

Competence trust among providers as fundamental to a culturally competent primary healthcare system for immigrant families

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Aim: To explore how an organization's trust in the cultural competency of other service providers (*competence trust*) can influence the effectiveness of a services network in meeting the needs of recent immigrant families. **Background:** Primary health care for recent immigrants arriving in Canada is delivered through a network of community-based services. To ensure the functioning of the network and its ability to facilitate access to needed services for new arrivals, network members need to be able to work together collaboratively. A case study involving services for an urban community in Atlantic Canada was undertaken in 2009 to explore how service organizations worked together to address the needs of recent immigrant families with young children. This paper focuses on provider perceptions of cultural competency among local service organizations and how this influenced trust and desire to work together for the benefit of families. **Methods:** The case study utilized both social network analysis and qualitative inquiry methodology. Twenty-one of 27 selected organizations responded to the online social network survey, and 14 key informant interviews were conducted. Social network measures and network mapping were used to demonstrate trusting relationships and associated interactions, while interview data were used to explain the relationships observed. **Findings:** Perceived cultural competency affected the degree of trust and collaboration within the services network when addressing the needs of recent immigrant families. *Competence trust* toward other providers increased the desire and commitment to work together, while lack of *competence trust* created avoidance. Non-government organizations were identified among the most culturally competent. The perceived positive and negative experiences of families with different providers influenced the level of trust among network members. The development of systemic cultural competences within a services network is needed in order to improve collaborations and access to services for immigrant families.

Keywords: cultural competence; primary healthcare system; recent immigrants; social network analysis; trust

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Introduction

Recent arrivals to Canada may encounter a variety of challenges during the settlement process (Hyman, 2001; Simich *et al.*, 2005). Those with young children have the added responsibility of ensuring their children's well-being, and for this reason are more likely to seek out services that can help to address their needs as a family (Karwowska *et al.*, 2002; Lipson *et al.*, 2003). Individual services may have limitations in what they can offer to immigrant families, particularly if they are inexperienced in dealing with the unique circumstances of families in transition (Isaacs, 2010). Relationships with other service providers, having different assets to offer families, could therefore be an important resource to providers wanting to serve their clients. This paper addresses how the quality of these relationships can contribute to the outcomes experienced by families in terms of the types of services made available to them.

Several researchers have identified trust among organizations as one of several indicators and facilitators of inter-organizational collaboration (Hudson *et al.*, 1997; D'Amour *et al.*, 2005; 2008; San Martín-Rodríguez *et al.*, 2005; Ivery, 2007; Ryan-Nicholls and Haggarty, 2007; Shi and Collins, 2007; Martin-Misener *et al.*, 2008; Walker *et al.*, 2009). Client referrals and communications among service organizations are examples of collaborative activities (Provan *et al.*, 2004; Radermacher *et al.*, 2011), but with whom an organization collaborates will depend on several factors – among them, confidence and trust in the competency and accountability of the other agency (D'Amour *et al.*, 2005; Shipilov *et al.*, 2006).

The concept of trust between organizations is somewhat elusive, being highly conditional on several factors that influence the formation and quality of relationships. These can include socio-political influences such as pre-defined mandates, funding sources and priorities established for institutions (D'Amour *et al.*, 2005), but also the attributes of the partnering agencies themselves that manifest in the trustworthiness of each partner – their credibility, reliability, and integrity (Seppänen *et al.*, 2007). Trust itself is evolutionary and reciprocal with feedback loops responding to the relationship as much as to the influences that form the relationship in the first place (Mayer *et al.*, 1995; Sengir *et al.*, 2004). Trust among service

providers working with new immigrants requires its own form of attention in order to capture how trust interplays within and supports a culturally competent system that is both collaborative and prepared for diversity (Radermacher *et al.*, 2011).

The research question addressed in this paper and as explored in the case study described here and elsewhere (Isaacs *et al.*, 2012), was as follows: 'How do the perceived cultural competencies of different community-based organizations affect the delivery of PHC services for young children of recent immigrants?' Cross *et al.* (1989), defined *cultural competence* as a set of 'congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables the system or professionals to work effectively in cross-cultural situations.' Propositions relating to the research question were:

- The cultural competency of organizations has an important influence on the relationships formed among organizations.
- Organizations will report greater trust in competent partners and interact more with those trusted.
- Connections to culturally competent organizations increase the reach of PHC services in meeting the needs of immigrant children.

The case studied consisted of a group of community-based services available to recent immigrant families with young children from zero to six years of age living in a neighbourhood of a mid-sized urban centre in Atlantic Canada. In the context of this study, the cultural competency of a service organization refers to its ability and preparedness to work with the unique health related needs of recent immigrant families with young children. For purposes of comparison and measurability, a construct of *competence trust* was adopted. *Competence trust* as used in the trust literature is defined as a belief in the other's ability to do the job or complete a task (Norman, 2002; Wakabayashi, 2003; Black, 2007). In this study, *competence trust* referred to a belief in the other's cultural competencies when working with recent immigrant families.

Methods

More details concerning methods, sample selection and the instruments used are described in Isaacs *et al.* (2012). Organizations selected for

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inclusion in the case study either provided services to recent immigrants and/or to families with young children living in a neighbourhood with a proportionately high concentration of immigrant residents relative to the rest of the municipality (Statistics Canada, 2007). Data was collected through an online social network survey and through interviews with key informants.

Social network survey

Twenty-seven organizations meeting the selection criteria were asked to participate in the survey. The director or lead manager of each of the 27 organizations was asked to identify representatives who could respond to the survey on their organization's behalf. Respondents to the survey were initially asked to describe their own organization, including a question about their organization's cultural competency: 'Overall, how well prepared is your agency/program for dealing with the unique needs of recent immigrant families?' with the optional responses 'not very prepared', 'somewhat prepared', 'mostly prepared', and 'very prepared'. This latter question was vetted by a regional expert in cultural competency.

The survey instrument also included a list of 31 organizations consisting of the 27 originally selected to be surveyed, plus four proxy organizations representing generic service groups – family doctors, day cares, walk-in clinics, and cultural associations. Service sectors represented on the list included public health programs, primary care services, immigrant services, family outreach and drop-ins, child and legal services, family counselling, and a group of other services that included housing, food banks, cultural associations, and a local public library. Respondents were asked about the frequency of their and their co-workers' contact with each of the other 30 organizations listed. They were then asked about their work with each organization in relation to recent immigrant families. Questions concerned different types of interactions (ie referral to, referral from, information sharing, and resource sharing). To create a measure for *competence trust* toward other organizations, respondents were asked, 'to what degree do you and your co-workers trust each organization's ability to address the unique needs of recent immigrant families with young children?', with the response options 'not at all', 'somewhat', 'mostly', 'absolutely', and 'unsure'.

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A response of 'absolutely' and a combined response of 'mostly or absolutely' were the two different measures of *competence trust* used in comparisons with the other relationship variables.

A sociogram (network map) using NetDraw (Borgatti, 2002) was created to display *competence trust* relationships among the organizations listed in the survey. For purposes of this display, only 'absolute trust' relationships were mapped in order to preserve the credibility of all organizations involved (ie less trusting relationships are not displayed). Relationships were illustrated by the connecting lines and organizations by the nodes in the map. Node size was used to indicate organizations of relative prominence based on in-degree centrality (Scott, 2006) in the *competence trust* (absolute trust) network.

Jaccard's similarity coefficient (Dunn and Everitt, 1982) was calculated to determine associations between *competence trust* and frequency of contact among network members. Coefficient values were generated using UCINET (Borgatti et al., 2002). Standard errors to test for the significance of association were calculated using quadratic assignment procedures (QAP; Hanne-man and Riddle, 2005). This method was repeated to determine associations between *competence trust* and 'referral to', 'referral from', 'share information', and 'share resources' with other organizations.

An attributed score of *competence trust* for each organization was calculated based on the number of times an organization was trusted mostly or absolutely in its preparedness to meet the needs of recent immigrant families by other survey respondents. This was also a measure of in-degree centrality for *competence trust*, although less restrictive than the measure used in the network map. Organizations placed in the upper quartile on both the self-assessment score for cultural competency, and on the *competence trust* score were accepted as culturally competent – this was an arbitrary cut-off to select and then explore attributes of culturally competent organizations in this services network.

Key informant interviews

One-on-one interviews were conducted with purposefully selected key informants representing different service provider professions and organizations serving the neighbourhood under

study. Interviews lasted between 45 and 90 min, following a process of descriptive qualitative inquiry (Sandelowski, 2000). Informants were asked about conditions that influenced their relationships with other organizations when addressing the needs of young immigrant families. In particular, respondents were asked how the experiences of families with other organizations influenced the respondent's own relationship with these organizations. Interviews were recorded. Transcriptions were imported into NVivo8 (QSR International, 2007). A process of constant comparative analysis was applied to identify key themes relating to relationship influences, cultural competency, trust, and access to services (Crabtree and Miller, 1999).

Triangulation of results

The network survey results were compared with key informant responses on constructs such as familiarity among service providers, and associations between working relationships and *competence trust* in partners. Key informants provided context to help explain organizations with high competency scores from the survey, both attributed by other organizations (the sum of *competence trust*) and self assessed competency. Provider perceptions of negative and positive family experiences with other organizations (eg how well another organization had treated the respondent's clients) were explored for their impact on provider-to-provider relationships as described by respondents and also portrayed in the network map.

Results

Twenty-one of the 27 named organizations (78%) participated in the social network analysis survey, with participation from all targeted service sectors. One-on-one interviews (12 in person and 2 by phone) were conducted with 14 key informants, representing different types of professions and community-based organizations working with recent immigrants.

The influence of competence trust on relationships

The *competency trust* network presented in Figure 1, displays the relationships of 'absolute' trust in others to work competently with recent immigrant families. Prominent members in this

network (high in-degree centrality) are identified by the larger sized nodes. One primary care service in particular stood out as highly trusted within the network of services. Greater *competence trust* was also attributed to various immigrant services, and a drop-in centre.

Competence trust was statistically associated with organizations interacting and working together. The statistical correlation between 'regular contact' (defined as in contact more than once a month) and '*competence trust*' was significant (Jaccard coefficient = 0.301, $P = 0.031$, for trust 'absolutely'; Jaccard coefficient = 0.357, $P = 0.024$, for trust 'mostly' or 'absolutely'). When *competence trust* included both 'mostly' and 'absolutely' trust relationships, *competence trust* was then also significantly associated with 'referral to', 'referral from', 'share resources', and 'share information' (Table 1).

Family experiences influencing the quality of relationships

The impact family experiences had on relationships between providers can be described as 'strengthening' in response to positive and helpful family experiences, 'cautioning' in response to culturally (or otherwise) insensitive experiences, and 'damaging' when experiences appeared to threaten families.

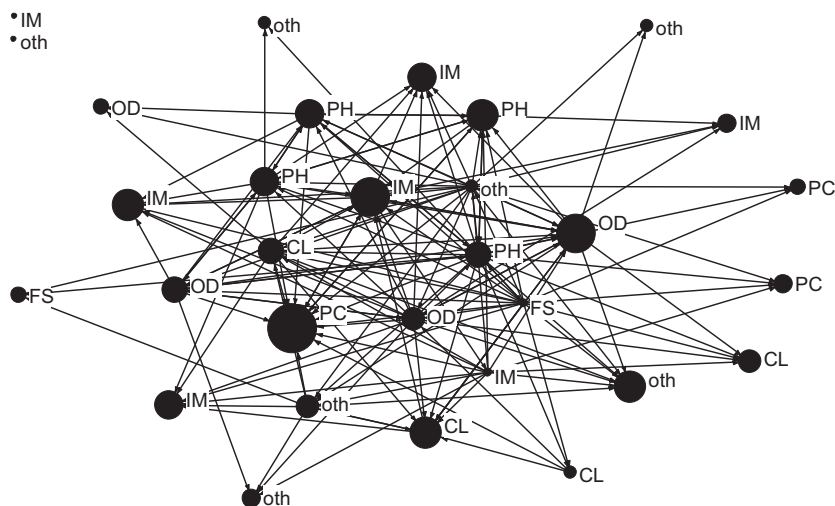
Strengthening – response to helpfulness

Key informants considered their client's experiences with other organizations as the litmus test concerning their approval of an organization and willingness to engage in future interactions. Positive experiences that were both instrumentally helpful but also broached with sensitivity toward families – that is, being involved 'in the families' lives, family focused, strength-based approaches, having the time, being open and adaptable – were key elements of obtaining approval, and often with a renewed commitment toward the relationship:

...they are actually one of our greatest resources when it comes to families with expectant mothers ... (It) seems that they have really done a lot of soul searching, [] so that we are really able to connect with them... 01

Cautioning – response to insensitivity/unhelpfulness

Providers were cautioned by the culturally insensitive experiences reported to them by



Service Sector:

PH	Public Health	CL	Child & Legal Services
PC	Primary Care	FS	Family Counseling Services
IM	Immigrant Services	oth	Other Services
OD	Family Outreach / Drop-in		

Figure 1 Competence Trust Network: 'Absolute Trust' (lines) toward organizations (circles) in their ability to address the needs of recent immigrant families with young children

Table 1 Correlations between trust and types of interaction among organizations

Networks compared	Trust mostly or absolutely		Trust absolutely	
	Jaccard coefficient	<i>P</i> -value	Jaccard coefficient	<i>P</i> -value
Trust and referral to	0.510	0.005	0.305	0.166
Trust and share information	0.462	0.045	0.264	0.394
Trust and share resources	0.281	0.007	0.261	0.009
Trust and referral from	0.430	0.001	0.300	0.052

Note: Jaccard's similarity coefficient applies to binary data indicating presence or absence of a relationship (Dunn and Everitt, 1982).

families, when relating to the other organizations involved in these experiences. Insensitivities such as a lack of culturally appropriate resources, not giving the family enough time, or being directive rather than supportive, were most often referenced. Concerns were raised in the context of inequitable access to programs normally offered to the general population, '... they feel like an outsider going to a mainstream service. They don't feel comfortable or understood. ... and then they don't come back,' 02. Using older children as

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translators in sensitive situations repeatedly incensed informants who qualified this as disrespectful behaviour on the part of providers. 'There are lots of reasons, lots of cultural reasons and simply fact reasons why it is absolutely inappropriate to have a family member interpret' 03.

Cautionary responses ranged from: delayed future contact or avoidance, engagement only out of necessity ('there's no one else'), or withdrawal from the relationship entirely. 'If it really became inappropriate or was not something that we felt

was respectful of the clients that we work with, we probably wouldn't continue...' 04. Tolerance for insensitive behaviour of other providers did, however, vary with willingness by some to see the potential for growth in the other. '(Y)ou know we all make mistakes, whether it's on our side or the client side or whatever, and if the system's too rigid and doesn't allow for any of us to make mistakes, I mean, it's going to fall apart' 05.

Damaging – response to families under threat

The most difficult forms of relationships experienced among providers were those perceived to be threatening for families. Issues around child protection or immigrant status gave authoritative agencies power to significantly disrupt the lives of these families if deemed necessary. Provider perceptions of cultural competency in the authoritative partners were coloured by their perceptions concerning the impact conflict with authority had on families. In some circumstances, providers felt the family's trust toward them, not just the partnering agency in authority, was being placed in jeopardy. Providers were sometimes pushed into situations of 'damage control', trying to minimize as much as possible the fallout on their relationship with the family, while recognizing the legitimacies of some of the concerns being addressed by the authority. Providers were left with the challenge of regaining the confidence of clients, having lost their clients' trust through association.

... and then if things don't go according to family's needs and expectations ...then there can be a lot of that mistrust and, 'why are you with me if you're not able to bring me my children back... what are you doing in my home? Have you done anything?' And sometimes, I wonder the same. 01

In this example, access to services for families was no longer so much about relationships between organizations, as much as it was about loss of trust toward those willing to help. In these situations, mediation to help families also involved educating other providers to improve their cultural understanding and sensitivities. If the provider was open to learning, relationships between providers were strengthened.

I work with [] lawyers on both sides... There's a frustration level that I sense

sometimes at their own lack of being able to communicate, right? It's new for a lot of people and some people have very strong feelings and emotions. But I feel most people I work with are very grateful and relieved that there's somebody there willing to do that mediation piece. 06

At times, providers also needed to work toward recovering relationships with their colleagues:

(Some) workers only comply with the rules and do not have enough flexibility. And everybody has different styles of work and I appreciate that. Any negative experience that I've had only encourages me more to go back to the organization, go back to staff, go back to management. 01

Figure 2 summarizes the three relationship dimensions among service providers and how the perceived experiences of families (helpful, unhelpful, and threatening) with another provider can influence these relationships leading to improved access through referral and further engagement, or else loss of access through disengagement and family withdrawal.

Trusted providers enabling family access to services

As reported by the providers interviewed, the willingness of families to utilize services often spun from family experiences and/or the characteristics of an organization that made the organization both welcoming and physically accessible. Accessibility included the location of services within the community, access to interpreters, being family focused, and having staff of different cultures. Four organizations were identified as exemplars of cultural competency, all four being placed in the top quartile of both the self-assessment cultural competency scores and attributed *competence trust* scores. The organizations consisted of a community health centre and three non-government organizations (NGOs) – two settlement services and a family drop-in centre.

From key informant interviews, attributes of commitment, responsiveness, adaptability, and openness were highlighted characteristics shared among the four organizations. The commitment of time to work with the complex needs of immigrant families and allow for the development

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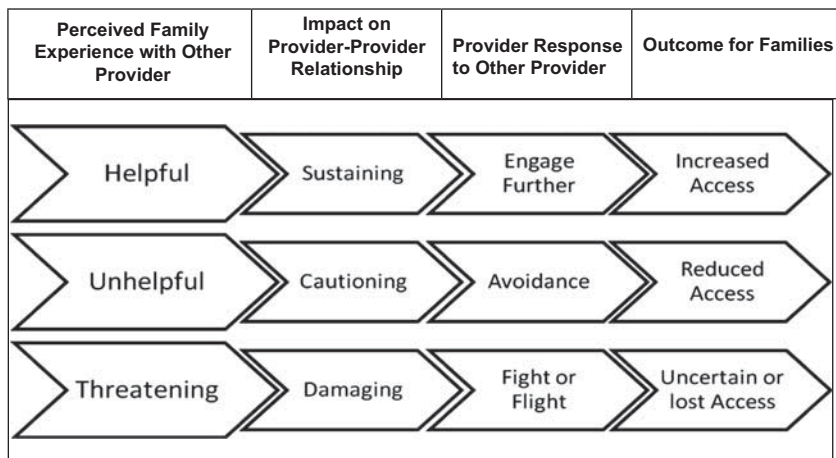


Figure 2 How provider perceptions of family experiences with other providers (helpful, unhelpful, or threatening) can impact relationships among providers and affect service access for families

of trust was thought essential: ‘...if you have the time you can listen and you can pick up on the questions people have. You can more easily pick up on the cultural differences. And, you can build a trust.’ 02. As well, being adaptable and hands on was important: ‘Do you want to drive over or we can call and make an appointment. We don’t mess around. We’re practical.’ 07. Being linguistically and culturally accessible was also important: ‘...we’ve had some families that have come into our centre just because they have seen lots of woman dressed in traditional Muslim dress. So, they sort of think this is a place that’s comfortable for me.’ 04. Finally, offering or enabling access to a diversity of services added value in meeting family needs: ‘So we help our clients register their children to school. We help them access health care, whether it’s primary health care through family doctors or whether it’s sometimes helping them even by [accompanying], going to the children’s hospital ...’ 01.

Discussion

As demonstrated in the literature and supported by this case study, community organizations do not work in isolation, but have an influence on the performance of the services system overall in meeting the needs of diverse communities (Kwait *et al.*, 2001; Provan *et al.*, 2002; Whitaker *et al.*, 2007). Within a culturally competent framework, *Primary Health Care Research & Development* 2013; **14**: 80–89

developing relationships of trust are important, and can be accomplished by interacting with clients and co-workers with openness, understanding, and a willingness to hear different perceptions (Davis-Murdoch, 2005). As illustrated in this case study, for a system of services to be culturally competent, *competence trust* can be the enabling factor that brings together the collective competencies of all partners into a process of exchange and interaction that is responsive to the needs of immigrant families. For families to have access to services, *competence trust* among organizations mattered – with lack of trust, workflow within the system under study was constrained and the nature of interactions was less open with more avoidance behaviour.

The model presented in Figure 2 introduced the concepts of threat for families and of conflict also experienced by providers, the consequences of which are likely to be negative for families without a skilled approach toward conflict resolution. The threat may be toward the integrity of the family if immigrant status or parenting concerns are the issue. Loss of trust among providers in this case may or may not have anything to do with cultural competencies in the partnering organizations. However, the outcome for the family is still experienced as negative with access to services for families placed at risk.

As a premise of organizational theory, adaptation and change is often resisted by the inertia of

the dominant organizational structures (Hurley and Kaluzny, 1987). Mainstream services within this case study, for example, held mandates to serve the general population, and were structured primarily under functional areas (eg well-baby programming) rather than align formally with local or selected community-specific objectives. Not surprisingly, of the four organizations recognized for their cultural competence, three were NGO's, organizations with the least financial stability but adaptive to the needs of new comers; the fourth organization represented an interdisciplinary model of primary care that differed from the traditional family practice model. Encouragingly, during the time of this study, new champions promoting the adoption of culturally competent practices and policies were emerging within conventional organizations and service structures.

In social capital terms, relationships among service providers are investments, with a likely desire among all parties to preserve the advantages gained through these relationships (Gulati and Higgins, 2003; Forbes and McCartney, 2010). In this case, those most invested in the issues faced by immigrants had potentially much more to gain through their actions in trying to promote the cultural competencies of others. Although some were willing at the extreme to end relationships if their interests in families were somehow compromised, for others, challenging less culturally competent agencies or severing ties could conceivably have resulted in losses of other kinds – access to needed skill sets and resources for example. In the words of one service provider, 'There's no one else.'

Limitations

Twenty-two percent of selected organizations did not participate in the survey. The lack of participation in the survey of all selected organizations may have missed relationships of interest for this study, although core service sectors were represented. Organizational representatives who declined from the study most often felt that their directives to work with immigrants or with the health concerns of young families were not explicit enough to warrant their participation. Organizations included in the study were selected on the basis of the biases of those consulted; however, pre-existing resources (eg a community resource

manual) created opportunities to challenge these biases. The researchers were unable to recruit multiple participants from each organization, and therefore results are potentially biased by the opinions of the organizational representatives. Respondents recruited with the help of directors or lead managers may have been selected on the basis of a desired response from their director. The results are based on the opinions of providers, not the immigrant families, as relationships among provider organizations were the focus of this paper.

In summary, revisiting the propositions presented in this paper, the cultural competencies of organizations in working with immigrant families as perceived by providers indeed impacted the 'quality' of relationships among providers. Trust in competent partners was evident. *Competence trust* – trust in the other's cultural competence – made partnerships with these organizations desirable. Providers saw value in partnering with culturally competent organizations in order to access and provide services to recent immigrant families with young children, but also as a means of learning and developing their own competencies. Culturally competent providers saw sharing and working with other organizations as a strategy for developing competencies within the services system overall, therefore improving access to services for recent immigrant families and their young children. As a policy objective that enables *competence trust* within a services system, it would be important for funders to recognize the value of existing culturally competent organizations as models and resources in cultural competence for other providers. The development of culturally competent skills in all provider agencies is ultimately important in order for families to benefit from an expansion of *competence trust* throughout the services network.

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