MHiMA
Mental Health in Multicultural Australia

Key Concept 3

Culturally responsive practice

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All individuals have ways of explaining their mental health and wellbeing. The way an individual understands, explains and expresses their mental health or illness is known as their explanatory model. This encompasses beliefs about the cause, onset, nature and duration of the illness or distress, as well as beliefs about treatment, healing and recovery. An individual's explanatory model will influence their degree of distress, their behaviour and their response to distress. It will also influence their pattern of seeking help and their engagement and compliance with recommended treatments.

Mental health services and individual workers who work within them, will often have very different understandings and explanations of mental illness from consumers who are from culturally and linguistically diverse (CALD) backgrounds. Culturally responsive workers must seek to understand the illness experience of CALD consumers in order to gain their trust and respect, determine shared priorities, and plan and implement sensitive and effective intervention, treatment and recovery.

Assessment and diagnosis

Mental health professionals are trained in using the definitions and formulations outlined in the DSM-5 and ICD-10 to assess and diagnose mental illness. There is evidence, however, that these classification systems are based on ethno-centric assumptions, and that the syndromes and conditions they describe are not universal.

The DSM-5 includes a broad cultural formulation which can reduce the probability of assessment and diagnostic errors when used by mental health workers when they work with CALD consumers. However the cultural formulation should not be considered a checklist of how to perform a culturally competent assessment. Rather, it should serve as a guide for the mental health workers' exploration of cultural issues as part of the assessment. The cultural formulation can also be used to communicate assessment findings, assist mental health workers to reflect on their work, help build the therapeutic relationship and inform treatment planning.

During assessments, mental health workers should remain aware that culture is not synonymous with ethnicity, religious belief, nationality or language, and that cultural processes will differ within the same ethnic or social group. Mental health workers should not make assumptions about culture in relation to beliefs, understandings and traits. In some cases, culture may not be central to a consumer's presentation, and attention to cultural difference

can sometimes be interpreted negatively by consumers and their families. An approach that is respectful, sensitive and consumer (and family) centred can help avoid misunderstanding and misinterpretation. Mental health workers can also seek out advice from cultural consultants or community elders and leaders to help better understand what might be important or significant for a client and their family.

Language barriers

Language is also a significant factor in assessments. The risk of confusion or misunderstanding about feelings, emotions and experience of mental illness are significantly higher when these are expressed in a second language. The consumer's first or preferred language should always be used when conducting a mental health assessment. This can be achieved by working with an interpreter or a mental health worker who speaks the consumer's preferred language. Cultural consultants can also be involved if the consumer is agreeable. These consultants can assist or inform the assessment by providing an enriched understanding of the cultural components involved in the consumer's presentation.

Treatment, intervention and other remedies

An individual's explanatory model not only determines their beliefs about the cause of their illness, it also influences their help-seeking behaviour (whether or not they will seek help, what type of help they will seek and who they will seek it from). Attention must be paid to the consumer's expectations of the mental health service, the individual worker and each clinical encounter. Mental health workers should work with consumers and families towards a shared understanding of treatment goals and how they can be met. Treatment planning involves a process of negotiation, where differences are acknowledged and common ground is identified. When mental health workers and consumers can reach a respectful and shared understanding, the treatments offered will be more likely to be accepted and valued by consumers and their families.

Additional key strategies to use when planning and implementing mental health interventions with CALD consumers:

- Consider the involvement of workers, consultants or advocates who share the consumer's culture or language. Consumers often express a preference for treatment and benefit more from it, when someone from a similar cultural background provides it.
- Be flexible and adaptable. Choose interventions that are appropriate to the consumer, modify existing interventions to make them appropriate to the consumer's situation, and consider how to incorporate traditional therapies and treatments. Mental health workers may need to expand their view on what constitutes a mental health intervention and take on a range of roles, such as advisor, advocate, facilitator, broker or counsellor.
- Use a strengths-based approach. Encourage consumer competence and resilience, and help them identify their own strengths.
- Offer practical interventions and supports. These tangible and understandable interventions are highly valued by many CALD consumers, and can help to alleviate symptoms. Mental health workers may need to intervene, or provide or broker support across a range of areas including settlement, housing, social security, education or employment.
- Engage with families and communities, as these can be critically important in providing the consumer a wide range of practical, social or support options. Be aware of potential issues when involving families, however, such as intergenerational conflict, different levels of acculturation within families, and changes in roles and power relationships.
- When English is not the preferred language, always use accredited interpreters in treatment planning and delivery with CALD consumers, families and community supports.

CALD consumers and their families may seek multiple forms of treatment. In many communities, both traditional healing modalities and bio-medical approaches are sought simultaneously. There is often a high reliance on general practitioners, particularly bilingual general practitioners. Approaches that are jointly provided by mental health workers and traditional healers have yielded notable positive clinical outcomes, particularly among consumers who were resistant to bio-medical treatment options. Similarly, positive results have been seen from incorporating religious and socio-cultural components into standard psychotherapeutic treatment for religious consumers.

Mental health workers should aim to maintain a culturally responsive approach throughout treatment. There is increased potential for positive outcomes when interventions acknowledge the existence of the consumer's ethnicity and culture, express appreciation for it, and place the consumer's problem in a cultural context.

Organisational planning

When planning mental health services for CALD communities consideration needs to be given to the additional time and expertise required to undertake assessments and treatment so that language barriers can be overcome and cultural differences understood. In particular sessions conducted with interpreters can take at least twice as long as an assessment conducted with a client who has a high level of English. Furthermore some groups may have particularly complex needs that require further in-depth assessment and complex treatment. For example refugees with trauma histories may require additional assessment time for mental health workers to:

- Build trust and create a safe environment
- Understand the complexity of their presentation
- Explore the cultural differences in explanatory models
- Build a therapeutic alliance with consumer and their family and friends.

Useful readings

American Psychiatric Association, (2000). Diagnostic and Statistical Manual for Mental Disorders IV TR, Arlington, Virginia, American Psychiatric Association.

Andary, L., Stolk, A. & Klimidis, S. (2003). Assessing mental health across cultures, Brisbane, Australian Academic Press.

Mezzich, J., Fabrega, H. & Kirmayer, J.(2009). Cultural Formulation Guidelines. Transcultural Psychiatry, 46 (3), 383-405.

Rohlof, H., Knipscheer, J. & Kleber, R. (2009). Use of the cultural formulation with refugees. Transcultural Psychiatry, 46 (3), 487-505.

The cultural formulation

Cultural identity of the individual

- Ethnic or cultural reference group
- Language abilities, use and preference
- Involvement with culture of origin and the host society.

Cultural explanations of distress

- Explanatory model – beliefs about cause, onset, nature and duration of the illness, and beliefs about treatment healing and recovery.

Cultural factors related to psycho-social environment and functioning

- Social stressors and supports
- Levels of functioning and disability.

Cultural elements of worker-client relationship

- Difficulties resulting from cultural differences, e.g. communication and language, relationship and rapport, reaching shared understanding.

Overall cultural assessment for diagnosis and care

- How culture impacts on diagnosis and care.

(adapted from American Psychiatric Association, 2013)