Toward Culturally Respectful, Responsive, and Equitable Mental Health Practice: Moving Away from the Myth of Cultural Competence
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Dr. Johnson is a scholar, author, and professor. He drew on 35 years of experience in the human services and substance abuse treatment fields to present a workshop that provided insight into ways of thinking and acting to facilitate a culturally respectful, responsive, and equitable practice approach when treating mental health disorder clients from diverse backgrounds.

In terms of a cultural competency framework, current teaching considers culture as the sum of race, ethnicity, gender, age, sexual orientation, and religion. Yet the idea that a worker can achieve complete cultural competency is a myth. Which parts of race, age, ethnicity, SOGIE, religion and more apply to the person sitting across the table from the worker? And does the worker's understanding of one individual's culture automatically transfer so that the worker understands a different individual's culture, when that other person shares the same cultural attributes? In practice, *siblings* can have significant cultural differences. The problem with the concept of "cultural competency" in practice is that it takes the characteristics of a group and applies them to an individual.

Culture is not quickly discoverable and easy to understand. The concept of cultural competency in the treatment setting is mythical because:

- It is based on the premise that one can become fluent and competent in another's culture in a short period of time.
- It is based on a narrow definition of culture (races, gender, etc.).
- It ignores the interactive nature of practice.
- It ignores the multiple, interacting cultures of clients and practitioners.
- It promotes ecological fallacy and stereotyping.

Workers only see and know clients in the worker's environment, rarely in the youth's environment, so rarely or never meet the cultural influencers in youth's lives. Workers rarely, if ever, understand the lifelong learning, stories, messages, myths, and facts taught to youths through and by family and communities that shape the youth's cultural systems, beliefs about the world and beliefs about *the workers* that are providing treatment or intervention. The result in practice is that workers can have a narrow approach based on their limited knowledge base yet deliver treatment from an "expert" position of power. Specific practice issues that result include:

- Resistance to help
- Misdiagnosis (occurs in about 50% of Black and Latino youths)
- Treatment refusal
- Cultural clashes and misunderstanding
- Disaffection with helping systems in the future
- Poor treatment participation

- Problems that are left untreated and become chronic
- Excess community stigma leading to social isolation and disconnection

Workers must be cognizant of the interactive nature of treatment and remember that there are four different cultures colliding in the treatment setting; the worker's, the client's, the agency's, and the system. Humility and acceptance of a worker's deficits in their understanding of a client's culture is the successful worker's first step. Equally important is avoiding the danger of misusing "practice privilege", the power differential that is naturally present, regardless of demographics, due to the clinician's role, college degrees, connections, expert status, legal and professional status and responsibilities, class status, and in the case of white, male workers, gender and race. Clients need to know that the worker is aware of that imbalance. Cultural respect and humility, as a basis for practice, posits that:

- Different cultural groups think, feel, and act differently, and that's OK.
- People within cultures are individuals that selectively and uniquely ascribe to cultural practices.
- No single culture is intrinsically superior or inferior to another.
- Information learned through interaction about the nature of cultural differences between people, people and institutions, their roots, and meanings must precede judgment and action.
- Interaction and/or negotiation is more likely to succeed when people understand the reasons for the differences in viewpoints, meaning, and/or behavior.
- Every culture has its own "common sense".

Remember also that clients have implicit biases about *workers*. Workers are also entering the therapeutic relationship with clients stereotyping them. One approach that is helpful for both clients and workers is for the worker to get the client to teach the worker, so the worker can understand the client better and help the client in the context of the client's experience, in other words, help them in a manner that *works* for the client. Be inquisitive. Ask them who they are, what they want, what their families, friends, and communities are like, and especially, focus on learning what clients believe about issues, what they value, cherish, like, and don't like. Ask clarifying questions. Do not assume, instead, ask.

Much of the work in developing a culturally respectful environment in the treatment setting is done at the start of treatment. Focus initially on relationship building, not problem solving. Be transparent. Allow the client a "seat at the table" with the ability to have a say in their care.

As Dr. Johnson put it, "At the end of the day, it depends on the relationships that we build not the diagnosis and assessments and therapies." Engage clients. Healthy outcomes are directly related to people's long-term connections to helpful, supportive people and systems.