World Mental Health Day

OCTOBER 10 2007

Mental Health in a Changing World:
The Impact of Culture and Diversity

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SECTION 1

INTRODUCTION

There are approximately 6.5 billion people living on planet Earth. Within that number, there are more people living outside their country of origin than at any other time in history. One person out of 35 is an international migrant — 3% of the global population. If we look at our world today, is there any single culture, race or religion that is 100% contained in one single country? We can find dramatically different languages, religions, family relationships and values, as well as views on health care and treatment wherever we go, including in our own respective countries. A female mental health professional born and trained in India may have moved to the United Kingdom and is seeing a male client born and raised in Ecuador — how do they communicate and how do each view the same mental illness?

Culture may influence many aspects of mental health, including how individuals from a given culture communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. Likewise, the cultures of the clinician and the service system influence diagnosis, treatment, and service delivery. Cultural and social influences are not the only determinants of mental illness and patterns of service use, but they do play important roles.

In the mental health care setting, culture impacts how people:

- Label and communicate distress
- Explain the causes of mental health problems
- Perceive mental health providers
- Utilize and respond to mental health treatment

How can we move forward and give the best care possible if we don't take into consideration the differences of those we are trying to help? How do we overcome the barriers of language and cultural differences, views of mental illness, gender issues, and different training and teaching methods? The 2007 World Mental Health Day Campaign will bring attention to transcultural mental health services and treatment. The World Federation for Mental Health looks forward to the opportunity of working together to develop an approach to health care that incorporates our cultural backgrounds and beliefs, deals with language barriers, and creates culturally sensitive forms of dialogue.

> *People are probably more tied to their cultural and ethnic beliefs when ill than when feeling well. Illness is stressful and may lead individuals to revert to what is known and comfortable.*
>
> **Foundations of Nursing, "Transcultural Healthcare," Foundations of Nursing**

This packet begins with a historical perspective from Eugene Brody, M.D. that challenges us to answer the question: how far have we really come in transcultural mental health and what more needs to be done? The packet itself includes information about the impact of culture on services and public understanding, the impact of culture across the life span, special issues of migrants and other displaced populations, an overview of some practices and programs from different countries and our call to action to develop a culturally competent system of care for all.

References:

Satcher, David. "Mental Health: Culture, Race, Ethnicity."
http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-6.html

Hogg Foundation, "Cultural Adaptation: Providing Evidence-Based Practices to Populations of Color"
http://www.hogg.utexas.edu/programs_cc.html

1.1 Definitions

Following is a listing of definitions for terms used in this packet. We hope they will be of use as you educate others in your community!

Acculturation (noun): 1. The modification of the culture of a group or individual as a result of contact with a different culture. 2. The process by which the culture of a particular society is instilled in a human from infancy onward. (American Heritage Dictionary)

Cross-cultural psychiatry is concerned with the cultural and ethnic context of mental disorders and psychiatric services. It emerged as a coherent field from several strands of work, including surveys of the prevalence and form of disorders in different cultures or countries; the study of migrant populations and ethnic diversity within countries; and analysis of psychiatry itself as a cultural product. (Wikipedia. http://en.wikipedia.org/wiki/Cross-cultural_psychiatry)

The definition of **culture** has long been a controversy and the term is used in a variety of ways. A few commonly-used definitions are:

> "[**Culture**] is that complex whole which includes knowledge, beliefs, arts, morals, laws, customs, and any other capabilities and habits acquired by [a human] as a member of society." The term sub-culture is used to refer to minority cultures within a larger dominant culture. (Taylor, E. in Seymour-Smith, C. (1986), Macmillan Dictionary of Anthropology).

> **Culture** is the collective programming of the human mind that distinguishes the members of one human group from those of another. Culture in this sense is a system of collectively-held values. (Geert Hofstede)

Cultural Brokering: the act of bridging, linking, or mediating between groups or persons of different cultural backgrounds for the purpose of reducing conflict or producing change. (Jezewski, 1990). A cultural broker is defined as a go-between, one who advocates on behalf of another individual or group (Jezewski & Sotnik, 2001).

There is no single definition of **cultural competence**. Definitions of cultural competence have evolved from diverse perspectives, interests and needs. Examples include:

> **Cultural competence** in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. (Betancourt et al., 2002)

> **Cultural competence** is the demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. But perhaps the most significant aspect of this concept is the inclusion and integration of the three areas that are usually considered separately when they are considered at all. (Lavizzo-Mourey & Mackenzie, 1996)

Cultural sensitivity: the understanding and tolerance of all cultures and lifestyles. It is crucial in the delivery of competent care. (Foundations of Nursing, Transcultural Healthcare)

Immigrant: A person who leaves one country to settle permanently in another country.

Migrant: any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country.

Multiculturalism: the preservation of different cultures or cultural identities within a unified society, as a state or nation. (http://dictionary.reference.com/browse/Multiculturalism)

Prejudice: a belief based on preconceived notions about certain groups of people. Prejudices can be unfair, biased beliefs. (Foundations of Nursing, Transcultural Healthcare)

In the 1951 Geneva Convention, the term **Refugee** applies to "any person who, due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. In the case of a person who has more than one nationality, the term 'the country of his nationality' shall mean each of the countries of which he is a national, and a person shall not be deemed to be lacking the protection of the country of his nationality if, without any valid reason based on well-founded fear, he has not availed himself of the protection of one of the countries of which he is a national." (Convention of 1951, Article 1A (2))

Stereotyping: to classify or categorize people, and believing that all those belonging to the same group are alike. Stereotyping infers preconceived but often incorrect, negative notions. (Foundations of Nursing, Transcultural Healthcare)

Transculturation: a term coined by Fernando Ortiz in 1947 to describe the phenomenon of merging and converging cultures. Adoption of aspects of other cultures: the change in a culture brought about by the diffusion within it of aspects from other cultures. (http://encarta.msn.com/encnet/features/dictionary/DictionaryResults.aspx?refid=1861721420)

1.2 Mental Health in Cultural Context: How Far Have We Progressed?

Eugene B. Brody, M.D.
WFMH Senior Consultant
WFMH President, 1981–1983
Secretary General, 1983–1999

In 1948, after the devastation of World War II, the founding document of WFMH called for a world community based on "respect for individual and cultural differences." It proclaimed the goal of mental health as the ability to "live with [one's] fellows in one world." By advocating equal treatment and opportunity for all, regardless of culture, ethnicity or socio-economic status, and including refugees, mentally ill persons and women, the new Federation challenged the values and practices of traditional and authoritarian societies. Four months later the new United Nations proclaimed a Universal Declaration of Human Rights: a group of privileges and protections regarded as universal and inalienable corollaries of being human. Embodying the view that at the core of human status an inherent worth or dignity deserves respect from others, these privileges and protections, understood as rights, included both individual freedoms and material entitlements. The freedoms emphasized rights of personal self-determination, freedom of conscience, and the inviolability of one's own body and personality. The entitlements included food, shelter, employment, education and access to social and medical care. The underlying message is that health and well-being cannot survive either the violation of basic freedoms or the deprivation of basic needs.

In 2007, nearly 60 years later, we stand at the threshold of a truly global century. Formerly distant peoples now compete for the same resources as they struggle to maintain their own cultures or fit into new ones. Refugees and other migrants cross national and cultural boundaries to escape poverty as well as war. They strain to deal with their personal and family traumas in the midst of diversity and change. The values of personal choice, achievement and autonomy in the industrial democracies still conflict with those of interdependence, community and lineage of more traditional societies. Traditional values and belief systems need not be sacrosanct. In some parts of the world they still continue the oppression of social minorities. Culturally defended practices, in the industrialized as well as the less-industrialized world, still perpetuate damaging discriminations based on gender, socio-economic power and hierarchical status.

Empathic collaboration across cultural and class boundaries, with helpers as well as help-seekers, requires that we recognize our interdependence with them. Living with diversity continues to be a work-in-progress. It is time to renew our commitment to inter-cultural understanding in the service of the intertwined goals of promoting mental health and preserving human rights.

Reference:

Brody, Eugene B. "The Concerns of Transcultural Psychiatry." Brief Communication: Joint Statement of the Committees on Transcultural Psychiatry of the American and Canadian Psychiatric Associations. *The American Journal of Psychoanalysis,* Vol. XXX, 2 (1968), pp. 179-181.

SECTION 2

THE IMPACT OF CULTURE ON SERVICES AND PUBLIC UNDERSTANDING

Increasing numbers of mental health professionals work with people who speak languages other than the main language of the country in which they reside. Diagnosis and treatment of mental disorders greatly depend on the ability of the individual to explain his/her symptoms and understand steps for treatment. Language and cultural barriers may cause insufficient or inaccurate information that may lead to an inaccurate diagnosis.

Public awareness and perception is quite different from one culture to another. Individuals in some cultures are more willing to seek help from professionals than others. In others, there is a low priority given to mental illness and, thus, resulting treatment may be poor and people don't put as much effort into seeking help as they might with a physical illness. In some areas, mental illness may be seen as bringing shame to the individual and his/her family.

The western model of health sees mental illness as something that must be cured. In such cases, services deal mainly with the person's disorder and often ignore other aspects that may relate to the individual's life and well-being. However, in other parts of the world, mental illness may be seen in a more holistic way, taking into account the mental and spiritual difficulties experienced by a person with mental illness. If individuals are not engaged on these levels, they are often discouraged from seeking help and, as mentioned earlier, may be poorly diagnosed.

Being in the hospital can be a difficult and frightening experience and it is made easier if there are people available who understand the individual's cultural background and needs; in other words, if such people are culturally sensitive.

It is especially important to adopt an integrative approach to mental health when working with people of diverse cultural backgrounds. James and Prilleltensky take a transdisciplinary approach in providing a framework for understanding and improving mental health in the context of cultural diversity. The framework draws on anthropology, philosophy, political science, and religious studies to understand the social, cultural, moral, and religious lives of individuals. In addition, community psychologists and social activists provide models of how to intervene at community and societal levels.

> *In an integrative view of health, the political, the economic, the moral, and the medical are inextricably linked.*
>
> **Kleinman and Becker**

James and Prilleltensky propose a framework for the pursuit of mental health in different cultures with four complimentary considerations:

- **Philosophical:** The vision of the good life, the good person, and the good society in life. In order to understand how special values shape the concept of mental health, the society's vision of the good life and good society must be examined. Individuals may be asked whether they

believe in liberal notions of individualism and self-determination or whether they tend to uphold communitarian and collective perspectives. An individual may believe that a "good person" shall not contradict the "expert" therapist and, thus, would be unwilling to say that the particular therapy was not useful. In some cultures with a high stigma attached to mental illness, a "good person" may not even seek the help of mental health providers. In addition, "a good family" may be one where family conflict and problems are not discussed outside of the family and, certainly, not in front of a stranger, i.e. the therapist.

> *The religion of any people is more than a structure of thought; it is experience, expression, motivation, intention, behaviors, styles, and rhythm. Its first and fundamental expression is not on the level of thought. It gives rise to thought, but a form of thought that embodies the precision and nuances of its force.*
>
> **Long, 1986**

- **Contextual:** the actual state of affairs in which people live. The work of social scientists is enhanced if they strive to understand what the social, economic, cultural, and political conditions of a specific community are and how these factors affect mental health.
- **Social and cultural norms:** At times, societal problems are treated at the level of the individual, rather than the level of society. The help offered to a person who has been abused is at the level of the individual in individual therapy. An example of an intervention at the given level of society would be a community intervention for violence prevention. It is clear that language is rooted in context. In one context, an expression such as "I have ants in my brain," might be seen as a delusion but may be a common expression in another culture.
- **Religious norms:** the redemptive view of suffering. While the medical model assumes that there is no meaning in suffering, many religious groups believe that suffering strengthens their bond with others and the Divine. In such cases, suffering is the vehicle for communication.
- **Moral norms:** the perception of what it means to be a "good person" and a "good family." For example, within the psychoanalytic framework, a good person is verbal, assertive, autonomous and insightful. Therapists may be frustrated with the client's "resistance" to completing questionnaires and activity logs, when the real issues relate to language barriers and cultural differences.

In providing services for diverse cultures, it is important to consider all aspects of verbal and non-verbal communication in order to avoid misunderstandings and conflict. Misunderstandings can exist even among those who speak the same language. Non-verbal communication is learned early in life, mostly by imitation and assimilation, and individuals are often unaware of the signals their non-verbal communication is presenting. We only become aware of this when we are misunderstood. Some examples of non-verbal communication with specific meanings are as follows:

- **Space:** Standing closer than the culturally comfortable distance can be understood as aggression or intimacy, depending on the situation. Standing farther away in some cultures may convey disinterest.

- **Touch:** Some cultures are more "touch-oriented" than others and touching one another may be interpreted either as conveying a connection or it can cause discomfort and negative reactions.
- **Handshakes:** Firm handshakes may be considered sincere and forthright in some cultures but may be seen as aggressive in others. A gentle handshake may be seen as a peaceful gesture or as a lack of commitment or interest. In many cultures, handshakes across gender are not acceptable.
- **Silence:** Individuals of some cultures tend to feel discomfort when a group in which they have joined is silent; others may find this to be most acceptable and to show reflection and respect. Not allowing for silence may be considered rude in some cultures.
- **Eye contact:** Making eye contact may indicate interest and forthrightness in some cultures; in others, avoiding eye contact is a sign of respect.
- **Smiling and laughter:** There are different meanings to smiles and laughter, including pleasure or happiness, surprise, embarrassment, anger, confusion, apology, or even sadness, depending on the culture.
- **Gestures with hands, arms, and feet:** Gestures may have many different meanings, depending on the culture. Standing with hands on one's hips may be seen as a very defiant posture; hands in the pockets can be considered impolite; pointing fingers may be considered impolite; showing the sole of the foot or shoe may be highly offensive in some cultures.

The National Alliance on Mental Illness (NAMI) suggests the following steps for outreach to diverse communities with the goal of assuring equal access to education and recovery:

1. **Identify the target group:** Once a group is identified, learn as much as possible about their characteristics and history. It is also helpful to research the group's beliefs about mental illness.
2. **Identify key community leaders:** Approach leaders of the selected community group and ask them to partner with you as they can help you identify community needs and successfully reach the group. In addition, because they are respected by the group, they will facilitate your access, trust, and attention from the group.
3. **Identify key community organizations:** Partnering with these organizations will provide a united front and increase outreach possibilities.
4. **Decide the major focus of the activities:** As part of a specific community, individuals may be helped by different types of outreach methods, such as culturally and linguistically appropriate pamphlets and booklets, establishment of a community-specific support group, an increase of diverse community membership, and lobbying governmental officials to increase funding for mental health services to a specific community.
5. **Dissemination and publicity:** Work with community organizations, such as churches, racial/ethnic clubs, libraries, schools, grocery stores, clinics, and any other area that the group frequents. Create press releases, public service announcements, and short newspaper articles and highlight the work in culturally appropriate media.

> *Culture Counts — One's racial or ethnic background bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have, and how much stigma they attach to mental illness.*
>
> **NAMI**

To be culturally sensitive, an individual must understand his/her own world views and those of other cultures. Caregivers should obtain cultural information and apply that knowledge when working and interacting with others. Working with people of different cultures requires flexibility and respect for other points of view and an understanding of culturally influenced health behaviors. Culture influences how people seek health care and how they behave toward health care providers. This is often even more pronounced with mental health care. If the mental health care provider possesses the knowledge and ability to communicate and to understand health behaviors influenced by culture, the barriers to the delivery of health care can be diminished or eliminated.

Kleinman and Benson advise that even the busiest clinician should be able to find time to ask clients (and, where appropriate, family members) what matters most to them in the experience of illness and treatment. The clinicians could then use that vital information in thinking through treatment decisions and negotiating with patients. This orientation becomes "part of the practitioner's sense of self, and interpersonal skills become an important part of the practitioner's clinical resources."

> *The focus should be on the patient as an individual, not a stereotype; as a human being facing danger and uncertainty, not merely a case; as an opportunity for the [mental health professional] to engage in an essential moral task, not an issue in cost-accounting.*
>
> **Arthur Kleinman**

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"Basic Steps for Successful Multicultural Outreach" National Alliance for Mental Illness. www.nami.org/multicultural

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Yan, Yorn. New Americans, New Promise. Fieldstone Alliance, St. Paul, Minnesota. 2006.

2.1 Culturally Sensitive Programming

The United Nations Population Fund offers an excellent "Guide to Working from Within: 24 Tips for Culturally Sensitive Programming," used here with permission, at http://www.unfpa.org/culture/24tips/cover.htm available in English, French, Spanish, Arabic, Russian, and German. While these tips are not directly related to mental health, they contain valuable lessons in considering culturally sensitive work in mental health.

> *In our development efforts in poor communities, we need to be able to work with people at their own level and to find common ground. We may not believe in what they do, we may not agree with them, but we need to have the compassion and the commitment to understand them and to support them as they translate universal principles into their own codes, messages and ways of doing things. Human rights is our frame of reference. And we use a culturally sensitive approach to promote human rights in ways that people can identify with and can internalize in the context of their own lives.*
>
> **Thoraya Ahmed Obaid, UNFPA Executive Director**

The 24 Tips, with slight annotations as indicated, are listed below:

1. **INVEST TIME IN KNOWING THE CULTURE IN WHICH YOU ARE OPERATING.** Understanding how values, practices and beliefs affect human behavior is fundamental to the design of effective programs. Nowhere is this understanding more important than in the area of power relations between men and women.
2. **HEAR WHAT THE COMMUNITY HAS TO SAY.** Before designing a project, find out from community members what they hope to achieve. Soliciting their views on different aspects of a project, from the overall strategy to specific advocacy messages, can foster local acceptance and instill a sense of ownership.
3. **DEMONSTRATE RESPECT.** Make an effort to show that you understand and respect the roles and functions of community leaders and groups, avoiding attitudes or language that may be perceived as patronizing.
4. **SHOW PATIENCE.** A great deal of dialogue and awareness-raising may be needed to persuade others to accept new ways of thinking, especially ones that challenge beliefs closely tied to individual and social identity. Invest as much time as necessary to clarify issues and address any doubts. If questions are not resolved, they may resurface later and derail progress.
5. **GAIN THE SUPPORT OF LOCAL POWER STRUCTURES.** Winning over those who wield power in a community, whether they be NGOs, women's groups, religious leaders or tribal elders, can be a crucial first step in gaining acceptance at the grass roots. Make sure your first encounter sends a positive message.
6. **BE INCLUSIVE.** The best way to dispel mistrust is through a transparent process of consultation and negotiation involving all parties.

7. **PROVIDE SOLID EVIDENCE.** Using evidence-based data, show what program interventions can achieve, such as saving lives. In addition to advocacy, such information can be used to clarify misconceptions and obtain support from policy makers and local power structures, including religious leaders. Credible evidence is especially important when the issues under discussion are controversial.
8. **RELY ON THE OBJECTIVITY OF SCIENCE.** Addressing culturally sensitive issues in the context of [mental] health can help diffuse the strong emotions that may be associated with them. A technical or scientific perspective can make discussion and acceptance of such issues easier.
9. **AVOID VALUE JUDGEMENTS.** Don't make judgments about people's behavior or beliefs. Rather, put your own values aside as you explore other people's thoughts and dreams, and how they think they can best achieve them.
10. **USE LANGUAGE SENSITIVELY.** Be cautious in using words or concepts that may offend. Frame issues in the broader context of health and healthy families and communities.
11. **WORK THROUGH LOCAL ALLIES.** Rely on local partners that have the legitimacy and capacity to influence and mobilize a community. Such partners have the added advantage of knowing what local people are likely to accept.
12. **ASSUME THE ROLE OF FACILITATOR.** Don't presume to have all the answers. Give up control and listen to others express their views, share their experiences and form their own ideas and plans. In an environment charged with ethnic or religious differences, assuming the role of facilitator sends a message of neutrality.
13. **HONOR COMMITMENTS.** Doing what you say you will do is a powerful way to build confidence and trust.
14. **KNOW YOUR ADVERSARIES.** Understanding the thinking of those who oppose your views can be key to successful negotiations. Analyze the rationale on which they base their arguments and be ready to engage in an ongoing and constructive dialogue.
15. **FIND COMMON GROUND.** Even with seemingly monolithic institutions there are different schools of thought. Look for areas of common interest that can provide entry points for working with nontraditional partners.
16. **ACCENTUATE THE POSITIVE.** When addressing harmful traditional practices, emphasize that both harmful and positive practices are found in all societies. This can help diffuse tensions around the challenging issues.
17. **USE ADVOCACY TO EFFECT CHANGE.** Well-planned advocacy campaigns are particularly important when project goals are likely to provoke religious or cultural controversy.
18. **CREATE OPPORTUNITIES FOR WOMEN.** Give women the opportunity to [express themselves] and demonstrate their capabilities. This can help diminish false, culture-based beliefs about stereotypical gender roles.
19. **BUILD COMMUNITY CAPACITY.** Reinforce a sense of ownership and ensure sustainability by strengthening the skills of community members, including health-care providers and peer educators.

20. **REACH OUT THROUGH POPULAR CULTURE.** In many parts of the world, music and dance are popular cultural expressions. Use them to communicate new ideas, and be sure to involve young people in the creative process.
21. **LET PEOPLE DO WHAT THEY DO BEST.** Often, an appropriate role for traditional or religious leaders is mobilizing communities or helping to reshape public opinion. Seek their engagement in these areas.
22. **NURTURE PARTNERSHIPS.** Cultivating relationships requires an investment of energy, patience, and time. Don't allow them to disappear just because [work] has ended. Sustaining partnership beyond a single [consultation] allows trust to mature, increasing the chances for positive results over the long term.
23. **CELEBRATE ACHIEVEMENTS.** Bringing accomplishments to the attention of others and publicizing success can create a sense of pride and reinforce community involvement.
24. **NEVER GIVE UP.** Changing attitudes and behaviors can be an excruciatingly slow process, especially in closed societies. Don't expect to accomplish everything at once. Even small changes are significant, and may be more enduring over the long term.

2.2 The Training of Professionals and Interpreters

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Even in countries that respect cultural diversity, it is rare to find mental health services or service providers effectively tuned to the diverse cultural needs of their clients. This reflects the lack of formal training in cultural competence of policy makers and planners, and those training or mentoring service providers. Cultural competence is a skill that is seldom acquired without formal training. In this fact sheet, we look at the formal training of professionals and interpreters working in culturally diverse mental health service settings.

Cultural Competence Training for Professionals
It is as essential for mental health professionals to be culturally competent as it is for them to be "clinically" competent. Training in cultural competence needs to commence at the very beginning of professional training so that awareness of and response to cultural diversity become incorporated seamlessly into emerging clinical skills. Not only do training programs need to include both didactic and clinical components, but most importantly, cultural diversity needs to be a lived experience for trainees. Clinical experience needs to take place in culturally diverse service settings, and ideally, within a multi-cultural training group.

Teaching formats should include didactic seminars, bedside or clinic-based teaching, cultural psychiatry case conferences and cultural psychiatry supervision or consultation. Among the subjects to be covered would be:

- The relationship between culture and human development and functioning in general, with particular focus on the relationship between culture and mental health
- Knowledge about the culture and history of the ethnic or cultural groups making up the local client population, including their world view and major spiritual and moral beliefs, behavioral and lifestyle norms, explanatory models of illness, idioms of distress, and healing practices
- Knowledge about culture-related social phenomena, such as acculturation, refugees, and minority issues
- How to make a culturally sensitive assessment of the client's mental health problem in the light of the foregoing, including the appropriate use of interpreters
- How to negotiate a culturally appropriate care plan, taking into account traditional healing practices and practitioners
- Sensitivity about the mutual impact of identity differences between the clinician and client in the professional relationship, including power dynamics, race, ethnicity, language, religion, class, age, gender and sexual orientation
- How to develop and monitor a culturally competent system of care
- How to conduct ethnographic and other relevant research projects required to increase cultural competence

- Knowledge about policy development and implementation for culturally competent systems of care

Training for Interpreting

Increasing migration globally is exposing ever more mental health service providers to culturally diverse client populations. Combined with growing acceptance of the need to provide culturally competent services, the use of language interpreters or translators has become a major challenge for service providers. The potentially adverse effects of using family members or service personnel have become widely recognized. At best, clients' confidentiality is compromised when family members are privy to sensitive information elicited during the course of mental health evaluations. At worst, family members in conflict with the client may abuse the interpreting role to further their own agendas. Service personnel frequently resent being taken away from their customary duties. Speaking the same language as the client does not mean that they share the same world view, or explanatory models of illness. All too often, they have unresolved acculturation issues themselves which may negatively influence the objective reporting of the client's responses. The interpreting process is beset with potential pitfalls, which can only be avoided if both professionals and interpreters receive training in this area.

These are some useful guidelines for professionals:

- Allow extra time for an interpreted interview
- Consider whether the age or gender of the interpreter needs to be matched to that of the client
- Explain clearly to the interpreter what you expect from them
- The interpreter should translate literally, not paraphrase
- Sit in a triangle with the client and the interpreter, so as to free the interpreter from the power dynamics of the therapeutic relationship. The interpreter's role is to assist both the client and the professional, not only the professional.
- Direct questions for the client to the client, not to the interpreter. Maintain eye contact with the client.
- Ask short, simple questions, one at a time
- At the end of the interview, ask the interpreter for any impressions they formed. Check your own impressions with the interpreter

In order to promote effective mental health practice in culturally diverse settings, interpreters need to be equipped with certain basic knowledge and skills. These include:

- Medical, psychiatric, psychological and social terminology
- Knowledge of normal and abnormal psychology
- Knowledge of current therapies used
- Knowledge of the client's culture
- Respect for cultural diversity
- Interviewing techniques
- Understanding non-verbal communication
- Understanding cultural influences on mental health assessment
- Appropriate methods of inquiry for sensitive areas of history taking, such as suicidal feelings, intimate relationships, and sexual practices

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SECTION 3

THE IMPACT OF CULTURE ACROSS THE LIFE SPAN

The threat to children and children's culture is not video violence but lack of culture among role models in society.

Bengt Göransson, Swedish Minister of Culture, 1982.

We are moving towards a world in which children and young people in the majority of countries are considerably more numerous than the adults and where one-fifth of the world's population will soon be between 15–24 years of age. The more children participate in cultural training and cultural life, the more they will know about their own personal identity. Being among the most vulnerable members of society, children are dependent on adults for their cultural orientation and role models and for their health awareness and care. Children rely on what they encounter in terms of language, environment, attitudes and values, as well as personal experiences and human contacts in forming their cultural identity.

At certain times in youth, individuals strive to be like the mainstream population in their schools and communities. Those with different cultural backgrounds, languages, dress, etc., may feel embarrassed by being different and may not understand and appreciate the positive aspects of their heritage. In striving to be like "everyone else," children may not see the value of speaking a language other than the mainstream language or having customs in their homes that are different from many of their classmates. Thus, when assessing the mental health needs of children and youth, it is sometimes more difficult to understand the conflict that may exist between these two worlds.

Today, television, the internet, video games, etc. often function as surrogates for communication between people. It is important to encourage children and young people to learn to know themselves, i.e. process their own problems, gain understanding of how others feel and think. In this light, they will learn more about themselves and their role in the community and society.

In her landmark book, *The Spirit Catches You and You Fall Down,* Anne Fadiman tells the story of a Hmong child being treated for seizures by western doctors and nurses and the conflict that exists between her parents and the medical establishment in the United States. The misunderstandings resulting from the existing cultural conflicts highlight the importance of cultural relevance to treatment. The child was surely the victim of these misunderstandings and was even put into foster care at one stage of her young life — even though her parents strongly believed that they were acting in her best interest in not abiding by the rules of the medical professionals who treated her. This book shows the disastrous consequences of a failure to communicate between cultures even when both believe that they are acting in the best interest of the child.

There are increasing numbers of children and families around the world with serious mental health problems. This fact, combined with the multicultural environments of most countries, increases a need for clinicians with developmental and cultural competence to provide adequate

mental health care for this population. According to Wright and Leonhardt, the culturally competent clinician:

- Values diversity
- Has developed the capacity for cultural self-assessment
- Is aware of the dynamics inherent when people from different cultures interact
- Has developed adaptations to diversity
- Has cultural knowledge

Culturally competent services are family-centered since the family is the child's primary system of support and family input is considered essential throughout the helping process. The family's cultural background and values, traditions, and level of acculturation and assimilation into the mainstream society are all relevant issues in a culturally responsive assessment. Stereotypes must be avoided and any practitioner must be knowledgeable about the developmental issues of children.

Living outside of one's culture can be uniquely difficult for adults, who have the majority of the responsibility for adjustment issues. Adults must support and protect their children and, at times, their parents. Children adapt more easily and learn languages more rapidly. Adults must be concerned about employment, housing, and the general well-being of their families. The stress in such situations can be particularly high especially when there are challenges in language ability. There is, at times, a power differential between adults and children, especially if children are called upon to serve as interpreters. Marital roles may vary from culture to culture, as with child-rearing practices. The role of women is different from culture to culture and a change in the basic function of the woman may cause additional tension in the family. In some cultures, adults hit their children as a form of discipline; in others, that is considered child abuse. Frustration, boredom, intolerable living conditions and lack of enriching employment opportunities may lead adults to substance abuse. These issues are sharply debated in local cultural, religious, and political contexts. Adults may be especially hesitant about seeking help for mental health issues as it might be seen as a sign of weakness and shame when other family members are depending on the adults for their care. They may feel the need to always show strength and not give in to seeking help. They are not young enough to adapt quickly as their children may be able to do and not old enough to be cared for by others without shame.

Worldwide, elderly people lead the World Health Organization's list of new cases of mental illness: 236 elderly people per 100,000 suffer from mental illness, compared to 93 per 100,000 for those aged 45 to 64, the next younger group. The elderly are treated quite differently in different cultures and cultural norms and traditions are particularly important in this population. In many cultures, the elderly are revered as being the bearers of love, knowledge, guidance, and wisdom. Many adults look back with appreciation on all that they learned from their elders, whether or not they fully realized it in childhood. Relationships between children and grandparents can be particularly significant even though individuals can gain a great deal from non-family members as well. When an individual is asked to reflect on those individuals from his/her past that had the most influence on their lives, the answer often highlights the importance of mentors and older family and non-family friends.

Among the things that I have discovered as an adult in my life is that I am a mirrored reflection of those daily contacts with the elderly men and women in my life. My childhood experiences are quilted pieces from all of the nurturers that claimed my rearing as their responsibility.

Vivian Filer, MS, MSN, ARNP

An elderly person, man or woman, is often designated, formally or informally, as the head of a household; a person to be respected and honored. In some cultures, elderly individuals are more likely to go to indigenous healers, whether religious and faith healers or others, when they aren't feeling well. Such individuals may not share that information with a medical professional so it is important that such beliefs be discovered early in a consultation.

In working with an elderly individual, it is important to show respect by addressing the individual by his/her formal name…not an informal use of the given name. In some cultures, physical contact such as a handshake or gentle touch by the health care provider is important to an elderly individual, while in others, it would be inappropriate to touch the person without permission. In many countries, the attire of the health care provider is important…the elderly may believe that an informal attire is not appropriate and would indicate a lack of respect for self as well as for the patient. Awareness of the religious and spiritual beliefs may also help with establishing a good relationship between provider and consumer. The role of family may be extremely important in making health care decisions. Many cultures stress the value of the extended family, a group that may be involved in all daily decisions as well as healthcare decisions. Individuals may not feel comfortable designating one person of a family to serve as a "proxy" when, instead, decisions would be made by an entire family.

Language is also a major consideration when working with the elderly. Individuals who have moved from one country to another may not learn the language of the new country; even within countries, there are different dialects. It is important to remember that language ability, particularly among the elderly, is not an indication of intellect and all efforts should be made to find a way to ensure that accurate communication takes place.

The use of an interpreter may interrupt the relationship between the professional and the consumer and guidelines as to confidentiality, professionalism, etc. should be required. There is a tendency for individuals to use family members and, even at times, children as interpreters. It is especially helpful, of course, if the healthcare provider and the consumer speak the same language so that interpreters are not needed.

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3.1 Promoting Cultural Diversity and Cultural Competency

Self-Assessment Checklist for Personnel Providing Behavioral Health Services and Supports to Children, Youth and their Families

Directions: Please enter A, B or C for each item listed below.
A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

Physical Environment, Materials & Resources

____ 1. I display pictures, posters, and other materials that reflect the cultures and ethnic backgrounds of children, youth, and families served by my program or agency.

____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children, youth and families served by my program or agency.

____ 3. When using videos, films, CDs, DVDs, or other media resources for mental health prevention, treatment or other interventions, I insure that they reflect the cultures of children, youth and families served by my program or agency.

____ 4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children, youth and families served by my program or agency.

____ 5. I insure that toys and other play accessories in reception areas and those, which are used during assessment, are representative of the various cultural and ethnic groups within the local community and the society in general.

Communication Styles

____ 6. For children and youth who speak languages or dialects other than the primary language, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

____ 7. I attempt to determine any familial colloquialisms used by children, youth and families that may impact on assessment, treatment or other interventions.

____ 8. I use visual aids, gestures, and physical prompts in my interactions with children and youth who have limited language proficiency.

____ 9. I use bilingual or multilingual staff or trained/certified interpreters for assessment, treatment and other interventions with children and youth who have limited language proficiency.

_____10. I use bilingual staff or multilingual trained/certified interpreters during assessments, treatment sessions, meetings, and for other events for families who would require this level of assistance.

11. When interacting with parents who have limited language proficiency, I always keep in mind that:

_____ * imitations in language proficiency is in no way a reflection on their level of intellectual functioning.

_____ * their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____ * they may or may not be literate in their language or origin or the language of the dominant culture.

_____12. When possible, I insure that all notices and communiqués to parents, families and caregivers are written in their language of origin.

_____13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

14. I understand the principles and practices of linguistic competency and:

_____* apply them within my program and agency

_____ * advocate for them within my program or agency

_____15. I understand the implications of health/mental health literacy within the context of my roles and responsibilities.

_____16. I use alternative formats and varied approaches to communicate and share information with children, youth and/or their family members who experience disability.

_____17. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____18. In group therapy or treatment situations, I discourage children and youth from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____19. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children, youth and their parents served by my program or agency.

_____20. I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice.

_____21. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).

_____22. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant or mainstream culture.

_____23. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children)

_____24. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest make in families.)

_____25. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

_____26. I recognize that the meaning or value of behavioral health prevention, intervention and treatment may vary greatly among cultures.

_____27. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.

_____28. I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.

_____29. I understand the impact of stigma associated with mental illness and behavioral health services within culturally diverse communities.

_____30. I accept that religion, spirituality and other beliefs may influence how families respond to mental or physical illnesses, disease, disability and death.

_____31. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.

_____32. I understand that traditional approaches to disciplining children are influenced by culture.

_____33. I understand that families from different cultures will have different expectations of their children for acquiring self-help, social, emotional, cognitive, and communication skills.

_____34. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 35. Before visiting or providing services in a home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____36. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children, youth, and families served by my program or agency.

_____37. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural and linguistic competence.

_____38. I keep abreast of new developments in pharmacology particularly as they relate to racially and ethnically diverse groups.

_____39. I either contribute to and/or examine current research related to ethnic and racial disparities in mental health and health care and quality improvement.

_____40. I accept that many evidence-based prevention and intervention approaches will require adaptation to be effective with children, youth and their families from culturally and linguistically diverse groups.

How to use this checklist:
This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment. There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children and youth who require behavioral health services and their families.

This self-test was developed by Tawara D. Goode of the Georgetown University Child & Human Development University Center for Excellence in Developmental Disabilities Education, Research & Service. Adapted from: "*Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings*" — June 1989. Revised 2006. Slightly revised and published with permission. http://www11.georgetown.edu/research/gucchd/nccc/documents/ChecklistBehavioralHealth.pdf Other valuable publications are available at their general website at: http://www11.georgetown.edu/research/gucchd/nccc/index.html

SECTION 4

SPECIAL ASPECTS OF MIGRANTS AND OTHER DISPLACED POPULATIONS

Individuals have moved from place to place throughout history for many different reasons. Such migrations, even when considered a positive move for one's well-being, put enormous stress on the individuals involved. Reasons for migration are varied and include family reunion, pursuing a better education or economic environment, fleeing persecution and seeking political or religious freedom. Refugees and asylum seekers, in general, have more traumatic experiences than other migrants. "Forced migration" has more harmful effects on an individual than those migrating to improve their financial status. No matter the reasons for migration, however, some degree of stress is always involved. Migration means breaking with family, friends, and established social networks, departing from traditional routines, value systems, and accepted ways of behaving and having to adapt to new social and psychosocial environments.

Every stage of the migration process carries specific risk factors that can lead to mental health difficulties. Prior to departure from places of origin, an individual may have experienced armed conflict, hunger, human rights violations or other traumatic experiences. When leaving one's culture, migrants may suffer a sense of loss: loss of home, career, position in society and identity loss, loss of support networks and an uncertain future. When settled in host communities, many factors may increase psychosocial vulnerability, such as cultural differences, racism, and unemployment. Language barriers may increase the sense of isolation and feelings of helplessness. Even when returning to one's country, if that is at all possible, people often find homes destroyed and loved ones missing. Addressing the psychosocial and mental well-being of migrant populations is an essential component of successful migration.

According to the Transcultural Mental Health Centre in Australia, women have more difficulty than men and older individuals have more challenges than younger ones. In general, some risk factors for mental health in migrants include:

- Decrease in socioeconomic status
- Lack of recognition of overseas qualifications, including educational and employment experiences
- Low levels of language learning and proficiency
- Separation from social, religious and cultural networks, particularly family and friends
- Social isolation and lack of support
- Prejudice and discrimination by the host population
- Traumatic experiences or prolonged stress prior to or during migration
- Acculturative stress
- Language and cultural barriers to mental health services access, including stigma about mental illness and lack of knowledge regarding available services
- Breakdown of traditional and family support structures, particularly family and relatives, with intercultural conflict being a major contributor

> *Migration is the process of social change whereby an individual moves from one cultural setting to another for the purposes of settling down either permanently or for a prolonged period…The process is inevitably stressful and stress can lead to mental illness.*
>
> **Bhugra and Jones**

There are a number of classifications of migrants:

- **Settlers** — those who plan to stay in the locations where they have migrated
- **Political exiles** — those who are forced to leave their homes for political reasons; i.e. they are exiled from their homes
- **Asylum seekers** — those who travel to another country and ask for political asylum once in the country
- **Refugees** — those who cross international borders fleeing war or persecution for reasons of race, religion, nationality, or membership in particular social and political groups
- **Displaced persons** — those who, through natural disasters or man-made circumstances, are forced to leave their homes

The World Health Organization estimated in January 1999 that there were some 50 million refugees and displaced persons worldwide. The International Organization for Migration estimated in 2006 that there were 200 million migrants worldwide. Women and children represent more than 50% of the total number; children include unaccompanied minors, orphans, child soldiers, detainees, child heads of households, women and girl survivors of torture and sexual violence. In addition, migrants include widows, the disabled, mentally ill and retarded and the elderly traveling alone. Furthermore, WHO estimates that more than 50% present mental health problems ranging from chronic mental disorders to trauma, distress and a great deal of suffering.

> *Culture can profoundly influence the way people experience mental illness. For example, in many cultures…people experience depression in bodily terms which can often lead to misdiagnosis. Language issues can further complicate diagnosis. To describe sadness, a Chinese person may use a term that is often translated as "congested." A doctor who does not understand the subtleties of the expression might offer treatment for allergies or the flu, rather than depression.*
>
> **Arthur Kleinman**

There are no easy answers for the management of mental health issues in the migrant population. Not all migrants go through the same experiences and/or settle in similar social environments. The reasons for migration are variable and the process of migration and subsequent cultural and social adjustment play important roles in the mental health of the individual. All of these factors must be taken into consideration when planning intervention strategies for this population. Issues for study include but are not limited to:

- The migrant's models of illness
- Migration status
- Experiences of migration
- Migration phase

- Adjustment
- Attitudes of the host society
- Cultural identity
- Cultural conflict
- Ethnic density
- Achievements and expectations

Some migrants may have experienced the most extreme forms of trauma and torture. Mental health providers must take into consideration the cultural aspects of the individual when working with such people. Assessment is made more difficult by language and cultural differences, time available for assessment, financial resources, and the shame many individuals feel about having experienced torture and related trauma. Often the signs of mental distress are related by physical symptoms, such as headache, abdominal pain, joint or muscular pain. The answers to questions about traumatic events may be influenced by:

- Trust or mistrust of the health care provider
- Trust or mistrust of the interpreter
- Gender issues related to the patient, interpreter, or health care provider
- Perception of the patient as to whether or not help can be accomplished
- Presence or absence of spiritual support and met or unmet spiritual needs
- Other cultural, language, and interpersonal factors

Despite the fact that mental health issues are prevalent in migrant populations, the psychosocial health of migrants is poorly addressed in most countries. Cultural and language barriers create major challenges for health care professionals and for migrants themselves, especially in mental health. Suggestions for relief workers, mental health professionals, refugee and migrant workers, and others are attached.

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4.1 Working with Migrants and Other Displaced Persons

In working with the migrant population, there are many considerations to take into account. While it is extremely difficult to generalize about these considerations, the following may serve as a preliminary guide for increased understanding of the challenges involved.

Considerations

- Mental health problems may be presented as physical problems — headache, stomach ache, etc. Look beyond the physical to a holistic model of health, incorporating the individual's cultural and religious values.
- Culture is a resource as well as a barrier; culture gives a sense of belonging. Culture may not only be the glue that holds a group together but it can also be the chief stressor in trying to adapt to new surroundings without losing their own identity or sense of self worth.
- There is much to learn from migrants to different countries — there are always different and better ways at looking at life. Remember that many migrants may have been in the upper class in their countries and it is likely that they have lost everything but one another, their dignity, and their faith.
- There is a need for more mental health professionals of every culture; bilingual and bicultural professionals are often in short supply.
- Language assistance is of particular importance to successful mental health services for migrants and may present a serious challenge for less-used languages.
- Resiliency is an important aspect of the culture and mental health of migrants.
- Culture offers protection but can also be restrictive to the individual.
- Cultures vary in terms of their view of the roles of men and women, children and parents. Power within the family may be quite different than in one's own culture. Children generally learn a new language much more rapidly than their parents and this often causes a reversal of roles in the family where the children may have more power. Marriages may be threatened due to changing roles, especially when women must work out of the home.
- Perceptions of time may be very different in different cultures: people from individualistic cultures are goal-oriented and concentrate on the future. People in other cultures place more emphasis on the past, honoring those who came before them. There are others who focus on the present as they don't know if they will have a future or not.

> *Mobile populations can be more vulnerable to mental health problems than the native population, due to their condition as migrants and their limited access to adequate services, especially if they can no longer refer to their traditional community support and remedies.*
>
> **International Organization for Migration**

- Western models of health care emphasize a patient's autonomy and the patient's "right to know" about their diagnosis and treatment options. This is not the case in all cultures and is contrary to the dominant beliefs of many societies. At times the family is the first to know

about health problems of their family member and it is the family that then decides how much to share with the patient.

- Stigma concerning mental health is greater in some cultures than in others. In some cultures, going to a mental health professional would be an indication of weakness and a cause for shame.
- Acculturation is a major factor for migrants: some adjust willingly and easily to a new culture, while others have strong attachments to their culture of origin and find transition difficult. In general, first generation migrants find acculturation more difficult than the generations following.
- Many cultures do not easily trust members of other cultures. It is important to build trust before moving ahead with specific mental health questions.
- A holistic approach is extremely important when working with migrants.
- In some cultures, making eye contact is a sign of disrespect; whereas, in western cultures, it may be perceived as a sign of depression. A Muslim female speaking with a male mental health professional may not make eye contact because of fear of sexual impropriety. A Navaho patient may avoid eye contact in order to avoid soul loss or theft.
- Individuals from some cultures are opposed to any physical contact from persons outside of their family.
- It is important to talk in the same terminology; ensuring that each person understands the other.
- Traditional healers from the migrant's home culture may assist the individual in getting access to health care in a culturally acceptable and meaningful way. Western trained mental health providers and traditional healers can bridge the gap between cultures and make the transition smoother.
- Sensory and visual elements can be triggers for trauma and it is important to note any such possibilities when communicating with migrants.

Recommendations

When working with migrants and displaced persons from other cultures, some basic guidelines apply:

- Find out the appropriate means of greeting men, women, and children in a migrant's culture. Learn the names the culture uses for emotional distress and mental illness. Many cultures understand mental illness in a spiritual or religious context. Religious or traditional healers use certain terms for such conditions and it is useful to use the same terms.
- Use simple straightforward terms that are easy to understand when asking migrants about possible mental illness, such as "Are you hearing voices that other people cannot hear?" Explore this possibility in a cultural sense.
- Be sure to tell the individuals that you will not tell anyone else anything that they say and that you will not say anything about them to anyone else without their permission. All aspects of the interview will be kept private, unless you understand that they plan to hurt themselves or others.
- Mental health care providers should discuss with an individual from a different culture, in advance of any consultation, how much information he/she would want shared with their family and, if the individual so wishes, he/she should sign a waiver of confidentiality form.

- When working with people of other cultures, it is helpful to find out as much about the country of origin as possible, reviewing cultural values, family structure, and appropriate behavior for members of the particular ethnic group. It is important, however, to remember that each person is unique and to avoid stereotyping individuals from the same culture.
- Mental health interpreters should be adequately trained, adhere to all ethical guidelines for confidentiality, and efforts should be made to establish a relationship of mutual trust. Migrants should not be made responsible for providing an interpreter, especially for mental health issues which are sensitive and require a high level of confidentiality.
- Address physical problems along with mental and emotional issues. In some cultures, symptoms for mental health problems are described in physical terms, while others provide psychological symptoms. It is important to go deeper and not take the symptoms as being exactly as described.
- When possible, a same-gender provider for physical, psychological, and spiritual care (when culturally appropriate) should be used and the same person should provide care.
- Psychosocial and environmental problems should be addressed with migrants: education, occupation, housing, economics, access to health services, legal issues, and primary support group.
- A cultural broker can be useful in assisting with communications as long as they are aware of their own cultural identity, the cultural identity of the members of diverse communities, and the social, political, and economic factors affecting diverse communities within a cultural context. They must innately understand values, beliefs and practices associated with illness, health, wellness, and well-being of cultural groups, traditional and indigenous health care networks, and medical, health care, and mental health care systems. Cultural brokers should also have a range of skills that enable them to communicate in a cross-cultural context, communicate in two or more languages, interpret and/or translate information from one language to another, advocate on behalf of patients/consumers, negotiate health care and other service delivery systems, and mediate and manage conflict.
- Structure the communication process with migrants (especially those with backgrounds different from the helper) in a way that will reduce any initial discomfort as the dialogue begins and to insure that each person knows what to expect from any consultation. Communication between individuals consists of listening, processing, and feedback and this is particularly important when working with migrants who may perceive different meanings from the communication. The following ways of accomplishing this goal are suggested by Tedla Giorgis:

    1. **Attending:** Demonstrating concern for and interest in the client through appropriate eye contact, body posture, and verbal messages.
    2. **Paraphrasing:** Mirroring the individual's statements using exact or similar wording.
    3. **Reflection of Feelings:** Expressing the essence of the individual's feelings, either stated or implied, regularly and accurately.
    4. **Summarizing:** Reviewing the main points discussed in a two-way communication, to ensure continuity and focus.

5. **Probing:** Directing the individual's attention inward to help the counselor and the migrant examine a situation in greater depth.
6. **Self-Disclosure:** Sharing (appropriately) personal feelings, attitudes, opinions and experiences to increase the intimacy of the communication.
7. **Interpreting:** Presenting the individual with alternative ways of looking at the circumstances being discussed.
8. **Confrontation:** Pointing out contradictions in the individual's behavior and/or statements, or guiding the client to face an issue that seems to be avoided.

Working with migrants can be an enriching experience for all individuals involved but it takes effort and patience to overcome the challenges of coming from diverse political, ethnic, and socioeconomic backgrounds. There is much to learn from each other and, if cultural respect and sensitivity are practiced, the rewards can be great.

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4.2 Mental Health Implications of Disasters

There are mental health implications in all disasters — whether they are natural disasters, such as earthquakes and hurricanes, or man-made disasters, such as war and interpersonal violence. The immediate needs of the population involved in natural disasters are often physical: shelter, food, water, and basic medical care. It is important to remember, however, that all people living in unstable situations suffer trauma. Very often, if individuals in these situations receive any mental health care at all, it is from individuals living outside of their own environments. Many of the transcultural issues highlighted in the fact sheet for migrants and other displaced persons relate to the consequences of disaster. This fact sheet is intended to highlight the importance of the transcultural mental health issues along with the physical issues following a disaster of any kind.

International aid organizations, such as "Doctors Without Borders" struggle to identify the most urgent needs in their response to disasters, considering finite resources. Should every project have an element of psychological care? Should mental health care even be considered when responding to massive famine and displacement? Doctors Without Borders believes that it is not *whether* mental health care should be a part of their missions, but rather *how and when* to focus on mental health.

> *What do you do if there is enough food, but no one wants to eat? Sometimes people are unable to eat because they no longer want to live. They may have witnessed the killing of their family.*
>
> **Kaz de Jong. Doctors Without Borders Mental Health Advisor**

Distress is a normal and understandable response to disasters, often caused by being directly at risk, concerned about family and friends, witnessing injuries and distress of others, or being caught up on the panic and confusion that often follows the events. Feelings and memories related to previous experiences of disasters and loss may resurface and individuals may be "re-traumatized" by such events. In addition, aid workers are also affected by such experiences and should be aware of the fact that they often need care as well, whether in the short term or the long term.

The Transcultural Mental Health Centre of the Diversity Health Institute of the Government of Australia has created fact sheets in a number of languages that are helpful to those coping with war or natural disasters. Communities have a history of coping with uncertain times with courage and strength. Supporting one another is a positive way of coping. Taking care of everyday tasks that need to be done remind people that life goes on and may help to minimize feelings of helplessness or preoccupation with the disaster at hand. It is time to ask for help if:

- One's sleep is badly affected
- One feels distressed, irritable, on edge or agitated much of the time
- One feels hopeless, despairing, miserable and as though one "can't go on"
- One has trouble concentrating, is distracted and cannot do normal tasks
- Memories of past trauma and loss resurface and become troublesome
- There are new physical symptoms or physical signs of stress such as trouble breathing, heart irregularities, or stomach problems
- One withdraws, becomes aggressive, or notes a personality change

The Center for Mental Health Services of the U.S. Substance Abuse Mental Health Services Administration has developed nine guiding principles for disaster mental health planners and front-line workers, which are discussed in detail on their website:

- **Principle 1:** Recognize the Importance of Culture and Respect Diversity
- **Principle 2**: Maintain a Current Profile of the Cultural Composition of the Community
- **Principle 3:** Recruit Disaster Workers Who Are Representative of the Community or Service Area
- **Principle 4:** Provide Ongoing Cultural Competence Training to Disaster Mental Health Staff
- **Principle 5:** Ensure That Services Are Accessible, Appropriate, and Equitable
- **Principle 6:** Recognize the Role of Help-Seeking Behaviors, Customs and Traditions, and Natural Support Networks
- **Principle 7:** Involve as "Cultural Brokers" Community Leaders and Organizations Representing Diverse Cultural Groups
- **Principle 8:** Ensure That Services and Information Are Culturally and Linguistically Competent
- **Principle 9:** Assess and Evaluate the Program's Level of Cultural Competence

The following concepts should be adopted by all disaster mental health providers, including those serving culturally diverse survivors. The concepts can also help administrators and service providers set program priorities. The concepts deviate in some ways from those on which mental health work has traditionally been based. However, their validity has been confirmed again and again in disasters of various types that have affected a broad range of populations (DHHS, 2000a).

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma—individual and community.
- Most people pull together and function adequately during and after a disaster, but their effectiveness is diminished by the effects of the event.
- Stress and grief in disasters are normal reactions to abnormal situations.
- Many emotional reactions of disaster survivors stem from problems of daily living brought about by the disaster.
- Disaster relief assistance may be confusing to some survivors. They may experience frustration, anger, and feelings of helplessness related to disaster assistance programs.
- Most people do not see themselves as needing mental health services following a disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be tailored to the culture of communities where they are provided.
- Mental health workers should set aside traditional methods, avoid mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of disaster.
- Social support systems are crucial to recovery.

Whether immediately following a disaster or months after the disaster occurs, it is vitally important that the mental health needs of survivors be addressed. It is an inevitable consequence of all disasters.

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SECTION 5

BEST PRACTICES IN TRANSCULTURAL MENTAL HEALTH

WFMH asked organizations in Australia, Serbia, and the United States to highlight their activities in the "Best Practices" section of the World Mental Health Day packet. These are only examples of what can be accomplished; there are many more around the world and we hope to hear from our friends and members about other programs that we should highlight on our website. We are developing a clearinghouse of information on transcultural mental health and are eager for as much information from around the world as possible.

"Best Practices" are successful initiatives that can demonstrate a positive impact on the lives of individuals and has the possibility of being replicated or copied by other individuals and organizations. The United Nations Educational, Scientific, and Cultural Organization (UNESCO) states that "any (best) practice must be adapted to the political, historic, cultural, social and economic context of the society in question." UNESCO further states that best practices must meet one or more of the following criteria but they do not have to meet them all:

- They are innovative: a best practice has developed new and creative solutions to common problems;
- They make a difference: it creates a positive and tangible impact on …(the lives of others);
- They have a sustainable effect: the result of the practice should be sustainable;
- They have the potential for replication: a best practice can serve as an inspiration to generate policies and initiatives elsewhere.

The following are the best practices for Multicultural Mental Health Australia, the Center for Rehabilitation of Torture Victims in Serbia, and the Center for Multicultural Human Services in Falls Church, Virginia, USA. It is our hope that you will find these reports to be of interest and use to you.

References:

United Nations Educational, Social, and Cultural Organization.
http://portal.unesco.org/shs/en/ev.php-URL_ID=3450&URL_DO=DO_TOPIC&URL_SECTION=201.html

5.1 Center for Rehabilitation of Torture Victims (IAN), Belgrade, Serbia

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The International Aid Network (IAN) is a local, nongovernmental, non-political, non-religious organization established in Belgrade in 1997. IAN is active in the field of mental health promotion and human rights protection through provision of psychosocial, legal and humanitarian assistance to refugees, internally displaced persons (IDPs), asylum seekers and other vulnerable people, including people with mental illness, people living with HIV/AIDS, ethnic minorities, unemployed women and juvenile delinquents.

History: IAN was founded with the immediate goal of establishing a service, a trauma center, to provide direct, free of charge psychological assistance, both through an SOS phone service and face-to-face counseling, for the victims of war and violence. The Trauma Center started its activities at a very difficult time: Milosevic's regime was hostile toward NGOs and the wars in Croatia and Bosnia left hundreds of thousands of refugees within Serbia's borders, many of whom were sheltered in collective centers without adequate help or specialized services. In addition, most international humanitarian organizations were withdrawing from the region (only to return after the outbreak of another Balkan war — this time in Kosovo).

IAN's activities include a variety of services oriented toward client needs: psychiatric and psychological, legal, medical, and educational.[1] Currently, IAN functions as a complex organization with approximately forty employees and collaborators and is functionally divided in four departments:

1. Health Department (hosting Center for Rehabilitation of Torture Victims, Expert Center for Mental Health and HIV/AIDS, and the Mental Health Group)
2. Educational Department
3. Human Rights Department
4. Research Department

Through its history, IAN functioned either completely isolated from the governmental health care and social system (until the fall of Milosevic's regime), or through an unofficial networking system with institutions and other NGOs. IAN only recently started developing pilot programs within governmental institutions, for the purpose of upgrading knowledge and skills and developing greatly needed services for groups at risk.

The IAN Center for Rehabilitation of Torture Victims (CRTV) started work in September 2000, with the financial support of the European Commission. The program was established as a result of our efforts to provide specialized and comprehensive psychosocial assistance to

individuals who were tortured during the wars in the former Yugoslavia, and members of their families. Since 2004 we have provided help to torture survivors in Bosnia (Republika Srpska) at the request and support of the UN Voluntary Fund for Victims of Torture (UNVFVT) and in collaboration with the Center for Torture Victims, Sarajevo.

The objectives of CRTV include:

- Provision of psychiatric, psychosocial, medical and legal support to victims of war-related or civil torture
- Provision of assistance for family members of torture survivors
- Organization of support and assistance to underprivileged groups that experience discrimination and whose human rights are violated by the authorities, groups or individuals on grounds of gender, ethnicity, religion, political or other affiliation
- Rehabilitation of traumatized persons — by treating the consequences of torture, maladaptive behavior, personality disorders, we aim to prevent further deterioration of their condition and, thus, enable the individual and his/her family to integrate socially and become active members of the community
- Prevention of torture and organized violence in our society by raising the awareness of the public about the issues of torture and violation of human rights and advocating for legislative changes
- Prevention of the transgenerational transfer of trauma through rehabilitation of torture victims

The help that we provide to our clients encompasses various services developed by IAN. The main focus is on psychosocial rehabilitation, which includes psychiatric treatment (with free-of-charge medicines, if needed), individual, group or family psychotherapy, general medical help (regular treatment, delivery of medicines and assured accessibility and referral to specialized institutions if needed), legal counseling, assistance in cross-border legal procedures (e.g. provision of documents, protection of property, repatriation), representation at the courts and educational and employment programs for survivors and their families. Mobile teams (consisting of a psychiatrist, medical doctor, lawyer and psychologist) visit collective centers and distant areas, providing assistance to those who are not able to travel to the Center.

Who are our clients? Most of our clients are refugees from Croatia and Bosnia and Herzegovina who fled from wars in 1991-1995. In addition, we have a number of clients who are internally displaced persons from Kosovo, including several individuals of non-Albanian ethnic origin who were attacked during March 2004. In the last years, we observed an increasing number of refugee men who were arrested by police in 1995, sent to paramilitary camps and tortured, just to be sent to the frontline. A large majority of our clients are of Serbian ethnic origin but there are also other nationalities as well as clients with mixed ethnic background.

In the past six years (January 2000-December 2006), we had a total number of 5524 clients (641 in 2006), among whom 2204 were direct victims of torture. The rest were either members of their families (who experienced some form of war-related trauma themselves), or other zvictims of war-related trauma, mostly refugees. An additional 2149 individuals were visited

by our mobile teams, either in collective centers in Serbia or in Bosnia and Herzegovina. In the latter group, the majority of clients were women (58%). Men were in the majority of victims of torture (75%), reflecting the fact that men were more often incarcerated and tortured during the wars. Among the victims of torture, 94% of the overall number were refugees, with a much smaller number being citizens of Serbia who were tortured during the war (2.4%) and only 2.8% being civilians who are victims of political violence. Most of our clients come from rural areas, are generally less educated, and elderly; out of 641 clients in 2006, 84.7% were men, only 2.1 had a university education, 61.1% were unemployed. Out of the total number, 33.9% were internally displaced persons from Kosovo, 56.7% were refugees from Croatia or Bosnia and Herzegovina, and 9.4% were from the local population of Serbia.

Specificity of our approach: CRTV's services are: 1) comprehensive (so that our clients can obtain maximum support at one place, ranging from social events to specialist medical services); 2) open for modifications in respect for client needs; 3) recognized by survivor groups and associations (IAN is continuously providing help to associations of beneficiaries and support through capacity building); 4) culturally and socially appropriate. In order to accomplish these goals, we attempt to support refugee initiatives more than pursuing our own agenda, or even implementing psychosocial programs coming from international agencies, which sometimes lack sensitivity toward cultural factors. A large number of IAN's employees came from different parts of the former Yugoslavia at the beginning of the war, bringing their own customs and social networks. This contributes to the fact that we are well recognized by a great number of beneficiaries.

Cultural Aspects of Trauma: We are currently implementing a project, along with several other NGOs from the region, entitled "Cultural Aspects of Trauma." There is a common agreement that the psycho-social interventions often implemented or developed in the countries of the region (more broadly, in the aftermath of disasters — natural or man-made) show a lack of sensitivity to the cultural aspects of the expression of symptoms and models of communicating psychological distress. As such, the organizations enrolled in CAT consider it important to pay special attention to providing culturally appropriate services in the future.

Offering "culturally appropriate services" represents a difficult enterprise as it requires adopting a set of definitions in regard to the objectives, targets, providers and methodology which can be highlighted now but need to be implemented over time.

Based on the actual level of our knowledge, thinking of culturally appropriate psychosocial interventions to cope with trauma leads us to interventions focused more on strengthening the community as a whole, rather than on individual symptoms. In addition, we focus on the processing or abreaction use of tools developed in cross-cultural encounters, (e.g. witnessing, social testimony and reparation, spiritual myths, legends and metaphors, etc).

Producing and implementing culturally appropriate psychosocial intervention tools, methods, and approaches should be one of the tasks of local organizations throughout the region that already have experience in designing and implementing such interventions. We welcome collaboration and consultation in that area.

[1.] These services were developed over a considerable period of time. Legal help was needed by refugees who were in the process of being repatriated to their country of origin (either Croatia or Bosnia) and this gradually came to include

various forms of help, including legal counseling, advocacy and the promotion of legislation for protection of human rights of our clients, all the way up to the representation of victims in front of national courts in cases of crimes of the State against individuals. The Educational Department at first provided basic training in information technology and English for refugee children, as a framework for better integration and psychological support. It gradually developed its activities into a long term system program of education for endangered groups such as the Roma, unemployed women, or juvenile delinquents sentenced by the court to additional education.

5.2 Multicultural Mental Health Australia (MMHA)

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Multicultural Mental Health Australia is a program that provides national leadership in multicultural mental health and suicide prevention for Australians from culturally and linguistically diverse [CALD] backgrounds.

MMHA uses a model of collaboration and partnership to address these issues. It also builds strategic networks with national mental health mainstream programs, state and territory mental health services and specialist transcultural centers. MMHA has strong links with mental health consumers, carers, advocacy groups, as well as refugee, torture and trauma services and the ethnic media.

MMHA also engages with government agencies and universities to improve access to services as well as facilitate access to information about these services. It primarily aims to improve the responsiveness and quality of mental health services to Australians from CALD backgrounds. Overall, MMHA relies on these partnerships to promote good mental health in Australia's diverse communities.

MMHA is funded under the National Mental Health and Suicide Prevention Strategy by the Australian Government's Department of Health and Ageing [DoHA]. This program could be seen as a model for governmental action that is implemented by an organization such as MMHA.

In 2004, DoHA produced the *Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia* (www.mentalhealth.gov.au) under the logo of the National Mental Health Strategy. The Framework illustrates a broad national approach to the mental health and wellbeing of people from culturally and linguistically diverse backgrounds.

Under this Framework, MMHA facilitates policy and program development by providing a range of services. These include advice and consultancy, management of special projects and the development of various resources. MMHA is also very active in the dissemination of mental health information through the Australian media, its own publications and the website.

MMHA's program revolves around meeting the *Framework*'s key goals of using a whole population health approach to mental health for people from CALD backgrounds. This entails preventative measures to safeguard Australia's CALD community from mental ill-health. MMHA works towards improving service responsiveness to cultural diversity, strengthening service quality and fostering culturally inclusive research, innovation and sustainability.

One of MMHA's roles is to enhance the profile of multicultural mental health issues nationally

as well as increase Australia's role and activities internationally through a network of organizational, community and academic links.

MMHA believes that in order for multicultural mental health issues to be addressed adequately, policy and service development, mental health promotion, capacity building and the infrastructure of general mental health services need to be addressed nationally.

MMHA focuses on collaborative work with consumers and carers; and joint ventures with mainstream, ethno-specific and multicultural agencies. These partnerships guarantee that programs and initiatives aren't duplicated.

MMHA's collaborations ensure that multicultural mental health and suicide prevention are embedded in the broader mental health reform agenda through the generic programs funded under the Australian National Mental Health Strategy.

In the context of national mental health policy, and to meet accepted standards of service delivery and workforce practice in Australia, MMHA believes that the provision of culturally competent and appropriate mental health services is the responsibility of all service providers. MMHA therefore provides special training to the Government and non-Government sectors on how to become culturally competent in the delivery of their services to people from CALD backgrounds.

MMHA further builds practical partnerships between the mental health sector and culturally and linguistically diverse communities by facilitating joint projects and activities designed to identify and support the needs of MH consumers and carers. MMHA also facilitates linkages between mental health professionals, academics and community workers by promoting and encouraging dialogue and research activities in the area of multicultural mental health.

This important work takes the following forms:

- Working in partnership with consumers at the level of individual care planning, in service development, and in systematic change. This is done with a commitment that policy and procedures will be backed by the appropriate allocation of resources to treat mental health consumers and carers from CALD backgrounds and ensuring that they are equal partners in building the capacity of mental health service providers and policy makers to provide culturally and linguistically relevant mental health services and programs.
- Focusing on the provision of information and raising community and professional awareness in the field of multicultural mental health by producing multilingual resources and tailored mental health awareness campaigns. The information and resources on mental health and mental illness are also targeted to CALD consumers, carers and communities focusing on prevention, early intervention, treatment, recovery and rights and responsibilities.
- Contributing to building a skilled and culturally responsive workforce by continuing to organize and sponsor conferences, workshops and training programs. The key focus is on the skills and competencies required by the mental health workforce to meet the needs of people from diverse backgrounds, as well as on promoting bilingual workers in multicultural or ethno-specific agencies who are often the first port of call for CALD mental health consumers and carers.
- Promoting a capacity building approach in the mental health workforce and the community

sector, to facilitate the implementation of goals by building and testing new models of care, as well as utilizing sustainable strategies and monitoring systems and practices.

Multicultural Mental Health Australia achieves all of this by:

- Using the "whole of government" approach by being proactive and reactive to new initiatives by all levels of government and jurisdictions — for example, by having MMHA representatives on most relevant government mental health committees and advisory boards and collaborating with peak mainstream mental health non-government organizations (NGOs).
- Having a Joint Officers Group of all Australian state and territory Mental Health Directors where regular meetings and contact provide opportunities to highlight the needs and gaps in services and seek prompt intervention.
- Participating in national mental health consultations in the design and implementation of new mental health services and programs.
- Having a broad committee of mental health experts, "The Consortium," which provides advice and support to the MMHA program. "The Consortium" represents an alliance of consumers, carers, the community, statewide specialist services in multicultural mental health and suicide prevention, population and public health, and the tertiary sector.
- The Consortium brings vast experience and established track records in multiculturalism and/or mental health to the MMHA. Their knowledge of transcultural mental health and extensive national and state networks provides invaluable advice to the project and facilitates connections to local communities, consumers and carers.
- These experts come from every Australian state and territory, as well as relevant educational institutions and interest groups like National Mental Health Consumers Network, the University of Adelaide in South Australia and Griffith University in Queensland — thereby providing MMHA with a very broad representation.
- Designing a consortium structure that enables appropriate participation by all organizations with an interest in multicultural communities without overburdening their commitments. It also allows for varying levels of involvement in the work of MMHA according to the relevance of that work to the individual organisation and the expertise each MMHA program area requires.
- Having a Working Group structure that allows for more involvement from experts, interest groups and parties in the main areas of MMHA's work. For example, the Editorial Board overseeing the publication of MMHA's quarterly magazine, Synergy; the Carers and Consumers Working Party and the Workforce Working Party, etc.
- Having a well-defined contract with the federal government funding body with very specific deliverables and set timeframes. Providing periodic progress reports to the funding body with evidence of achievements; as well as keeping in regular communication with the funding body's representatives.
- Designing a program of work that encompasses the five most important areas in achieving improved, relevant and responsive mental health services to people from CALD diverse backgrounds. These include Communications, Information and Media; Consumer and Carers Partnerships; Partnerships and Promotions, Workforce, Capacity Building and Suicide Prevention.

- Supporting and resourcing Consumer and Carer initiatives and programs; and broadening these to become nationally applicable.
- Producing periodic resources with wide and free distribution. For example, free subscription to the quarterly magazine, Synergy, which is also available on the website where past editions can be downloaded.
- Producing a monthly E-bulletin, which outlines the latest national and international mental health news and information that is general and also culturally-specific.
- Having over 30 relevant fact sheets available for free download on the web site at http://www.mmha.org.au/find/fact-sheets — which are all translated into up to 18 languages as well as links to other relevant sites for other multilingual information and the Diversity Health Institute, the umbrella organization within which MMHA sits within. www.dhi.gov.au\clearinghouse.
- Having a user-friendly and up-to-date website at http://www.mmha.org.au/mmha-products/books-and-resources, showing many additional resources that can be downloaded for free or purchased from MMHA.

5.3 The Center for Multicultural Human Services, Falls Church, Virginia, USA (CMHS)

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This Center for Multicultural Human Services (CMHS) offers a broad range of mental health, social, educational, health, and language services geared to the unique values and characteristics of individuals and families from diverse cultures. The Center is staffed by multi-ethnic and multilingual social workers, psychologists, psychiatrists, counselors, education specialists, art therapists, and graduate interns from local universities. Services are provided in 30 different languages and serve an average of 8,000 individuals and families every year. Their mission is to help people from ethnically diverse backgrounds succeed by providing comprehensive, culturally sensitive mental health and related services and by conducting research and training to make such services more widely available.

CMHS offers culturally sensitive therapy for children and adults experiencing cultural adjustment problems, family conflict, anxiety, depression, early attachment difficulties, physical or sexual abuse, and other traumas or psychological problems. Individual, family, and group counseling is available. Individualized treatment programs for children often include family, art, and/or play therapy in the child's dominant language. CMHS's multilingual staff is also available to respond to mental health crises. Psychological evaluations, provided in the client's dominant language, address a wide range of referral questions including evaluation of post-traumatic stress disorder, capacity for violence, ability to parent appropriately, and current cognitive and personality functioning. CMHS provides psychiatric evaluations and medication monitoring with interpreting services as needed. Other mental health services provided by CMHS include: intensive family services, anger management programs, parenting groups, and alcohol and drug education and counseling.

The Center programs related to mental health are as follows:

- The Program for Survivors of Torture and Severe Trauma was officially established in 1998 to address the consequences of human rights abuses. The mission is to assist survivors of politically-motivated torture by providing a comprehensive range of services to address the complex results of their torture.
- The Multicultural Domestic Violence Program uses a holistic approach to treatment and prevention of domestic violence, with the belief that every member of a family afflicted by domestic violence is a victim. Efforts are focused on the entire family, when appropriate, as well as the community beyond.
- LEAD School-Based Program: In direct response to the mental health needs of cultural and language minority children, CMHS has been operating its successful school-based LEAD (Leadership in Education, Achievement, and Diversity) program in local public schools, serving approximately 250 children and adolescents per year.

- Multicultural Mental Health Treatment and Evaluation Services: this program addresses the mental health needs of low-income, English-limited immigrant and refugee individuals and families for whom existing services are inaccessible due to language and cultural barriers.
- Training: For over 20 years, CMHS has offered clinical training programs for emerging professionals in psychology, social work, and counseling. These are model training programs for building the cultural competence of the U.S. mental health workforce in order to increase access to quality mental health care for critically underserved, culturally and linguistically diverse population.
- Self-sufficiency Service: CMHS offers transitional housing, legal assistance, classes in English as a second language, life skills and computer classes, mentoring and case management to help individual achieve self-sufficiency.
- Gang Prevention Program: CMHS works in jurisdictions throughout Northern Virginia to reduce youth violence and curb the appeal of gang membership among language and ethnic minority children. CMHS has developed a training manual to help others work with youth who are at risk of gang involvement.
- Technical Assistance Services: CMHS offers technical assistance to communities in the US that need guidance in developing service systems and practices that are responsive to the adjustment needs of refugees and immigrants. CMHS also assists overseas communities establish or refine programs serving torture survivors and traumatized children.

In addition, CMHS has a strong volunteer multilingual information and referral program to help newcomer populations in their efforts to adjust to their new environment.

While CMHS is a licensed mental health center, it offers services that respond to a variety of client needs. On intake all clients are assessed to identify challenges that are interfering with healthy functioning. These challenges may include basic needs, such as food and shelter, lack of support systems, family conflict, depression, etc. CMHS may address some of these needs directly or link the client with other community service agencies. This whole-person approach allows us to move clients from crisis or vulnerable status to stable or thriving status in a relatively short time. All services are provided in ways that recognize the client's strengths and the cultural, transportation, child care and other barriers they face in accessing services. In most cases clients are served by professionals and paraprofessionals who speak their language. Interpreters are used only when direct service staff do not speak the client's language. Services are provided in the client's home, school or other community site when this option best serves the client's needs. Childcare is provided for group activities at CMHS headquarters and in community settings. CMHS is proactive, organizing activities in the community to identify emerging needs and to establish a connection with community members who may need services. These engagement activities are often in collaboration with leaders of the Faith or ethnic community.

For download of newsletters and other materials, visit: http://www.cmhsweb.org/about/updates.html

References:

CMHS website: http://www.cmhsweb.org/programs/index.html

Pioneering Multicultural Mental Health and Human Services: A Case History of the Center for Multicultural Human Services. 2007 (see website)

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SECTION 6

MENTAL HEALTH IN A CHANGING WORLD: CALL TO ACTION

Recognition of the central roles of culture, race, and ethnicity on health is not novel. For decades researchers have explored the influence of culture on personality formation, symptom expression, help-seeking attitudes and behaviors, health and illness models, and treatment process and outcomes. Although significant progress has been made in understanding the relationship between culture and health, mental and behavioral health policy makers, researchers and service providers continue to be challenged to develop large systems of care that successfully meet the needs of individuals from diverse racial-cultural backgrounds.

The necessity for behavioral and mental health leaders to make more concerted efforts to recognize and act on the need for culturally sensitive systems of services has become even greater as nations and communities throughout the world reflect the results of several decades of increased migration and ethnic diversity.

This section of the 2007 World Mental Health Day campaign packet calls attention to several possible advocacy issues regarding the need to better understand the critical role cultural awareness plays in the planning and delivery of effective mental health services. In an ever-increasingly multi-cultural world, the delivery of appropriate and effective mental health services will be greatly influenced by the willingness and ability of policy makers, program planners, and local service providers to develop, implement, and sustain culturally sensitive systems of mental health services for children, adolescents, and adults who come from diverse cultural backgrounds.

This is not a new area of undertaking for mental health systems in many countries — particularly for those middle and high income nations that have been major destinations for migrants from countries impacted by periods of economic deprivation, political unrest, and armed conflict. Further, civil rights movements in a number of countries with large ethnic or indigenous populations in the past 30 years have resulted in considerable attention from research, policy and practice arenas to issues of culture in the effective delivery of mental health services. The multicultural counseling and therapy movement of the late 1980s pioneered an emphasis on tailoring treatments to the culture of the individual client in order to assure greater cultural relevance and sensitivity. However, most of these efforts have centered primarily on improving service policy and delivery for ethnic minorities in various countries (such as African Americans in the United States, Native-Canadians, aboriginal groups in Australia and New Zealand, etc.) — in other words, for groups that share some level of the same cultural patterns as the majority population.

The emergence in many countries of a growing multi-cultural mental health service workforce provides an increasingly important rationale for considering issues related to the influence of culture on mental health. In the context of transcultural mental health, disease pertains not only to the biological changes underlying behavior, but also mainly to health practitioners' considerations of clinical realities according to their models. Whereas disease falls in the category of

"the culture of the clinician," illness lies in a different domain. It refers to the individuals' and families' recognition, labeling and experience of behavior. The importance of identifying and acknowledging the social and cultural course of disease is stressed in cross-cultural settings.

Communities in moderate- to high-income countries are increasingly heterogeneous in ethnic composition. So is the mental health services workforce that provides care and treatment in both public and private community and institutional settings to people with mental health problems and disorders. Large numbers of mental health professionals working in community mental health centers, managed healthcare organizations, public health services, and public psychiatric institutions are foreign born individuals that are have received their training in the developed countries and stayed there to practice, or else received training in their native country and have been recruited to migrate to a developed country (this is especially true with nurses). Thus, it is not at all uncommon in today's public mental health services environment to have a practitioner from one country/culture treating an individual from a very different culture — neither of which is native to the community or country where they live and interact. Treatment service teams are often composed of professionals who are themselves from countries with diverse culture and varied perspectives about mental illnesses and their treatment.

Thus, there are several key issues concerning the "role of culture in mental health" that need to be considered — and that can become the topics for grassroots and/or national mental health advocacy efforts addressing the influence of culture in mental health services planning and delivery:

1. The role that cultural orientation plays in how mental health professionals think about mental disorders and mental health problems, recognize symptoms, accurately diagnose, and effectively treat these problems in patients that may have a different cultural orientation
2. The role that culture plays in how individuals, family members, and communities perceive and respond to symptoms of mental health problems — how and where they seek help or treatment in dealing with these problems
3. The role that culture plays in the interaction of mental health professionals with patients from a different culture — how do these different cultural perspectives play out in the community- or institutional-based treatment settings (such as choice of treatment, compliance to treatment, and involvement of family caregivers)
4. The role that cultural perspective about mental health and mental disorders plays in the general workforce (business and industry), particularly within employee assistance programs, medical and family leave policies, health insurance coverage, public health services priorities, etc.).

A number of model guidelines for promoting the development of culturally competent/sensitivity in mental health service systems have been developed by governmental agencies, service delivery programs, and researchers. Several of the leading models are described in The Handbook of Racial-Cultural Psychology and Counseling, (in a chapter by Arthur C. Evans, *et.al*) entitled "*Developing a Framework for Culturally Competent Systems of Care.*" One such model is the product of efforts by the US Department of Health and Human Service Office of Minority

Health to outline a set of organizational practices needed for the provision of culturally competent services:

Recommended Standards for Culturally and Linguistically Appropriate Health Care Services

1. Promote and support the attitudes, knowledge, and skills necessary for staff to work respectfully and effectively with clients and each other in a culturally diverse work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Utilize formal mechanisms for community and consumer involvement in design and execution of service delivery, including planning, policymaking, operations, evaluation, training, and, as appropriate, treatment planning.
4. Develop and implement a strategy to recruit, retain, and promote qualified, diverse, and culturally competent administrative, clinical, and support staff who are trained and qualified to address the needs of the racial and ethnic communities being served.
5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent services.
6. Provide all staff with limited predominant language proficiency access to bilingual staff or interpretation services.
7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpretation services.
8. Translate and make available signage and commonly written client educational materials and other materials for members of the predominant language groups in service areas.
9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical and nonclinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.
10. Ensure that client's primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as in any client records used by provider staff.
11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, and clinical outcomes data for racial and ethnic groups in the service area, and become informed about the ethnic/racial needs, resources, and assets of the surrounding community.
12. Undertake ongoing organizational self-assessment of cultural and linguistic competence and integrate measures of access, satisfaction, quality, and outcomes for culturally and linguistically appropriate services into other organizational internal audits and performance improvement programs.
13. Develop structures and procedures to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by clients and staff about lack of fairness, cultural insensitivity, or difficulty in accessing services, or denial of services.

14. Prepare an annual progress report documenting the organization's progress with implementing culturally and linguistically appropriate services, including information programs, staffing, and resources.

Australia's Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia

Australia has taken what is probably the most formalized approach to integrating culturally and linguistically appropriate mental health services planning and delivery into national and state health systems through the *Framework for the Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia.*

The Framework was developed for the Australian Health Ministers' Advisory Council National Mental Health Working Group by the National Multicultural Mental Health Policy Development Steering Group and Multicultural Mental Health Australia, and was released in 2004. (Please note the report on the work of Multicultural Mental Health Australia on page 5-6).

The Framework is described as a tool to:

- Promote the recognition of the role that culture plays in the wellbeing of Australia's multicultural communities
- Identify the specific mental health needs of these communities, and
- Inform the development of services to meet these needs.

The Framework is intended to complement Australia's existing mainstream mental health policy by focusing on specific issues for people from diverse backgrounds. It describes a national approach to the mental health and wellbeing of the country's multicultural population and sets out aims, principles and key policy areas where action is needed.

The aims of the Framework are to:

- Promote the mental health and wellbeing of all people in Australia from multicultural communities
- Prevent the development of mental health problems and mental illness
- Reduce the impact of mental illness on individuals, families and communities, and
- Assure the rights of all people from diverse backgrounds with mental illness.

The Framework sets out four priority areas for action to achieve these aims, and identifies concrete tasks, expected outcomes and responsibilities. These areas are:

- A population health approach to mental health for people from culturally and linguistically diverse backgrounds
- Improving service responsiveness to cultural diversity
- Strengthening quality, and
- Fostering culturally inclusive research, innovation and sustainability.

The Framework's development was undergirded by a set of well-articulated guiding principles, among them:

- Provision of culturally competent, responsive and efficient mental health services requires partnerships between and across the health and welfare system and with consumers and carers from diverse backgrounds.

- A culturally competent workforce is fundamental to the provision of culturally appropriate mental health services.
- A recovery focus, which respects consumers' personal, cultural and spiritual belief system, and that of their families, carers and community, should drive service delivery.
- Achievement of better mental health outcomes for multicultural consumers, their families and carers requires funding models and allocation of resources which consider the needs of diverse populations.

Developing, adopting, and implementing an ambitious national framework to promote and encourage integration of culturally and linguistically appropriate services into a nation's mental health planning and delivery system cannot be achieved only by the efforts of the health and mental health sectors. As the summary of the Australian Framework plainly states:

> *The challenge of developing culturally inclusive public policy and services requires commitment at all levels of government and action across a range of sectors. The Framework recognizes the need for partnerships and collaborations between government, individuals, communities and organizations to identify and respond to the needs of Australia's diverse populations.*
>
> *Commonwealth, State and Territory service providers, in partnership with individuals, their families, communities and non-governmental organizations, must collaborate to design and deliver culturally appropriate health and mental health services.*

This statement serves as a most appropriate and compelling "Call for Action" for World Mental Health Day 2007, addressing the theme "***Mental Health In A Changing World: The Impact Of Culture And Diversity.***" The World Federation for Mental Health hopes that governmental and non-governmental organizations commemorating World Mental Health Day 2007 on October 10 will include in their campaign plans an advocacy and education element to encourage state/provincial and national mental health authorities to consider establishing their own "Framework" for integrating culturally and linguistically appropriate strategies in their mental health services and systems plans. WFMH urges governments to create similar Frameworks within their mental health plans that reflect the principles, aims, and priority areas for action described in the Australian plan. Advocacy to develop, implement, and sustain such a framework would be a significant and lasting contribution of World Mental Health Day 2007.

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