental health-related calls (VPD, 2013; City of Vancouver, 2014). There are an estimated 3,000 to 6,000 individuals in Vancouver at high risk for mental health crisis, and 300 currently in crisis. 2,000 of those individuals with severe mental health issues are living in single room occupancy (SRO) hotels in the Downtown Eastside and are not receiving sufficient levels of care. 2/3 of the city's homeless population are found to be in urgent need of more appropriate mental health and substance use services (City of Vancouver, 2014). There have also been concerns of severely mentally ill persons committing violent crimes, posing risks to public safety, and being involved in suicides

(VPD, 2013). These growing issues raise questions about whether or not mental health services currently in place are adequately meeting the needs of their service users.

Coinciding with the system's lack of capacity to meet the needs of those with severe mental illness, mental health clients' experiences within the health and mental health care systems have not been overwhelmingly positive (Benson, 2013; Clarke et al., 2007; Clarke et al., 2014; Wen, Hudak, & Hwang, 2007; Dow, 2011; Glass & Arnkoff, 2000; Knis-Matthews, Richard, Moccia, Patel, Salomone, & Stein, 2012; Krausz et al., 2013). In addition to facing barriers associated with their social locations, clients' negative experiences with health and mental health services are associated with stigma and discrimination related to their marginalized statuses, service providers who are ill-informed about working within clients' cultural contexts, and cultural differences between the service user and the service provider. These experiences are significant not only because they are disempowering for clients who are marginalized, but also because they are reflective of service gaps related to quality of care and client satisfaction with care. Additionally, they have a myriad of effects on clients' future involvement with services, client outcomes, and ultimately, society (Breeze & Repper, 1998; Dow, 2011).

Purpose of Thesis

My reasons for writing this thesis stem from my personal interests in the research topic and from my years of working in mental health services in the community. Through my own observations and in numerous conversations with clients, I have had a glimpse into clients' experiences of disempowerment within the mental health system, and at times, my own feelings of helplessness in supporting them. I have gained through these experiences an awareness that mental health services sometimes serve the interests of

service providers more so than service users. I have observed clients having treatment imposed on them with little input of their own, with expectations for them to assimilate into preexisting models of treatment far removed from the clients themselves. Clients that I have worked with have also been presented with a false sense of choice when it comes to support services and housing options, because there really are no other alternatives that would adequately meet their needs. And although mental health services have shifted towards community integration, this has not resulted in meaningful social citizenship of mental health clients within the communities in which they live.

My personal and professional encounters led me to seek out a career in social work so that I could better support clients and work towards social change. Social work has helped shape how I think about mental health and illness, which I now understand within the intricate layers of power and oppression. In particular, I have great interest in learning about clients who are multiply marginalized by their social locations and their mental health statuses, and the injustices they face as they navigate their everyday lives.

By embarking on this journey, my hope is to gain greater insight into clients' experiences with cultural competence in mental health services through their own perspectives, and to better understand how their experiences speak to the development of culturally competent, anti-oppressive mental health services moving forward. While I am strongly committed to anti-oppressive practice and have integrated many of its tenets into my social work practice framework, I am aware of my own positions of privilege and oppression. While completing this thesis, I sought to engage in continuous self-reflection by starting where the client is at and maintaining a not-knowing stance. I am also cognizant of the expert-based knowledge in mental health, and my role in the production

of that knowledge through the completion of this study. Thus, a secondary purpose of this thesis is to expand client voice in a field dominated by academics and professionals.

I am conducting this research with the recognition that research can be an oppressive process in itself. It can be used as a tool for the exclusion of ‘others’ as research typically takes place within institutions of power, and is a way in which knowledge is generated, regulated, and realized (Smith, 1999). It is demonstrated in the preferential use of western research methodologies that guide research and that are assumed to be objective and value-free. Additionally, knowledge acquisition through research relies on Eurocentric classification systems and conceptualizations of phenomena that privilege western ways of knowing. Research involves the categorizing, labelling, and describing of study participants’ lived realities, and the ascribing of meaning to their experiences (Smith, 1999).

Documenting phenomena through the use of language and vocabulary gives power and legitimacy to people’s lived realities by privileging one way of knowing over another (Smith, 1999). I am mindful of this deep connection between research and people’s worlds in the research process; however, I acknowledge that I am still prone to my own biases. As such, I have taken measures to counter these personal assumptions, which will be discussed in Chapter Three. I hope this thesis is a small step towards making room for alternate ways of knowing in academic and professional research for the purpose of expanding client voice in a field dominated by experts.

Theoretical Framework: Cultural Competence and Anti-Oppressive Practice

Social work and other helping professions have been involved in the continued development of cultural competence in mental health education and practice. However,

existing models have faced their share of criticism and implementation has been challenging.

Cultural competence refers to proficiencies that are thought to be necessary for practitioners to be knowledgeable and skilled in; these proficiencies enable them to work effectively across difference, typically with members of marginalized groups (Bernard & Moriah, 2007; Dean, 2001; Williams, 2006; Abrams & Moio, 2009). While cultural competence has historically been associated with culturally sensitive work with racial and/or ethnic groups, its definition has evolved in recognition of the intersectionality of social categories such as gender identity, sexual orientation, socioeconomic status, age, (dis)Ability, religion, etc. (Abrams & Moio, 2009; Dean, 2001).

Cultural competence strives to integrate the significance of culture in meaningful and equitable ways. Proponents of its approach argue that simply being culturally sensitive is not sufficient when working with diverse populations. Cultural sensitivity views one's social location as a stable marker of an individual's needs without consideration for the power dynamics present or one's unique circumstances. Cultural competence transcends cultural sensitivity in that it necessitates client empowerment, self-awareness of the practitioner, an analysis of power embedded in dominant structures, critical thinking, and development of an allied therapeutic relationship through its practices (Tervalon & Murray-García, 1998; Williams, 2006; Capell, Veenstra, & Dean, 2007; Pon, 2009). Through this lens, culture is defined as a shared history, identity, and experience that distinguishes a particular social group from another, but is also understood as individually and socially constructed, and always evolving (Dean, 2001; Capell et al., 2007; Guarnaccia & Rodriguez, 1996). Because every person is different in

the ways their social categories intersect, no two individuals' social locations are ever truly identical. It is in these ways that cultural competence is complementary to an anti-oppressive social work practice framework.

Anti-oppressive social work practice “represents a commitment to social justice and social change within social work” (p. 121) and draws from several social work theories and perspectives including social constructionism, anti-racist theory, and critical social work (Campbell, 2003). It is based on the notion that relations of power and oppression operate on multiple levels in that individual problems always speak to issues within the broader sociopolitical context (Campbell, 2003). Anti-oppressive practice works to deconstruct and transform relationships of power and oppression, with the understanding that positions of privilege and oppression are intersecting, multiple, and unique to the individual (Campbell, 2003; Pollack, 2004; Hines, 2012).

Anti-oppressive practice acknowledges that social work as a profession itself has served as a means for social control and the regulation of marginalized groups, as has been the case in child welfare, residential schools, and the criminal justice system (Pollack, 2004; Baines 2011). Social work discourse risks further excluding clients, as social workers are producers and gatekeepers of knowledge and are involved in the naming of clients' realities. Anti-oppressive social work practice thus requires the practitioner to engage in continuous learning, reflexivity, and self-reflection, as knowledge is subjective, socially constructed, and always partial and changing (Hines, 2012; Campbell, 2003; Dean, 2001). In contrast to traditional social work approaches that are deficit-focused and expert-based, anti-oppressive social work aims to practice power-with rather than power-over clients by positioning client as expert, engaging in

consciousness-raising and capacity building, and drawing on clients' ways of knowing, strengths, and resistance to oppression (Baines, 2011; Pollack, 2004; Dean, 2001).

Within the context of mental health, anti-oppressive practice aims to problematize and effect change on a system where psychiatry dominates other forms of knowledge. It moves away from the medical model which situates mental illness within the individual by viewing clients in their environments, seeking to explore clients' meanings of their thoughts and behaviours, and understanding their situations as shaped by their experiences (Pollack, 2004; Morley, 2003). Anti-oppressive practice politicizes the social and economic structures that give legitimacy to laws, policies, and social norms that allow for the continued maltreatment of marginalized clients in an already disempowering mental health system (Abrams & Moio, 2009; Pollack, 2004). It strives to redress the power imbalance that exists between service users and service providers. While not discounting the contributions of medicine, anti-oppressive practice recognizes individual and cultural differences between clients, and examines mental health and well-being through a sociopolitical lens (Craig, 1999). Anti-oppressive practice works towards social justice on a systemic level while taking into account an individual's social location which contributes to their mental health and well-being.

The following chapter will be a literature review of the subject matter. It will provide a summary of how mental health services in Vancouver have changed over time to suit sociopolitical interests. Client experiences in health and mental health services and the different understandings and challenges of cultural competence will also be discussed.

CHAPTER TWO: LITERATURE REVIEW

This chapter will review the literature pertaining to the research topic, beginning with an in-depth examination of how mental health services in Vancouver have evolved to meet the needs of the current sociopolitical climate. It will also explore the experiences of mental health clients in health and mental health service settings, and further discuss the various models of cultural competence that have been developed.

A Closer Look at Mental Health Services in Vancouver

Following the Second World War, the federal and provincial governments took on a central role in the provision of health services with the introduction of the welfare state. It was believed that the welfare state would bring about reductions in social inequalities by guaranteeing minimum standards of care for all Canadians regardless of their positions in society (Graham, Swift, & Delaney, 2012; Hunter & Miazdyck-Shield, 2006). The welfare state would expand people's rights of citizenship and protect those most in need, such as those with (dis)Abilities or chronic illness (Hunter & Miazdyck-Shield, 2006).

A centralized, public administration of universal health care was secured when the governments introduced cost-sharing programs in the forms of the Canadian Assistance Plan (CAP) and the Medical Care Act in 1966, which funded health services across the provinces and territories (Graham et al., 2012). Using a needs-based model of eligibility, mental health care was rolled out through the widespread institutionalization of those determined to be mentally ill and requiring ongoing hospitalization. In British Columbia, the provincial facility for the care of these individuals was Riverview Hospital (BCMHSUS, 2009).

Changes to Canada's participation in the global economy beginning in the mid-1970s saw the devolution of the welfare state and a shift towards a market-based model of health and social policy whereby government, driven by neoliberal ideologies, reduced its scope of programs. These market state principles emphasized decentralization, deregulation, reductions in government spending, privatization of public goods and services, and individual rights and responsibilities (Graham et al., 2012). The erosion of the welfare state was spurred on by the implementation of the Canada Health Act of 1984, followed by the Canada Health and Social Transfer (CHST) in 1996, which reduced federal-to-provincial government transfers for health and social programs. The CHST was then divided into the Canada Health Transfer and the Canada Social Transfer in 2004 to separate health and social spending altogether, and to further restrict the range of services provided by the state (Feldberg & Vipond, 2009; Graham et al., 2012).

The province of British Columbia delegated responsibility for the delivery of mental health services to local levels of governance. The province's Mental Health Initiative (1990) and the Mental Health Plan (1998) facilitated decentralization and deregulation by emphasizing community capacity building and moving mental health treatment centres 'closer to home' (BCMHSUS, 2009). In 2001, the regional health authorities were established as it was argued that they were best positioned to identify and respond to local needs in a timely manner. (Graham et al., 2012; Bryant, 2009; BCMHSUS, 2009). Local ownership and payment arrangements set out by the health authorities would allow for more integrated services to reduce spending and increase access to care through the contracting out of services to community organizations (Feldberg & Vipond, 2009).

Policy changes, technological advances in medicine, and growing sentiment against the warehousing of mental health patients in facilities have resulted in community-based living and support services becoming the preferred method of treatment, while inpatient beds are now intended only for the most severe, acute cases. When clients are admitted to hospital, their treatment is characterized by short stays and outsourcing of services to the community, as well as cutbacks in beds, staffing, and other ‘luxuries’ (Armstrong & Armstrong, 2003). The goal for these individuals is often reintegration into the community before any outstanding issues can be properly addressed. In this way, service users remain stuck in limbo between living at risk in the community and re-hospitalization.

Mental health service providers today operate much like private sector corporations. Neoliberal principles emphasizing self-sufficiency, individual responsibility, and assimilation into existing structures through community care are evidenced by how mental illness, treatment, and recovery are conceptualized. This trend is exemplified in the care philosophies prominent in Vancouver’s mental health services, including the medical model, population health approach, psychosocial rehabilitation, harm reduction, Housing First, Intensive Case Management (ICM), and Assertive Community Treatment (ACT) (VCH, 2013; Graham et al., 2012). While these service models are said to be in response to the growing number of individuals in the community in need of mental health services, data shows that many service users with severe mental illness and substance use issues are nearing or have already reached a level of crisis that requires more long-term, intensive treatment and supports but for whom services are not available (VPD, 2013; City of Vancouver, 2014).

The dominant discourse in mental health remains centred around the medical model, which locates mental illness as a (dis)Ability arising from within the individual in need of fixing by medical experts. Psychiatric drugs are central to treatment as mental illness is framed within the context of pathology. This model targets the individual's presenting symptoms for intervention in order to reduce costs associated with health and crime as a result of one's personal choices (Roe, 2005). Factors related to the social determinants of health remain on the periphery as the medical model emphasizes individual deficits and omits the sociopolitical processes that contribute to one's psychosocial condition (Cowan, Banks, & Crawshaw, 2011; Hiranandani, 2005; Pollack, 2004). In contrast, a social model of mental illness situates it within historically-, socially-, and environmentally-constructed contexts, and draws attention to society's failure to provide the appropriate supports to meet the needs of service users. As such, the (dis)Ability of mental illness is also understood as impairments within the environment that are in need of intervention rather than just the individual (Hiranandani, 2005).

Mental health is an area that is highly professionalized, where the scientific, positivist approach of the medical model is very evident. It is well documented in the prolific use of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), which dictates diagnostic criteria and classification of mental illnesses (Pollack, 2004). Provisions for treatment are named and defined by professionals while clients are viewed as passive recipients of the professional's expert knowledge (Cowan et al., 2011). In this way, the wave of new and improved models of care is perceived by some as serving an interest to generate more human service professions rather than to support clients (Roe, 2005).

The Ministry of Health's (2010) *Healthy Minds, Healthy People*, outlines the province's population health approach for mental health and substance use. In a free market state, the population health approach's preoccupation with individual responsibility, efficiency, and scarcity is used to focus limited resources on clients deemed most in need of treatment services. Although this approach views people with severe mental illness and substance use issues as having complex needs requiring intensive treatment, this perception has not resulted in mandating minimum standards of care for this very vulnerable population. As well, this approach assumes that the same treatment is effective for all individuals within a population as they are considered to be homogenous.

Recovery-focused models of care centred around the development of life skills, such as psychosocial rehabilitation (PSR), are often used in conjunction with psychotherapy and psychiatric treatment. To promote recovery, strengths-based, client-centred care and integration into the community through citizenship rights and responsibilities is emphasized (PSR/RPS Canada, 2014). Deconstructing the underlying principles of PSR finds that its primary tenets underscore the objectives of the market economy. Although PSR recognizes that external supports are significant to recovery, it places responsibility on the client to work towards recovery by acquiring the skills necessary to lead a productive life as independently as possible (Hunter & Miazdyck-Shield, 2006). Integration and inclusion into the community is thus defined in terms of assimilation by taking on the functions of the market economy, typically through gainful employment in the paid workforce (Guarnaccia & Rodriguez, 1996). Vocational services work in tandem with government programs that emphasize selective entitlements and

active programming to track marginalized clients into precarious employment. This is intended to accommodate labour market needs and to ensure less dependence on social assistance. As a result, clients are perpetually left struggling in low income circumstances (Hunter & Miazdyck-Shield, 2006).

Harm reduction has expanded rapidly in Vancouver's mental health services as a way to promote health and mitigate risks associated with the sex trade, homelessness, and substance use. Its rhetoric conveys a more compassionate, non-judgmental approach to working with service users, but a closer look at its underlying constructs reveals the workings of the decentralization of power and a more covert form of social control. The decriminalization and medicalization of problematic substance use has given harm reduction more legitimacy through the scientific calculation of risk. With the ability to stabilize clients medically, the harm reduction model continues to allow harm to individuals while relieving the state of its burden to properly address the underlying social, economic, and political causes of those harms. The deregulation of the state works to devolve responsibility from the state to the local and individual levels through the hegemony of self-regulation (Roe, 2005). At the same time, harm reduction extends the arm of the state to those on the margins of society who have typically been 'hard to treat'. Some understand harm reduction as the new infrastructure of institutionalization for the supervision and coercion of marginalized individuals in the community (Roe, 2005).

The growing popularity of Housing First, Intensive Case Management (ICM), and Assertive Community Treatment (ACT) teams are based in a harm reduction philosophy targeting at-risk populations in the city. A Housing First approach believes that housing interventions with support services is the first step to stabilizing homeless individuals

with concurrent disorders (MHCC, 2013). ICM involves a case manager who provides outreach and brokers access to support services. Similarly, ACT teams work as one single interdisciplinary unit to provide mental health and support services to clients in the community. Studies show harm reduction is an effective mental health and substance use treatment model; however, indicators of success are often evaluated using measures that do not reflect client interests (MHCC, 2015; Ministry of Health, 2010, 2012).

Notwithstanding the limited capacity of the current mental health system, the provision of mental health services in British Columbia continues to be problematic due to the priority of market interests over client needs. The struggle for service providers then, becomes one of providing culturally competent, anti-oppressive mental health services within the context of a neoliberal, free market state. Within this sociopolitical environment, mental health clients' experiences have not been overwhelmingly positive.

Mental Health Client Experiences

Mental health clients' experiences in service settings have largely been negative due to facing additional barriers when accessing care. On top of struggling to have their basic needs met, clients must deal with stigma and discrimination, gaps in service, and cultural differences (Wen, Hudak, & Hwang, 2007; Benson, 2013). Clients have also had positive experiences, though to a lesser extent. These encounters are associated with staff members who have a positive impact on interactions with clients (Clarke et al., 2014; Wen et al., 2007; Glass & Arnkoff, 2000; Cross & Singh, 2012; Elstad & Eide, 2009).

Mental health service users often experience double stigma in that they experience stigma associated with their mental health status as well as stigma engrained in society or within their cultural enclaves in regards to their social categories or histories

(Knis-Matthews, Richard, Moccia, Patel, Salomone, & Stein, 2012). Double stigma is also understood as the discriminatory practices imposed on marginalized individuals by various segments of society such as politicians, clinicians, and citizens (Gary, 2005).

As a result of their negative experiences, many individuals with severe mental illness are reluctant to seek care and often wait until they are too sick before they seek help, while others simply do without (Feldberg & Vipond, 2006). Despite their apprehensions, a lack of resources and safe places in the community means many do end up presenting to hospital where they are subject to a range of negative attitudes held by staff members (Clarke, Dusome, & Hughes, 2007; Dow, 2011). Even then, hospitalization rates do not accurately reflect the actual levels of mental illness in the community as many will not go to hospital (Cross & Singh, 2012).

Feedback from both clients and workers indicate a lack of knowledge and training among service providers in working cross-culturally with individuals from marginalized backgrounds. In a study by Clarke et al. (2007), emergency room staff expressed feeling ill-equipped to work with patients with mental illness, reporting that they lack the skills to properly assess and treat these patients, and particularly those with concurrent disorders. This study also indicates that the accuracy of mental health assessments by emergency staff is low in comparison to other medical presentations (Clarke et al., 2007). In another study, mental health patients are described by nurses as 'difficult'; however, this label may have more to do with nurses who feel their competence is being questioned rather than the patient's actual behaviours (Breeze & Repper, 1998). Staff members also report frustrations with the revolving door of mental health clients' presentations. A lack

of feedback and follow-up also instills a sense of hopelessness and a ‘why bother’ attitude among staff members (Clarke, Usick, Sanderson, Giles-Smith, & Baker, 2014).

The gatekeeping of services by health and mental health professionals often means that clients must be able to make a case for treatment before they can receive it. A stark example of this practice is the treatment of transgender people for gender identity disorder, where clinicians play a large role in diagnosing and determining a client’s readiness for gender transition before medical options can be accessed (Benson, 2013). Transgender clients report that therapists are not well-informed about gender identity issues, display transphobia, and neglect to consider the psychosocial aspects of gender transition such as finances and quality of life (Benson, 2013). According to these clients, this kind of ignorance casts doubt on the professional’s capabilities and impedes on their ability to understand and support clients (Benson, 2013).

Experiences of unwelcomeness involve a sense of superiority on the part of service providers. These staff members make assumptions about clients and their circumstances, and can be judgmental, disrespectful, and rude. Feelings of guilt, shame, and embarrassment arise when clients are treated punitively for self-harming or displaying suicidal behaviours, when they are legitimately seeking help (Benson, 2013; Clarke et al., 2014). Service users are also stereotyped or misunderstood based on their presentation (Benson, 2013). Additionally, clients’ presenting mental health symptoms have not been taken as seriously as physical complaints, and in turn, their physical health concerns are often dismissed by hospital staff. Clients report having to endure long waits as they are not considered a priority (Clarke et al., 2014). Negative interactions involving staff members also indicate communications styles that are mechanical or lacking

altogether. Clients have expressed feeling ignored, rushed, and dehumanized by staff who are not empathetic and who do not make the client feel heard (Wen et al., 2007).

The cultural superiority of mental health experts contributes to misconceptions about clients being non-compliant or uncooperative, and denies clients a voice about their lived experiences (Craig, 1999). Understandings and expressions of mental illness differ across cultures and individuals. As well, cultural cues offer insight into clients' help-seeking behaviours, symptoms that are exhibited, communication styles, health care decision-making, appropriate interventions, patient and provider expectations, and compliance with treatment (Dow, 2011; Capell et al., 2007).

Mental health service users feel disempowered in how they are treated in inpatient psychiatric units, especially when admitted involuntarily. In British Columbia, mental health clients can be apprehended under the Mental Health Act (RSBC, 1996) if deemed necessary by a person of authority. Clients have been forced against their will into seclusion rooms and subjected to unwanted treatments and heavy drugs which result in adverse side effects. The power imbalance between client and worker have made clients feel silenced, degraded, and undignified (Glass & Arnkoff, 2000). Research also suggests that stigma and discrimination in the mental health system is evident in how individuals with mental illness are often inappropriately incarcerated (Gary, 2005; Pollack, 2004).

Service settings themselves are not always conducive to supporting clients in mental health crises. The busy, fast-paced environment of the emergency department does not allow for thorough mental health assessments which are more complex and time consuming. This environment is also a trigger for many clients and further exacerbates their mental health symptoms (Dow, 2011). Many find the lack of privacy and high

traffic area to be overstimulating and frightening. Clients report a fear of attending alone due to lack of advocacy. Some emergency departments in Canada have responded to these gaps in service by hiring psychiatric emergency nurses (Clarke et al., 2007).

The disconnect between the client's own culture and that of the mental health system affects utilization of mental health services. The system's Eurocentric, individualist view of mental illness dominates assessment and treatment (Dow, 2011). It adheres to strict binaries when it comes to understandings of mental health and well-being, gender identity, sexuality, and (dis)Ability (Benson, 2013; Hiranandani, 2005; Travers, 2008). Research indicates that clients' alignment with a clinician's background actually influences the treatment that is prescribed (Dow, 2011). Thus, service users from marginalized backgrounds contend not only with unfamiliarity with the system, but with practitioners who misinterpret their cultural experiences (Dow, 2011). In fact, misdiagnosis and inappropriate treatment of mental illness occur at higher rates among members of minority groups, and individuals from marginalized backgrounds are more likely to receive an Axis I diagnosis (Craig, 1999; Cross & Singh, 2012).

When the cultural identities of clients are disregarded, mental health service providers miss opportunities to develop treatment plans that are more aligned with the client's culture and that can contribute positively to a client's outcomes. For example, some clients find religious beliefs and activities to be effective coping strategies (Dow, 2011). Language barriers and a lack of minority staff can impede on communication and rapport building. Psychotropic medications have been found to have different effects across racial and/or ethnic groups (Craig, 1999). A better understanding of alternative health practices utilized by the client can facilitate a better treatment plan and mitigate

adverse effects due to negative interactions between prescribed medications and other remedies (Dow, 2011; Knis-Matthews et al., 2012; Craig & Singh, 2012).

Exploring a client's in-group values and family members' traditional roles have been found to reveal additional sources of support. It can help to identify supports that can counter isolation, prevent decompensation, and offer explanations about one's reluctance to seek help in order to preserve family or in-group pride (Dow, 2011; Knis-Matthews et al., 2012). A better understanding of cultural dynamics can also help to explain family discord around treatment and facilitate conflict resolution. It can help to explain distrust of the system in regards to issues such as immigration, privacy, and confidentiality (Dow, 2011).

Research findings indicate that improved mental health outcomes depend on the quality of the helping relationship. Clients who have had positive experiences with mental health professionals describe these staff members as professional and knowledgeable about the information and support provided; they are warm, kind, patient, empathetic, compassionate, and attentive, and they genuinely care about their clients as individuals and believe they have value and worth (Clarke et al., 2014; Wen et al., 2007). Clients who have had positive interactions with staff feel listened to, understood, validated, respected, and reassured (Glass & Arnkoff, 2000). These workers make efforts to involve the client's support network, integrate their cultural influences, advocate for the client, and take a collaborative approach that de-emphasizes the power differential between client and worker. Clients have had positive experiences when their opinions are taken seriously, participation in decision-making is supported, and choice are maximized (Elstad & Eide, 2009). Research finds that these factors improve client involvement and

outcomes (Cross & Singh, 2012). Additionally, service settings that are positive are described as supportive, warm, protective, and safe.

When it comes to understanding clients' experiences in mental health services, it is important to acknowledge that they have not been well documented. The existing literature is lacking in client perspectives as marginalized populations have historically been, and continue to be, excluded in research and thus does not fully capture their views (Abrams & Moio, 2009). With the information that is available, it is clear that the development of more culturally competent mental health services that result in positive client experiences is essential as these services come to shape client perceptions of service providers and outcomes down the line.

Cultural Competence, Anti-Oppressive Practice, and Mental Health Services

Cultural competence refers to skills, knowledge, attitudes, and values that enable practitioners to work effectively with clients across different social and cultural contexts (Abrams & Moio, 2009; Nardi, Waite, & Killian, 2012; Bernard & Moriah, 2007; Dean, 2001; Williams, 2006). Cultural competence draws attention to the significance of culture in shaping clients' lives and health outcomes (Abrams & Moio, 2009). It is based on the recognition that there are gaps in traditional approaches to mental health services that are not meeting the sociocultural needs of marginalized groups (Cross & Singh, 2012; Bernard & Moriah, 2007). In an effort to improve the outcomes of marginalized individuals with severe mental illness, cultural competence has become a core component of mental health services (Capell et al., 2007).

Modernist views of cultural competence focus on knowledge acquisition, skill development, and diversity in staff recruitment. Under these notions of cultural competence, it is the assumption that culturally-specific knowledge and skills, or shared cultural background with clients, allows the worker to have the insider knowledge and rapport necessary to work effectively with clients (Abrams & Moio, 2009; Bernard & Moriah, 2007; Dean, 2001; Whaley & Davis, 2007; Williams, 2006).

These models of cultural competence have been criticized for failing to appreciate the social construction of culture, the intersectionality of oppression that clients face, and the client's own agency in shaping culture (Abrams & Moio, 2009). The top-down conception of culture reinforces the notion that culture is fixed and that once formal learning by the professional is complete, the practitioner can then claim expertise over the client. Additionally, cultural knowledge acquired by the worker may be based on misconceptions or stereotypes about a given culture which the worker then goes on to reinforce (Bernard & Moriah, 2007). From an anti-oppressive practice standpoint, these models of cultural competence do little to empower mental health clients.

Post-modern understandings of cultural competence focus on reflexivity on the part of the practitioner and recognizes the multiple forms of marginalization an individual can face at any one time (Abrams & Moio, 2009; Dean, 2001). These approaches view culture as individually- and socially-constructed, and recognizes that group members are not homogenous (Dean, 2001). An individual's culture is viewed as being influenced by multiple social categories that intersect and interact to help shape the individual; and in turn, that individual has the agency to participate in ongoing transformations of culture (Abrams & Moio, 2009; Guarnaccia & Rodriguez, 1996). Self-reflection is intended to

allow the worker to gain greater awareness of their own values and biases that they bring into the helping relationship (Abrams & Moio, 2009; Bernard & Moriah, 2007). By seeing clients' lives as multi-faceted, the worker seeks to incorporate the client's worldviews into the helping relationship (Guarnaccia & Rodriguez, 1996; Dean, 2001; Rozas & Smith, 2009). Based on this information, workers can then make adaptations to practice skills, modify aspects of the helping relationship, and integrate cultural considerations into formal assessments and treatment plans (Abrams & Moio, 2009; Ganesan & Janzé, 2005; Williams, 2006).

A critique of post-modern approaches to cultural competence is that while it acknowledges that individuals each face multiple forms of marginalization, it inadvertently equalizes categories of oppression and downplays the salience of race, which continues to play a significant role in the marginalization of people of colour and contributes to colour-blindness (Abrams & Moio, 2002; Bernard & Moriah, 2007; Dean, 2001). Race and/or ethnicity within this context is often misunderstood as only encompassing refugee, immigrant, and newcomers and excludes racial and/or ethnic minorities who have settled into local communities for many years but who are still on the margins of society (Bernard & Moriah, 2007). Through this lens, cultural competence is also problematic because it positions those who do not adhere to dominant, Eurocentric views as having deficits requiring intervention (Abrams & Moio, 2009; Pon, 2009). This basis for cultural competence depicts 'whiteness' as normative and neutral, while 'othering' and devaluing other groups.

Another criticism of this understanding of cultural competence is its claim to redress the power imbalance between client and worker when mental health professionals

inherently have more power and influence in the therapeutic relationship. Even if the client and practitioner are assumed to have mutuality in meaning making, practitioners are not immune to the cultural influences embedded in the academic and professional institutions within which they practice. And although clients do have a reciprocal relationship with culture, their expressions of culture and agency change depending on the individual and the given context. In the same way, mental health professionals cannot presume that the same approach will be appropriate for a given client across time and place (Abrams & Moio, 2009; Guarnacci & Rodriguez, 1996). Simply adapting existing models of treatment and therapy based on a client's current perspective is not sufficient for culturally competent, anti-oppressive practice (Whaley & Davis, 2007).

Current perspectives of cultural competence more aligned with the values of anti-oppressive practice define cultural competence as an ongoing process of learning and understanding another's perspective, and recognizing that practitioners only have partial knowledge. There is less focus on acquiring culturally-specific knowledge and imposing one's expertise onto a client's situation, and more on using client perspectives to guide intervention (Dean, 2001; Bernard & Moriah, 2007; Whaley & Davis, 2007). This approach acknowledges that once a worker presumes to know everything, the worker has then appropriated another's culture to assert their own dominant position. It views client as expert and uses the worker's not-knowing stance to gain understanding of clients' meanings and experiences (Dean, 2001). This model emphasizes process rather than the attainment of competencies in recognition of practitioners' incompetence in knowing everything (Bernard & Moriah, 2007; Tervalon & Murray-Garcia, 1998).

Cultural safety is gaining prominence in the area of cultural competence. Cultural safety is significant when it comes to working with Aboriginal communities as service providers work to redress inequitable health and mental health statuses among Aboriginal peoples as a result of the historical and intergenerational trauma of colonization (Josewski, 2012). Cultural safety is a process as well as an outcome that shifts attention away from the 'other' in treatment to redress the power relations that contribute to the continued marginalization of Aboriginal communities through mental health services (Josewski, 2012). It involves a critical examination of how marginalized groups are treated within the dominant culture (Bernard & Moriah, 2007; Dean, 2001).

Cultural competence models have been criticized for their inability to adequately address service gaps, and particularly in an anti-oppressive way. Its many conceptualizations have led to confusion as to what actually constitutes cultural competence, and its lack of specificity has also been an impediment for creating concrete learning and practice objectives in the helping professions (Abrams & Moio, 2009; Williams, 2006). These inconsistencies have led to ambiguity around the ways in which mental health service providers develop their philosophies of care (Nardi et al., 2012).

The area of mental health poses additional challenges when it comes to providing culturally competent, anti-oppressive services. As service users often come to participate in services involuntarily, the potential for power-sharing is already significantly reduced due to the intrusive and paternalistic nature of treatment (Cowan, Banks, Crawshaw, & Clifton, 2011; Pollack, 2004). This is evidenced by the use of certification under the Mental Health Act (RSBC, 1996), secure wards and severe diagnoses, and heavy reliance on the medical model and expert-based clinical judgement (Glass & Arnkoff, 2000).

When an individual enters the mental health system, they are subjected to biopsychiatric, Eurocentric, middle-class ideals of illness, assessment, and treatment (Craig, 1999; Guarnaccia & Rodriguez, 1996). This relegates the client to a limited framework for validating their experiences, diagnostic labeling, treatment options, and communication styles (Craig & Singh, 2012). Other important social and cultural factors that affect one's mental health like marginalized status, trauma, violence, and abuse, for example, are often overlooked (Pollack, 2004). Treatment centred around individualism, self-determination, and authority figures is also not always compatible with non-western ways of knowing. In these and many other ways, the mental health system can be considered a culture in itself (Dow, 2011).

Cultural competence has largely focused on individual work with clients and not enough has been done to effect change on a structural level (Abrams & Moio, 2009; Josewski, 2012; Bernard & Moriah, 2007). This is demonstrated in the lack of formalized policies and procedures around culturally competent practice, and a lack in the body of work on integrating policy into practice (Bernard & Moriah, 2007; Capell et al., 2007; Whaley & Davis, 2007). Other areas requiring further development include addressing the stigma of mental illness and building up organizational cultural competence as issues of institutional power and oppression are often neglected (Bernard & Moriah, 2007). Minority representation among staff is also a contentious issue as employees are inevitably hired into institutions that already have a pre-existing culture and into positions that have limited opportunities to engage in policy making (Bernard & Moriah, 2007).

Lastly, research literature on the efficacy of cultural competence models has been limited (Capell et al., 2007). There are few evidence-based practice guidelines and

measurement tools to build on existing knowledge. The multiple constructs of cultural competence also make it difficult to evaluate reliability and validity (Capell et al., 2007; Josewski, 2012). Evaluation tools in mental health services remain preoccupied with cost savings or are based on measures that are operationalized to privilege powerful stakeholders rather than client interests (Bernard & Moriah, 2007; Capell et al., 2007).

With increased pressure to provide effective care to marginalized individuals with severe mental illness and limited resources to accomplish it, policy makers and service providers are in agreement that a more responsive approach is essential to remedying issues related to cultural competence in mental health services. The approach taken thus far appears to have been for political gain than clients' mental health and well-being. Clients continue to have negative experiences due to gaps in service located within staff members, service settings, and the system in general. Despite their limitations, the values and principles of emerging models of cultural competence are more aligned with those of anti-oppressive practice, and have more potential than previous approaches to examine and redress relations of power and oppression in mental health services.

This chapter provided a closer look into how philosophies of care in mental health services in Vancouver have changed over time to accommodate the needs of the free market state. Mental health clients' overall negative experiences with health and mental health services were also discussed, as were the cultural competence models currently in practice and the criticisms and challenges they face. The following chapter will review the research design and methodology used for this study. The study's objectives, strengths and limitations, and ethical considerations will also be explored.

CHAPTER THREE: METHODOLOGY

This chapter provides an overview of the research design and methodology used to carry out this study. It will begin with a brief summary of the research objectives followed by a rationale for the study's qualitative research design and the methods utilized for sampling, data collection, and data analysis. The chapter concludes with a discussion of the study's strengths, limitations, and ethical considerations.

Research Objectives

The objectives of this thesis were to learn more about cultural competence in mental health services through the perspectives of clients from marginalized backgrounds, and to better understand the implications of their experiences on mental health services. This study investigated the following questions: (1) What are the experiences of mental health clients, who identify as members of marginalized groups, with cultural competence in mental health services in Vancouver? (2) What are the implications of these experiences on the development of culturally competent mental health services?

Grounded in the values of anti-oppressive social work practice, this study recognizes that clients from marginalized backgrounds have traditionally been and continue to be marginalized further by the mental health system. As such, another function of this study was to centre client perspectives within a knowledge base typically dominated by experts through the use of first voice accounts (Morley, 2003; Pollack, 2004).

Study Design

This qualitative study used an exploratory research design to gain greater insight into mental health clients' lived experiences with cultural competence in mental health services. An exploratory approach is complementary to the purposes of this study as its aim is to discover new learning about a topic rather than to explain a phenomenon or test a theory (Rubin & Babbie, 2011).

Qualitative methods were chosen as the method of inquiry because its features best align with the study's objectives and with the values of anti-oppressive practice. They are characterized by an understanding that realities and the meanings of those realities are subjective and multiple. Thus, a commitment to situating study participants within their environments is required (Kirk & Miller, 1986; Mays & Pope, 1995). A qualitative design is best suited for in-depth studies of complex phenomena, such as that set out by this study, which involves exploration among a smaller sample and where data cannot be easily reduced to numbers. Qualitative methods allow for more flexibility in these circumstances (Rubin & Babbie, 2011; Streubert Speziale & Carpenter, 2007).

Sampling

Purposive sampling and snowball sampling was used to recruit study participants. Purposive sampling was selected as a method of recruitment because it allows for a deeper understanding of a targeted population (Rubin & Babbie, 2011). In this case, clients with mental illness who identify as members of marginalized groups and who have lived experiences with cultural competence in Vancouver's mental health services were studied. To recruit study participants, I connected with various mental health service providers to make research interests known within the community; this also provided

opportunities for them to direct me to other options for recruitment. Recruitment flyers (please see Appendix B: Recruitment Flyer) were posted and distributed at two community mental health drop-in centres in Vancouver with their permission (please see Appendix C: Permission to Post and Distribute Recruitment Materials Form).

Once recruitment was in motion, snowball sampling was utilized wherein study participants were able to refer other clients who met the inclusion criteria to participate in the study (Rubin & Babbie, 2011). Snowball sampling complemented purposive sampling with the recognition that clients who are marginalized often face additional forms of social exclusion and may be difficult to reach. Thus, efforts were made during recruitment to meet clients where they were at by using word of mouth amongst peers.

In order to participate in the study, each study participant had to meet the following inclusion criteria: (1) is a current client of mental health services in Vancouver such as mental health teams, mental health housing, drop-in centres, community groups and programs, etc. (2) has a diagnosed major mental illness, such as schizophrenia, major depression, bi-polar disorder, etc. (3) is at least nineteen years of age, (4) self-identifies as a member of a marginalized group based on race, ethnicity, gender, sexuality, class, age, (dis)Ability, religion, or other self-identified social categories (5) can communicate in English, (6) is willing and able to give informed consent to participate in the study, and (7) is prepared to speak in a sixty minute one-on-one interview about their personal background and experiences with cultural competence in mental health services. Verification of study participants' eligibility to participate in the study was through self-identification only to protect confidentiality, and no additional screening tools were utilized to confirm diagnoses, membership in groups, or ability to participate in the study.

Exclusion criteria applied to clients who I have worked with in the past or who I currently work with. In total, ten mental health clients participated in the study. This number is consistent with the literature on saturation of data when utilizing thematic analysis (Guest, Bunce, & Johnson, 2006); it is also a feasible sample size to manage practically.

Data Collection

I conducted in-depth, semi-structured interviews with each study participant. Study participants were asked fourteen questions following an interview guide (please see Appendix F: Interview Guide) which explored study participants' backgrounds and their understandings of and experiences with cultural competence in mental health services in Vancouver. Follow-up questions were also asked based on the study participant's responses for further exploration of points of interest. The interviews were audio-recorded using Windows 7 Sound Recorder and I transcribed them into text using Microsoft Word 2013 where it was stored and organized. Study participants were also asked to complete a survey for the collection of demographic information (please see Appendix E: Demographics Survey).

A document review of five government and mental health publications was also conducted to explore the current framework for culturally competent mental health services set out by policy makers and service providers.

Data Analysis

Thematic analysis was used to encode and analyze data collected from the individual interviews and from the document review. Thematic analysis is a process for encoding, analyzing, and reporting patterns within data (Boyatzis, 1998; Braun & Clarke, 2006). It works to capture both reality as experienced by study participants as well as the

underlying constructs that influence their realities (Braun & Clarke, 2006). It also involves the ability to recognize, interpret, and conceptualize data that is meaningful (Boyatzis, 1998). Thematic analysis offers flexibility in exploring themes within data in that it is not limited to the exploration of one source of information nor is it bound by any one method of inquiry (Boyatzis, 1998; Braun & Clarke, 2006). Thematic analysis draws from a variety of sources from which to code and analyze data in a systematic way; this method serves to increase accuracy and sensitivity in interpreting data (Boyatzis, 1998).

Thematic analysis can be inductive and driven by the raw data collected; conversely, it can be deductive, theory-driven or driven by previous research, or it can fall somewhere along the continuum (Boyatzis, 1998; Braun & Clarke, 2006). This study sought to centre study participants' perspectives rather than to fit their responses into any particular construct. As such, thematic analysis of data collected was inductive and data-driven. A deductive approach was also used at a later stage of analysis to identify underlying constructs that help shape clients' realities to better understand their implications. Similarly, anti-oppressive social work practice was drawn upon to examine the sociopolitical context and rhetoric of the reports reviewed, and to better understand the study findings' implications.

I reviewed the interview transcripts several times in order to immerse myself in the data and become familiar with its depth and breadth (Braun & Clarke, 2006). Each unit of data was initially paraphrased or briefly summarized, allowing for as many potential codes as possible. The entire data set was then reviewed again and similar patterns of meaning and points of interest were categorized accordingly.

The coded text was reviewed again, and recurring themes were identified, defined, named, and further refined into sub-themes. Each code was assigned a label, a definition of the theme or sub-theme, a description of the theme's or sub-theme's indicators, qualifications and exclusions, and examples. Special care was taken to allow for maximum differentiation between the various codes (Boyatzis, 1998). After the entire data set was coded, it was reviewed once again to ensure the meanings of each unit of data accurately reflected its corresponding code and vice versa, and to verify that no data was missed (Braun & Clarke, 2006). Themes and sub-themes were examined for any relation to one another, and were analyzed on a more interpretive level to examine underlying constructs and implications on mental health policy, mental health services, and social work practice; this process was overseen and reviewed by the thesis supervisor. The document review was completed using the same methods of thematic analysis as the interviews.

Strengths and Limitations

This study had both strengths and limitations in regards to sampling, data collection, and data analysis. The extent to which this study's research design and methodologies encompassed the values of anti-oppressive social work practice and the study's rigour and trustworthiness were also carefully considered.

Purposive and snowball sampling allowed access to individuals who are marginalized and typically hard to reach, such as clients who are homeless or at risk of becoming homeless. These sampling methods, in conjunction with recruitment at two low barrier drop-in mental health centres in the community frequented by clients from marginalized backgrounds, were driven by anti-oppressive practice principles of situating

clients in their environments and meeting them where they are at. As a result, clients did not incur any costs by participating in this study as interviews were conducted at a time and place of their convenience. These sampling methods did, however, inadvertently exclude other populations who are differently marginalized and whose experiences may have been different. For example, this study excluded non-English speaking clients from sharing their personal experiences, which itself is not culturally competent.

In terms of data collection, working with a small sample size allowed for the collection of a rich, descriptive data set from the study participants. The drawback, however, is that the results of this study cannot be reliably applied to other settings, though that is not the goal of this study (Coffey & Atkinson, 1996).

While it was initially proposed that the individual interviews be sixty minutes long, most study participants were only prepared to speak about their experiences for approximately thirty minutes. The shorter interview time limited the amount of data collected, but was found to be sufficient in capturing clients' experiences while being respectful of their comfort levels in sharing their personal stories. This time frame was also found to be adequate for elaborating on clients' responses using follow-up questions on topics that were significant to them, which valued their ways of knowing and reduced projection on my part (Boyatzis, 1998). Due to practical constraints and those related to confidentiality, member checking was not done and study participants' responses could not be further validated (Boyatzis, 1998).

Audio taping the individual interviews and having hard copies of reports for the document review reduced variation in observations as it allowed for consistent and repeated reviews during analysis (Boyatzis, 1998). Although audio recordings could not

capture non-verbal communication, I worked to mitigate this by verbalizing my observations of these cues as they arose during the interview.

I spent time with each study participant to explore their definitions and experiences of cultural competence in mental health services. The full range of meanings that could be included within the concept of cultural competence were explored (Rubin & Babbie, 2011). The study did not seek to compare and contrast clients' understandings according to one objective definition of cultural competence, but to understand their subjective interpretations of and experiences with cultural competence in mental health services (Kirk & Miller, 1986; Mays & Pope, 1995). I ensured that the codes attributed to units of data were mutually exclusive of one another. I also reviewed the data set multiple times and compared the data to the code to ensure it met the code's criteria and vice versa (Boyatzis, 1998). To avoid bias, I was reflexive and used a learner stance during my interviews with study participants; where I felt I began to make assumptions, I asked follow-up questions for clarification.

Using thematic analysis allowed for the collection and analysis of data from multiple sources and methods of inquiry. By using both an inductive and deductive approach, this study used both a bottom-up approach to incorporate client knowledge and experiences in the literature and a top-down approach to examine the rhetoric embedded within service frameworks set out by policy makers and service providers (Coffey & Atkinson, 1996). Clients' words were kept intact as much as possible through the use of direct quotations so that first voice and context would not be lost (Boyatzis, 1998; Braun & Clarke, 2006).

The sharing of data and analysis was limited to myself and my thesis supervisor through a secure shared drive to protect confidentiality. Measures were taken to mitigate any exclusion of data or possible bias; for example, data was reviewed multiple times and coded and analyzed by myself, then reviewed by the thesis supervisor to compare for agreement and consistency across raters as needed (Boyatzis, 1998).

Thematic analysis is not intended to confirm or disprove any particular theory, but anti-oppressive social work practice was drawn upon to guide the research and analysis of the data. I made efforts to be mindful of study participants' social locations and engaged in self-reflection throughout the research process.

Ethical Considerations

Ethics approval was granted by the Dalhousie University Research Ethics Board prior to commencement of this study (please see Appendix A: Letter of Approval). Permission was obtained from two community mental health service providers to post and distribute flyers for the purpose of recruiting study participants. Informed consent was obtained from each study participant prior to their participation in the study.

I have a strong commitment to anti-oppressive practice and draw from many of its tenets in my practice. I work in mental health, am a Registered Social Worker, and am bound by the ethical codes of the British Columbia College of Social Workers. To avoid conflict of interest, clients who I have worked with or currently work with were excluded from participating in the study.

Ethical considerations were also made in regards to the social locations of study participants, all of whom identify as belonging to marginalized groups and who are further marginalized by their mental health diagnoses. As such, efforts were made to

meet clients where they are at throughout the research process from recruitment through to providing the results. Study participants were each provided an executive summary at the conclusion of the study.

I am mindful that many clients who are marginalized come to participate in the mental health system involuntarily and are not always informed about the processes imposed on them. As such, I made efforts to offer study participants as much information and as many options as possible. Their voluntary participation in the study was emphasized, their rights as study participants were explicitly stated to them, as were limits to confidentiality. To be more service user-friendly, the term ‘cultural sensitivity’ was used to introduce the research topic rather than ‘cultural competence’, which is a term typically relegated to academic and professional circles.

The study participants were given opportunities to review the informed consent form (please see Appendix D: Informed Consent Form), as well as the option for me to review it with them. After the study participants reviewed the informed consent form, they were given the opportunity to ask questions or raise any concerns. They were given the option to choose how they would like to be provided with an executive summary of the study results, and were given the option of using the first name, a pseudonym, or no name at all for the purpose of referencing direct quotations.

Efforts were made to ensure study participants felt safe and comfortable during the individual interviews. I worked collaboratively with each study participant to establish interview guidelines where they could inform me of any topics that may be triggers or sensitive to them, and how they would like to indicate that they need a break or would like to stop the interview.

Due to the sensitive nature of discussing personal experiences of mental illness, measures were also taken to ensure the safety and comfort of study participants post-interview. At the end of each interview, I checked in with each study participant about any supports they had to debrief with if any discomfort or triggers did arise. Study participants were also offered a list of mental health services that they could connect with should they wish to speak to somebody at a later time. No study participants reported feeling distressed as a result of their participation in the study.

This chapter provided the research objectives, study design, and research methodologies for carrying out this thesis. The next chapter will take a look at the research findings of this study in detail.

CHAPTER FOUR: FINDINGS

This chapter presents the findings from the individual interviews with study participants and from the document review of government and health officials' reports. The themes and sub-themes discussed here reflect the different understandings of cultural competence in mental health services that have been identified. They are supported by first voice accounts of mental health service users' experiences and excerpts from service providers' publications. Client experiences with cultural competence in mental health services are explored throughout this chapter as they pertain to each theme and sub-theme. The chapter will begin with a participant profile that provides a snapshot of study participants' demographic backgrounds, followed by an overview of the themes and sub-themes that emerged from the data.

Participant Profile

Ten mental health service users each completed a demographics survey in addition to participating in an interview following an interview guide. The demographic information was collected through self-identification of various social categories including age, gender identity, sexual orientation, highest level of education, main source of income, racial and/or ethnic background, religious background, mental health diagnoses, health comorbidities and/or (dis)Abilities, other self-identified social categories, mental health services utilized, and other social services accessed. This information is presented in Tables 2 through 10. Table 1 below provides a brief synopsis of each study participant.

Participant Profile

Pat holds a university degree and is now retired. She describes herself as a disabled senior, and speaks positively about the supports she receives. Pat identifies feelings of powerlessness as most significant to her as a client in the mental health system.

Troy is Caucasian-Métis and is on disability pension due to (dis)Abilities related to his mental and physical illnesses. In his interview, he shares his experiences of stigma and how he overcame them.

Ed is currently living in a single room occupancy (SRO) hotel and is on Persons with Disabilities (PWD) disability assistance. He volunteers at a local food bank and is paid a monthly honorarium for his work. Ed's main concerns with mental health services revolve around housing.

Chris immigrated to Canada as a child and has a rich family history. During his interview, Chris talks about the experiences he has had in a variety of service settings including his mental health team, in supported housing, while living in an SRO, and in the time he spent homeless.

Denise identifies as fourth generation Blackfoot and is on PWD. In her interview, she discusses the ways her mental illness has affected other areas of her life and vice versa.

Jim has a post-secondary diploma and works part-time at a local hospital. Jim has been in the system since he was a child and makes many insightful observations about the workings of the mental health system during his interview.

Louise is married with three adult children and lives in a co-op with her husband. Like many other study participants, Louise is on a limited income and this is an important consideration for her when it comes to cultural competence, as is being listened to.

Prima is Métis, Welsh, and Swedish, and is on PWD. In addition to her mental illness, Prima also experiences hardships related to her social location. Prima is closely connected with her spiritual side and takes a holistic approach to managing her mental health and well-being.

James identifies his low income status as having significant impacts on his mental health and on his life in general. He is currently homeless and takes issue with service providers who violate clients' rights and who offer support but do not follow through.

Nola is a First Nations woman who lives in supported housing with her husband. Nola speaks positively about how psychiatric medications prescribed by her psychiatrists have changed her life for the better, but negatively about staff in her building who she feels are abusive.

Table 1: Participant Profile

Nine (9) of the ten study participants were between the ages of 26 and 64, and one (1) was over the age of 65. Five (5) identified as female as their gender identity and five (5) identified as male. In regards to sexual orientation, eight (8) of the study participants identified as heterosexual or straight, one (1) identified as homosexual or gay, and one (1) identified as celibate. This information is displayed below in Table 2.

Age	Number of Participants
26 – 64	9
65+	1
Gender Identity	Number of Participants
Female	5
Male	5
Other	0
Sexual Orientation	Number of Participants
Heterosexual or straight	8
Homosexual or gay	1
Celibate	1

Table 2: Study Participants' Age, Gender Identity, and Sexual Orientation

Study participants were asked about their highest level of education and main source of income. One (1) study participant held an undergraduate degree and two (2) others had post-secondary diplomas. Four (4) study participants had some post-secondary education, one (1) had high school completion, and two (2) had some high school education. Five (5) of the ten study participants had Persons with Disabilities (PWD) designation and were receiving (dis)Ability assistance while two (2) others were receiving income assistance. One (1) study participant was on Canadian Pension Plan (CPP) disability pension and one (1) study participant's income was through a private pension. One (1) study participant's main source of income was through part-time employment. Three (3) study participants supplemented their main source of income with volunteer positions through which they received monthly honorariums. This information is listed below in Tables 3 and 4.

Highest Level of Education	Number of Participants
Some grade school	0
Some high school	2
High school completion	1
GED completion	0
Some post-secondary education	4
Post-secondary diploma	2
Undergraduate degree	1
Graduate degree	0
Post-graduate degree	0

Table 3: Study Participants' Highest Levels of Education

Main Source of Income	Number of Participants
PWD disability assistance	5
Income assistance	2
CPP disability pension	1
Private pension	1
Employed part-time	1
Employed full-time	0
Employed temporary/casual/seasonal	0
Volunteer supplement	3*

Table 4: Study Participants' Main Sources of Income

*Supplement to main source of income

The racial and/or ethnic backgrounds of the study participants were diverse, as were their religious backgrounds. Three (3) study participants were Caucasian or White, two (2) identified as First Nations, one (1) was Caucasian and Metis, one (1) was English-German, one (1) was Portuguese, and one (1) was Metis, Welsh, and Swedish. Their religious backgrounds include atheist (2), Roman Catholic (2), agnostic (1), Anglican (1), and four (4) identified none. This information is available below in Tables 5 and 6.

Racial and/or Ethnic Background	Number of Participants
Caucasian or White	3
First Nations	2
Caucasian and Metis	1
English-German	1
Portuguese	1
Metis, Welsh, and Swedish	1

Table 5: Study Participants' Racial and/or Ethnic Backgrounds

Religious Background	Number of Participants
None	4
Atheist	2
Roman Catholic	2
Agnostic	1
Anglican	1

Table 6: Study Participants' Religious Backgrounds

Mental health diagnoses (please see Table 7) of schizophrenia (4), bi-polar disorder (2), major depression (1), and dysthymia (1) were identified among study participants. Some had multiple diagnoses: one (1) identified as having anxiety, depression, and attention deficit and hyperactivity disorder (ADHD), and another (1) had bi-polar disorder, post-traumatic stress disorder (PTSD), anxiety, and depression.

Mental Health Diagnosis	Number of Participants
Schizophrenia	4
Bi-polar disorder	2
Major depression	1
Dysthymia	1
Anxiety, depression, and ADHD	1
Bi-polar, PTSD, anxiety, and depression	1

Table 7: Study Participants' Mental Health Diagnoses

Some study participants experienced additional health comorbidities and/or (dis)Abilities (please see Table 8) such as arthritis (2), alcoholism (1), chronic pain (1), hepatitis C (1), partial deafness (1), and sleep apnea (1). Other social categories (please see Table 9) that were identified as significant include artistry (1), housing issues (1), immigrant status (1), married with kids (1), being a single parent (1), and spirituality (1).

Health Comorbidities and/or (dis)Abilities	Number of Participants
Arthritis	2
Alcoholism	1
Chronic pain	1
Hepatitis C	1
Partially deaf	1
Sleep apnea	1

Table 8: Study Participants' Health Comorbidities and/or (dis)Abilities

Other Social Categories	Number of Participants
Artistry	1
Housing issues	1
Immigrant status	1
Married with kids	1
Single parent	1
Spirituality	1

Table 9: Study Participants’ Other Social Categories

Study participants reported using a range of mental health services including drop-in centres, mental health teams, supported housing, in-hospital psychiatry, short-term stabilization units, community organizations, consumer-driven networks, a therapist or counselor, and vocational services. Social services that study participants utilized included BC Housing, community centres, and homeless shelters. These services are displayed below in Table 10.

Mental Health Services	Number of Participants
Drop-in centre	8
Mental health team	7
Supported housing	6
Hospital – Psychiatry	4
Short-term stabilization unit	2
Community organizations	1
Consumer-driven network	1
Therapist or Counselor	1
Vocational services	1
Social Services	Number of Participants
BC Housing	1
Community centres	1
Homeless shelter	1

Table 10: Study Participants’ Utilization of Services

Five documents consisting of four reports and one piece of legislation were examined for the document review. These documents along with keywords pertaining to culture or cultural competence are listed in Table 11.

Document Reviewed	Keywords Pertaining to Culture or Cultural Competence
Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (Ministry of Health, 2010)	<i>Culturally-specific approaches; culturally distinct plan; culturally specific, coherent spectrum of prevention, early intervention and specialized care; culturally appropriate mental health education initiatives; to foster cultures; cultural environment; cultural rights; cultural dislocation; cultural expectations; cultural needs</i>
Improving Health Services for Individuals with Severe Addiction and Mental Illness (Ministry of Health, 2013)	None found
Improving Health Outcomes, Housing and Safety: Addressing the Needs of Individuals with Severe Addiction and Mental Illness (Vancouver Coastal Health, 2013)	None found
Caring for All: Priority Actions to Address Mental Health and Addictions (City of Vancouver, 2014)	<i>Culturally appropriate systems of care; culture of wellness; Aboriginal culture (3); alignment with one's culture; connection to culture; re-united with culture; culturally safe and relevant services; culture as medicine: Cultural competency/safety; cultural sensitivity</i>
Mental Health Act (RSBC, 1996)	None found

Table 11: Document Review

Themes and Sub-Themes Identified

Based on study participants' understandings of and experiences with cultural competence in mental health services, in culmination with service providers' definitions and provision of culturally competent mental health services, several themes and sub-themes emerged. Clients' personal stories and observations from the document review speak to definitions of cultural competence in the following six domains:

Cultural competence in the programs offered

- Health and wellness activities
- Low or no cost programs
- Making social connections

Cultural competence as work with members of marginalized groups

- Doesn't apply to me
- Culture in general terms
- Focus on Aboriginal peoples

Cultural competence as representation of marginalized groups

- Meeting like-others
- Multicultural staff and clients
- Client involvement

Cultural competence in the qualities exhibited by staff

- Having "a certain way of carrying themselves"
- Staff as expert
- They do the best they can versus it's just a job

Cultural competence as "having all my needs looked after"

- Mental health and physical health
- Mental health and low income status
- Mental health and housing

Cultural competence is "a lack of discrimination"

- Powerlessness and hopelessness
- Violation of rights
- Stigma
- Strength, Resistance, and Resilience

Cultural Competence in the Programs Offered

Most study participants are connected to a mental health team where they meet with their psychiatrist, case manager, and other mental health professionals. All of the study participants attend a drop-in mental health service centre in downtown Vancouver and also regularly access other services in the community that may or may not be mental health-focused. In addition, some study participants live in mental health supported housing and some have had experiences in hospital and tertiary care settings.

Study participants have had positive experiences with programs that take their social locations into account. These programs, provided in some detail below, include health and wellness promotion groups that offer opportunities for therapy and skill-building, and low or no cost programs. Through these programs, clients are able to connect with others on an interpersonal level, though group settings are not always ideal.

Health and Wellness Activities

Clients speak positively about health and wellness programs including acupuncture, swimming, Clean Start, Healthy Heart, and low cost meals. Louise talks about Butt Out, a smoking cessation group that helps her develop skills “*to deal with no cigarettes*” as she is a low income smoker. She also describes how the walking group has been beneficial to her mental health: “*I walk and then I get feeling better [in my head]*”. Pat remembers a time when she wanted to return to school to get a Master’s degree. As she says, “*The occupational therapy support was there, but I wasn’t eligible for grants or anything*”. Having adequate staffing levels but insufficient funding to support clients’ goals is identified as a barrier to cultural competence in mental health services.

In addition to the existing programs, Troy would like to see a mental health professional on site at drop-in centres who is readily available if a client needs to talk to someone, rather than having to wait for an appointment at their mental health team. He would also like to see groups like anger management, meditation, and yoga. Jim suggests more programs directed at life skills development such as hygiene or financial planning, and more emphasis on addictions recovery, which he feels is currently lacking. Some programs serve dual purposes in that they contribute to health and wellness, as well are geared towards low income clients.

Low or no cost programs

Low or no cost programs utilized by study participants include a variety of activities and services such as gardening, clothing donations, weight room, laundry services, a library, low cost meals, food bank, etc. In addition, some study participants hold paid volunteer positions within service settings that help supplement their income.

One program highly praised by clients is the low cost meals offered at the drop-in centre. Louise, who is on PWD, describes why it is so important: *“I need nutrition, to pay attention to my nutrition”*; other clients express their appreciation for the weekly meals served in supported housing. Low income clients are able to have their physical health and nutritional needs met through programs such as these.

Another program that study participants enjoy are the recreational activities and outings available through mental health leisure programs; for example, a pool table, day trips, visits to the aquatic centre, arts and crafts, bingo, games, singing group, coffee chat, and nails and grooming. These low or no cost programs provide clients opportunities to participate in leisure activities that they would otherwise not be able to afford to access. They also help clients to make important and valuable social connections with others.

Making social connections

Study participants’ experiences reveal how the social aspect of programming in mental health services can have its pros and cons. The following are study participants’ feedback about how group settings contribute to their mental health:

“I live alone, I have a cat. So I just do it to get out of my place and I eat. And it keeps me, and this place, it’s for my mental health, really. This is part of my program coming here every day. This is part of my routine ... I just need a space away from my scene ... like a break. Solace. You need solace. We all need solace.” – Troy

“I just come to [the drop-in centre] and I hang out for a few days and I feel better. It’s safe, it’s comfortable, I don’t hurt anybody and nobody’s hurting me. It’s a really good place just to come and spend a few days and not have to think about anything.” – Jim

“When I’m not working I’m really used to, in the morning to kind of get myself out, have some kind of sociability, and the staff here is always good if you’re not feeling well.” – Jim

“Well it’s helped me take a lot off my shoulders and a load off my mind because it distracts me and I don’t have to think about so much cause I’m keeping my mind occupied with something that’s healthy and wise. So, you know, it doesn’t affect me so much, with my bi-polar, PTSD, anxiety, so. Cause I’m keeping my mind active by doing the activities that are here.” – Denise

Conversely, group settings can sometimes have a negative effect on one’s general sense of safety and well-being. Prima describes her experiences: *“Sometimes you have to be careful cause on some days, right? Maybe there’s nowhere to get a moment’s peace, and if you have a headache or something, you know? Like that happened to me, and that was like the worst. It was noisy in my building and it was really noisy here too”*. Prima’s experiences describe the difficulties of not being able to find any peace and quiet to herself in her supported housing building nor at the drop-in centre. With no relief, Prima feels her only other options are the hospital, suffer until her medications take effect, or self-medicate.

Prima also had a bad experience working at an organization that employs marginalized women intended to bring them together in a safe place. Prima experienced the opposite and felt excluded by the other women. In the end, she felt she had to leave that position to *“protect [herself] from situations that are causing [her] strife”*. Another reason Prima found it difficult to stay at that organization was having to take on the personal trauma of the other women:

“They would talk about stuff that was really remorseful and that’s all they would talk about. And the training was so hard because every single one of them had a story. I have a story too, but I’ve learned how to you don’t have to pour it out every time and make it, and get everybody upset. And it was like, I felt so fucking used after it because like I’ve been just put through fifteen other women’s hell. And it went on like this for two years so forget it, right?”

For Nola, other clients’ mental health has had a negative effect on her: *“Well people, some of them are really have moods and it affects me ... some of them they act like spoiled children and they make you angry. And to avoid that I only come in twice a week”*. She elaborates: *“Sometimes the staff talks to them but you can tell when they’re sick and they start saying really mean things and they’re screaming and shouting. Or they’ll come in stoned or drunk”*. As a result of others clients’ behaviours, Nola has had to limit her time at the drop-in centre.

The business hours of mental health services can impede on clients’ abilities to connect with peers, especially for those who are homeless. Not having others to talk to outside of business hours exacerbates James’s feelings of depression and isolation. And while Jim finds the social aspect of group settings to be beneficial, he hopes to see more programs that generate more meaningful discussion among service users.

Cultural Competence as Work with Members of Marginalized Groups

Cultural competence is commonly understood as work with members of traditionally marginalized groups; however, this definition is interpreted differently by clients and service providers. Some feel it does not apply to them at all while some understand culture, and therefore cultural competence, in general terms. Furthermore, others view cultural competence as especially relevant to Aboriginal peoples.

Doesn't apply to me

The individual interviews and the document review find that for some, cultural competence is work with members of traditionally marginalized groups, with recognition that these individuals face additional challenges. For example, in *Healthy Minds, Healthy People*, the Ministry of Health (2010) touches on how the “*conflicting cultural expectations*” (p. 22) between members of immigrant and refugee families can be a stressor. It also considers seniors to be a group with specialized needs that require “*an appropriately integrated response that addresses the clinical, functional, psychosocial and cultural needs of this population group*” (p. 24). Similarly, the City of Vancouver’s (2014) targets youth as a group that would benefit from “*culturally appropriate systems of care*” (p. 26) through improvements in their “*overall culture*”. As such, some study participants initially felt that cultural competence in mental health services was not relevant to their situation.

When asked what cultural sensitivity in mental health services means to him, Jim’s first reaction is:

“To me, per se, not much. But I’ve seen other people, my neighbour who’s a gay man. I’m surprised he was telling me about some of the issues facing gay people, and it’s more involved than I would’ve thought, that I would’ve recognized ... So I understand there’s a lot of issues facing different people: Language barriers, adapting to a new culture. But myself, personally, I don’t feel that I’ve been through much.”

Similarly, Pat has this response: “*Well I would think that this wouldn’t really apply to me because I’m Caucasian and, you know, single parent, well not single parent but Anglo-saxon protestant kind of stereotype and I always think people who need cultural sensitivity are people who speak English as a second language or who are First*

Nations or something like that". These understandings of cultural competence vary from other definitions that view culture as society more generally.

Culture in General Terms

Service providers have an understanding that specific population groups have diverse needs related to their sociocultural circumstances that require different service approaches, but these groups are not always explicitly described as cultures and thus services for these groups are not seen as requiring cultural competence (Ministry of Health, 2010). For example, the SAMI population is recognized as requiring the most intensive levels of treatment due to the complex health and psychosocial issues they face and are marginalized by. The two reports outlining service guidelines for this population, however, make no references to culture or the need for culturally competent mental health services (Ministry of Health, 2013; VCH, 2013).

The document review finds that culture is more commonly used to refer to society in a more general sense. Healthy Minds, Healthy People (Ministry of Health, 2010) uses 'culture' in this way: "*With regards to youth, it's important to take into account normal risk-taking and to foster cultures and create environments in which the healthy choice for young people is the easy choice*" (p. 13). While this excerpt speaks to working with youth, the use of 'culture' actually points to society as a whole. In the Reduce Stigma and Discrimination section, it reads: "*A cultural environment that respects and protects basic civil, political, economic, religious, social and cultural rights is essential to mental health and healthier choices about substance use*" (p. 18). Here, 'culture' is used to describe systems in society that impact on individuals with mental health and substance use issues

in the areas of health care, employment, education, justice, and housing; ‘culture’ is then used in the context of rights afforded to citizens of society (Ministry of Health, 2010).

Caring for All (City of Vancouver, 2014) alludes to the idea that people have their own individual cultures: “*Alignment with one’s culture and sense of purpose is important in prevention and recovery from addictions*” (p. 52). This understanding expands the interpretation of culture as pertaining to one’s unique social location, but the report does not elaborate further. In other sections of the report, it talks about prioritizing public education on Aboriginal culture and integrating Aboriginal culture in schools and other public spaces. Even though ‘culture’ here points to Aboriginal culture, the target of intervention is actually on educating the general public. That being said, there are also priorities outlined in the report directed at Aboriginal peoples.

Focus on Aboriginal Peoples

Particular attention is paid to members of Aboriginal communities who would typically be participants of culturally competent mental health services. Earlier, Pat makes the same observation. Troy demonstrates a similar understanding: “*Ohh, culturally sensitive, yeah. Like, yeah, I know what you mean. I thought of First Nations or something like that*”.

Service providers understand culturally competent mental health services as significant to First Nations peoples. The Ministry of Health (2010) discusses the development of “*culturally-specific approaches*” (p. 3) and a “*culturally distinct plan*” (p. 3) in partnership with B.C.’s Aboriginal communities. It recognizes the need for a “*culturally specific*” (p. 10) spectrum of care and “*culturally appropriate*” (p. 10) mental

health education initiatives in partnership with Aboriginal communities (Ministry of Health, 2010).

The City of Vancouver (2014) also recognizes the importance of having culturally competent mental health services available to First Nations communities in the Caring for All report: *“For Aboriginal Peoples, including youth, connection to culture as a sense of identity and a source of pride is fundamental to wellness. Being re-united with culture plays a significant role in healing and wellness and needs to be recognized along with the western model of health care. Culturally safe and relevant services also positively impact the ability for people to access mainstream addictions services”* (p. 32). The City intends to adopt a more holistic approach more reflective of Aboriginal culture. The report describes *“culture as medicine”* (p. 35) for Aboriginal peoples and touches briefly on the connection between cultural competence and cultural safety (City of Vancouver, 2014).

There is recognition among service users and service providers that the effects of colonization, intergenerational trauma, and cultural dislocation on Aboriginal peoples in Canada have resulted in the overrepresentation of Aboriginal peoples in the SAMI population, and underrepresentation of their interests within mental health services. Thus, culturally-specific considerations need to be taken when working with this group (City of Vancouver, 2014; Ministry of Health, 2010).

Cultural Competence as Representation of Marginalized Groups

Meeting like-others

Study participants reflected on their experiences with cultural competence in mental health services in relation to their own unique backgrounds and situations. Clients share that the presence of like-others offers feelings of inclusion and acceptance, serves

as a means of validating and normalizing their own experiences in mental health, and builds a sense of community.

These statements support the notion of feeling included and accepted:

“It helps if there are a few staff members who belong to marginalized groups like there are here ... it would just give you more of a feeling of being accepted.”
– Chris

“You can talk about more things, you can talk about things more freely with members of your own group.” – Chris

Meeting like-others serves to validate and normalize one’s experiences:

“Ever since I met her I’ve been feeling kind of better because I at least had in my hand tangible proof of someone else, there’s other people pretending you’re not, saying you’re just on drugs and things like that. This is a living person ... and so just since meeting her and stuff I’ve felt maybe not so crazy, right?” – Prima

“It’s nice to have a gay doctor like I do ... because he took more interest in my letters than someone else probably would’ve.” – Chris

It also works to build a sense of community:

“The best part was meeting other members and finding out they were gay. Because I have been able to chat with them on a regular basis when they’re downstairs, when they’re here. Knowing that they’re gay and they’ve introduced me to other people who didn’t attend the group who were also gay.” – Chris

“We’re all in the same boat here so we all support and help each other. We do what we can, you know, respecting each other.” – Denise

“Everybody gets along ... it’s pretty good. There’s all ... a mix here so everybody gets along.” – Troy

While meeting like-others speaks to the positive aspect of cultural competence through the representation of culturally-specific group members, study participants’ responses indicate that this definition is not fixed because they simultaneously view cultural diversity as an indication of cultural competence as well.

Multicultural staff and clients

Having multicultural staff and clients within mental health service settings is identified as a sign of cultural competence. Troy says:

“Well one thing about it that I’ve noticed here is that they hire multicultural staff here ... so it’s a very multicultural place, so I like that aspect of it ... they have a real mix of people that come here too that have, [client] members and staff members, so I kind of like that. I think that’s very good.”

Prima observes there are no staff members from any racial and/or ethnic minority groups at her mental health team. She describes feeling *“really nurtured by like, women who are from another nationality that are older”*, and that *“everything else is pretty stagnant and plain”* without cultural diversity. She speaks positively about a chat group that she attends, saying, *“It’s nice because there’s elders here ... it’s just nice to listen to them talk; it’s something I enjoy”*. Clients’ observations demonstrate that service users from a variety of backgrounds see a benefit of a culturally diverse presence and a good mix of multiculturalism among staff and clients is an indicator of cultural competence.

Client involvement

Study participants discussed the extent of their involvement in mental health services. All of them were connected with mental health services as participants, and most have been asked for feedback based on their experiences as service users. Some recall completing annual feedback surveys around program satisfaction, quality of food served, staff members, and sense of safety. Others remember being asked for feedback informally or in passing on a monthly or weekly basis, while others not at all. Study participants report seeing improvements based on the feedback that they have provided. Some speak about their level of involvement with program facilitation and development, and others talk about not having had opportunities to do so. None of the study

participants have been offered a chance to participate in decision-making at the organizational level. These results are illustrated in Table 11 below.

Client Involvement in Mental Health Services					
Study Participant	Giving feedback	Treatment planning	Program facilitation or operations	Program development	Organizational decision-making
1	Yes	No	No	Yes	No
2	Yes	No	No	No	No
3	Yes	No	Yes	No	No
4	Yes	No	No	No	No
5	Yes	No	No	No	No
6	Yes	No	No	No	No
7	Yes	No	No	No	No
8	Yes	No	Yes	No	No
9	No	No	No	No	No
10	No	No	Yes	Yes	No

Table 12: Client Involvement in Mental Health Services

Pat talks about her involvement with the Consumer Advisory Committee at her mental health team which she describes as “*an opportunity for consumers at any given team to have input about what the team is going to do and what they’re going to have guest speakers or anything like that*”. She adds that the ideas shared are indeed implemented by the team and as such is “*an empowerment process for the consumers*”. Prima states that although she has not facilitated any groups herself, she has observed others doing so. Other clients participate in paid volunteer activities that contribute to the operations of mental health programs such as the food bank, meal program, etc.

Although some study participants are not offered opportunities to give feedback or to be involved in treatment or program planning, not all study participants find this to be problematic as some service users do not wish to be involved in these activities. Others do find the lack of consultation to be an issue:

“I was at a meeting, it was a coffee chat, I think. One of the guys started talking about a problem he had with the staff the other day. He couldn’t get his lunch or something. And he was cut off and told that the coffee chat wasn’t the time to talk about staff problems, you should talk to staff, right? The guy had no way to talk to anyone about it other, unless it’s talking to staff about the problems he has with staff.” – James

James believes mental health service settings should have a process in place whereby members can voice their concerns to one another, or peer support workers who can mediate conflict between staff and clients. Jim feels more service user involvement is needed at the organizational level to inform mental health services: *“I think more peer involvement on a lot of programs, addictions, financial decision making at the very top level would be really positive”*.

Service providers recognize the need for more service user involvement in mental health services when it comes to redressing the health inequities experienced by Aboriginal peoples. The Tripartite First Nations Health Plan was developed in partnership with the federal and provincial governments, and the Leadership Council representing B.C.’s First Nations was created in response to this gap (Ministry of Health, 2010). Caring for All (2014) was developed in consultation with youth, Aboriginal peoples, and substance users. It speaks about establishing a peer-informed system and the value of peer support in navigating and advocating for service users; the City plans to carry this out by developing partnerships with community organizations that support peer initiatives (City of Vancouver, 2014).

In contrast, the strategy for the SAMI population does not have any recommendations for more service user involvement in treatment or program planning; its emphasis is on enhancing the capacities of service providers (Ministry of Health, 2013; Vancouver Coastal Health, 2013). As previously mentioned, the needs of the

SAMI population are not considered to be culture-related, so there are no plans to address any service gaps with respect to cultural competence. Aside from service provision, staff make up an important component of cultural competence as well.

Cultural Competence in the Qualities Exhibited by Staff

Cultural competence is perceived as a quality that staff members encompass. Some of these characteristics entail a general way of working with mental health clients, and some are understood more as learned expertise. Evidently, the way staff members present themselves have a lasting impression on clients as some are seen as doing their best while others are perceived as just doing their jobs.

Having “a certain way of carrying themselves”

James describes culturally competent staff as having “*a certain way of carrying themselves that’s productive for people with mental health*”. These staff members are:

“very neutral where they don’t trigger people, they don’t make judgments, they don’t frown ... [they would] make more of an effort to plug you into stuff. To realize that sometimes people with mental health issues and depression are really reluctant to go and try and reach something or sign up for something or to go and approach somebody about something and it just seems like a tedious bunch of work to write some note.”

Clients’ experiences speak to staff who practice in a culturally competent manner:

“They talk to me, and they pay attention to who I am ... they just speak to me, and they ask me questions about how I’m doing ... they’re really nice staff. They listen to me. And they try and help me when I have a problem.” – Louise

“They’re great people ... Yeah they were really supportive ... and then if you’re upset you can go talk to them about your problems ... they are very positive. And they say hi when you want to say hi, but they don’t interrupt you constantly to get your, to see how you’re feeling and stuff like that. And I like that.” – Prima

“They’re very nice ... like there’s sort of congeniality over just some simple things like the routine of the lunch ticket being ticked off.” – Pat

“She was incredibly helpful. And she always pointed out with great sensitivity, she knew she didn’t want to push you over the edge ... and very carefully to judge what I can do to improve the situation.” – Jim

“They’re not pushy.” – Troy

There have also been times when clients had interactions with staff who were insensitive or ignorant towards marginalized individuals with mental illness and the issues they face. Jim has many memories of these instances with mental health professionals. He describes a court-appointed psychiatrist he saw who would fall asleep during their sessions, was very distracted, answered personal phone calls, and spoke in ways that would be triggering. Jim described this psychiatrist as *“unprofessional, unhelpful, and he should’ve been removed”*. He talks about an addictions worker who would speak about addictions in ways that were not conducive to someone in recovery: *“This guy was saying, well don’t drink too much, try to limit it”* when Jim was working towards complete abstinence from alcohol. The same addictions worker would tell Jim about his wine and cheese parties, which Jim feels was *“silly”*. After reflecting on these experiences, Jim says, *“it’s almost like he gave me, I was using him as an excuse to continue my addiction”*.

Troy shares an experience where after he was physically assaulted at a mental health service centre, none of the staff members checked on him in the days after. Based on this experience, he feels *“there could be more compassion”* from staff. Nola feels staff are insensitive in that they only talk to her when they need something from her.

According to study participants, staff who practice cultural competence are those who are sensitive towards clients and the issues they face. They encompass attributes such as being nice, congenial, helpful, supportive, caring, attentive to clients as unique

individuals, not pushy, and always there to listen. Staff members who are not culturally competent are described as distracted, triggering, unprofessional, unhelpful, inattentive, insensitive, abusive, always complaining, and lacking in compassion. These qualities imply that cultural competence requires a way of conveying sensitivity towards people in recovery, and is more than just the acquisition of expert knowledge.

Staff as expert

Cultural competence is also measured by the expertise of staff, and some clients find it beneficial to rely on their expert knowledge while others feel it can sometimes impede on the therapeutic relationship. Study participants understand cultural competence as when staff's expert knowledge is demonstrated in the accuracy of assessments, awareness of treatment options and community resources, and in offers of support that actually materialize into observable outcomes. Staff are also considered culturally competent when their expertise does not override clients' ways of knowing. These staff members practice in an ethical, professional, and appropriate manner. The City of Vancouver's (2014) stance is that cultural sensitivity training will help primary care experts be culturally competent.

Denise, Jim, and Nola describe culturally competent staff as those who can accurately assess a situation and respond appropriately and in a timely manner by connecting clients with or referring them to support services. Jim remembers a time when he was unwell but felt reassured knowing that the staff person helping him was well aware of the resources available to him and was working hard to find him a place for short-term stabilization where he would be safe until he felt better. Denise describes this type of professionalism as exhibited in "*the way they handle things ... "they don't beat*

around the bush ... they're right on top of things". According to Denise, culturally competent staff have the skills and knowledge to make a person feel safe and comfortable.

Negative experiences of cultural competence with mental health experts are associated with those who impose their expertise on the service user yet do not value the client's perspective, nor do they have any lived experience of their own. Jim talks about an experience he had that speaks to this point:

"The therapist there who had a degree in addictions, but never experienced any of it herself. And she was, I thought, completely inept. When I began going to AA and I could relate to the people talking AA and NA about their own histories, I had a lot more in common with them. And they could give me a lot of more valuable feedback and I could relate to them. I could be feel part of it and I trusted them more because they've been through it."

Jim adds, *"A lot of people especially with advanced degrees, they might be very good on academics. But it doesn't equate with being good at other things ... so just because you're a therapist, doesn't make you a good one ... some are just more astute than others"*. Jim emphasizes that a mental health professional's knowledge is only partial: *"A psychiatrist is only as good as the information provided by the client"*. He goes on to point out that psychiatrists can be wrong, and that they have misdiagnosed too.

Culturally competent experts are those who see clients as individuals who are not bound by their diagnosis and who change throughout their lives and across situations. Jim illustrates it in this way: *"Every patient is different. You doing the same tools and skills you get in university is not going to work on every patient. Every patient is different. But you definitely have to have the patient motivated and involved and with a clear understanding of where they're going in all this"*. Denise also stresses the importance of recognizing each client as unique in that *"everyone is in the same boat but we handle it in*

our own way”, and mental health professionals can practice this by being open-minded and *“listening to what we have to say. We’re people too”*.

Cultural competence in assessment and treatment should be a collaborative process between psychiatrist and patient, according to Jim: *“I think the therapist should, after he is relatively confident in his assessment, they should present to the patient a very clear map, of where they think the patient is now and how to get where the patient wants to be”*. In cases of disagreement, Jim feels a client should be able to ask the psychiatrist to re-assess the strategy or request to see another psychiatrist. He suggests a referral process whereby clients can get feedback about a psychiatrist from others clients.

Several study participants note that conversations with their psychiatrists are often relegated to clinical topics such as medication management and discussions of any presenting symptoms. Nola does not view this as problematic as she thinks highly of her psychiatrist, describing him as providing her with *“a miracle drug”* that has given her life a sense of normalcy. Others understand this expert position of the psychiatrist as a lack of interest or caring for the patient as a person. Pat is pleased that her psychiatrist takes an interest in other areas of her life, like when he was supportive of her joining a job club for people aged fifty five plus.

They do the best they can versus they’re just doing their job

Culturally competent staff members understand that clients face multiple hardships, genuinely cares about their situations, and make a concerted effort to support these clients in getting their needs met. The following comments from study participants speak to this regard:

“Somebody actually cares about your situation and tries to make an attempt to understand it.” – James

“They do their best with what they can do here at the facility that they’re at ... they do the best they can to help us with whatever we need for housing and for whatever you need, for whatever’s bothering you, they talk to you.” – Ed

“They are trying or endeavouring to make the place better.” – Troy

Despite doing their best, staff members’ best efforts sometimes fall short, which leads study participants to question whether staff are actually trying their best or that they are just doing their job and do not actually care at all:

“You wonder how they, why they hired them. They’re not bad people. They probably are educated, went to university and all that. It’s just, I don’t know, I’m not an expert.... Some of them don’t even look like they care.” – Troy

“It would be quicker if you know people care, somebody’s there to say how are you doing?” – Troy

“They haven’t even asked really that much, I mean, to be honest. They don’t. They’re just here to pick up the cheque, I guess, or whatever.” – Troy

“Well I don’t know, they don’t care too much. Maybe that. Maybe they do a little bit. But I don’t really think they care too much. They’re just doing their job to the best of their ability.” – Ed

“Some people are more legitimately concerned about their patient and their client than others, and some are there for a pay cheque.” – Jim

At the same time, study participants can appreciate that staff themselves are constrained by limited resources. Ed is mindful of this when he talks about the long wait list for low income housing. Clients also recognize that they cannot be too hard on staff because the job is not easy and that staff are people too. As Troy puts it,

“People have good days and bad days like yourself or somebody’s tired or ignored them or somebody thinks they, you know. You know, I’m not too, you give the benefit of the doubt. Well, staff members are nice but some of them they don’t look, you know. This job could be tough working here around here. Imagine you worked here or something like that. Nobody fights but it’s just, it’s a mental it’s not physical it’s mental. This is not a physical job.”

Although study participants are empathetic towards staff members' circumstances, it does not make it any less frustrating when they are not able to see real results. Offers of support come off as superficial and the lack of follow-up or follow through and poor communication conjures up negative feelings for study participants. James's comments below provide more insight into this perception:

"But you know, how's it going? What is that? There's no point." – James

"Like what the hell? Who do I talk to now? Am I supposed to go ask five people every day if they've heard something or what? ... if they say they're going to help you with something ..." – James

Jim emphasizes how staff members' jobs are inherently tied up in politics and bureaucracy at the systems level, which impedes on potential for cultural competence in mental health services. He says, *"I don't know the financial health of the place but there are budget considerations, the hierarchy. People have their careers, and their jobs, and their family life"*. He adds, *"Well the staff here, they have their, I suppose it can be like any workplace, there's the boss, he delegates whatever to the other staff. And I guess everybody has a superior to answer to ... and sometimes I have to speculate people keep the programs going for their own career. It's like the criminal justice system it could easily be reformed and improved but there's too many careers involved too much money involved"*. Study participants' responses indicate cultural competence among staff members is a matter of being able to practice in a way that helps clients have all their needs met within a system that puts up barriers to doing so.

Cultural Competence as "Having All My Needs Looked After"

"People in mental health services who don't have the same kinds of experiences you do, so try to kind of stretch your minds a little bit to try to put themselves in their shoes."

This statement made by James describes cultural competence as being mindful of the other circumstances that mental health service users face in their everyday lives, in addition to those that have to do with their mental illness. Study participants stories reveal that their mental health impacts on other areas of their lives and vice versa, and their respective social categories intersect and interact in different ways. Pat describes her intersecting social location of mental health (dis)Ability, aging, and physical (dis)Ability in this way: *“When people ask what I am I say I’m a disabled senior now, so not just senior, so that’s my label”*.

Clients’ responses indicate cultural competence as mental health services that take a more integrated approach and does not focus solely on their mental health but views them as people with individual needs and circumstances. Nola describes these services as having *“everything to offer”*, and Ed defines cultural competence as helping clients *“with whatever we need”*. In addition to having access to mental health services, Ed is able to receive support with income assistance, get referrals to doctors, obtain identification, and help with housing applications at the drop-in centre, but there are no services available there that are able to address his physical health needs.

Mental health and physical health

Pat feels she is well supported not only in the area of mental health, but also her physical health. Through her family doctor, she is able to access specialists for her sleep apnea and community programs for her arthritis. As well, she is able to access home support through her mental health team to relieve stressors related to her mental and physical ailments. Pat describes a positive experience in having her self-identified needs met when her psychiatrist was supportive of her staying at her current team even though

she had reached the age to be transferred to the older adult mental health team “*which is pretty much all seniors and usually people who have dementias of some kind*”.

Troy also shares his positive experiences with having all of his needs met through mental health services. At the drop-in centre where he is a regular, Troy is able to receive acupuncture treatment which helps alleviate the symptoms he has related to anxiety, headaches, and arthritis. As a member, he is able to go swimming at the aquatic centre which also helps with his arthritis.

In some cases, mental health treatment has actually served to compromise one’s physical health. For Nola, her psychiatric medications make her extremely tired, which compromised her ability to manage them properly. As a result, she almost overdosed and her medications now need to be managed by her husband. Prima had a similar experience when she was initially prescribed psychiatric medications that were so heavy they made it hard for her to walk. In addition to physical health needs, clients also have needs in regards to their low income.

Mental health and low income status

The literature shows that those with mental illness are overrepresented in the low income population and study participants’ demographic backgrounds match this profile. Being on a limited income affects study participants’ everyday lives in a multitude of ways. Study participants use the following words to describe the impacts of their low income status: “*difficult*”, “*poor*”, “*my clothes distinguish me*”, “*it really limits the things you can do*”, “*disheveled*”, “*bored*”, “*you’ve got to buy the minimal*”, and “*there’s nothing to bring anybody over for, like, come over to my place it’s so great. You know? Like I don’t have a television*”.

Cultural competence in mental health services are those that take clients' socioeconomic status and material conditions into consideration. Because it is difficult to make ends meet on such limited funds, some find it helpful when staff members assist with budgeting and money management. James and Prima speak positively about service providers that offer complimentary items such as coffee, razors, and weekly meals. Others suggest more programs aimed at improving financial literacy among clients.

Being on a limited income can impede on one's mental health and well-being when it prevents a client from accessing goods that have therapeutic benefits. According to James's research, full spectrum lighting and other items such as plants and aquariums would help to counter his depression yet he cannot afford to purchase these items for himself. He would like to see these therapeutic tools incorporated into the physical surroundings of service centres, as well as more natural lighting.

Mental health services, and social services in general, neglect to consider clients' low income status when it comes to travel costs and transportation barriers:

“Well it's really a problem in a lot of these social agencies, not just mental health services but all of them is they give you phone numbers and addresses and they tell you to go here and go there for whatever. When you're poor it's a real pain in the butt to get around, to travel around. It'd be nice if they had an approach that was more, rather than each person doing one little piece they kind of sort of a person who kind of oversees that.” – James

When it comes to Persons with Disabilities (PWD) on account of mental illness, housing is another issue low income clients have to deal with.

Mental health and housing

Housing is an area of contention for many study participants, and the challenges that clients face in regards to mental and physical health and low income status often overlap into this domain as well. Housing issues clients deal with include being subjected

to violent and unsafe environments, exposure to mental health and substance use triggers, inadequate supports, and having limited to no options.

Study participants raise concerns around violence and safety in low income housing. Prima talks about her circumstances: *“All I know is I haven’t been stabbed yet living in the building ... I’m still living there, and there’s been lots of incidents. But I’m still living there I know that they’ve dealt with more appropriately. Like they’ve moved people out and stuff like that. So that’s good”*. James describes his situation: *“I called police a few times. There’s all kinds of crap happening in that building. It’s a fucking zoo. Pardon my language ... They’re out of control. They lead loud, violent, crazy lives. They make noise and they make, they have arguments. They destroy property. They threaten people, they’re always looking to see what they can steal from you”*.

The presence of multiple agencies in one site impedes on continuity of care and is a barrier to addressing the issues faced by tenants. Prima has this to say: *“You have to go, for the Coast floor, you have to talk to the staff downstairs. And then also they say that they’re not the ones who move in people. So they’re getting away with murder, basically. That’s why I said, I haven’t been stabbed yet. And that’s my opinion on it ... Sometimes their music gets loud or a guy’s on drugs and stuff and that’s really annoying and that I’ve said, and they didn’t do anything about it”*. Staff’s hands are tied when they are employed by one agency but decision-making for certain issues are governed by another.

For some clients, low barrier housing being the only option available means that interactions with and disturbances involving other tenants are unavoidable and these incidents make one’s circumstances worse:

“Well I can’t afford a decent place to live. I’d like to live in a decent place where I don’t have to share a bathroom with junkies and active crack users and people like that. I’m not going to rent a place like that. I’d rather live in a shelter.”

– James

“I just couldn’t handle it anymore. I had to leave.” – James

“I have to like ... listen to stuff that goes on in the building that I don’t want to have anything to do with and it’s not good for me anyways. It makes you sick, right? But I’m like good at defending myself, and protecting myself, and going to make myself feel better if someone makes you bad but at the beginning I was like ... like major anxiety.” – Prima

For Chris, the issue with housing has been that service providers were not very supportive when he was decompensating. Having been evicted and becoming homeless when he was exhibiting acute mental health symptoms, he states, *“Since I’ve been living there, I’ve never displayed any symptoms of schizophrenia to anyone, since I’ve been living there the second time”*. This is a conscious decision on Chris’s part not to disclose his symptoms anymore because he fears he will be evicted and become homeless again. When he began to feel better the first time around, he was able to secure a place in a bug-infested SRO, which he says is a step up from homelessness though it was still less than ideal. The risk of losing housing if clients present as ill means that they may not be forthcoming about their mental health issues and thus will not receive the support that they need.

Finding and maintaining safe, stable, and affordable housing is an issue faced by many study participants as there are very limited options for low income individuals, and especially in cases where the service user needs mental health supports. Ed talks about the issues he has been facing with housing:

“Maybe they don’t have much to offer right now. It’s hard. Houses are very limited in BC. Well, in Vancouver anyways it’s really hard to get housed. Big long waiting list. And there’s very little for low income people for housing and stuff

like that. So, very small, not many buildings ... It's much worse for us ... there's always a period of time you gotta wait for housing. Whatever comes available for housing too. Very limited, people not moving out, or very limited for housing for us low income people. Very limited ... waiting is crazy but that's the way it is."

Being low income and having mental illness severely limits the choices one has in finding housing, and study participants feel like they are trapped. When asked if he had a choice to move into the SRO, James replies:

"I don't really feel like I did. I was at the Salvation Army shelter and the worker there was like, well I'll take you to a few places. She took me to the Europe Hotel run by the Affordable Housing Society but they were full and they have a waiting list. She took me to the Lion Hotel. So I felt like, ok, they'll probably kick me out of the shelter or something if I don't rent a place. I don't know, I had to get a place, I felt. It was a big mistakes moving in there. I really feel the last two years of my life have just been wasted and I haven't been able to get done anything I've wanted to get done."

Prima also feels pressured to accept inadequate housing because there are no other suitable options that would meet her needs:

"I didn't want to live with women who were in the sex trade because none of them liked me in my condo I lived in. So I've been looking for a building that just houses women, but is a free coming and going building. But make sure that there's no drug dealers that can come there. And that's what I want, a mental health building for me ... Well there's no building available yet, BC housing, for a person like me. So hopefully soon. Cause I'm just, there's younger people, or more mentally ill, or with HIV, or in the sex trade, or with kids. There's just no building for like, yeah, I don't know. Hopefully there will be one."

When asked how the area of housing can be improved to be more sensitive to individuals with mental illness, study participants hope for higher priority for people with mental illness, shorter wait times, and more housing options that are not just low barrier where they are forced to live with other tenants who actively use substances or are triggering in other ways. In addition to the stressors related to the intersections of mental illness, physical health, low income, and housing, clients also face discrimination within these domains.

Cultural Competence is “A Lack of Discrimination”

Clients’ experiences with instances of disempowerment, stigma, and discrimination discussed in the literature review are shared by study participants who deal with these issues on a daily basis as a result of their membership in marginalized groups and mental health status. These encounters speak to areas of mental health services where cultural competence is lacking as many of these experiences occur within service settings and with staff members.

Study participants talk about their experiences of discrimination from the general public. Prima feels she is different from other women in that she is *“not treated like every other woman though ... not a lot of options, very little options and no respect and very little money”*. Nola can think of two instances where she was a victim of scams and was jeopardized due to her limited income and her old age.

Chris describes cultural competence in mental health services as *“a lack of discrimination”*, and he feels that slurs should be *“met with a ban for at least some period of time”*. Chris remembers an incident where he attended an appointment at his mental health team and was pleased to find that they did not discriminate against him because he was homeless: *“I liked the fact that they didn’t bring up the fact that I was homeless, even though I used to bring my sleeping bag to the appointments with me”*.

Denise talks about a particular conversation she had with her team that was discriminatory: *“Well it’s the way they were asking questions. I was like, you know, you’re asking me like as a child when I’m an adult ... I have a mental illness but I’m smart”*. When asked what their response was, she says, *“They said they’re not trying to make me feel stupid, they’re just trying to help me”*. She continues, *“When I speak my*

mind then it's taken seriously. Shouldn't have to do that because it's very frustrating. And then I exhaust myself cause I'm so angry and frustrated. Then I end up getting more exhausted". Denise would like to see the following: "Remember that we're people too. You know, we're not infants, we're people too. Just because we have mental illnesses, doesn't make us stupid ... try to understand us and where we're coming from".

Discrimination is also felt by study participants in the earning cap imposed on them by Persons with Disabilities (PWD) disability assistance policies. Currently, the maximum amount a person with PWD status can earn is \$800 before their benefits are cut back. In addition, Jim has to report his earnings every month.

Powerlessness and Hopelessness

Clients have experienced discrimination as a result of their mental health status, and service providers within the mental health system are often the source of that discrimination. For some, being in the system has meant certification under the Mental Health Act (RSBC, 1996) which puts them at an even greater disadvantage as clients. Pat describes her experience with the extended leave process:

"You absolutely are beholden to keep your appointments and stay on your medication ... and that I find very frustrating ... and to get off it you either have to have a review panel or a review panel procedure or hire a lawyer to go to court for a judge to get off it. So it's quite serious. So I find that very frustrating to be under those circumstances ... that I'm not trusted to my own devices, that I'm not trusted to keep my appointments by myself and I'm not trusted to take my medications without having to, you know. Like for example, for a while I was on injection medications and I didn't like that. But I gained the trust of my psychiatrist and now I'm on oral medications so that was a big step. So, but I'm still on extended leave. And it's because he doesn't want me to end up having to be arrested by the police for unseemly behavior in the community or being rude to people or things like that which has been construed as an episode for me and I have been taken to the hospital on those grounds."

As the above quote illustrates, the certification process is very frustrating not only because the onus is on the client to present their case to the psychiatrist, but also because the psychiatrist holds the power to determine the client's wellness and trustworthiness, and to reduce the client's personal experiences to a medical diagnosis. Pat describes the use of restraints as "*cruel*".

Prima feels a sense of hopelessness as a result of being certified: "*It's like you're in the zone for the rest of your life and you just have to learn to deal with it*". She describes having been treated unfairly when she was first certified and the doctors as being "*too rigid*". In order to access help, she feels she needs to present as "*flexible, easier to work with because you want the service*".

Clients are disempowered even when they are not certified. Chris expresses dissatisfaction with how information about him is communicated freely among service providers because the supported housing agency "*made [him] sign a consent form for release of information when [he] moved in*". As a result, Chris feels "*cheated with a lack of dignity*". He also feels he was not fully informed about the premise of semi-independent living as he was not provided with all of the information until moving day.

Prima expresses her feelings of hopelessness:

"My sister really wants me to get a job so we can get into market housing together. And I can get out of this whole loop where you want to access services ... but the services suck, or they don't have any for you, which renders you mentally ill because you are without things you need. And so then they have you right there in a jail. It's not fair when it starts out from when you're a baby and it's still going on when you're forty."

Pat talks about her frustrations with the medical disease model of mental illness and treatment, and how the system discriminates against other ways of knowing. She refers to it as "*patriarchal*", "*archaic*", and limited to "*orthodox medication*". She

voices her frustration with when she brought some research to her psychiatrist about an alternate form of treatment: *“No discussion. Absolutely no discussion, just blanket statement. It’s not entertained here”*. Pat expresses her sense of defeat: *“If you’ve got any ideas outside the conventional wisdom then you’re stuck”*. She further elaborates: *“It’s like walking on eggshells because if you get the least bit aggressive about it, then they think you’re decompensating and getting sick. So it’s a very dangerous thing to do and I’ve just kind of bit the bullet now ... I’m putting up with the situation”*. Prima shares a similar sentiment: *“I don’t really have an opinion. I just accept how it is”*.

When asked how she would like to see the mental health system change, Pat states, *“Well for one thing I think a patient should be allowed to state their wishes without threat of being, without the mental health act feeling threatened that they’re going to.. that their position of authority is being threatened by their patient with upstart ideas ... and they’re so quick to quash it all ... you can tell the circles of my hospitalizations have been when I’ve been adamant and wanted to go off my medication”*. The power mental health professionals have to reinforce their own agenda at the expense of silencing client voice is a barrier to cultural competence.

Violation of Rights

Study participants feel their rights have been violated as a result of being a client in the mental health system. Many of these instances involve interactions with staff members who impede on their rights. Chris talks about how accepting supported housing means he must *“submit to a suite inspection every three months”* and based on the housing worker’s assessment alone, conclusions are made about how he is doing and recommendations are made about what the next steps should be.

James talks about his dissatisfaction with staff members, saying they are part of the problem: *“There are people who think they have the right to unlock your door when they feel like it even though you’re not actually one of their clients ... they treat you like, I don’t know, like a hamster in a cage on display”*. He feels staff should have respect for clients’ basic constitutional rights such as rights to privacy and security of person. As a result of his negative interactions with staff, James has developed a distrust for service providers and has since *“avoided them completely. I didn’t have any relationship with them at all”*. He adds that he has *“an aversion to social workers because of my experience with them”*.

Pat has a similar perception:

“There are consumers in the world who are not satisfied with the way the mental health system handles you when you are in psychotic state. For example, you’re taken to the hospital and committed for thirty days. The first thing they do is put you in pajamas and lock your clothes in the cupboard. And some people find that really offensive cause they think, really overdoing taking away your civil liberties. And to the point that those of us that are really radical think that is abusive.”

Nola had an encounter with a worker who she describes as *“abusive”*: *“Every time, ‘let me look in your closet’. I said ‘what for? There’s nothing to see here’. She said I wanted you to go through everything and throw it away. I was so stupid I listened to her. She said ‘in the dumpster’ ... she was very mean about it.”* *“We have almost nothing, we got rid of 75% of our stuff”*. According to Nola, workers should not be intrusive and should not be complaining about clients’ lives: *“Well I think people should mind their own business. Because if I went to her place and started talking about her water spots and her closet and her clothes, I would be kicked out of there”*. She recalls another incident where she placed religious pamphlets in a common area and a worker did not take too well to it: *“Since she was gay and a lesbian she’s complaining to the*

librarian about Christian literature. And she was against that. I put them on the table and she grabbed them and threw them all in the garbage”. Nola points out that at another service centre, staff had no problem with her distributing those materials. As a result of staff members invading her personal boundaries, Nola no longer feels comfortable approaching them.

Stigma

Clients are privy to the stigma others hold about mental illness. Troy describes his (dis)Abilities as invisible, and the disbelief he receives from others. Jim points to how as a result of stigma, people with mental illness are “*down on [them]selves*” and “*become very passive and accepting to their position in life*”, and feels service users should “*fight back with everything they have*”. The comments below provide more insight:

“I think of disability, it makes me feel like I’m on a pension. Like you feel more ... instead of saying I’m on welfare you say I’m on disability pension so it’s more, you feel less embarrassed. It’s a status thing ... you don’t feel there’s a stigma to it as much there’s a lot of stigma associated with saying I’m on welfare.” – Troy

“The key, the operative word is mental. Are you mental? Are you retarded? Or something like that. But again it has stigmas to it, so ... But now I’m more, I’m proud of it ... I just think that I’ve just matured ... I came to realize that it has to come from within ... don’t be embarrassed, doesn’t really matter, just accept who you are ... I had to not be phony with myself ... you may think like no there’s nothing wrong with me, I’m fine, I’m normal. But I’m not. I mean I’m not crazy, I wouldn’t hurt anybody violently. But I do have mental health issues. So I’ve come to terms with that, like, I’m comfortable with that” – Troy

“I know some people have that stigmatism around mental health. I never get it because it’s always been a part of my life ... so I never had any kind of shame or stigmatism around any of my mental health issues or addiction issues. Because they were so readily apparent ... people ask me, do you have any mental health issues? I immediately say yes. I recognize I’ve taken steps, and I’ve come to learn that’s a lot more than a lot of people who actually need to do.” – Jim

Strength, Resistance, and Resilience

The stories shared illustrate the hardships clients face on an everyday basis, and when accessing mental health services. Despite their struggles, clients display many qualities of strength, resilience, and resistance to oppression, which are evidenced by these personal accounts.

Clients who for many years have been subject to stigma and discrimination associated with their mental health diagnosis have found ways to overcome these internalized feelings of shame and embarrassment. Troy now feels pride when he tells others he is a client. He reports feeling more comfortable with it, attributing it to maturity and self-acceptance. Troy has also developed strategies for dealing with ignorance by emphasizing his disability in response to those who judge him for being on ‘welfare’.

Jim reports that he is immune to the stigma of mental illness. He feels he has “*a more accurate view of the world*” and acknowledges that he has taken the necessary steps to get to where he is now. Jim has been able to apply the advanced reading skills he learned as a child in therapy to his everyday life today, and as a result has become very well read in finances. Using this knowledge, Jim practices financial discipline and self-care, so even though he is on a limited income, he does not consider himself to be poor. Similarly, Ed budgets his limited income to provide for himself. He is very knowledgeable about resources for accessing low or no cost meals, clothes, and other items.

Learning from her own experiences, Prima has come to be “*good at defending [herself], and protecting [herself], and going to make [herself] feel better if someone makes [her] bad*”. She also demonstrates resilience in the way she maintains a positive

outlook on life and will “*always try to look at the bright side*” of things in spite of the challenges she has faced, and describes herself as “*a good person*”.

Clients voiced their dissatisfaction with mental health services, and with housing in particular. Despite having to navigate the challenges of being in shared spaces with others, clients are able to show empathy towards others who have their own struggles. For example, Prima has very bare living conditions, but is still mindful that she lives on a mental health floor and is polite and respectful to her neighbours anyway. In the same way, even though others’ behaviours interfere with her enjoyment of the drop-in centre, Nola recognizes that these are times when they are not well. And as a result of his own experiences, Jim is nicer and happier with the people that he meets.

Clients’ experiences also demonstrate instances of resistance. Denise recognizes that “*there’s actually lots we can do that a lot of people misjudge us for*”, and talks about how despite being belittled by service providers, she speaks her mind and stands up for herself. Chris became homeless as a result of being evicted, but he displays resistance in the way he was “*going to show them what they had done to [him] by remaining homeless*”. Pat is encouraged by a consumer-driven group that is investigating the injustices experienced by consumers in the mental health system. Client strengths and resistance speak to remarkable resilience in the face of oppression and marginalization.

This chapter presented the findings from the individual interviews and the document review. The findings present many understandings of cultural competence, and that there have been negative but also positive experiences with cultural competence. The next chapter will go into a more in-depth analysis of the findings and discuss the implications of these findings on policy, service, and practice.

CHAPTER FIVE: DATA ANALYSIS

This chapter presents the analysis of the study findings by exploring the relationships among the themes and sub-themes identified. The analysis will provide evidence for the implications of client experiences with cultural competence in mental health services on mental health policy and services, and anti-oppressive practice.

The study results support the research literature which finds that definitions of cultural competence are many and varied (Abrams & Moio, 2009; Williams, 2006; Bernard & Moriah, 2007). Clients' personal experiences are also influenced by processes embedded within systemic structures (Graham, Swift, & Delaney, 2012; Roe, 2005; Hunter & Miazdyck-Shield, 2006). In contrast to the generally negative tone of clients' experiences documented in the literature (Clarke, Usick, Sanderson, Giles-Smith, & Baker, 2014; Wen, Hudak, & Hwang, 2007; Clarke, Dusome, & Hughes, 2007), study participants' experiences have been positive overall. The negative aspects of their experiences that speak specifically to cultural competence in mental health services provide new learning for this study.

The themes and sub-themes that emerged illustrate the numerous ways in which cultural competence is understood and experienced, and convey the following messages:

Cultural competence operates on different levels

The roles and expectations of staff members

The piecemeal configuration of services

Clients' intersecting social categories have compounding effects

Cultural safety versus culturally-specific spaces

Cultural competence is a moving target

Cultural Competence Operates on Different Levels

Cultural competence exists at the structural and individual levels, which interact with and affect one another. Cultural competence at the structural level affects clients' everyday interactions with mental health services and staff. The underlying constructs that inform service providers' philosophies of care also play a role in day-to-day operations. In turn, the impact of client experiences and outcomes necessitates a response from policy makers through continued program development and evaluation.

Within a neoliberal context, the effects of decentralization and harm reduction in particular have been felt most by study participants. Disruptions to continuity of care impede on the 'qualities exhibited by staff' and 'having all my needs looked after' aspects of cultural competence. Staff are put in difficult positions where the support they are able to offer is constrained by systemic barriers, and any issues that arise and the means to resolve them are often beyond their control. This leads clients to perceive a lack of expertise and a sense of indifference from staff who are "*just doing their jobs*". These challenges are most apparent in low barrier settings where property management, treatment, and support services are often provided by different agencies within one site. Service users and providers are in agreement that housing is an essential part of recovery, yet the way in which harm reduction is carried out through the widespread development of low barrier housing is not conducive to healing. Service users like James and Prima who have firsthand experiences of these situations feel powerless to change their circumstances because staff are not able to provide adequate supports.

Study participants' experiences illustrate the dominance of the medical model and professionalization in treatment and support services where clients' circumstances are

reduced to a label in isolation from their sociocultural environment (Roe, 2005; Cowan, Banks, & Crawshaw, 2011; Hiranandani, 2005; Pollack, 2004). The privileging of the expert's way of knowing over the client's way of knowing works against cultural competence when characterized as "*a lack of discrimination*". Clients' stories of how they are looked down upon when they offer their views and opinions and mental health professionals not taking well to their authority being challenged are impediments to cultural competence in the therapeutic relationship (Breeze & Repper, 1998). Clients accept the interventions that are prescribed out of fear of incurring any negative consequences, such as certification under the Mental Health Act (RSBC, 1996) or further violation of their rights, like in the cases of James and Nola. Internalized feelings of powerlessness and hopelessness lead clients like Pat and Prima to reluctantly accept their disadvantaged positions.

These experiences call attention to the culture of the mental health system and speak to the notion of 'othering' where because clients' ways of knowing are different from conventional wisdom, they are made out to be invalid and inferior (Bernard & Moriah, 2007; Abrams & Moio, 2009; Pon, 2009). Staff too are an important consideration because there is an expectation that they be culturally competent within a system that at times works against it.

The Roles and Expectations of Staff Members

Cultural competence in the realms of staff who have "*a certain way of carrying themselves*" and 'staff as experts' are thought to be important for both frontline staff and mental health professionals. According to study participants, there is a perceived difference in how these two qualities are applied to different roles. Cultural competence

as staff who have “*a certain way of carrying themselves*” is more salient when it comes to frontline staff who work with clients on a daily basis. Culturally competent staff members encompass soft skills that are conducive to providing emotional and practical support to clients who are marginalized by their social locations and mental illness simultaneously. The qualities of culturally competent staff described by study participants are comparable to those documented in the research literature (Clarke et al., 2014; Glass & Arnkoff, 2000, Cross & Singh, 2012).

‘Staff as expert’ is emphasized when it comes to mental health professionals such as psychiatrists and therapists. Contrary to the common understanding of cultural competence as the accumulation of specific knowledge about particular groups (Abrams & Moio, 2009; Williams, 2006), study participants understand cultural competence as professionals who are knowledgeable about mental health in relation to a client’s diagnosis and treatment, and not so much in their ability to bridge cultural gaps. ‘Staff as expert’ still works against cultural competence when the professional’s expertise is used to exert power over clients. As such, ‘staff as expert’ does not negate client as expert or ‘other’ their ways of knowing (Bernard & Moriah, 2007). The study findings and research literature concur that when this happens, it is the staff person’s lack of personal experience and ignorance of a clients’ circumstances that is emphasized (Benson, 2013). In this way, the ‘representation of marginalized groups’ is characterized by the inclusion of multiple perspectives and not merely in the number of diverse clients present.

Both the qualities of staff who have “*a certain way of carrying themselves*” and ‘staff as expert’ are valued aspects of cultural competence, but they hold different weight in the eyes of clients depending on the staff person’s role. The contributions of staff in

the therapeutic relationship cannot be minimized as these interactions have lasting effects. Although clients can appreciate the contributions of medicine offered by experts, such a limited scope of treatment and support is not adequate in addressing the social determinants of health. This shortcoming is exemplified by how clients must often seek out supports at multiple service centres in order to have all of their needs met.

The Piecemeal Configuration of Services

Clients' experiences with cultural competence as "*having all my needs looked after*" speak to the fragmented framework of services in Vancouver. While there is a wide variety of programs offered to clients, they are not always provided within the same service setting. Study participants report regular attendance at health, mental health, and social services located at a number of different sites around the city in order to meet all their needs. A client will typically be connected with a psychiatrist and case manager at a mental health team, be a member at a local drop-in centre for meals, socialization, and programs, attend another service centre for additional programming, visit a community centre to access services that are not available at the mental health centres, and also link in with a primary health clinic. This list excludes the occasional visits to hospital, social services, short-term stabilization units, specialists, etc.

Bearing in mind that many clients are multiply marginalized and require access to a broad spectrum of services (Ministry of Health, 2010; VPD, 2013; VCH, 2013; Krausz, Clarkson, Strehlau, Torchalla, Li, Schuetz, 2013), the piecemeal configuration of services creates barriers related to transportation and communication between and among service users and service providers. The contracting out of services to community agencies adds to the confusion and frustration service users feel when navigating the disjointed system.

The limitations of this arrangement also tie in with the concept of ‘staff as expert’ where clients perceive a lack of cultural competence when staff’s offers of support do not materialize into tangible outcomes; ‘they do the best they can’ but their best comes off as half-hearted. Feelings of ‘powerlessness and hopelessness’ arise when nothing changes despite clients and staff making a concerted effort due to disjointed services. Mental illness and other social categories work together and separately to have profound effects on clients’ lives. In the provision of mental health services, the intricacies of these intersections are not always taken into consideration.

Clients’ Intersecting Social Categories have Compounding Effects

Different categories of marginalization as experienced by clients are intricately tied and have cumulative effects. Study participants’ experiences demonstrate how one aspect of their social location impacts on other areas of their lives in a myriad of ways. The intersections of mental health, physical health, low income, and housing have been found to be particularly significant in clients’ lives, with the relationship between mental illness and low income being the most salient. Clients are caught in a dilemma where as a result of their mental illness, they have been deemed Persons with Disabilities (PWD) and are on a limited income. In turn, being low income often means they are forced to live in at-risk conditions that further exacerbate their mental and physical health symptoms. Challenges related to these social categories are further complicated by housing issues and service environments that expose clients to additional sources of disempowerment, stigma, discrimination, stressors, and triggers.

Mental health services providers seem to be cognizant of the social categories that are significant to clients’ lives, as evidenced by the range of services offered. In this way,

service providers' mindfulness of clients' circumstances reflects cultural competence as "*having all my needs looked after*" by not ranking one category of oppression over another, as was argued in the literature review (Abrams & Moio, 2009). At the same time, service providers' negligence of how these intersecting social categories interact and impact on each client's life is a shortcoming of current services.

Cultural Safety versus Culturally-Specific Spaces

The 'representation of marginalized groups' in mental health services speaks to two different understandings of cultural competence. On one hand, 'meeting like-others' highlights the need for culturally-specific programs that focus on the interests of traditionally marginalized groups. This provides a forum for members of underrepresented groups to connect and speak on issues pertaining specifically to group members. This type of programming would be relevant to Aboriginal communities or where there are language barriers, for example (Abrams & Moio, 2009; Ganesan & Janzé, 2005, Williams, 2006). Culturally-specific spaces also speak to cultural competence as 'work with members of marginalized groups'. From an anti-oppressive practice point of view, this understanding implies that culture is fixed, that group members are all identical, and assumes that culturally-specific adaptations to mainstream interventions can be as such. These drawbacks diminish opportunities for individual agency, power-sharing, and capacity building (Abrams & Moio, 2009; Dean, 2001).

Others interpret cultural competence as 'multicultural staff and clients' within a service setting that has a good mix of individuals from various backgrounds. It does not seem to matter as much to clients whether or not they share the same cultural background as those represented. Clients' observations demonstrate that culturally competent mental

health services do not necessarily have to be exclusive to members of a particular group, as it is typically understood. Cultural competence from this standpoint fosters a sense of safety and community in the diversity that is present.

The notion of cultural safety adds an additional layer to cultural competence. Safety is experienced as ‘having all my needs looked after’ and ‘in the programs offered’ when it comes to physical safety free from violence and stressors in service settings and low income housing. Cultural safety is violated when clients experience distress as a result of being in an unsafe environment, such as when other clients are acting in ways that pose a risk to another’s mental health and well-being.

Cultural competence as ‘the qualities exhibited by staff’ and “*a lack of discrimination*” allude to emotional safety in being able to participate in programs and share one’s own perspective without being re-traumatized by other clients or further victimized by staff. This understanding draws attention to the need to redress power relations within the mental health system (Josewski, 2012). This lens requires service providers to look introspectively into whether systems and services are providing the proper supports to clients or further disempowering clients by viewing them as having deficiencies in need of intervention. Framing ‘culture in general terms’ shines light on how those who are marginalized are mistreated by dominant society (Bernard & Moriah, 2007; Dean, 2001).

Cultural Competence is a Moving Target

Understandings of culture and cultural competence are both general and specific. Marginalized populations are not always conceptualized as distinct cultures requiring culturally competent services. In turn, the target of intervention is dependent on which

definition of culture or cultural competence is applied in a given situation. Cultural competence is not a static intervention that can be applied uniformly across situations. Instead, cultural competence is better understood as a moving target that is flexible and falls along a continuum of approaches, contexts, and circumstances.

Whether culture is made in reference to a specific marginalized group or society in general, client experiences show there are multiple strategies for cultural competence in each case. Some study participants aligned with the ‘doesn’t apply to me’ notion of cultural competence because they understood cultural competence as work with members of traditionally marginalized groups. The paradox between this definition and the understanding of cultural competence as ‘representation of marginalized groups’ demonstrates that the meanings of cultural competence, and thus clients’ needs are relative and situational. The same can be said about how cultural competence is implicated at the policy, service, and practice levels.

Implications for Mental Health Policy

A concern raised about cultural competence is that not enough work has been done to effect change at the systems level (Abrams & Moio, 2009). Cultural competence in mental health services as experienced by clients reveal several areas for further development in mental health policy.

Study findings reveal that participation in the mental health system can be a very disempowering experience, especially for those who have been certified and/or are on extended leave under the Mental Health Act (RSBC, 1996). Recognizing that many clients are already marginalized and are made even more so through their participation in mental health services, there is potential for making the provisions around certification

and/or extended leave a more equitable and collaborative process like in the areas of informed consent for treatment, conditions of leave, and the review panel hearing. With more and more treatment and support services being provided in the community, policy makers may also consider making amendments to the Mental Health Act (RSBC, 1996) to be more inclusive of mental health service provision in the community.

Client experiences speak to the importance of having safeguards in place to ensure their rights are protected across service settings and organizations. As it currently stands, the procedure for informing clients of their rights are mandated in designated facilities but not in the community (RSBC, 1996); clients who wish to obtain information must do so on their own or be able to secure an advocate. Government officials could expand the role of a central regulating body such as the BCMHSUS to investigate all clients' concerns to ensure they do not fall through the cracks when community agencies are left to investigate grievances internally. Similarly, a standard bill of rights that applies across all service settings and organizations, and a consistent procedure for informing clients of those rights and evaluating service providers' protection of those rights would provide more transparency, accountability, and recourse to service users and to the general public.

Further development is needed in policy to establish practice standards for culturally competent mental health care and education. Policy guidelines would offer more clarity and consistency around the delivery of culturally competent services across various levels of care. One of the difficulties with cultural competence raised is the concept of culture, which can be vague and limited in scope, as demonstrated by the document review (Ministry of Health, 2013; City of Vancouver, 2014). Expanding the

definition of culture by going beyond traditional categories of race and ethnicity would give the cultural experiences, views, and interests of marginalized individuals with severe mental illness more legitimacy and a greater platform to be heard.

Study findings indicate that stigma and discrimination of individuals with mental illness is still prevalent in society and within service settings. ‘Culture in general terms’ speaks to the prejudice and ignorance that exists in society and targets intervention on societal structures and the members of society within them rather than on marginalized clients. More policy initiatives can be directed at addressing the stigma and discrimination embedded within societal processes and within the mental health system’s culture. This approach to intervention is more in line with the social model of mental illness (Hirandani, 2005).

Clients’ level of involvement in programs indicate potential for greater participation and capacity building in consultation and decision-making to promote cultural competence, equitable opportunities, and client empowerment at the policy level. Not all clients wish to participate in organizational processes; however, opportunities for engagement is a reflection of cultural competence (Elstad & Eide, 2009). The study findings show that client involvement has been limited in the political and organizational realms. For example, the City of Vancouver has made a commitment to work with organizations with peer initiatives but this does not necessarily involve working directly with service users themselves (City of Vancouver, 2014).

More client representation in mental health policy and program development would bring about change in the culture of the mental health system. Expanding client knowledge within a culture where the medical model and professionalization is deeply

engrained can begin to redress the issues of institutional power and oppression. The development of program evaluation tools that reflect client interests such as client definitions of positive outcomes or client satisfaction with services also support cultural competence in this regard. These indicators are arguably better measures of a program's success than commonly used tools that assess for cost savings or other outcomes that serve political or economic interests (MHCC, 2014; Ministry of Health, 2010).

The study findings are consistent with the research literature which demonstrate how current service approaches serve, and are driven by, neoliberal interests (Roe, 2005; Graham, Swift, & Delaney, 2012; Hunter & Miazdyck-Shield, 2006). Policy makers need to re-evaluate the merits of harm reduction for whom it is actually meant to serve. Harm reduction does consider the circumstances of a very specific, small group of individuals, but the rapid expansion of its 'one size fits all' philosophy is not culturally competent and makes a blanket statement about clients' needs, which in fact are not being met. Harm reduction needs to be better understood as just one approach along a continuum towards recovery and should not be implemented as a final destination as it is for so many in Vancouver. Policy makers need to revisit their harm reduction strategy as its purpose of regulating behaviour may actually be driving clients further into marginalization and mental illness (Roe, 2005).

The downloading of responsibility to care for those with severe mental illness causes disruptions to continuity of care as several community organizations often operate within the same site under different mandates. Staff members themselves need more opportunities to communicate and collaborate with others at the structural and service

levels. Clients' awareness of systems processes in mental health demonstrate their ability to participate in mental health policy and in their own care in a greater capacity.

Improving cultural competence in mental health policy will take careful evaluation of whether mental health services and providers are actually working in the clients' best interests or of those in power. Cultural competence at the policy level requires the mental health system to relinquish some of its power through greater consultation and shared decision-making with staff and clients. Introducing updated or new legislation and policy, more collaboration, and redistribution of resources and interests would do better to support cultural competence. Cultural competence in mental health policy is necessary not only because it is socially just but because policy has an important role in informing culturally competent mental health services.

Implications for Mental Health Services

Observations made by study participants and from the document review suggest ways to enhance mental health services with consideration for clients' diverse social locations. Study findings also show areas where service providers have already taken steps to integrate clients' sociocultural needs and identities in meaningful ways.

Reducing barriers and stressors associated with the intersection of mental illness and low income is a way of improving cultural competence in mental health services. By offering mental health services together with other services frequently utilized by clients such as health and social services, clients would be able to have all their needs met at one time in one place. A more integrated service setting would also reduce issues related to transportation and continuity of care, with potential to enhance ease of access, communication, collaboration, and client outcomes.

Programs that take into account clients' low income status, and material conditions in particular, are considered to be culturally competent by service users. As study findings and the research literature show (Wen et al., 2007), clients' struggles to have their basic needs met can have adverse effects on their mental health and vice versa. Material things such as complimentary or low cost food, hygiene, and household items, are a consideration for service providers who are not already offering these services.

Changes to the physical surroundings of service settings would also contribute to cultural competence by helping clients have all their needs met in recognition of the intersections of marginalization that are present. James gives some examples of how having more full spectrum lamps, natural lighting, nature and greenery, and aquariums can help mitigate symptoms of depression and create a more welcoming environment for individuals who cannot afford to implement these coping strategies on their own.

The busyness of emergency departments that is triggering for some (Dow, 2011; Clarke et al., 2007) crosses over to mental health service settings as well. Having a designated quiet space for clients to relax or meditate would demonstrate sensitivity towards their circumstances. Study participants indicate that quiet moments away from noise and triggers are hard to come by, especially those who utilize low barrier services. When clients cannot escape the commotion of these environments, their mental and physical health symptoms are further aggravated.

Better supports are needed to help clients navigate the mental health system. Figuring out program schedules, deciphering staff members' roles and responsibilities, and learning about triggering people and geographic areas to avoid are just some of the challenges clients have identified. Programs to bridge cultural differences between clients

and the system can improve cultural competence and continuity of care. A suggestion made by a study participant is to have a case worker assigned to each client; there is potential in this respect for peer support to take on this role.

Mental health services are culturally competent when there is a diverse mix of backgrounds and perspectives. Service providers should be mindful of the cultural representation among staff and clients. That being said, this approach does not negate the need for opportunities to meet like-others and discuss culturally-specific topics.

Culturally competent mental health services takes into account clients' various needs in the supports offered and within service settings. It requires a more integrated approach to providing equitable health, mental health, and social services, and greater collaboration and communication between service users and providers. The study findings affirm the notion that mental health professionals cannot practice in isolation and must take into consideration the cumulative effects of clients' social locations on their mental health and well-being.

Implications for Social Work Practice

The experiences of study participants point to areas of social work practice that can be improved upon when it comes to cultural competence. In the context of anti-oppressive practice, cultural competence is understood by clients as the way practitioners interact with clients and use their expert knowledge to support and advocate with clients in ways that are empowering and does not marginalize them further.

The expert professional within the medical model based in Eurocentric ideals of treatment and therapy is in contradiction to cultural competence as defined by clients (Craig, 1999). Clients do depend on the practitioner as the expert, but that expertise does

not mean clients' ways of knowing should be discounted or devalued. Cultural competence means that the cultures that are present are treated as equal, whether one is the dominant culture or otherwise. This approach affirms the need for the practitioner to take a strengths-based, not-knowing stance to gain a better understanding of the client's expertise (Baines, 2011; Pollack, 2004; Dean, 2011). Practitioners who strive for cultural competence practice 'power-with' clients rather than 'power-over' them, and have a willingness to learn from clients.

The current population health approach recommends that those with increased severity of mental illness receive increased intensity of intervention (Ministry of Health, 2010). Through a culturally competent, anti-oppressive lens, service providers would take a closer look at those with more severe forms of mental illness as indicators of areas where there are gaps in culturally competent practice and as reasons why clients' needs are not being met. This more social model would encourage practitioners to practice humility in their own cultural incompetence, rather than seeking to exert dominance over the client's culture through assimilation. Similarly, evaluation of client outcomes would not dwell on a client's deficits but rather, look at whether or not the treatment team is practicing in a culturally competent manner.

Some feel mental health services should be mandatory while others believe clients cannot be forced or compelled to participate. In cases where a client's participation is involuntary, motivation and involvement of the client within a safe and comfortable environment should be emphasized, as per study participants' feedback. Being open-minded and taking a collaborative approach with clients is also regarded as being

culturally competent, as is an interdisciplinary practice that maximizes communication, collaboration, and continuity of care.

Study findings illustrate the prevalence of stigma and discrimination held by service providers. In addition to continuous self-reflection of one's own biases, more education and training in cultural competence is needed in professional and academic realms to allow opportunities for practitioners to think critically about existing service models, forms of social control that they may be reinforcing, and their own practice framework. As the study findings note, cultural competence education and training does not entail a mastery of knowledge but a way of working with mental health clients that does not disempower them further. In working towards social change and social justice, transformations of power are possible through culturally competent, anti-oppressive practice that makes room for client voice and acknowledges the limits of mental health professionals' expertise.

This chapter analyzed the findings of the study and explored the implications of clients' experiences on mental health policy, services, and practice. Links to the research literature were made, and the connections among themes and sub-themes were also explored. The chapter following will bring the thesis to a close by summarizing the topics that were covered.

CHAPTER SIX: CONCLUSION

This final chapter concludes the thesis by tying together the research literature, the study findings, and the analysis of those findings. It will review the study's objectives and its methodology. The study's strengths and limitations are outlined and the chapter ends with a discussion of areas for further exploration.

Summary

On top of the challenges mental health clients already face in relation to their social location, these individuals encounter additional forms of marginalization when accessing mental health services (Ministry of Health, 2010; VPD, 2013; VCH, 2013; Krausz, Clarkson, Strehlau, Torchalla, Li, & Schuetz, 2013). In Vancouver, the number of clients reaching levels of crisis has actually been climbing in the last several years (VPD, 2013; City of Vancouver, 2014). The persistence of health and mental health inequities experienced by marginalized clients reaffirms the notion that the significance of culture cannot be dismissed when providing care. Cultural competence is understood as an essential part of working with individuals with severe mental illness, yet culturally competent interventions are constrained by the sociopolitical context.

The provision of mental health services does not occur in a vacuum and its processes often diminish client voice while reinforcing the system's own medical and neoliberal ideals. These prevailing philosophies contribute to gaps in service where cultural competence is lacking, and thus to clients' negative experiences. Capturing these experiences are significant because they have important ramifications on client involvement and outcomes, and society as a whole. It is these instances that offer new learning for service providers, and what this study set out to explore.

The objectives of this thesis were to gain insight into cultural competence in mental health services in Vancouver through the perspectives of clients who identify as members of marginalized groups, and to explore the implications of their experiences on the development of culturally competent mental health services. Furthermore, this study sought to expand client voice in a field dominated by academic and professional experts. This study incorporated anti-oppressive social work practice into its research methodology, as well as its findings and analysis.

This thesis used an exploratory research design to study the subject matter and qualitative methods to collect data. Individual interviews were conducted with study participants and a document review was also completed to get a better grasp of various understandings of and experiences with cultural competence in mental health services. Thematic analysis was used to encode and analyze the data.

Cultural competence encompasses a range of liberating processes that enable service providers to offer effective and equitable services alongside clients of all different sociocultural identities. The themes and sub-themes identified captured clients' and service providers' various understandings and experiences of cultural competence. Cultural competence was understood in the context of programs offered, as work with members of marginalized groups, and as representation of marginalized groups. The qualities exhibited by staff and having all of one's needs look after were also indicators of cultural competence, as was a lack of discrimination.

The numerous ways in which cultural competence is defined and experienced indicate several key messages about cultural competence in mental health services. Cultural competence operates on different levels and interact with clients' social

locations in intricate and complex ways. Cultural competence is flexible and context-based, and is conceptualized differently depending on the staff member's role, configuration of services, and target of intervention. Cultural competence also involves careful consideration for the cumulative effects of clients' intersecting social categories, and what these intersections mean for the individual. The notion of cultural safety in particular was significant across many of the themes and speaks to the need for a redistribution of power in mental health that do not push clients further to the margins.

Clients' experiences have important implications for mental health policy and services, and for anti-oppressive social work practice. Through an anti-oppressive lens, transformations of power are indeed possible through culturally competent approaches that encompass power-sharing, ongoing learning and critical reflection, and practitioner as ally. The experiences of study participants also reveal their strengths, resistance, and resilience in the face of oppression; using a strengths-based approach to capture these instances was a strength of this study.

Strengths and Limitations

Aside from the strengths and limitations related to its methodology discussed in Chapter 3, this study holds additional strengths and limitations. Grounding the subject matter in anti-oppressive practice values minimized the potential for further marginalizing clients in the research process and results. As well, using an anti-oppressive approach allowed clients opportunities for consciousness-raising through reflection, and strayed away from a deficit-based account of their experiences.

Since all of the study participants were currently utilizing community mental health services, this study did not capture the full spectrum of experiences across care

settings, though some did speak about their experiences in acute and tertiary care. Those who are differently marginalized and those from other walks of life were also excluded.

Conducting a document review rather than actually interviewing policy makers limited the perspectives of those in administration. This study also excluded the voice of frontline staff who have day-to-day interactions with clients. Exploring these views would have provided a more well-rounded look into cultural competence in mental health services, and would be an idea for future study.

Areas for Further Exploration

Several points of interest that came from the findings were beyond the scope of this study. Further exploration is needed to help service providers navigate the balance between supporting clients through group programming and the challenges of providing services within these settings. The same can be said for the complexities of supporting those who are exhibiting signs of decompensation while ensuring the safety and well-being of other clients in the vicinity. Service providers also need to be mindful that while group programs allow access to more clients at one time, they do not allow much room for individualized or culturally-specific work, which is another area for further study. A deeper look into clients' heritage and ancestral roots as sources of group strengths and experiences can also be explored. The implications of merging substance use with mental health services also needs to be studied further. Lastly, the examination of sociopolitical and economic conditions that create marginalized statuses in the first place is an important area for further exploration.

Final Reflections

Completing this research has reaffirmed for me the notion that learning is never complete. There will always be something in a given situation I do not know that can only be gained by working collaboratively with clients. This work has challenged my own assumptions about clients and the mental health system, and has encouraged me to think differently about what I take for granted as knowledge. Listening to clients' personal journeys has certainly been a humbling experience when reflecting back on my own practice and what I had thought was culturally competent. Completing this study helped shaped me as a researcher in being mindful of how to conduct research in light of my own biases, and gather and report information in an anti-oppressive way.

The purpose of this thesis was to explore cultural competence in mental health services by learning from client experiences. The study findings built on existing research knowledge and offered new insights into the development of culturally competent, anti-oppressive mental health services. Despite its criticisms, the study results indicate there is great potential for cultural competence at the policy, service, and practice levels. The findings also captured the complex and multifaceted nuances of clients' social locations; and in spite of the hardships they face, mental health clients hold strengths and capacities to participate in transformations of a system of which they are affected by the most.

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APPENDIX A: Letter of Approval



Health Sciences Research Ethics Board Letter of Approval

January 12, 2015

Ms Bien Chu
Health Professions\Social Work

Dear Bien,

REB #: 2014-3369
Project Title: Cultural Sensitivity in Mental Health Services: Learning From Client Experiences

Effective Date: January 12, 2015
Expiry Date: January 12, 2016

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans*. This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,

A black rectangular redaction box covering the signature of the sender.

Dr. Brenda Beagan, Chair

APPENDIX B: Recruitment Flyer



RESEARCH PARTICIPANTS WELCOMED

We are currently recruiting clients who identify as members of marginalized groups to participate in a study to learn more about their experiences with cultural sensitivity in mental health services.

Participants interested in sharing their experiences must meet the following criteria:

- are a current client of mental health services in Vancouver such as mental health teams, mental health housing, drop-in centres, community groups and programs, etc.
- have a diagnosed major mental illness such as schizophrenia, major depression, bi-polar disorder, etc.
- are at least 19 years of age
- self-identifies as a member of a marginalized group based on race, ethnicity, gender, sexuality, class, age, ability, religion, or other social categories
- can communicate in English
- are willing and able to give informed consent to participate in the study
- are prepared to speak in a 60 minute one-on-one interview about their personal background and experiences with cultural sensitivity in mental health services

Participants will receive a \$10 Tim Horton's gift card for their participation. For more information or if you are interested in participating, please contact:

Bien Chu, graduate student & principal investigator
School of Social Work, Dalhousie University
Phone: #604-353-3207 **Email: bien@dal.ca**

APPENDIX C: Permission to Post and Distribute Recruitment Materials Form



Cultural Sensitivity in Mental Health Services: Learning from Client Experiences

Permission to Post and Distribute Recruitment Materials

I, _____, _____,
staff member's name staff member's position

grant permission to Bien Chu, the principal investigator of this study, to post
and/or distribute recruitment flyers at _____ of
name of site

_____ for the purpose of recruiting study
name of mental health organization

participants.

The principal investigator will be responsible for the removal of recruitment flyers posted in the facility and recruitment flyers shall not be posted or distributed any longer than six months from today unless further permission has been granted.

Signatures:

Staff member's name Staff member's signature Date

Researcher's name Researcher's signature Date

APPENDIX D: Informed Consent Form



Page 1/4

Cultural Sensitivity in Mental Health Services: Learning from Client Experiences Informed Consent Form

Lead researcher: Bien Chu, Master of Social Work thesis student

Thesis advisor: Dr. Wanda Thomas Bernard

Contact information: Bien Chu Phone: #604-353-3207 Email: bien@dal.ca

Introduction

We invite you to take part in a research study being conducted by Bien Chu who is a graduate student at Dalhousie University, as part of her Master of Social Work program. Your participation in this study is voluntary and you may withdraw from the study at any time without any penalties; withdrawal from the study is possible until the first phase of analysis is complete. The study is described below. This description tells you about the risks, inconvenience, or discomfort which you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Bien Chu.

Purpose of the Study

This study aims to learn more about clients who come from marginalized backgrounds, their experiences with cultural sensitivity in mental health services, and what these experiences say about mental health services.

Study Design

This study will involve individual interviews with 8-10 mental health service users. Information collected from these interviews will be analyzed for any themes to learn more about the experiences of clients and their implications for culturally sensitive mental health services.

Who can Participate in the Study?

You are invited to participate if you are a mental health client in Vancouver with a diagnosed major mental illness (such as schizophrenia, major depression, bi-polar disorder, etc.), at least nineteen years of age, and self-identify as a member of a marginalized group (such as by race, ethnicity, age, class, gender, sexuality, ability, religion, etc.). You will need to be prepared to discuss in English, your personal background and experiences with cultural sensitivity in mental health services. You may participate if you are willing and able to give informed consent, unless you are a client of the researcher.

Who will be Conducting the Research?

Page 2/4

Bien Chu is the main researcher of this research study. She is a Master of Social Work student at Dalhousie University. She is a registered social worker and has worked in mental health as a mental health worker for seven years. She also holds a Bachelor of Arts in Psychology and Sociology from the University of British Columbia and a Bachelor of Social Work from the University of Victoria. The research supervisor, Dr. Wanda Thomas Bernard, has over 35 years of social work practice, including work in the field of mental health and has been an educator for over 25 years.

What you will be asked to do

You will be asked to complete a demographics survey and answer a series of 10-15 questions related to your personal background to better understand your cultural identities and your experiences with cultural sensitivity in mental health services; follow-up questions will also follow. The meeting will take place in a mutually agreed upon location in the community, should take ninety minutes in total (twenty minutes to review the informed consent form, ten minutes for the demographics survey, and sixty minutes for the interview) and will be audio-recorded. You will later be provided an executive summary to review the results and instructions on how to access the final thesis.

Possible Risks and Discomforts

While there are no significant risks associated with participating in this study, discomforts may arise when discussing certain topics related to your personal experiences within the mental health system that may trigger an emotional response. The researcher will work to alleviate any distress by coming up with interview guidelines with you prior to the interview to ensure your concerns are addressed. The researcher will check-in with you regularly throughout the interview to ensure your comfort. You do not have to answer any questions you do not want to, and are free to leave the interview at any time. At the end of the interview, the researcher will also review with you supports that are available if you would like to debrief with someone after.

Possible Benefits

There are no direct benefits to you as a result of participating in this study. It is the hope of the researcher that through your participation, new research knowledge about culturally sensitive mental health services from the perspective of clients can be gained.

Compensation and Reimbursement

You will receive a \$10 Tim Horton's gift card honorarium for participating in the study. The time and location of the interviews will be at your convenience and should be at no cost to you.

Confidentiality and Anonymity

Page 3/4

Steps will be taken to make sure confidentiality is respected as much as possible. Anonymity is not possible as face-to-face interviews are required for the study. Your identity will be used for coding data and to cite direct quotations by first name, pseudonym (or false name), or no name, if you prefer. Please note that confidentiality cannot be guaranteed if you choose to use your first name. Also, confidentiality cannot be guaranteed for information you choose to share with others outside of the interview about the study. Information collected, including audio-recordings, will be used for this research study only and saved on the researcher's personal computer which is password-protected and kept in a secure place hidden from plain sight in the researcher's private home. The researcher's thesis advisor may also have access to this information via an online file sharing program.

There are circumstances where confidentiality cannot be guaranteed; for example, in instances where the researcher has a duty to report suspected child abuse or neglect, expressed potential self-harm, or expressed harm to others. You will be notified if any of these matters arise.

Questions

If you have any further questions, please feel free to contact the researcher, Bien Chu, through phone #603-353-3207 or email bien@dal.ca. You will be notified of any changes or new information to the study that may affect your willingness to participate in the study.

Problems or Concerns

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Catherine Connors, Director, Research Ethics, Dalhousie University at (902) 494-1462, ethics@dal.ca; Collect calls are acceptable.

Cultural Sensitivity in Mental Health Services: Learning from Client Experiences
Signature Page

I, the study participant,

_____, have read the explanation about this study. I have been given opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study; however, I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

In addition to the above, I also explicitly consent to the use of (please circle):

- my first name _____,
- a pseudonym (a false name) _____, or
- no name

for the purposes of storing data and for the use of direct quotations in reporting.

I would like to be provided an executive summary of the results by (please circle):

- mail or e-mail to _____ or
- none

Signatures:

Research participant's name	Participant's signature	Date

Researcher's name	Researcher's signature	Date

APPENDIX E: Demographics Survey



Page 1/2

Cultural Sensitivity in Mental Health Services: Learning from Client Experiences Demographics Survey

Study participant ID _____

Please consider the following when completing this survey:

- This information will help us to describe the participants in the study.
- Please answer the questions honestly and to the best of your ability. Please skip a question and move on to the next one if you are not comfortable answering it.
- Your responses will remain confidential and anonymous.

Please mark an 'X' in the box next to the response that applies to you. If a written response is required, please write your answer in the line provided.

1. What is your age?

- 19-25
- 26-64
- 65+

2. What is your gender identity?

- Female
- Male
- Other: _____

3. What is your sexual orientation? _____

4. What is your highest level of education?

- Some grade school
- Some high school
- High school completion
- GED completion
- Some post-secondary education
- Post-secondary diploma
- Undergraduate degree
- Graduate degree
- Post-graduate degree

5. What is your main source of income?

- Employment
 - Full-time
 - Part-time
 - Temporary/Casual/Seasonal
- CVS-Community Volunteer Supplement/TVP-Therapeutic Volunteer Program
- Income assistance
- Other: _____

6. What is your racial/ethnic background? _____

7. What is your religious background? _____

8. What is your mental health diagnosis?

- Major depression
- Bi-polar disorder
- Schizophrenia
- Other: _____

9. In addition to your mental illness, do you have any other (dis)Abilities? If yes, what is your diagnosis?

- Yes: _____
- No

10. What mental health services have you used or are currently using? For example, a mental health team, mental health housing, drop-in centres, community groups and programs, etc.

Past:

Current:

11. Please list any other social or cultural categories that you feel are significant to your own identity that have not been mentioned above.

APPENDIX F: Interview Guide

Interview Guide

I. Interview guidelines

- Are there any topics that may be triggers or sensitive to you that I should be aware of?
- How would you like to signal that you need a break or want to stop the interview?

II. Client's background

- What is your mental health diagnosis?
- What marginalized social or cultural groups do you identify yourself to be a member of?
- What does culturally sensitivity in mental health services mean to you?

III. Experiences with cultural sensitivity of mental health services

- What mental health services are you currently connected with?
- Can you tell me about some of your experiences with cultural sensitivity at [named mental health services]?
- Were the staff sensitive to your cultural identities? Please explain and give examples.

IV. Cultural sensitivity and anti-oppressive practice

- How are your cultural identities considered together in assessment and treatment planning? Please explain and give examples.
- How are your cultural identities included in the programs and services offered? Please explain and give examples.
- Are you given opportunities to be involved in program and service development? Please explain and give examples.

V. Ending the interview

- When it comes to cultural sensitivity, do you think there are currently things missing from the ways mental health services are delivered? Please explain and give examples.
- How would you like to see it change?
- If you need to talk to someone about any discomfort or triggers that came up during this interview, is there someone you can talk to? *Study participants will be provided a list of mental health services.*

APPENDIX G: List of Mental Health Services in Vancouver

Mental Health Services in Vancouver

The following support services are available if you would like to speak to someone about any discomfort or triggers that may have come up during the interview.

Vancouver Crisis Centre #604-872-3311

Provides 24-hour support to people in crisis or distress, information on local services, mental health support, support to seniors, or if you just need someone to talk to

KUU-US Crisis Line #1-800-588-8717

Offers 24-hour Aboriginal-focused crisis support.

Mental Health Emergency Services #604-874-7307

**SUCCESS Chinese Help Lines Cantonese #604-270-8233
Mandarin #604-270-8222**

Provides emotional support and information to Chinese-speaking callers.

HealthLink BC #8-1-1

Speak to a registered nurse about your symptoms, talk to a pharmacist about medication and drug questions, or access non-emergency health information.

Access mental health services:

Vancouver Adult Mental Health Intake #604-675-3997

Access to mental health services and mental health teams for adults in Vancouver.

Vancouver Older Adult Mental Health Intake #604-709-6785

Access to mental health services and mental health teams for older adults in Vancouver.

Canadian Mental Health Association of Vancouver #604-872-4902

Offers support groups and wellness programs to people living with mental illness.

Mood Disorders Association of BC #604-873-0103

Offers support groups, wellness programs, and psychiatric clinic to people living with mental illness.

Prism Services, Three Bridges Community Health Centre #604-658-1214

Provides mental health and substance use support, counseling, and health and housing information to the LGBTQ2S communities.