16 Conclusion: The Future of Cultural Consultation

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In this chapter we reflect on the lessons learned from over a decade of work by the cultural consultation service. We consider the challenges of implementation and evaluation, the evidence for impact on health outcomes the implications for mental health policy, the design of health care systems, the training of professionals and everyday clinical practice.

The findings from the CCS project are important because they indicate significant unmet needs for mental health services for Indigenous peoples, immigrants, refugees and asylum seekers. At the same time, the CCS project suggests that outpatient consultation provides an effective means of responding to some of these needs. A service like the CCS can support mainstream health care, provide ongoing training within clinical institutions and create a context that allows professionals from diverse backgrounds to make systematic use of their linguistic and cultural expertise.

As seen in many of the case vignettes presented in this volume, the cultural consultation service has documented serious errors in diagnosis and inadequate treatment of mental health problems that reflect a lack of clinical attention to culture and social context. Systematic attention to these issues can lead to more comprehensive assessment, more effective treatment and better clinical outcomes.

Outpatient consultation is a familiar process for health professionals. Family physicians are accustomed to referring patients for specialist evaluation, and collaborative care models provide a natural way to incorporate attention to culture in mental health services. The dilemma, of course, is that a referring clinician must recognize the need for consultation, convey this to the patient in an acceptable way, find the appropriate resources and be able to apply any recommendations effectively. All of this presumes a substantial degree of cultural awareness or competence on the part of the referring clinician. This requires training in cultural aspects of mental health. The virtue of the consultation approach is that it works with the existing health system framework and improves continuity of care by reducing segmentation and there can be a spillover effect from consultations so that other patients in the clinician's practice benefit from new knowledge and skills.

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Globalization is increasing the rate and intensity of culture contact and exchange. Rather than resulting in a standardization or homogeneity of experience, however, these exchanges are leading to the emergence of new forms of hybrid identity. At the same time, the networks that bind people together through the Internet and social media are providing opportunities for new forms of identity and community. Along with this come changes in the meanings of culture itself. Recent years have seen significant changes in the demography of Canadian cities, which have made issues of culture more salient. While Canada has always been a nation of immigrants, the older waves of mainly European immigrants have shifted to be predominately people from the Asian and southern countries. Many of these cultures have substantially different values at the levels of individual psychology, family structures and community—all of which affect the nature of mental health problems and solutions.

At the same time, the post 9/11 environment of anxiety has contributed to new waves of xenophobia and restrictive immigration legislation in many countries. Commitments to the protection of refugees have weakened, undermining both the right of asylum and the conditions for productive resettlement. Recently, the Canadian Federal government increased the use of detention for refugee claimants and, simultaneously, drastically cut their health care coverage. There are ongoing legal challenges to this retrograde policy. However, in the meantime, failed refugee claimants and other migrants with precarious status, who arrived in Canada as temporary workers or with a visa, are likely to form an increasingly important group of undocumented persons in need of health care. These vulnerable individuals and families constitute an important challenge for the health system.

While globalization has broken down barriers between nations and cultures and encouraged cultural exchange, intermixing and hybridization, it has not resulted in a global monoculture (Burke, 2009). Indeed, one reaction to this exchange has been the reassertion of local ethnic identities and boundaries to exclude the cultural “Other.” In many jurisdictions, there have been increasing calls for less accommodation and more assimilation of immigrant and refugee communities. Even within Canada, there are notable regional differences in policies and attitudes toward migration and cultural diversity. For example, Quebec has a provincial government that is currently proposing a “charter of secularism” to insure that religious values and symbols are kept out of the public sphere. This is consistent with laicism and republicanism in France but very much counter to the spirit of multiculturalism. On the other hand, Québec is the only provincial government that has officially stated that it will cover the cost of health care for refugees, because the federal policy is unacceptable in terms of Québec values. This illustrates the local paradoxes in facing otherness and the complex ties between welcoming policies and collective history.

There is increasing recognition of the importance of culture in psychiatry. The US National Institute of Mental Health sponsored a culture and diagnosis work group that made many recommendations for DSM-IV only some of which were incorporated, most notably the outline for cultural formulation (Mezzich et al., 1999). DSM-5 has expanded on this with a cultural formulation interview and supplementary modules that provide a way to collect clinically relevant information about illness experience, culture and context. To make effective use of this information, however, clinicians need better understanding of the biological, psychological and social processes through which culture influences normal development, psychopathology and adaptation. The ongoing revisions of ICD-10 have also emphasized the importance of culture and its interaction with clinical utility. It will be interesting to see how the growing body of work on cultural idioms of distress and local nosological systems influences this international document.

Paths to a Culturally Safe and Competent Mental Health Care System

Cultural consultation provides a way to improve the overall competence of practitioners and institutions. The case centered approach fits with the

explicit mandate, everyday tasks and practical concerns of health care institutions. At the same time, discussion of issues of social and cultural context in specific cases highlights systemic issues and implications of standard practice in health care institutions. In a sense, it reveals the culture of the institution, pushing back against medicines "culture of no culture" (Taylor, 2003).

Recognition of culture points to the need for adaptation of service models and interventions and a variety of approaches have been developed (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). Unfortunately, there have been no comparative evaluation studies of the merits and limitations of any of these models, so that it remains difficult for planners to choose from among the different approaches and models for the development and maintenance of specialized services (Bhui et al., 2007; Renzaho, Romios, Crock, & Sonderlund, 2013). This is a general problem with applying evidence-based approaches in the area of cultural diversity (Whitley, Rousseau, Carpenter Song, & Kirmayer 2011). In the absence of evidence for a specific model, the CCS has followed the main trends in contemporary psychiatry and psychology in terms of effective psychosocial and psychotherapeutic interventions but has also built on the experiential and cultural knowledge of its clinicians and cultural brokers to expand the repertoire of available interventions and adapt them for particular patients. There is a need for more work developing innovative interventions that may rely on different mechanisms of healing and adaptation rooted in social processes of culture and community and for rigorously evaluating these practices.

Access to Services

The CCS experience documented important gaps in the delivery of mental health care to refugees, immigrants and First Nations peoples. Many of the patients referred to the CCS had needs for services that went beyond what was available to them in the health care. These cases required more time and more resources (e.g., interpreters, culture brokers, meetings with extended family, linkage with community organizations) than comparable cases from Canadian-born patients to accomplish basic clinical tasks of diagnostic assessment and treatment planning. Given this greater demand and the technical and logistical complexity of conducting an adequate assessment, in many cases a basic assessment with an interpreter had never been attempted even though patients had been in the treatment system for many years. The use of the cultural formulation and strategies for working with cultural difference are still not widely known by clinicians and have not been given sufficient attention in professional training or continuing education.

The CCS facilitated access to services in several ways. Through its collaboration with the regional refugee clinic and other community organizations, the CCS provided service for underserved groups who usually do not receive mental health care. For patients already in the health care system, the CCS provided links to clinicians, interpreters, culture brokers and community organizations with knowledge and expertise in working with specific ethnocultural groups. By providing access to specialized consultation that increased the knowledge and clinical skills of clinicians, the service improved the quality of care of patients. Finally, by creating a place for professionals from different disciplines to learn to use cultural perspectives in their work, the CCS contributed to building capacity to respond to diversity within the mainstream health care system.

The development of a specialized resource like the CCS also brings with it certain problems. Increasing clinicians' awareness of and sensitivity to cultural issues leads to an increase in demands, which can quickly exceed the capacity of the team. It may also lead clinicians to think that cultural issues are outside their areas of competence and should all be referred. Regulating intake by adjusting the catchment area or criteria for referral reduces accessibility for those who may be in greatest need. The CCS also raises expectations in terms of the need for various forms of specialized treatment that may not exist, e.g., psychotherapy or family therapy in different languages and expertise

in working with survivors of torture. This can exert useful pressure on the health care system, motivating the development of new services, but it can also create frustration in settings where resources are limited. Interestingly, however, many of the basic CCS recommendations fall within the range of nonspecialized interventions recommended by the WHO in the Mental Health Gap Action Program (mhGAP) modules, designed to be feasible in low-income countries (World Health Organization, 2010). This reflects the role of cultural consultation in addressing basic needs that are sometimes displaced by technical interventions in high-resource settings with specialized health care. In many cases, CCS consultations emphasize providing psychological first aid built on cultural coping strategies, family and community-based psychosocial care and restoring the ruptured social networks that are essential for recovery and well-being.

The CCS increasingly recognized the need to offer time-limited treatment interventions and long-term follow-up to meet the needs of referring clinicians and patients to have access to basic care. On the other hand, the Transcultural Clinic at the MCH, which offered comprehensive treatment and longer-term therapy from the start, found that it quickly became backlogged and was unable to respond to its unique populations (including refugee children). As a result of this and of the difficulty of sustaining a specialized transcultural clinic in a hospital setting, the MCH considered a move toward more consultative services based on supporting care providers in other parts of the hospital and other institutions or community settings. Thus, both services, although starting out with different models, converged on a mix of consultation-liaison (mainly diagnostic assessment and treatment planning) and direct treatment provision (including various forms of individual and family therapy and aspects of case management, coordinating care from many providers). The ideal situation would seem to be a service that primarily serves consultation and training functions but has the capacity to follow complex cases with a network of diverse providers.

Person-Centered Medicine and Communication

There has been much recent interest in person-centered care as a counterbalance to the tendency in biomedicine to focus on treating the disease rather than the person (Mezzich et al., 2010). The work of the CCS fits squarely with this person-centered approach but expands it by focusing not only on individual illness experience but on the family, community and social-systemic contexts of suffering and healing. The CCS assessment process attends to the voice of patients and clinicians to identify their most pressing needs and concerns. The consultant views patient and clinician as embedded in social systems and institutions—including health care, social services, education, immigration and community organizations—that frame their concerns and present them with a limited set of options. By providing a place to consider diverse perspectives on illness and healing and think outside the limits of conventional frameworks, the CCS has promoted the use of innovative interventions for mental health problems.

The CCS approach reflects core values, global strategies and specific clinical tactics. At the level of values, the CCS adopts an ethical stance that grants the primacy and validity of patients' own stories, which include both illness narratives and autobiographical accounts that situate their personal predicaments and aspirations in their life trajectories. Eliciting and understanding this story requires adequate communication which, in turn, entails the use of interpreters and culture brokers to insure that patient and clinician can grasp each other's meaning and intentions. Interpreters are integrated into the CCS team as partners in the assessment and treatment process. While recognizing that interpreters cannot provide an unbiased view or perfect window onto patients' experience, they are nevertheless absolutely essential to go beyond the imprecision and error found when there are significant linguistic barriers to communication. Full communication is the basis for the CCS assessment and any subsequent intervention.

The CCS approach is based on an epistemological view that recognizes the fluidity and multiplicity of narratives and perspectives so that, contrary to the juridical view of the refugee review board and other institutions, no one story suffices or can be privileged as the "final" truth. This multiplicity is found not only in the illness narratives of patients and their families but also among members of the health care team. It is reflected in the composition of the CCS team and the discussions that take place at the CCS case conferences. The aim in this colloquy is not to reach a simple consensus but to elicit and hold a range of hypotheses or options that provide potential trajectories for interventions that can promote healing and recovery.

Given the problems that the CCS regularly identifies in routine care and the health care system as a whole, its work necessarily involves a stance of advocacy. This is expressed both through actions on behalf of individual patients or ethnocultural communities and through an ongoing research program that aims to document the vital importance of cultural consideration for improving quality of care.

Service Integration and Continuity of Care

The work of the CCS cuts across sectors of the health and social service systems and so can contribute to improving continuity of care. The service works with many different types of health care and social service providers, accepting referrals from both frontline and specialty settings. In the process of making sense of a given case, the CCS may convene workers from several different institutions representing sectors of health, social services, education and legal systems. The CCS case formulation often identifies multilevel or multi-system problems that call for the expertise of several professions and the need for collaboration across institutions and with community organizations. Getting some of these people together around the same table to discuss a difficult case often has ramifications beyond the immediate clinical problem, as mutual understanding, common goals and new forms of collaboration can emerge. Even when the relevant professionals and concerned parties are unable to meet face to face, the CCS team may act as a go-between through successive conversations with different stakeholders and can identify intersectoral issues where collaboration can resolve shared problems and bring mutual benefits.

The CCS thus challenges the tendency for segmentation of care and, by focusing on a set of issues that lie beyond the expertise of any single professional or institution, encourages open dialogue, collaboration and partnership. This is important not only in remote rural communities, where such segmentation seems especially absurd, but also in highly resourced urban milieus where institutions may compete for resources or struggle to protect their turf and areas of responsibility.

The experience of the CCS also shows how building links with the community can identify resources to untangle complicated cases and provide opportunities for treatment and social reintegration that go beyond the limitations of conventional mental health care.

Health Outcomes and Cost-Effectiveness

Due to the extremely heterogeneous nature of the cases seen by the CCS, the relatively brief intervention and the lack of direct patient contact in many cases, it has proved difficult to demonstrate the impact of the CCS on specific health outcomes and evaluate its cost-effectiveness. For many or most patients seen by the CCS, it appears there were significant changes in service use, diagnosis and treatment in individual cases that had dramatic impact both on their long-term well-being and functioning and on the ultimate costs of their care to the health and social service systems. Although there are cases in which the CCS assessment and recommendations clearly had an immediate, dramatic effect, for most cases other situational factors also played an important role in the outcome. A report from Jacques Ramsay, coroner in Quebec, based in part on

consultation with the CCS, described six cases of mortality directly related to obstacles in accessing health care for migrant refugee or undocumented patients (Gouvernement du Quèbec, 2007). While language barriers and the lack of appropriate use of interpreters were major reasons for these tragic outcomes, other issues including institutional racism, prejudice and discrimination, cultural misunderstandings and the politics of migratory status were all significant contributors to these deaths, which illustrate the risks of cultural blindness and ethnocentrism in clinical practice.

Some of the cases seen by the CCS had received no mental health evaluation or treatment, despite lengthy periods of contact with health care, and were clearly costing the system much more because of this neglect than they would have if effective treatment had been provided at the outset. Problems that may be amenable to a relatively brief intense intervention, like having an interpreter available to make a proper diagnosis at the start, may become more complicated and refractory to treatment over time as errors occur, trust in care providers and institutions erodes and the functioning of the individual and family deteriorates.

The CCS has also seen many patients who have been in treatment for lengthy periods of time but never received a culturally oriented assessment with an interpreter. Reassessment often led to substantial changes in diagnosis and treatment plan. In many cases, patients who had not been receiving any effective treatment for their conditions were accurately diagnosed and enrolled in appropriate treatment. In some cases, this involved children who had been incorrectly diagnosed due to a lack of use of interpreters and cultural expertise and who had been treated for years with inappropriate medications and other interventions. The personal and social cost of this systematic mismanagement is enormous. Of course, this is not only an economic or health care issue but also an ethical and human rights concern.

The existence of the CCS raised awareness about a host of issues related to culture throughout the health care system. Among the unanticipated effects of the service was a great increase in interest in training in cultural psychiatry among students in medicine, psychiatry, social work and nursing. The opportunity to participate in the CCS has attracted trainees from psychiatry, psychology, social work and other disciplines to McGill postgraduate programs. The availability of this type of clinical experience may have a major impact on the skills and orientation of future generations of mental health practitioners.

Obstacles to Implementation and Sustainability

Our experience with the CCS identified important obstacles to the implementation of cultural consultation services and culturally sensitive care more generally. Some of these obstacles stem from limited resources and time pressure in the health care system, but there are subtler obstacles that reflect ambivalence in the broader society that is reflected in the local values and practices of health care institutions and professionals. Hospitals, clinics and other social service institutions that initially welcomed the effort to provide culturally responsive care found it difficult to understand and integrate the social perspectives and interventions provided by the CCS, which fell outside the framework of routine practice. This problem was especially evident when the CCS uncovered institutional biases or structural problems that required substantial change in standard practices or bureaucratic routines. It also occurred when professionals accustomed to working with limited models and treatment algorithms were required to think more contextually and integrate multilevel and multisectoral interventions into their practice.

The CCS followed a consultation model with the aim of supplementing existing mental health care and upgrading the skills of practitioners throughout the health care system. However, because of problems in access to psychiatry and other mental health services throughout the system, there was pressure to replace the consultation-liaison model with an outpatient treatment team approach that could provide basic care to take some of the load off existing services. There was

also pressure to respond to crises or emergencies (e.g., imminent deportation) or provide quick consultations to expedite disposition of cases.

Finding the requisite resources (consultants with expertise in cultural psychiatry, culture brokers, interpreters, community supports) for patients from particular cultural backgrounds was sometimes difficult, especially when the local immigrant community in question was small, which was the case for many newcomers.

One barrier to addressing cultural diversity in mental health care is the prevalent ethnocentrism of health care providers and planners. For example, some clinicians asserted that they did not need to consider culture explicitly because they treated every patient equitably and on their own terms. Unfortunately, this liberal "colour blindness" often was expressed in clinic routines and procedures that did not accommodate important variations in patients' needs and expectations.

This lack of accommodation of the patient's reality was also evident in attitudes toward language. Despite the clear indications in the literature and potential medico-legal implications of inadequate communication, many hospitals and clinics underutilize existing interpreter resources because practitioners are satisfied with a minimal level of communication with their patients or find it too difficult logistically to obtain the requisite help. This is sometimes justified by claiming that newcomers need to adapt by learning to speak the host country language. In the context of Quebec, this claim is reinforced by a general concern with the need to protect and promote French as the official language.

There was also a tendency to reframe social structural and economic problems in cultural terms and so divert attention from larger issues that demand political action. For example, issues related to Aboriginal health have been framed in terms of culture when there are obvious social structural problems related to poverty, marginalization and disempowerment that are major determinants of health disparities in this population (King, Smith, & Gracey, 2009; Reading & Wien, 2009). At the same time, explicit attention to culture may be very appropriate as much of the oppression endured by Aboriginal peoples involved deliberate devaluing and suppression of their traditions (Kirmayer, Brass, & Valaskakis, 2008). Similarly, many families from racialized minorities referred from youth protection face structural problems related to patterns of migration and discrimination within Canadian society (Chapter 13). Yet valorizing and supporting bicultural identities and the traditions of their parents and grandparents can be an important component of helping migrants strengthen a sense of individual identity and collective belonging.

By insisting that cultural issues are important and demonstrating that culturally competent care requires specific knowledge and skills, the CCS also challenged the complacency of existing institutions. The focus on cultural competence and safety as relevant to patient care implied that professionals needed to acquire new knowledge and skills and new ways of doing their work and this sometimes evoked apprehension and resistance to change. Insuring that consultations were framed in accessible language and emphasized the transfer of skills and strategies reduced this apprehension. In many cases, it was possible to present cultural information within the framework of family theory and therapy, which reinforced clinician's sense of competence and made interventions easier to understand and integrate into existing treatment plans.

Reflecting the current dominance of reductionist biological models and pharmacological treatments in psychiatry, some psychiatrists did not recognize social, cultural, economic or other structural issues as important dimensions of psychiatric care. Others did not see the consultation as useful even for difficult cases, usually because they viewed it as too time-consuming or intrusive. Concerns voiced by clinicians who had not used the service included the impression that such consultations would increase their workload, were too lengthy, would take too long to arrange and therefore would not respond to the need for timely resolution of clinical problems. Many of these clinicians would prefer to hand over difficult cases altogether rather than go through the consultation process and perhaps receive recommendations that required that they work in unfamiliar ways.

Sustainability has been a challenging issue for the CCS. In particular, funding has remained difficult to secure. In large part, this reflects the continuing perception by many policy makers, administrators and clinicians that culture is peripheral to the goals and methods of mental health services. As a result, a service like the CCS is not a budgetary priority.

In the Quebec version of the Canadian system of universal health insurance (Medicare), funding for psychiatrists is covered by the state on a fee-for-service basis, but support for other mental health professionals (i.e., psychologists, nurse practitioners, social workers) must come from hospital or clinic budgets or else be paid by the client directly. As a result, it is difficult to sustain an interdisciplinary team without commitment from a hospital administration or comprehensive community clinic. As well, because cultural consultation often requires coordinating the efforts of multiple consultants, interpreters, culture brokers, patients and their families, there is a need for skilled clinical administrative staff who can provide telephone intake and triage and organize the work of the service. Finally, building collaborative relationships with ethnocultural community organizations takes time and effort that may not meet immediate clinical needs but lays the groundwork for effective interventions at a later time.

Transferability: Implementing Cultural Consultation in Other Settings

Although the CCS was developed in a particular context, we believe that it can be easily adapted to different settings and health care systems. In fact, similar services have been developed in other cities with modifications based on the needs of the local communities and practitioners. The basic requirements to transfer of the model include:

1. An explicit commitment (ideally long term) on the part of regional health and social service authorities and institutions to improving the quality of mental health services by addressing cultural diversity.
2. Information about the kinds of diversity in the local population and the specific service needs of particular groups. It is important to recognize that lack of use of services does not indicate lack of need. Minority groups often underutilize mental health services because they fear stigma or discrimination. Insuring cultural safety of institutions and addressing negative attitudes toward mental health services in the community will eventually increase use of services by marginalized groups. Hence, the initial effect may be an increase in cost. When this is averaged over time, however, better access will lead to more efficient use of services and better health outcomes.
3. A willingness to work closely with representatives of ethnocultural communities and community organizations to identify unmet needs and potential resources for the delivery of culturally appropriate mental health care. This requires understanding the internal diversity of cultural communities and provides the opportunity to build up a network of resources that can be deployed in the assessment and management of specific cases. This process can also contribute to reducing psychiatric stigma and educate the community to be more effective consumers of available services. This work must scrupulously respect issues of confidentiality, which are particularly delicate in small ethnocultural communities.
4. The process of implementation involves identifying staff with the requisite skills and obtaining infrastructure support (consulting rooms for individual and family meetings, administrative and secretarial support, telecommunications, videoconferencing, Internet access). It is important to locate the service in a place within the health care system that makes it acceptable to both patients and clinicians, preferably a nonpsychiatric setting that is easily accessible to the cultural communities and clinicians who are being served.
5. The core staff for the service will generally include an individual or small group of clinicians with expertise in cultural psychiatry or cultural-clinical psychology. This includes familiarity with the elements of cultural

assessment and formulation and the techniques of consultation-liaison work. Usually, clinicians obtain this expertise by training in specialized programs and by ongoing efforts to reflect on their own ethnocultural background and learn from clinical experiences with diverse populations.

6. The ready availability of a pool of professional medical interpreters is essential for work with newcomers or others with limited proficiency in the languages of mainstream institutions. Ideally, these interpreters should have specific training in mental health issues to allow more accurate assessment of mental status, deal with complex cases of trauma and manage their own emotional reactions and countertransference.
7. Similarly, the service requires a group of culture brokers (some of whom may be bilingual, bicultural clinicians or interpreters) who can serve as go-betweens in clinical communication and provide information on relevant cultural context and background. Funding, supervision and support must be arranged for each of these types of collaborators.
8. The vitality of the service will be greatly enhanced by assembling a multidisciplinary team of culturally diverse professionals open to rethinking standard practices. In addition to adding to the available expertise and ability to respond to specific populations, this team can also provide the solidarity and support needed to challenge and transform existing institutional policies and practices.
9. Given the innovative clinical model and interventions of the CCS, there is a need for a flexible institutional framework that can adapt to the pragmatic aspects of cultural consultation including changes in the number and type of patients referred to the service, the need to engage extended families and community organizations in decision-making processes and the need to collaborate with other institutions.

Policy Implications

The CCS documented significant unmet need for services among ethnocultural minorities, including immigrants, refugees and Indigenous peoples. The analysis of cases seen in the cultural consultation services and transcultural clinics indicates that language, cultural background and racism all diminish access to mental health care or undermine the relevance and reception of conventional care. Many of the cases seen in our clinics had inadequate treatment for mental health problems, in some cases despite having been "in the system" for years. In a significant number of cases, the absence of interpreters or culture brokers and the cultural complexity of the cases prevented adequate assessment in conventional mental health care settings.

Given the great diversity of immigration to Canada, ethnospecific clinics are not practical for most groups, in most regions. For small communities, specialized clinics may also be undesirable because they cannot provide the requisite privacy and anonymity for patients, since everyone in the community knows everyone else.

While there are grassroots community initiatives that address the mental health needs of immigrants and refugees, there remains a significant lack of coordination of resources as well as a lack of a coherent structure to manage the needs of an increasingly diverse population. As well, there are too few clinical consultants available to support primary care and frontline workers in the community.

Our results suggest that there is a need to balance three sources of help for culturally diverse populations: (1) to increase awareness and skills at the level of primary care, (2) to support community services and improve liaison with professional mental health care and (3) to provide specialized teams with cultural knowledge and language skills essential to work with patients who require a high level of expertise to diagnose and treat their problems.

The model we advocate involves the development of specific cultural consultation services which can provide assessment and treatment planning as well as networking with community resources for clinicians in primary care, psychiatry, social services and other mental health disciplines. This service can also contribute directly to the training of interpreters and culture brokers as well as developing links with helping resources within the cultural communities. Given the need for simi-

lar resources (clinicians from specific backgrounds, interpreters, culture brokers) for both consultation and treatment, the most useful services will allow a combination of consultation with the availability of intervention and follow-up for complex cases or those requiring specialized resources.

Health care and social service institutions must enable clinicians who have specific cultural knowledge and skills to devote time to cultural consultation and to train other clinicians in this domain. They should also make it easier for practitioners to access and use interpreters and culture brokers. This requires supporting the additional time and personnel needed to work interculturally and across languages as well as recognizing (and recruiting) clinicians with diverse backgrounds and linguistic skills. This includes budgeting funds and establishing systems to remunerate culture brokers for their time and expertise.

There is a need to support community services and improve their liaison with professional mental health care as well as to develop culture brokers who can work closely with clinicians to mediate clinical encounters and identify appropriate resources to assist with the social care of patients.

Implications for Training

An important goal of the CCS is to increase the cultural competence of the mental health care system as a whole by addressing the training needs of frontline workers in primary care and mental health. Much of the training effort of the CCS has gone on through case conferences and consultations responding to the immediate clinical concerns of referring individuals and organizations. To address broader training needs, we reviewed training models and developed teaching materials and in-service training workshops for health and social service professionals.

The review of training approaches used three strategies: (1) a systematic review of available literature on cultural competence training using PsychLit, PubMed and Google Scholar search engines; (2) a brief survey questionnaire and subsequent conversations with international leaders in the field addressing pedagogical philosophy, methods, models, trends and gaps in cross-cultural training in mental health; and (3) on-site visits to local, national and international programs. The initial version of this review appeared as an appendix in the CCS evaluation report (see www.mcgill.ca/ccs).

A growing body of literature supports the need for cultural competence training in mental health. Although there is general agreement that the notions of race, ethnicity and culture have been conflated and inappropriately applied in clinical settings, there are various training models emphasizing different issues, including anti-racism, cultural awareness, cultural competence, cultural safety and culture-specific or generic approaches (Kirmayer, 2012a). Training manuals have been developed for use in university programs, continuing education and clinical settings. Most follow a modular format with readings and exercises to address a spectrum of issues related to cultural awareness and skill development. However, there is limited evidence to support the effectiveness of most training programs in terms of either cognitive and attitudinal changes or ultimate impact on clinical skills and practice.

Much of the work on cultural competence comes from the United States, Australia and the UK where concepts and categories of ethnocultural and racialized identity differ substantially from those in Canada and other places (Kirmayer, 2012a). In recent years, the Mental Health Commission of Canada and Aboriginal groups have adopted the notion of cultural safety as a rubric under which to develop training and intervention models (Mental Health Commission of Canada, 2009, 2012; Smye, Josewski, & Kendall, 2010). This recognizes the continuing legacy of colonialism and state policies that have disempowered and oppressed Indigenous peoples. Immigrants, refugees and racialized ethnic minorities also experience systematic disadvantage that must be addressed in creating institutions and modes of practice that are culturally safe and respond to the needs of patients, families and communities. Cultural safety will require attention to specific social structural and historical issues in each setting. Table 16.1 lists some of the strengths and limits of different

Table 16.1 Levels of cultural competence

	Institution	Practitioner	Technique
Strategy	Organizational cultural competence	Clinical cultural competence	Cultural adaptation of interventions
Examples	Institutional policies of equity, antiracism, cultural diversity awareness	Ethnic matching of clinician and patient	Adjusting style of interaction and communication to patient
	Insuring that administration and staff are representative of ethnocultural composition of communities served	Training of professionals in specific and generic cultural knowledge, skills and attitudes	Matching intervention to patient
	Engaging communities in policy making, planning, and regulation of services	Referral to other professionals and helpers in the community	Cultural adaptation of interventions
		Use of culture-brokers or mediators	Adoption of new interventions
			Referral to other sources of help or healing
Benefits	Can organize systems and services in ways that are responsive to needs of specific groups	Can facilitate initial trust	Can tailor intervention to take into account specific psychological or social issues and processes
	Can address issues of power and discrimination, empowering community and resulting in greater equity, safety and trust in institution	Linguistic match facilitates communication	May improve acceptability of intervention
	Can improve access and acceptability through community relationship to the institution and through design of specific programs	Shared cultural background knowledge facilitates mutual understanding	Can mobilize personal and community cultural resources for resilience and recovery
		Can provide role of modelling of successful or resilient individuals from similar background	Can identify culture-specific goals and outcomes that require alternative therapeutic approaches
Limitations	If focus is primarily on representativeness of governance and staff, actual delivery of services may be conventional	Match may be crude or approximate (owing to differences in ethnicity, subculture, social class, education, dialect, etc.)	Adaptation may be superficial or purely cosmetic
	Institutional policies may not result in actual changes in behaviors of staff	Clinician may not know how to apply their own tacit cultural knowledge to clinical care	May lose elements essential for efficacy
	Ethnospecific services may constitute a form of social segregation and fail to transform the general health care system	Clinicians may be feel typecast, professionally limited or marginalized	Culturally-grounded methods may not address issues related to cultural hybridity or culture change
		Patients may feel singled out, racially categorized, stereotyped	Culture-specific or traditional methods may be socially conservative and do not allow patients opportunity to escape from culturally mediated or rationalized forms of oppression
		Patients may feel exposed to scrutiny by their own community and may wish for the psychological distance or privacy associated with meeting a cultural "outsider"	Interventions may not be familiar or appealing to patients who eschew tradition and value other ("modern," scientific) approaches

approaches to cultural competence and safety in training and the organization of health systems (Kirmayer, 2012b).

To address the need for locally appropriate training approaches, the CCS established a multidisciplinary group to assess the education needs of different professionals and develop specific training activities in (1) primary care, (2) interpreter and culture-broker programs and (3) graduate training programs. The primary care work group comprised physicians, social workers and frontline workers who identified cultural training needs in their respective disciplines. The group met regularly to coordinate these activities.

Group members have been active in intercultural training. They organized workshops to increase the competence of clinicians in the domain of culture and mental health, particularly for refugee services, and to know how to make appropriate use of specialized services. An interpreter training subgroup included administrators from the Regional Board of Health and Social Services, who were responsible for the training and deployment of interpreters throughout the health care system. This group made recommendations for improving the training of interpreters in the domain of mental health. It also interfaced with the primary care group to help train practitioners to make appropriate use of interpreters, since there was evidence of underutilization of interpreters.

A subgroup addressed postgraduate training for psychiatrists and mental health professionals as well as with philosophy and methods of training and education at a more global level. This group organized an Advanced Study Institute on Models of Training in Culture and Mental Health in May 2001 as part of the annual McGill Summer Program in Social and Cultural Psychiatry (www.mcgill.ca/tcpsych). Papers from a subsequent workshop on "Rethinking Cultural Competence from International Perspectives," held in April 2010, have appeared in *Transcultural Psychiatry* (Kirmayer, 2012b). This work culminated in the framing of guidelines for training in cultural psychiatry produced by the Section on Transcultural Psychiatry of the Canadian Psychiatric Association (CPA-TPS) and endorsed by the CPA Standing Committee on Education (Kirmayer, Fung, et al., 2012). These guidelines are available online and are being supplemented with training materials including readings, video lectures and links to other training resources (see: www.transcultural-psychiatry.ca). Table 16.2 summarizes some of the major themes and content areas in these guidelines, which are deliberately broad and inclusive and which can be adapted for other professions.

In collaboration with the McGill Division of Social and Transcultural Psychiatry and specific teaching hospitals, the CCS has supported monthly seminars for mental health professionals in the community. A series based at the Montreal Children's Hospital entitled "Culture and Clinic Rounds" used case-based presentations to focus on clinical assessment issues including trauma and organized violence, family separation and reunification, psychotherapy with South Asian women and boundary issues in transcultural psychiatry. A second series of monthly meetings based at the Jewish General Hospital (where the CCS is located) on "Culture & Community Mental Health" focused on research and clinical issues in community psychiatry. Topics included minority origin professionals in health and social services; women, racism and the mental health system; rape as a crime of war; linkages between community organizations and mental health professionals; dilemmas of ethnic match; and the asylum-seeking process.

An integral goal of the CCS has been to promote dialogue with existing community resources in culture and mental health. To that end, CCS consultants have met with staff involved with training in community organizations to identify training needs and plan relevant workshops and other activities. Partners in these activities have included the regional network providing treatment and supervision for those working with survivors of torture (Réseau d'Intervention auprès des personnes victimes de violence organisée, RIVO); the regional coordinating group for immigrant refugee organizations (Table de Concertation des organismes de Montréal au service des réfugiés et

Table 16.2 Core knowledge, skills and attitudes for training in cultural consultation

Knowledge
Prevalence of mental health among specific ethnocultural groups and populations
Cultural variations in idioms of distress, symptom presentation, illness explanatory models and cultural syndromes
Ethnic differences in response to medications, including pharmacokinetics (metabolism) and pharmacodynamics (drug response, susceptibility to side effects)
Interactions of culture with gender, age and social status
Sociocultural stressors, including migration, poverty and discrimination
Skills
Conduct and organize a culturally oriented assessment
Ability to negotiate sociocultural factors, such as healer–patient role expectations and power dynamics, that influence clinical engagement and alliance
Conduct a culturally valid mental status examination
Produce a cultural formulation
Consider cultural issues and present an integrative biopsychosocial–spiritual understanding
Develop a culturally appropriate treatment plan
Cultural adapt psychotherapy, pharmacotherapy and other interventions
Appropriate management of ethnic differences when using pharmacotherapy and somatic therapy
Direct patients to relevant community resources
Modify style of communication to facilitate rapport with patients and their families
Appropriate use of linguistic and cultural interpreters
Work with interpreters and culture brokers
Consult and collaborate effectively with other physicians, health care professionals, agencies, religious leaders, community leaders and cultural consultants as appropriate
Attitudes
Reflect on and recognize one's own biases and assumptions
Demonstrate integrity, honesty, compassion and respect for diversity
Understand ethical issues that concern diverse populations
Recognize power differences and dynamics in professional collaborative relationships
Demonstrate respect for diversity in working with teams
Aware of power dynamics and take appropriate steps to address inequity owing to sociocultural forces within teams
Participate in and promote quality assurance that takes into account cultural and equity issues
Ensure equitable allocation of health care resources and access to care
Identify and understand the impact of racism, access barriers and other social factors leading to mental health sequelae and health disparities in disadvantaged groups
Knowledge of major regional, national and international advocacy groups in mental health care
Ability to engage in effective mental health promotion strategies, including community educational talks and workshops
Advocate effectively for the biopsychosocial, cultural and spiritual needs of patients and their families within the health care system and community

Based on Kirmayer, Fung, et al. (2012)

immigrantes, TCRI); a training center for organizational cultural competence (Institut Interculturel de Montréal, IIM); the local branch of the Canadian Mental Health Association, a lay advocacy group; a regional coalition of about 80 cultural community organizations (Alliance des Communautés Culturelles pour L'égalité dans la Santé et des Services Sociaux, ACCESSS); and a social service organization for immigrants (Centre sociale d'aide aux immigrants). We identified areas of potential collaboration with these organizations, including training mental health professionals in intercultural awareness and skills, information and resource sharing and the development of a mechanism for providing ongoing clinical consultations for mental health professionals working

in an intercultural context. Often groups working on intercultural mental health care were unaware of the contributions of other groups locally, nationally and internationally.

Cross-cultural training is a necessary component of clinical training for all mental health professionals. However, in most educational and practice settings, it remains largely undeveloped. In particular, most mental health professionals receive no training on how to work with interpreters and culture brokers and no systematic education in cross-cultural assessment or intervention.

Clearly, there is a need to strengthen training of mental health practitioners in concepts of culture and strategies of intercultural care. This should include recognition of the value of clinician's own linguistic and cultural background knowledge as added skills. Professional training should provide explicit models for integrating tacit cultural knowledge and current best practices in mental health care. Trainees should be given opportunities to reflect on and make use of their own cultural backgrounds and to employ their linguistic skills in working with patients.

There is a particular need to train mental health practitioners to work with interpreters. This must become a standard part of all graduate training programs in psychology, psychiatry, nursing, social work and other health and social service professions. In-service training and continuing education programs should be provided for practitioners to refine their skills in intercultural communication and collaboration with medical interpreters.

Interpreting in the context of mental health care is especially demanding because of the technical need to transmit not only the gist of what someone is saying but its precise form and quality (set against a backdrop of cultural norms) in order for the clinician to assess the patient's mental status. Mental health interpreting also involves emotionally intense and challenging situations that may affect all participants. Interpreters therefore need additional training in mental health as well as supervision and support to work with potentially distressing or traumatizing situations.

There is also a need to develop training for clinicians, interpreters and other knowledgeable community members who can play an important role as culture brokers. This requires addressing specific ethical issues that challenge the narrow role currently assigned to interpreters (Chapter 6).

Finally, quality assurance and accreditation standards for training programs must specify the components of cultural safety and competence in detail (e.g. knowledge, skills and attitudes) and insure they are addressed in training program curricula, evaluation and recertification. Only formal monitoring can insure that these issues are fully integrated into training and certification of professionals so that knowledge, skills and attitudes essential for cultural safety and competence become part of the core expertise of every mental health professional.

From Consultation and Clinical Services to Advocacy

As we have shown throughout this book, the political dimensions of culture are very often at the forefront in the consultation process. Intergroup power relations and the stresses and injury that stem from social exclusion—whether through the structural violence of poverty, microaggressions of discrimination in daily interactions, institutionalized racism or as a result of restrictive policies of immigration and asylum—are sources of social suffering that may be expressed as mental health problems or complicate the course of recovery. From the perspectives of public health, clinicians have a responsibility to advocate for changes in social policy that will promote mental well-being, prevent illness and facilitate recovery. In the same way that clinicians advocate for anti-bullying measures and for restricted access to firearms, clinicians working with ethnocultural minorities, immigrants or refugee must advocate to improve the quality of services, recognition and protection and to decrease the social adversity that vulnerable groups confront.

While advocacy for individual cases to support a refugee claim or facilitate access to services is highly valuable, clinicians should also advocate as a group to improve the way in which their

societies welcome immigrants and refugees and support their resettlement. In a context of increasing xenophobia, this can be a challenging endeavour, and the creation of international networks of advocacy can help local advocates persist, despite institutional pressures, to keep human rights issues on government agendas. These rights include not only the protection of the right of asylum but also the right to health, education and the protection of the child's best interest. Recognizing that we are fundamentally cultural beings and require hospitable communities and participation in traditions to flourish, there are also international rights to culture itself (Kirmayer, 2012b). Mental health services that work with culture as a resource for individual and collective resilience can contribute to the protection of this right.

Building Communities of Practice

In 2007, a meeting of about 200 clinicians and leaders of government and community organizations from across Canada produced a set of recommendations for addressing health disparities and cultural diversity in health care (National Transcultural Health Conference, 2007). The recommendations emphasized the concept of cultural safety, achieved through explicit attention to cultural issues in health care, including the development of the skills of cultural competence, the use of trained interpreters and culture brokers, involving both linguistic translation and cultural mediation; ready availability of culturally appropriate information on illness and treatment in multiple languages through oral, written and visual materials accessible through Internet websites, social media or standalone audiovisual kiosks; building on cultural knowledge through partnerships with communities; and the development of local, regional and national networking. Many of the ideas from this conference have been incorporated into subsequent work by the CCS, particularly through the development of Internet web-based resources for training and clinical services.

To insure that the work of cultural consultation has maximum impact, frontline workers need easy access to resources and support to provide culturally appropriate care. One efficient way to achieve this is through the use of web-based resources and other information communication technologies which offer several advantages for promoting intercultural care. First, they allow for networking, creating links between community groups, clinicians and government organizations. Secondly, they allow for much wider accessibility, making these materials and tools available in rural or remote locations. Specific resources can be determined through needs assessment and during ongoing consultation with stakeholders but would likely include (1) training and self-assessment materials for continuing education in cultural competence (Lim, Hsiung, & Hales, 2006); (2) multilingual mental health information resources for patients, families and professionals; (3) specific material on key issues including ethnocultural variations in diagnostic and neuropsychological assessment and response to psychiatric medication; (4) guidelines for the design and implementation of cultural consultation, community-based collaborative care and ethnospecific mental health services; and, eventually, (5) consultation for specific clinical and organizational issues related to cultural diversity in mental health care.

Intercultural work can be both exceptionally demanding and rewarding. Many practitioners concerned with cultural issues find themselves a lone voice in their local health care system. There is a need to develop a community of practice through networking to bring together and support individuals who can spearhead the development of services like the CCS and who are actively engaged in intercultural work. This network can exchange information and support a national clearing house for models of intervention, clinical resources and training materials. This network can also sponsor interdisciplinary training activities and collaborative research across centers.

With support from the Mental Health Commission of Canada, we have developed a web-based Multicultural Mental Health Resource Centre (www.mmhrc.ca). The MMHRC is essentially an Internet portal to provide easy access to material useful for intercultural mental health

Table 16.3 Contents of a Web-based resource for multicultural mental health

For health care providers
• Guidelines for working with interpreters and culture brokers and for specific patient populations or clinical problems (e.g. immigrants, refugees, survivors of torture)
• How to locate resources needed for intercultural care (e.g. interpreters, culture brokers, community organizations)
• Self-study and assessment materials for cultural competence
• Updates from current clinical and research literature on culture and mental health
For patients and their families
• Mental health information factsheets in multiple languages
• Self-help materials
For community organizations
• Information on mental health services
• Stigma reduction materials for diverse groups
For policymakers, planners and administrators
• Information on policies, law and human rights declarations related to diversity in mental health care at different levels of jurisdiction (i.e. local health care systems, regional, national)
• Criteria and measures for organizational cultural safety and cultural competence
• Demographic information on ethnocultural communities
• Models and approaches to the design of services for culturally diverse populations

Source: www.mmhrc.ca

care (Table 16.3). The website brings together links to resources and other sites useful to primary care and mental health practitioners, patients and their families, community organizations and policy makers. For clinicians, the site provides information on cultural assessment and formulation, migration-related health issues, methods for the use of interpreters and culture brokers and ways of helping patients to access community resources. For patients and their families or caregivers, there is multilingual information on common mental disorders and materials for self-care and information on health resources as well as links to local and national community organizations. For health administrators and planners, the site serves as a clearing house for information on models of care and best practices in addressing cultural diversity in psychiatry and mental health care. This includes bringing together materials developed in other countries to give a comparative perspective on available strategies and facilitate local, national and international networks for knowledge exchange in this area. An associated e-mail listserv provides a vehicle to announce programs and make requests to the network for information. Video podcasts, a blog and other social media are used to share ideas within the network and can attract a wider audience to enlarge the community of practice.

Conclusion: Valuing Cultural Diversity

Every culture has its own styles of reasoning and raison d'etre rooted in certain core values and ways of life. Culture is of value for each individual as it is essential to the realization of one's full personhood with a range of competencies that build on collective history and accomplishments. Culture is of value to the group or community as a means of weaving people together with common purpose and coordinated roles in a larger system capable of creating institutions that far outreach the capacity of any individual. Beyond culture as a primary good for each individual or collectivity, we can recognize the diversity of cultures itself as a good, on analogy to the ecological role of biological diversity in insuring the viability of ecosystems in situations of stress and change. This global diversity can be valuable even to a relatively homogeneous or monocultural society. Every language and cultural tradition offers us imaginative possibilities that may help us adapt to new circumstances or address some of the limitations, injustices and inequities in our own way of life.

Recognizing the creative value of the encounter between different traditions works against the stale and stultifying arguments for exclusion or assimilation that arise from limited imagination and engagement with others. When the other is viewed only in terms of problematic difference, we miss the creativity of exploring a new worldview that can challenge and invigorate our own, whether through dialogue or hybridization. Rather than viewing others from a distant, disengaged and uninformed view of their

experience, which inevitably leads to stereotyping and prejudice (and sometimes is used to justify our own fearful reactions and aggression), we can engage them directly in dialogue and in the process enlarge our imagination of what it is to be human.

If we value diversity for any or all of these reasons, we must work to create forms of community that can sustain it. Along the way, we must do our best to protect the global diversity that is our collective cultural capital. Our willingness to work for this diversity, at home and internationally, reflects the level of our interest in and respect for others—and for the other in ourselves, born of our own hybrid histories, identities and experiences. The politics of alterity shapes our social world but it also has echoes in the recesses of each individual's psyche as we write and rewrite our personal stories of identity. Health services are crucial arenas where diverse people come together in times of crisis with an openness born of the urgency of their predicament and the commitment to a compassionate response. The appropriateness and effectiveness of this response depends on recognizing the person in their individuality, which, in turn, draws from their participation in multiple cultural communities. Multicultural mental health care allows us the opportunity to explore cultural identities and engage communities to in an effort to understand and help others in ways that are grounded in recognition of both our common humanity and our essential differences.

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