

# crosscurrents

SPRING 2008  
VOL 11 NO 3

The Journal of Addiction and Mental Health



## Cultural competence

Making a world of difference

### **BARRIERS TO CARE**

Why we still need ethno-specific mental health services

### **RACISM AND MENTAL HEALTH**

Cultural competence must take an anti-oppression stance

### **Lace up, don't light up**

Exercise can help with smoking cessation

### **MORE THAN WORDS**

Health care interpreters play key role in quality care

### **SPIRIT OR SCALPEL**

Partnering western medicine with faith communities

### **Generation Rx**

Taking action on teen prescription drug abuse



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Centre for Addiction and Mental Health  
Centre de toxicomanie et de santé mentale

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*Wildflowers*, Sari Alter, acrylic on plexiglass 16" x 12"

Sari studied English at the University of Toronto and has been painting for more than 20 years. She explores spirituality through her art.

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Several weeks ago I visited a therapist for an interview. When I arrived, I noticed that her door was slightly ajar. Taking this as a sign that she was free, I knocked quietly. The therapist came to the door and told me she was finishing up with a client. She later explained that the client was a male Orthodox Jew, in whose culture a man should avoid being alone with a woman who is not his wife unless other people are in earshot and have access to the room. This is an example of cultural competence in mental health care – services that are sensitive to and responsive to cultural differences.

In recent years, Canada has witnessed a mind-boggling expansion in the ethnocultural diversity of its population. According to Statistics Canada projections, about one in five people in Canada will be a member of a visible minority by 2017.

Despite our multicultural character, availability and accessibility of relevant, culturally competent health care is still lacking. Yet nowhere is the importance of culturally competent care greater perhaps than in the delivery of mental health services, where cultural issues and communication between client and care provider are a critical part of the services themselves. Indeed, culture plays a large role in shaping health-related values, beliefs and behaviour – how people seek help, communicate and interact with one another, how symptoms get manifested and what

roles family and community supports play.

At the clinical level cultural competence means providing services that respond appropriately to a person's unique cultural differences. But cultural competence extends far beyond the clinical encounter. It involves addressing broader, systemic issues such as disparities in health care engendered by racism and oppression.

This issue of *CrossCurrents* urges health care providers to embrace cultural diversity in their day-to-day practice and to help move cultural competence from the margins into the mainstream.

CAMH's deputy chief of nursing practice, Rani Srivastava, opens with a call to action to health care providers, arguing that cultural competence is not merely a practice in itself, but that it should be a core component of any service. Sarah Hamid-Balma draws from her personal experience to discuss the importance of understanding cultural expressions of mental health issues. Kim Goggins discusses why quality interpretation services must be more accessible to clinicians and clients.

This issue also emphasises the need for cultural competence at the systemic level. Anne Ptasznik's article about Hong Fook, an ethno-specific mental health agency in Toronto, discusses some of the ongoing barriers to accessing mainstream mental health services. Avril Roberts' article about

racism and mental health challenges the mental health system to embrace an anti-oppression framework. Kim Goggins discusses how mainstream mental health and addiction services can partner with traditional faith communities and healers to improve client care. Finally, the Last Word column argues that incorporating Aboriginal traditions into mainstream mental health and addiction services will improve the quality of care for Aboriginal clients.

Enjoy this stimulating issue. Send us your comments and ideas. It is your input that furthers the dialogue around mental health and addiction issues.

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## a view from CAMH

The focus on cultural competence in this issue is a relevant one for CAMH – and for all of us who provide health care anywhere in Canada. We remain a nation of Aboriginals and immigrants, and for the latter it's only a question of how long ago we arrived in this country.

Transcendent qualities for culturally competent care include respect, openness and curiosity on the part of all clinicians. It is not the impossible goal of encyclopedic knowledge of all cultures, races and ethnicities that carries the day. Rather, it starts with simple gestures such as inquiring how people wish to be addressed and learning how to pronounce their names properly. This takes less than 60 seconds at the beginning of a clinical encounter, but it sets an enduring and remembered tone right at the outset. It is the first step in asking the people

we serve to teach us about themselves, their values, beliefs and traditions. This is not an "add-on." It is an essential component of our task, even as we look for signs and symptoms of recognizable disorder, to contextualize these reproducible patterns in the unique trajectory of an individual.

Similarly, we must not make assumptions about individuals based on group memberships. Diversity exists within as well as between. We can easily fall into stereotyped thinking about other groups while appreciating the wide range within the one we happen to belong to. Thus, as CAMH's Rani Srivastava points out in her introduction to this issue, cultural competence has to include taking a hard look at our own assumptions and reactions.

Most of us are in this line of work because of our curiosity about people, our wish to learn more and our desire to help. Textbooks of cultural competence can point the way and provide some skills for the journey, but the source of true knowledge is within the people we serve. The rate-limiting step is the degree of our willingness and ability to learn from them.

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## Early psychosis: Acting before the horse has left the barn

There continues to be controversy about the merits of early detection and treatment for youth psychosis, as seen in the Last Word column of the winter issue of *CrossCurrents*. The onset of psychosis can result in lifelong psychological changes. However, the diagnosis is often delayed because of uncertainty and no distinct biological markers or a “litmus test” for identifying early psychosis.

One obvious criticism is that of predictive validity in current studies and problems with the diagnosis of “false positives.” The goal of early intervention studies is to develop a database of predictive factors, markers and pre-psychotic symptoms that define early phases of illness. Research in the field is guided by principles of “do no harm” and by recognition of the high cost of a later diagnosis to the individual.

International collaboration has led to a shift from attempting to calibrate the prodrome – a period of disquiet, depression and subtle personality/behavioural changes – towards identifying individuals “at risk” for psychosis.

Individuals with pre-psychotic features are already in distress and are help-seeking. First episode individuals often have substantial impairments in their mood, cognition and social functioning. Most are caught late and have been ill for months or years before presenting to the ER. This period of symptomatic distress or duration of untreated psychosis (DUP) has been correlated with

evidence of irreversible gray matter changes on MRI, residual features, treatment resistance and a poorer overall prognosis.

Robinson demonstrated that 118 first episode patients who received appropriate treatment had only a 14 per cent chance of achieving an adequate level of recovery of psychological and social functioning after five years. The reality is that complete recovery from a first episode is very limited and the relapse rate was over 80 per cent after five years. This suggests that relapse is the rule not the exception. Other personal costs of late diagnosis can include vulnerability to depression, suicide attempts and substance abuse problems.

Recent research with the “at risk” population has provided further evidence about the link between DUP, brain changes and transition to a first episode. Both Simon in Switzerland and Eastvold in Utah have studied cognitive functioning in healthy controls, “at risk” subjects and first episode individuals. Both found that healthy individuals performed best, followed by “at risk” individuals who had modest intermediate cognitive impairments when compared to first episode subjects. This may lead to selective neurocognitive tests to assess vulnerability for psychosis.

Imaging studies have demonstrated brain changes over the first five years of active psychosis resulting in a 10–20 per cent decrease in grey matter in areas associated with cognition, organization and positive and negative features. Pantelis found that high-risk individuals who developed psychosis had greater gray matter loss than those who did not progress. Similarly, Davatzikos showed that “at risk” individuals had subtle but less marked grey matter changes in the same areas of the brain than is typically affected in first episode patients.

In 2007, Lappin found a correlation between a longer DUP (over 26 weeks) and greater loss of grey matter in the areas responsible for organization, memory, learning and positive features. The ability to correlate early identifiable brain changes with evolving signs of psychosis may allow us to identify early those at risk. These studies would not be possible without having an early intervention focus.

New psychosocial/talk treatments are being studied to potentially prevent the emergence of psychosis. (Even though most medication studies show an advantage in reduction of early symptoms, the focus is now on neuroprotective agents to stabilize the brain at a critical period.) Clearly one size does not fit all and a combination of therapeutic approaches could offer the best opportunity to delay, modify or prevent onset of psychosis. The goal is to have an array of evidence-based approaches available for those already at risk and in distress.

We have had over 100 years of a “watch and wait” approach; it is time to change the game plan. By offering help at an earlier stage and through effective public health campaigns to inform the community about risk factors and availability of services, we hope to change the view of schizophrenia.

Early intervention provides an opportunity to treat people before the chronic deficits and demoralization set in. Our current status quo of “too little too late” – “after the horse has left the barn” would not be acceptable in any other branch of medicine. ■

**Dr. Irvin Epstein**

PSYCHIATRIST, CENTRE FOR ADDICTION AND MENTAL HEALTH

### NEW!

## Working with Immigrant Women

### Issues and Strategies for Mental Health Professionals

Editors: Sepali Guruge and Enid Collins  
350 pages • \$34.95

This book addresses the gap between the needs of newcomer women and established structures and practices in Canada’s mental health care system.

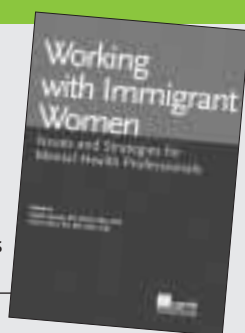
With an interest in changing paradigms in mental health practice, the multidisciplinary group of authors examines current research and suggests practice strategies for mental health professionals.

*Working with Immigrant Women* highlights the intersecting oppressions experienced by women while emphasizing their strengths and resiliencies. It also demonstrates how women are active participants in shaping their health.

Topics include:

- theoretical perspectives
- the role of spirituality, social determinants of depression, cultural interpretation and barriers to accessing services
- working with specific groups such as Sudanese, Caribbean, lesbian, refugee and older women and girls
- trauma, domestic violence and postpartum depression.

The book is a valuable resource for health care professionals, educators, researchers and policy-makers, and is an ideal course text.



To order, contact **Sales and Distribution**  
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## Lace up, don't light up: Incorporating exercise into smoking cessation programs

ELIZABETH SCOTT

It's not news that regular exercise and staying away from smoking are healthy lifestyle choices. It's also not news that starting a regular exercise routine or quitting smoking can be difficult. So what happens when you try to do both? Trying to quit and get physically active may seem like too much to tackle at once, but research is showing that exercise may actually help with smoking cessation.

A 2007 review of a dozen studies on exercise and smoking published in the journal *Addiction* found that smokers abstaining from smoking who did moderate exercise like walking or isometrics reported reduced cravings and withdrawal symptoms from nicotine.

Dr. Guy Faulkner, an assistant professor in the Faculty of Physical Education and Health at the University of Toronto, says that research to support the connection is growing and clinicians are starting to get the message. "Trying to get someone to quit smoking and increase their exercise may once have seemed too challenging," says Faulkner, adding that this fear of setting clients up for failure has prevented some clinicians from using exercise to help clients manage cravings and withdrawal symptoms. But that's starting to change, as evidence shows that exercise as an adjunct to standard care such as counselling and nicotine replacement therapy (NRT) increases short-term abstinence compared to standard care alone.

Exercise is not just for people who are trying to butt out. It may play a harm reduction role for those who feel they cannot or do not want to quit. Studies have found that smokers who are physically active live longer and have lower rates of cardiovascular disease than inactive smokers. They also report more cessation attempts – and more attempts means more chances for success.

Faulkner says that choosing to make exercise an integral part of their lifestyle may give some smokers the boost they need to quit: "A person who is thinking of quitting may be looking to change their identity from someone who is a smoker to someone who is more health conscious," he says. Exercise is a

natural fit. Indeed, raising client awareness and concern for their overall health – and turning that concern into real action – is any health care provider's goal.

The real challenge for clinicians often lies in how to encourage inactive smokers to get moving and stay that way. "A change in perceptions of what we mean by physical activity and exercise is needed," says Faulkner.

*Evidence shows that using exercise as an adjunct to standard care such as counselling and nicotine replacement therapy (NRT) increases short-term abstinence compared to standard care alone*

"If you think of exercise as just 30 minutes of moderate activity such as a brisk walk most days of the week, you can start setting small goals with clients – maybe five or 10 minutes a day," gradually increasing the time to 30 minutes. Faulkner says that although it may be challenging, "clinicians often have the skills to motivate people to become more physically active. It's more a question of whether clinicians buy into the potential that physical activity can have."

Members of one online smoking cessation support group who were contacted by *CrossCurrents* wholeheartedly support the role of exercise in quitting. Richard Krueger, for example, who decided to make "2008 the year of better health," says that while exercise distracts from cravings, it gives him much more: "My breathing has become easier and my daily workout routine reminds me of how good it feels to be a non-smoker after 10 years of addiction." Krueger's workout, which involves 45 minutes on a recumbent bicycle or elliptical machine, has also helped him shed five pounds – impressive to many of the smokers who fear the weight gain that may accompany quitting. Smoke-free at the two-month mark, Krueger says, "It feels great to pair smoking cessation and exercise, and I continue both because I never want to feel the way I used to again."

Meghan Carlson, who smoked three-quarters of a pack a day for 16 years, also knows the benefits of exercise. "It gives me

an outlet for a lot of nervous energy, alleviated the withdrawal headaches and gave me something other than smoking to focus on." Carlson identified weight gain as a concern, adding that some women use this fear as an excuse for not quitting or for resuming smoking. But, Carlson says, exercise relieved some of her fear, giving her a focus and improving her physical health and overall

mood. "A big part of quitting is making the decision to quit and being able to defend that decision to yourself," says Carlson. "Exercise really helped keep me on an even keel by minimizing some of the worst symptoms of withdrawal."

From a population health perspective, the ideal strategy would involve innovative smoking cessation programs that include an exercise component, targeting the public. Romilla Gupta, a health promotion consultant with the City of Toronto, says that currently the public health sector does not have well-researched exercise and smoking cessation or relapse prevention programs for people to use. However, existing public health messages encourage people to exercise as part of other behavioural strategies to deal with cravings and withdrawal symptoms. Exercise advice is embedded into a number of other messages, such as use NRT, talk to a support group or have a buddy system in place.

On the research front, studies are now looking beyond the short-term effectiveness of exercise in smoking cessation. Faulkner is involved in research that examines exercise maintenance for long-term cessation success, which, as he explains, "is about trying to help people develop the skills to become independent exercisers." In the meantime, Faulkner offers this simple evidence-based strategy for clinicians to use with clients: "Short bouts of moderate activity can help people deal with cravings." ■

## Generation Rx: Taking action on teen prescription drug abuse

LESLEY YOUNG

Linda Gardiner knows first hand the dangers of prescription opioids – drugs prescribed to manage chronic or severe pain. She blames addiction to high-prescribed dosages of OxyContin, one such pain reliever, in the death of her son Chad, who took his own life in 2004, in part, because he felt he had nowhere to turn for help. Chad, 26 at the time, became addicted to the opioid over a one-year period after it was prescribed to treat pain from back injuries sustained in a car accident. “He wanted to be remembered for who he was and not for who he had become,” says Gardiner. “He was ashamed at the desperation of it all.”

This tragedy has motivated Gardiner to raise awareness of opioid abuse by sharing her story and listening to others through her web site, [oxyabusekills.ca](http://oxyabusekills.ca). She often hears from other parents who are struggling with a child’s abuse of OxyContin, children often much younger than Chad was.

Their stories reflect recently emerging trends in prescription opioid abuse among teens in Canada and the United States. The Ontario Student Drug Use and Health Survey (OSDUHS), the longest ongoing survey of adolescent drug use in Canada, in 2007, looked for the first time at prescription opioid abuse among teens. The study, conducted by the Centre for Addiction and Mental Health (CAMH) in Toronto, found that 21 per cent of students in grades 7 to 12 admitted to taking a prescription opioid for non-medical purposes within the previous year. Just over three-quarters said they got the drugs at home. In 2007, the number of students who reported using OxyContin doubled from the 2005 survey to two per cent. Also disconcerting is the possible link between opioid abuse and abuse of other drugs. A study of U.S. elementary and high school students published in *Pediatrics* in 2006 found evidence that the non-medical use of prescription medications, particularly opioids, may be associated with an increase in general substance abuse problems.

Since awareness of the problem is relatively new, yet the threat of abuse is, literally, close to home, health care professionals and policy-makers are grappling with ways to

prevent prescription opioid abuse among youth. Generally, there is a feeling that once more is understood about the problem, appropriate policies, including anti-diversion strategies and prescription drug monitoring programs, can be developed. Education and awareness among youth and parents are also key, but few such programs exist.

Easy access is a big issue. “North America has an enormous abundance of psychoactive drugs coming through the medical system,” says Benedikt Fischer, director of the Illicit Drugs, Public Health and Policy Unit at the Centre for Addictions Research of British Columbia. “We prescribe more prescription opioids than any other country or region in the world,” he says, pointing out that Canada is the world’s top per capita consumer of a number of opioids. Fischer says policy is required to alleviate the flooding, but that finding practical solutions is a real challenge.

Gary Roberts, senior advisor with the Canadian Association for School Health in Ottawa, says that despite regulations in Canada forbidding direct-to-consumer prescription drug advertising (ads can only name a drug or what it treats, not both), American spillover and the Internet render the law ineffective.

Part of the lure and danger of youth abuse of prescription drugs is the false belief that because they are legal and prescription-based, they are safe. “Young people must be informed that abusing prescribed medication can be just as dangerous as using illicit street drugs,” says Gail Czukar, president of

the Canadian Executive Council on Addictions (CECA). “We need more research on the extent and nature of prescription drug abuse in Canada. We need to determine what monitoring and anti-diversion strategies will best address this growing problem,” adds Czukar, who is also vice-president of Policy, Education and Health Promotion at CAMH. CECA called for greater policy focus on prescription opioid abuse (including diversion onto to the illegal market) in the federal government’s new National Anti-Drug Strategy announced in early 2007. The strategy is criticized for focusing on high-profile illegal drugs and failing to provide support for harm reduction strategies.

Unfortunately, there is very little research on anti-diversion strategies, according to a 2007 editorial in *Addiction*, which made some recommendations based on what research exists in Australia, the United Kingdom and the United States. It found that strategies that aim to identify individuals at high risk of diversion or abuse are much more costly and likely to have a lower health impact than strategies that identify liberal prescribers (there are fewer prescribers and there is a paper trail). The editorial also suggests that professional regulation may be a more effective deterrent if it results in more immediate action such as loss of entitlement to prescribe, as in the U.S., compared to a finding of professional misconduct by tribunal, as in Canada.

Experts agree that better ways of monitoring diversions are also needed. In Canada, only a few provinces have prescription

### PRESCRIPTION DRUG ABUSE: A GROWING GLOBAL TREND

A 2006 study in the *Canadian Medical Association Journal* found that heroin is no longer the opiate of choice among Canadians with substance use problems – prescription opioids such as morphine and OxyContin are taking its place. Researchers studied street users in seven cities across Canada in 2005 and found that heroin remained the most common illicit opiate only in Vancouver and Montreal. In the five other cities – Edmonton, Toronto, Quebec City, Fredericton and Saint John – prescription opioids like Percodan were most common.

On the global front, prescription drug abuse has outstripped traditional illegal drugs such as heroin, cocaine and Ecstasy in parts of Europe, Africa and South Asia, according to the UN-affiliated International Narcotics Control Board.

monitoring programs in place, according to a 2006 article in the *Canadian Association Medical Journal*. Nova Scotia is one of them. It recently implemented a new online system in pharmacies throughout the provinces, providing pharmacists, physicians and the Nova Scotia Prescription Monitoring Program with real-time data on prescribing and use of monitored drugs.

As for youth abuse of opioids, Fischer says we know even less. “Before we can do anything in the system we need to gather more evidence to understand what is behind these phenomena,” he says. “Is it a substitution effect from other illicit drugs? Are these people self-medicating? Or is it simply that there is an increase in availability sitting around in people’s medicine cabinets?”

Whatever the answer, the sooner problem users can be identified, especially among youth, the more that can be done to treat them, says Fischer, who would like to see tools developed for identifying abuse for school settings. The fact that many students get the prescription opioids from home indicates that teen prescription opioid abuse cannot be dealt with as an isolated phenomenon, says Fischer. “This behaviour happens in the wider context of the social environment. There are many stressors and factors at work that make it tempting for people to resort to prescriptions drugs.”

Action is already underway through the Community Partnership on Drug Abuse in Cape Breton, Nova Scotia. Initially formed in 2004 to be a six- to nine-month committee to address the increase in OxyContin use in Cape Breton, the partnership is now entering its fourth year. The infrastructure turned out to be an effective grassroots way to deal with various substance abuse issues, including youth prevention, says the partnership’s executive director, Marilyn O’Neil. “It’s such a simple and effective idea – to have police, health authorities and educators at all secondary and post-secondary school levels, doctors and pharmacists and parents of addicts all sitting at the same table.” The integrated approach to active problem-solving has been tremendous, she adds.

The partnership consists of three working

groups – education and prevention, treatment and community safety – reporting to a steering committee on which sit senior members of various key organizations, for example, the CEO of the Nova Scotia District Health Authorities and the Chief of Police. This way, when working groups present to the committee, the very people responsible for initiating change, such as obtaining funding, are able to put recommendations into action. The group has also been strong on the government lobby front, being the driver behind putting the Nova Scotia Prescription Monitoring Program online.

The partnership recognizes the importance of including youth themselves in developing effective prevention and education strategies. The partnership held a youth summit last year, where 40 youth met to talk about drug abuse and drug messaging. Action coming out of the summit includes the development of a permanent youth committee and the launch later this year of an education web site for youth.

The partnership is also currently implementing a program called Asset Building for Communities, developed by the U.S. Search Institute. The first phase involves surveying the youth of Cape Breton to discern where they are in terms of “assets.” “There is a strong correlation between the number of assets students have and how successful and prosperous their lives are,” says O’Neil. Once deficits are determined, programs such as peer mentoring will be developed to help build assets, such as strong social supports and better grades at school. “With assets, kids have more going for them so they are better able to cope when things aren’t going their way, and so they know who to talk to and where to get resources when they need them,” says O’Neil.

With prescription opioid abuse among youth emerging as a trend across the country, the hope is that action to address the issue will gain momentum. Education and awareness campaigns, alongside strong anti-diversion policies and drug monitoring programs, may be the best way to keep prescription opioids where they belong – in the medicine cabinet. ■

### What are opioids?

Opioids are a family of drugs with morphine-like effects. Their primary medical use is to relieve pain. Other medical uses include control of coughs and diarrhea and the treatment of addiction to other opioids. Prescription opioids include morphine, codeine, oxycodone (OxyContin, Percodan, Percocet), hydrocodone (Tussionex), meperidine (Demerol) and hydromorphone (Dilaudid).

### How are opioids taken?

Prescription opioids are taken orally as a tablet or capsule or in liquid form. Used non-medically, they can be crushed and snorted or cooked and injected intravenously.

### What are the effects of opioid abuse?

Low doses of opioids suppress the sensation of pain and the emotional response to pain. They may also produce euphoria, drowsiness, relaxation, difficulty concentrating, nausea, vomiting, constipation and loss of appetite. With higher doses, these effects are more intense and last longer. Long-term use can cause mood instability, impaired night vision, decreased libido and menstrual irregularities. Withdrawal symptoms include uneasiness, yawning, tears, diarrhea, abdominal cramps, goose bumps and runny nose.

### What are the dangers of opioid abuse?

Opioids slow down the part of the brain that controls breathing and in large quantities can stop breathing, leading to death. People who seek the euphoric effects of opioids may take more and more of the drug as tolerance develops. As the amount taken increases, so does the risk of addiction and overdose. Injecting opioids carries the risk of infection and disease from dirty needles. Opioid drugs are particularly dangerous when taken in large quantities or when combined with other depressants, such as alcohol or benzodiazepines.

*Adapted from Do you know ... opioids, Centre for Addiction and Mental Health, 2003*



**Cognitive impairments may play role in alcohol dependency**

Differences in certain regions of the brains of people with alcohol dependency impair the ability to compare short-term versus long-term rewards, according to research from the Ernest Gallo Clinic and Research Centre in Emeryville, California. Scientists used functional magnetic resonance imaging to study the brains of nine abstinent participants with alcohol dependency and 10 controls with no history of alcohol dependency. Participants were asked to choose between a smaller monetary reward available immediately and a larger amount to be received later. As expected, those with alcohol dependency chose the immediate reward almost three times more often than did the controls. The tendency to choose immediate rewards was associated with increased activity in the parietal cortex, dorsal prefrontal cortex and rostral parahippocampal gyrus. In contrast, increased activity in the lateral orbitofrontal cortex was associated with the tendency to wait for larger rewards. These regions have all been experimentally linked to the comparison of value and outcome. The study also found that participants carrying a less active variant of the catechol-O-methyltransferase (COMT) gene, which helps control dopamine activity in the brain, were more likely to choose immediate rewards and showed increased activity in the dorsal prefrontal cortex and posterior parietal cortex. The presence of this variant of the COMT gene appears to deplete dopamine in the brain's cortex. The authors suggest that these findings may lead to cognitive therapies that would help people improve their decision making as part of a recovery plan.

*Journal of Neuroscience*, December 26, 2007, v. 27: 14383–14391. Charlotte A. Boettiger et al., Ernest Gallo Clinic and Research Center, Emeryville, California.

**Abnormalities in brain associated with borderline personality disorder**

New research from Weill Medical College of Cornell University in New York has highlighted the role of brain abnormalities underlying borderline personality disorder (BPD). Scientists used functional magnetic resonance imaging to study brain activity in response to negative emotions among 16 individuals with BPD and 14 controls. Participants were scanned while performing an emotional linguistic go/no-go task. They were asked to press a button when shown a word in normal font or refrain from doing so when shown a word in italics. Researchers contrasted participants' responses to negative words with their responses to emotionally neutral words. As expected, individuals with BPD rated the negative words more negatively than did controls. When responding to negative words, individuals with BPD displayed less activity than controls in two parts of the ventromedial prefrontal cortex involved in the regulation of emotions: the medial orbitofrontal cortex and the subgenual anterior cingulate cortex. The responses of individuals with BPD to negative words also showed increased activity in the limbic regions of the brain, notably the amygdala – regions also associated with the regulation of emotions. The authors state that their findings may help develop better diagnostic instruments and treatments. One limitation of the study is that 11 of the individuals with BPD were taking medication for their illness, although this was taken into account in the analysis.

*American Journal of Psychiatry*, December 2007, v. 164: 1832–1841. David Silbersweig et al., Weill Medical College of Cornell University, New York, New York.

**Tantrums may signal psychiatric disorders in children**

Lengthy, aggressive or violent tantrums among preschool children may indicate the presence of a psychiatric disorder, according to research from the Washington University School of Medicine in St. Louis, Missouri. The study looked at 279 preschoolers aged 3 to 5. Of these, 150 were considered healthy, 54 had a disruptive disorder (attention deficit/hyperactivity disorder, conduct disorder or oppositional defiant disorder) without depression, 21 had depression without disruptive disorder and 54 had both depression and a disruptive disorder. The children with a disruptive disorder only and those with both depression and a disruptive disorder were significantly more likely than healthy children and children with depression only to have excessive tantrums with aggression. Those with depression were more likely than the disruptive preschoolers to engage in self-injurious behaviour during tantrums, while those with both depression and a disruptive disorder were more likely than disruptive children to do so. The authors conclude that preschoolers exhibiting one of five "tantrum styles" should be referred for a mental health evaluation: those who consistently display aggression toward caregivers or destructive behaviour toward objects, those who injure themselves during tantrums, those who have 10 to 20 tantrums during a 30-day period or average more than five tantrums a day, those who have tantrums averaging more than 25 minutes and those who are typically unable to calm themselves without the help of a caregiver.

*Journal of Pediatrics*, January 2008, v. 152: 117–122. Andy C. Belden et al., Department of Psychiatry, Washington University School of Medicine, St. Louis, Missouri.

**Pregnant women with bipolar disorder risk relapse if they discontinue medication**

Women with bipolar disorder who discontinue mood stabilizer treatment during pregnancy have an increased risk of a recurrence of mood episodes, according to research from the Harvard Medical School in Boston, Massachusetts. The findings are based on DSM-IV assessments of 89 women with bipolar disorder (61 with bipolar disorder type I, 28 with type II) whose mood was normal at conception. Of these, 62 discontinued mood stabilizer treatment at the start of their pregnancy and 27 continued treatment through pregnancy. The women were followed throughout their pregnancies and for 12 months thereafter to ascertain their symptoms and the treatments they were following. Women who discontinued mood stabilizer treatment turned out to be twice as likely as those who continued treatment to experience a recurrence of a mood episode (depression, mania or hypomania). Those who discontinued treatment abruptly had a 50 per cent risk of recurrence within two weeks, whereas those who discontinued gradually took 22 weeks to reach a comparable level of risk. Although it is common for women with bipolar disorder to discontinue mood stabilizer treatment during pregnancy to avoid adverse effects on the fetus, the authors recommend that future treatment plans take into account the risk of mood disorder recurrence. In particular, maintenance treatment during pregnancy may be the best course of action for women who experience severe bipolar disorder with frequent recurrences.

*American Journal of Psychiatry*, December 2007, v. 164: 1817–1824. Adele C. Viguera et al., Department of Psychiatry, Harvard Medical School, Boston, Massachusetts.



**Diagnostic criteria for generalized anxiety disorder may exclude many**

New research from the Stanford University School of Medicine in Stanford, California, indicates that the current DSM-IV diagnostic criteria for generalized anxiety disorder (GAD) exclude many individuals who experience chronic anxiety and hyperarousal. The study examined 18 participants seeking treatment for frequent, unpleasant tension over the previous six weeks, as well as 18 participants who could be considered calm. Only five of the tense group could be diagnosed as having GAD using DSM-IV criteria. Each participant was examined using structured interviews and questionnaires. Tests of skin conductance level (SCL) were also given over a 24-hour period to measure sweat gland activity as an indicator of stress levels. The tense group reported more worry, more stress, more depression and poorer sleep than the calm group. The calm group had fewer periods of sleep disruption than the tense group. Calm individuals showed longer runs of SCL declines both when awake and asleep, indicating longer periods of relaxation among calm participants. One-minute waking SCL levels were higher among the tense group, indicating an inability to relax. Overall, the results indicate fewer and shorter periods of relaxation among tense participants. Interestingly, people in the tense group were able to achieve SCL declines comparable to those achieved by the calm group when they were instructed to sit quietly and relax after a three-minute walk. Since the majority of participants who showed symptoms could not be diagnosed as having GAD, the authors conclude that the current DSM-IV criteria for the disorder define a subtype that is not typical for chronic anxiety in general, leaving many individuals excluded from psychological and pharmaceutical research.

*Journal of Psychiatric Research*, February 2008, v. 42: 205–212. Walton T. Roth et al., Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, California.



**Brief ER-based interventions can target alcohol dependency**

A screening, brief intervention and referral to alcohol treatment (SBIRT) intervention in hospital emergency departments can be effective in reducing drinking among people with alcohol dependency, according to research from the University of Connecticut Health Centre in Farmington, Connecticut. Researchers recruited 1,132 alcohol dependent individuals from 14 sites across the United States. The 551 participants in the intervention group received a written list of referral resources and a brief intervention (the Brief Negotiated Interview); the 581 participants in the control group received only the written handout. Three months later, alcohol consumption among those who received the intervention was 3.25 fewer drinks per week than in the control group. Those in the intervention group also reported that the maximum number of drinks consumed per occasion was almost three quarters of a drink less than for controls. When participants were divided into those considered either dependent or those merely at risk of developing dependency, the at-risk group was more likely to benefit from the Brief Negotiated Interview. Among at-risk participants, 37 per cent of those given the intervention no longer exceeded low-risk limits for alcohol dependency at follow-up, compared with 19 per cent of controls. Among participants with alcohol dependency, 20 per cent of intervention participants no longer exceeded low-risk limits, compared with 18 per cent of controls. The authors caution that it remains to be seen whether the benefits seen in this study can be maintained over longer periods of time, given that previous meta-analyses have found that the benefits of brief intervention tend to decline after the first three months.

*Annals of Emergency Medicine*, December 2007, v. 50: 699–710.e6. The Academic ED SBIRT Research Collaborative, Department of Behavioral Sciences and Community Health, University of Connecticut Health Center, Farmington, Connecticut.

**Second-hand smoke increases children’s risk of allergies**

Exposure to tobacco smoke in early infancy may increase a child’s risk of developing allergies, according to a study from the Karolinska Institute in Stockholm, Sweden. Researchers surveyed 4,089 families regarding their children’s allergies as well as environmental factors such as the parents’ allergies and the children’s exposure to tobacco smoke. The parents completed questionnaires when their children were two months old, and subsequently when they were one, two and four years old. Blood samples from 2,614 children were analyzed at age four for the presence of immunoglobulin E (IgE) antibodies which would indicate sensitization to common allergens. Children who had been exposed to second-hand tobacco smoke at two months of age turned out to be 28 per cent more likely than those who were not exposed to show evidence of sensitization to indoor airborne allergens or food allergens. In particular, they were more likely to be sensitized to food allergens and indoor inhalant allergens such as mould, cat dander and dust mites. Exposure to tobacco smoke had little effect on sensitivity to outdoor pollen allergens. Interestingly, the sensitizing effect of exposure to tobacco was largely restricted to children whose parents had no allergies, while children whose parents had allergies were largely unaffected. These findings, according to the authors, support the theory that damage to the mucous membranes lining the airways plays a role in the development of allergies.

*Thorax*, December 2007, online, doi: 10.1136/thx.2007.079053. Eva Lannero et al., Institute of Environmental Medicine, Karolinska Institute, Stockholm, Sweden.

# Making a world of difference

## Why cultural competence is a need, not a luxury

BY RANI SRIVASTAVA

CANADIAN SOCIETY IS BECOMING INCREASINGLY DIVERSE. DATA FROM the 2006 census show that one in five Canadians are “foreign born,” and this population is increasing at about 14 per cent, nearly four times the rate in the Canadian-born population. Since the definition of foreign-born does not include non-permanent resident (such as students, individuals with work permits or refugee claimants), the actual proportion of foreign-born persons in Canada is likely higher. Ontario continues to be a preferred destination for more than half of newcomers, and large urban centres such as Toronto, Montreal and Vancouver are home to nearly 70 per cent of recent immigrants. Although immigration is a major contributor to our cultural landscape, it is not the only factor. The 2006 census shows that the number of people who identify as Aboriginal is increasing and has surpassed the one million mark. Given these demographics, it seems obvious that health care agencies need to respond to a culturally diverse population. But that is easier said than done.

Culture is intimately connected to health care. It influences how people experience and report symptoms, which remedies they seek and how. Misdiagnosis and miscommunication can occur when clinicians fail to recognize diverse ways of expressing distress. This is particularly true in mental health, where the clinician is often the diagnostic as well as the therapeutic instrument, with little objective assessment data from other sources such as blood tests or x-rays. Clinicians often struggle to determine whether behaviours deemed inappropriate in mainstream society really do reflect illness or whether they reflect cultural needs or traditions.

Over the years, two key issues have emerged from discussions around understanding and responding to cultural issues in health care. First, culture plays a pivotal role in health and illness; second, the culture of clinicians and the health care system affects diagnosis, treatment and access to services.

*The overall goal of cultural competence is to improve the quality of care and help reduce or eliminate health disparities*

This means that cultural competence needs to be practised not just at the level of the individual care provider but also at the level of the organization and the broader health care system. We must recognize that our health systems – and the education system that trains health care providers – are built on a western, biomedical model of health beliefs and health care delivery. As a result, health care providers have little formal training around how to understand and incorporate the range of health beliefs and cultural paradigms that exist in our complex, multicultural society.

Cultural competence is as complex a concept as the society it reflects. Cultural competence is the ability of health care providers to work effectively in cross-cultural situations. While older terms such as “cultural sensitivity” and “cultural awareness” referred to an appreciation of and respect for cultural differences, “cultural

competence” takes the concept one step further to include the ability to ultimately put this knowledge and skill into action.

The essential role of cultural competence in good health care has been reinforced through increasing evidence of health disparities. Studies have documented disparities in access to health care, as well as health care quality and health outcomes for racial and ethnic minorities across a wide range of clinical specialties. The 1988 Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees found that within the mental health arena not only do minorities have less access to mental health services, they are less likely to receive the needed services, often receive a poorer quality of mental health care and are often underrepresented in mental health research.

Increasing diversity and these growing health disparities have made the need for cultural competence an urgent call to action. The overall goal of cultural competence is to improve the quality of care and help reduce or eliminate health disparities. This is done by improving access to care and building trust and engagement with diverse clients and communities. Cultural competence includes valuing cultural diversity, being aware of one’s own personal and professional biases, understanding the dynamics associated with “difference,” learning about different cultures and cultural issues and adapting one’s approach to care to fit the needs of individuals and communities. Being culturally competent does not mean knowing everything about every culture or needing to abandon one’s own cultural identity; instead, it involves a willingness to accept the idea that there are many ways of viewing and approaching the world.

But acceptance and action are slow to come. Why is there more talk than action in providing culturally competent care? Part of the answer may lie in the fact that current conceptions of culturally competent care challenge health care providers to examine their own personal and professional biases, rather than merely learn about cultural differences. Self-awareness is recognized as a critical attribute, but self-awareness can be hard to acquire and old ways of working can be hard to change. We must also acknowledge that awareness and intentions do not result in change without purposeful action. When it comes to cultural competence, action must occur at all levels of the health care system. To achieve the changes necessary in clinical care, policy-makers and educators need to rethink the standards for quality in a multicultural society. Organizations need to develop strategies to infuse the policy and standards in day-to-day services.

In the meantime, we cannot wait for someone else to take action. Gandhi said, “Each one of us must be the change we want to see in the world.” Indeed, the first steps in the journey toward cultural competence are paved with the commitment to making a difference and acting on it – something each of us can do. ■

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# Culture-specific syndromes

## It's all relative

BY SARAH HAMID

I'M A LIVING, BREATHING EXAMPLE OF THE ETHNIC DIVERSITY OF B.C., indeed, Canada. Despite a mixed Parsi and Afghan ancestry, two mother tongues before English, and a non-Canadian birthplace, I have been immersed in Canadian society since the age of five – almost as far back as my memory begins.

I'm also a living, breathing example of a visibly ethnic individual with a mental illness. And like so many others in this increasingly multicultural North American continent of ours, I am in a unique position of having access to at least two ways of interpreting the root of my illness: the North American way, and an “Asian” way.

Lower Mainland [B.C.] clinicians have given me the label “major depressive disorder.” However, whenever I make progress with my medications, my Afghan aunt tells me she essentially wishes that no one should *nazar* me. That is, no one should give me the “evil eye,” long thought of in Latino, Mediterranean, and Islamic cultures as a main cause of sickness and misfortune. My aunt's statement doesn't have the same power in my Canadian home as it would have had in the Afghan one I could have grown up in, but it comforts me nonetheless. Her saying she doesn't want *nazar* to take place is a statement of protection and luck, given almost in the same spirit that “break a leg” is to a stage actor.

Many people may think my aunt's way of interpreting my emotional distress is “folksy” or even “cute.” But it's not. In its own cultural context, it is not only just as viable an explanation as “major depressive disorder” is, but it is in fact more so because it has a meaning to middle-easterners that the Western diagnosis just can't touch.

When I say “it's all relative” in the title of this article, I mean exactly that: describing mental illness is relative to the culture that is interpreting that illness. I can't even remove the Western bias that I've grown up with in writing this article. After all, calling mental illness an “illness” at all (or “disorder” or “disease” with “symptoms,” “diagnosis,” and “treatment”) places a psychological phenomenon firmly in the world of biology, medicine, and physical causes of human behaviour. But the medical model is not the only way to interpret a problem. Just like a native language is a shorthand by which people of a nation or culture can communicate with each other easily, so is a locally understood way of talking about psychological problems a kind of shorthand. It's a point of entry for talking about feeling out of sorts within one's self. It's a metaphor a person in that culture knows he or she can use to express distress, initiate discussion, and negotiate help from the family or community. That

metaphor carries a special power because it has instant meaning in the system of understanding the entire community shares.

My use of the word “metaphor” here is not accidental. Anthropologists have identified a culturally-sensitive way of talking about culturally different types of interpretations as “idioms of distress.” “Idiom” is another way of saying a culture-specific metaphor or symbol; “distress” covers the feelings of pain, negative changes, and general “not-feeling-myself”ness. So whether a psychological condition is attributed to the loss of one's soul, the loss of the vital essence of semen, the interference of evil spirits or other supernatural forces, or problems with the heart, the point is that each culture has, in the course of its unique evolution, come up with an interpretive tool its citizens can accept and use with each other to describe what's wrong in the head, heart, and body.

In the wake of all the cultural awareness messages in the '90s, all of this may seem like common sense. But the fact of the matter is the study of psychiatry in the Western world still maintains a strong bias

*“Of all the medical specialties ... psychiatry has the most pervasive relationship to culture. Psychiatry is, to begin with, a window on a culture's sources of distress and on the human consequences of such distress”* —Arthur Kleinman

in favour of finding similarities rather than differences across cultures and of uncovering “universals” in mental disorder. Arthur Kleinman says, “This bias should not surprise us. Much cross-cultural research in psychiatry has been initiated with the desire to demonstrate that psychiatric disorder is like any other disorder and therefore occurs in all societies and can be detected if standardized diagnostic techniques are applied.” Although the biomedical model of North America and Western Europe has been certainly useful in managing a vast number of psychiatric symptoms, it may have been pushed so far as to obscure other models for interpreting similar complaints.

Kleinman and other cultural psychiatrists and medical anthropologists have gone on to argue that too much cross-cultural psychiatric research assumes that cultural differences are a superficial “mask” – a layer that must be peeled away to reveal the real, biological “fact” underlying the disorder. The danger of this bias though is illustrated by the old cliché “in the eyes of a hammer, everything looks like a nail.” In the cross-cultural psychiatry context, this saying warns that even if there are some universal mental disorders, that doesn't mean there are only universal mental disorders with variations only in name. When dealing with human culture, it is



much more complex than that. Biology and environment are too intertwined. A failure to understand this complexity can lead to misdiagnosis and inaccurate research.

For an example of easy misdiagnosis, *taijin kyofusho* is a Japanese phobic reaction associated with fear of others in social situations. A Western psychiatrist unfamiliar with this disorder in its native context might think it must be “just another name” for “social phobia.” However, there is an important difference in Japan that a

## CULTURAL CONTEXT AND DIAGNOSIS

The DSM-IV lists 25 disorders known as culture-specific or culture-bound syndromes, defined as “recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category.” Cultural variations also exist that may affect the assessment and diagnosis of psychopathological conditions. Here are some examples.

### Adjustment disorders

In some cultures, long-term grief and worship may show respect for the deceased.

### Anxiety disorders

Panic disorder. Symptoms resembling panic attacks are common in cultures where members have strong beliefs in witchcraft or evil spirits. In cultures where women have limited access to public life, such as in some Arabic cultures, agoraphobia may be an inappropriate diagnosis.

Obsessive-compulsive disorder. Religious rituals, like those of Egyptian Muslims, may involve excessive praying, washing and ordering of objects.

### Mood disorders

Major depressive disorder. Depression symptoms vary in their expression. In some Asian cultures, depression is expressed as physical ailments rather than as sadness or guilt.

### Personality disorders

Paranoid personality disorder. People who are not familiar with the customs and norms of a society may be more guarded and may seem like they are paranoid when in fact it is a survival adaptation.

Schizophrenia, schizoid and schizotypal personality disorders. Hallucinations and delusions may be normal, for example, the fear of being attacked by evil spirits in Nigerian culture. Different cultures display different levels of defensive behaviours, detachment from social activities and range of emotions. Some religious practices may appear schizotypal, for example, voodoo ceremonies, speaking in tongues, belief in life beyond death, mind reading and magical beliefs associated with health and illness.

Hema Zbogar

Source: *Handbook of Multicultural Mental Health: Assessment and Treatment of Diverse Populations*

treatment approach based on the diagnosis “social phobia” would not recognize. In our individual-centred rather than group-based society, the Western concept of social phobia typically sees a person’s fear and anxiety as being directed towards potential criticism by others. So, for instance, you obsessively worry about your zipper being down because you are worried about being laughed at. But in Japan’s *taijin kyofusho*, the focus is not on the self but rather on the embarrassment the individual does not want to inflict on others. It may be hard for us to understand that a person could worry about making someone else uncomfortable with virtually no thought of one’s own potential embarrassment, but it is just this kind of subtle yet significant nuance that Western psychiatrists need to understand if they hope to serve a multicultural clientele made of such differing worldviews.

In terms of research consequences, poor understanding of the cultural contexts of mental complaints does not bode well for being sensitive to translation in cross-cultural research. For example, “feeling blue” or “feeling down” is a common idiom of distress in the English language and can be useful in diagnosing depression when asked on written tests. However, a straight translation of this conversational phrase would have no meaning in non-Western languages. Only spending time living in other cultures could pinpoint the conversational phrases used to talk about various emotional states.

For another example, Kleinman relates the story of a test translated into Hopi, an American Indian language. The screening test had concepts of guilt, shame, and sinfulness in the same sentence, but the bilingual researchers realized each term had distinctive meaning and had to be separated out into three questions to get an accurate response. The findings would have had little meaning without this realization.

Kleinman notes that attention to culturally meaningful translation can yield amazing findings. For example, a Vietnamese-language depression scale for use with U.S. Vietnamese refugees found “shameful and dishonored” but not “guilt” to be important factors in discriminating depressed from non-depressed Viet-Americans. Further studies of why guilt is less a symptom of depression among Vietnamese than it is for Westerners could yield valuable insights into stigma across cultures which could, in turn, spark further research into cultural conceptions of mental illness.

Culture and ethnicity are part of our personhood. Individuals who are living with a mental illness necessarily come up with their own ideas of what’s going on inside them even before they visit a clinician (if they do at all). And those ideas are often shaped by one’s cultural background and the ways of understanding the world with which one has grown up. Any successful client-centred approaches to therapy have to mesh with the individual’s own worldview. Therefore, the only way to suggest the best courses of treatment action is to understand culture-specific “idioms of distress” as well as the person’s own unique take on those idioms. Only when modern psychiatry can embrace this kind of ethnocultural study for its own sake, not just as a means to proving the universality of mental disorder, do people stop becoming nails to the biased eye of the hammer and start becoming people again. ■

Excerpted with permission from *Visions: BC’s Mental Health Journal*.

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# Cultural competence on the front lines

The need for cultural competence in practice reflects the realities that health care practitioners face every day in their work with clients with mental health and substance use issues. *CrossCurrents* recently asked you to send us your thoughts on how you see culture, specifically, issues of ethnicity and race, manifest in your work. Here's what some of you had to say:

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I have had clients from cultures that do not accept women as therapists or that allow only a therapist of the same sex as the client. It is also important to be aware of religious rituals, for example, those involved in Ramadan, when doing home visits or group therapy.

— addiction therapist, Ottawa, ON

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It is important to be aware of dietary requirements or restrictions related to culture or religion and to respect them, for example, in residential treatment.

— alcohol rehabilitation counsellor, Brookline, Massachusetts

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We have an Aboriginal client who speaks of his interaction with “spirits.” We are treating him for schizophrenia, but we need to respect the strong Aboriginal connection to spirits. We must keep in mind that the goal is to treat the illness not to medicate the client’s cultural beliefs.

— concurrent disorders specialist, Edmonton, AB

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In one-on-one therapy, I am often aware of differences in communication and around boundary issues and self-disclosure. I have a client in whose culture avoiding eye contact is a sign of respect, not detachment or discomfort. I’ve witnessed different levels of comfort with self-disclosure – clients’ comfort with how much both they and I disclose within the therapeutic setting.

— addiction counsellor, Windsor, ON

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I had a client who was a recently widowed older Italian woman. She would only wear black, which is a gesture of respect and grieving. However, I found myself judging her for doing this, to the point of wanting to tell her to try to wear colour for a day. I had to stop myself.

— community mental health nurse, Hamilton, ON

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Racism is an experience we continue to struggle with in our work. We deal with countless cases of youth whose issues have not been properly diagnosed. We recognize the oversight involved in misdiagnosing the psychological impact of experiences of devaluation, dehumanization and loss of the individual’s community.

— social worker, Halifax, NS

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We had a black youth who was a practising Rastafarian. He maintained a scruffy, unkempt look, which when combined with him being a black man, was threatening to some of our white female staff, who had to check their personal biases. This shows how issues of race, culture and gender are intertwined.

— youth outreach worker, Toronto, ON

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Sometimes our agency policies conflict with the cultures of our clients. We have a policy that youth must save a certain percentage of their earnings. This assumes that one’s earnings belong to the worker, which is not true in all cultures. Some youth tell us they cannot save the specified amount because they must send money home to support the family. Clients have been discharged for not complying with policy.

— youth outreach worker, Toronto, ON

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We see kids involved in fire setting. We need to be aware that fire is used in socially and traditionally sanctioned ways in rural Native communities, so recommending that the child not be involved with fire is unrealistic when fire is a way of life. Recommendations have to shift to ways of supervising and training the child to use fire as safely as possible.

— child psychiatrist, Thunder Bay, ON

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I have had to examine how some of the theories informing my clinical practice apply across cultures. For example, I have worked with clients in whose culture it is common practice to “give” children to grandparents to raise for several years as an act of respect. It made no sense to criticize this cultural practice but it did seem helpful to discuss children’s attachment needs.

— mental health counsellor, Hamilton, ON

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Clients who immigrated in their teens or early adulthood may be hit with depression after having postponed grieving the loss of their country of origin. It may occur years later, after they have worked hard to build lives in Canada.

— psychologist, Kitchener, ON

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# “Hopefully in five years we can kiss ourselves goodbye”

## Why we still need ethno-specific mental health services

BY ANNE PTASZNIK

IT ALL STARTED OVER DIM SUM. PSYCHIATRISTS DR. TED LO AND Dr. Peter Chang met with Raymond Chung, a social worker, and several colleagues to discuss how to better meet the mental health needs of Toronto’s Chinese community. They identified two key issues: the lack of language and cultural competency among hospital and other mental health service staff and underutilization of mainstream services by the Chinese population.

It was at this meal that the foundation was laid for what is now the Hong Fook Mental Health Association, an ethnocultural agency serving Toronto’s East and Southeast Asian communities. But while the importance of providing newcomers with linguistically and culturally appropriate services has generally been accepted, the question remains: How can this best be achieved? The founders of Hong Fook opted for a consultation-liaison model, rather than providing direct service, which would involve providing training and support to hospital staff and educating members of East and Southeast Asian communities to use existing resources. The organization would ultimately serve as a bridge to mainstream mental health services. Chung recalls thinking, “Hopefully in five years we can kiss ourselves goodbye.”

That was more than 25 years ago. Hong Fook, which translates as “health and happiness,” has not gone out of business. In fact, celebrating its silver jubilee last year, the agency has grown from a staff of four to more than 50, working in two locations, one in Toronto’s Chinatown and the other in the suburbs. Last year, Hong Fook worked with more than 600 individuals and families.

But is Hong Fook’s rapid growth really the mark of success? Given the founders’ original vision of ensuring that people from diverse cultures would with time be better integrated into mainstream organizations, Hong Fook’s success suggests continuing barriers to accessing mental health services. The story of why Hong Fook has flourished while integration efforts have floundered is a tribute to the strength of the founders, staff and community volunteers involved with the organization; but it also highlights the changes that need to occur in the mental health system, not only locally, but also nationally, if this country is to meet the needs of its diverse population.

When Hong Fook first started, partnerships were formed with four downtown hospitals, with Hong Fook staff there one day per week. It took some time to inform hospital staff about the facilitative

role that these workers could play, but even after their services began to be used, mainstream services never developed the capacity to work independently without the ongoing support of Hong Fook workers, which was the original hope.

Chung, who became Hong Fook’s executive director in 2001, says that for the first 10 years they tried to support people to go to other available services. The frequent complaint, however, was that services had a long enough waiting list without creating services for non-English-speaking clients.

When deinstitutionalization was introduced in the 1980s, community support programs were seen as a necessity. Funds became available to hire case managers, and Hong Fook decided, with much debate, to switch service models. Once it started providing direct service, it was difficult not to continue. For example, the agency started providing its own supportive housing and offered other housing through partnerships. This service grew quickly from three housing units in 2000 to 80 units today. Chung says it would be difficult to transfer the supportive housing program to a provider that does not have the language capabilities or the cultural understanding of Hong Fook staff.

Hong Fook’s growth can be attributed in part to outreach when population numbers indicated a need. In 1984 and 1998, respectively, Hong Fook expanded its services to the Cambodian and Korean communities. Understanding that not all communities see mental health and mental illness from a Western perspective, the agency determines the most culturally appropriate approach. For example, five years ago when a Korean-speaking psychiatrist recommended working with family members because they are major partners in recovery, a meeting was held to provide more information about mental illness. Only two people came out, so Hong Fook took a different tack, including starting a peer leadership program. Now more than 20 family members meet once per month for mutual support.

Success has posed a dilemma. Whenever mainstream organizations have a Chinese-speaking client, their reaction is, “There’s Hong Fook, ship them out, it’s their responsibility,” says Chung. Some consumers and family members tell Chung they don’t want to go to mainstream agencies; they feel comfortable at Hong Fook, where they can see people from their own culture, speak their own language and

eat their own food. Chung, who still philosophically supports integration, asks, “So what do we do? Listen to our consumers and communities or look at pushing the system to integrate?”

Chung insists that there could be choice. He is frequently asked how integration can be achieved with so many different ethnocultural communities and limited health care dollars. He recommends using a population health-based approach to see whether the diverse communities are getting their fair share of the resources in particular areas. If not, he recommends redirecting some funding toward that community’s needs and slowly, over time, the inequities would be addressed. “Diversity is not built in one day,” he says, “but we need to take that kind of action.” While this may slightly increase the waiting list for mainstream agencies’ current clients, it would ensure more access for members of marginalized communities.

Lo agrees that there needs to be better planning, starting with a national mental health strategy. He was recently invited to participate on the Canadian Mental Health Commission’s Service Systems Committee and hopes that ultimately there may be some change stemming from those discussions. Lo says that while Toronto is behind in serving the needs of its 180 language groups, Canada is one of many countries worldwide grappling with this issue.

Lo says there also needs to be planning both by provincial health ministries and the planning and funding bodies, which varies from province to province. In Ontario, the new Local Health Integration Networks (LHINs) present opportunities for more integrated planning but they also introduce challenges, as in Toronto alone there are five LHINs to work with to address this issue.

Lo spent two years working with the Toronto–Peel Mental Health Reform Implementation Task Force, co-chairing a committee that recommended setting up a system responsiveness office within the proposed mental health organizing body. While he believes “watchdog” was too strong a word, he saw this office as having the potential to ensure accessibility to cultural and other marginalized groups. But this report was shelved and the recommendations never implemented. Without planning, these groups do not have lobbying power and become one of many vying for services.

When the Hong Fook founders submitted their proposal for the agency, funders asked, “If we give you Chinese and Vietnamese funding, what about the 56 groups that are lined up at our door tomorrow that will ask for money?” And yet, other than Across Boundaries, an ethnocultural mental health service that takes an anti-racist approach, Toronto has, after 25 years, no other ethnocultural-specific mental health services. While not every community has the leadership, resources and size of population to develop its own resources, Lo believes that those who do should be given support to develop these much-needed services.

Lo also sees changes needed at the organizational level. Staff do not only need to reflect the populations served, which some organizations have made some headway in doing; organizations need to ask, “Does it filter down to how the institution is relating to the other community?” For example, is there signage in other languages and are programs addressing a concrete need?

Lo has not given up on cultural consultation as a way to help treatment teams consider cultural factors and resources in addressing the needs of multiple groups. He says this goes beyond language, although he does encourage the use of cultural interpreters. While some organizations bring in interpreters for psychiatric assessments,

they need to think more broadly from a cultural perspective. For example, if a client is new to Canada and does not know the city, is a staff member sent out with her on a pass to buy clothes or food?

Finally, there needs to be a long-term strategy for training and development in school curricula rather than just having a few elective courses in diversity. Lo and some of his colleagues are currently working with psychiatry residents to provide this knowledge throughout their training.

As for the future, ensuring that mental health services become more accessible for diverse newcomers remains a priority for Hong Fook. It would like to share its experience and knowledge more with members of other ethnocultural groups. The agency has also begun to educate settlement workers about mental illness in the hopes that there can be earlier intervention. Another focus is broadening the concept of mental health and wellness. Lo says that diverse cultural groups can bring ideas and practices from all over the world that can enrich the mental health system.

Whether the mental health system will implement the changes necessary to become more accessible to diverse ethnocultural communities over the next 25 years remains to be seen, but it is likely that Hong Fook will be there, leading the way. ■

#### A SNAPSHOT OF DIVERSITY

Chinese Canadians constitute the country’s largest visible minority group. The Chinese languages are Canada’s third most common mother tongue group, behind English and French. In 2006, about 1,034,000 people or 3.3% of the population reported one of the Chinese languages as their mother tongue. This was an increase of 18.5% from 2001.

In Ontario, in 2006, nearly half a million people reported one of the Chinese languages as their mother tongue, representing 4.1% of Ontario’s population, up from 3.7% in 2001.

Among the visible minority groups projected to grow fastest between now and 2017 are Koreans, whose population is expected to more than double.

About 410,900 Chinese and 45,300 Vietnamese speakers live in Toronto. By 2017, more than 1 million people in Toronto will be South Asians and more than 735,000 of these will be Chinese. More than half of Canada’s South Asians and about 40% of Canada’s Chinese will live in Toronto in 2017.

The majority of the population in Vancouver will be visible minorities in 2017. Nearly one-half of these will be Chinese.

Source: Statistics Canada



Hong Fook co-founders Dr. Ted Lo and Raymond Chung

Liza Yip

# More than words

## Health care interpreters play key role in quality care

BY KIM GOGGINS

IT'S 2 A.M. WHEN A MAN WALKS INTO A B.C. EMERGENCY DEPARTMENT. The Ethiopian man is obviously distraught and his hands are covered in blood. He is speaking so fast in broken English and Amharic that no one can understand him. After the physician treats the serious knife wounds to the man's hands and witnesses what he perceives to be the man's fear of whomever assaulted him, he makes arrangements to report the crime to police. If an interpreter had been called, the doctor would have learned that the wounds were self-inflicted and arranged for the man to see a psychiatrist through this crisis.



Meanwhile, at a mental health clinic in Ontario, another misunderstanding is created, as a young girl struggles to interpret the ramblings of her Cantonese-speaking mother, whose rants jump from one topic to another. Rather than repeat what her mother is saying to the psychiatrist, the daughter paraphrases what she believes to be the important information, in the process leaving out details imperative to making an accurate diagnosis.

These two composite scenarios are examples of what can happen without a qualified mental health interpreter. What is surprising is that given Canada's multilingual character, these sorts of situations still happen. According to the 2006 census, 41 per cent of newcomers to Canada speak neither official language. In Toronto, 46 per cent of residents report a mother tongue that is neither French nor English, and the city has the highest proportion of foreign-born residents of any city in the world, with more than 100,000 newcomers arriving each year.

As the country becomes increasingly multilingual, advocates insist that the need for properly trained interpreters is not a special request but a basic need, which requires policy recognition. Unlike the case in the United States, no nationally established policies to oversee the profession exist, says Axelle Janczur, president of the Healthcare Interpretation Network (HIN) and director of Access Alliance Multicultural Community Health Centre in Toronto. "There are still no generally agreed upon standards across the various sectors and that's something we've been advocating for and talking about for some time," she says.

Suzanne Barclay, director of the Provincial Language Service (PLS) within the Provincial Health Services Authority of British Columbia (PHSA), says there are still times when health care workers do not use the services of an interpreter. "It happens even in areas where a system is in place. Sometimes it may be a timing issue; sometimes it could be related to the perceived cost; or a health care professional may not know the process to request an interpreter," she explains, adding that educating clinicians on the importance of using interpreters is a goal of the PLS.

Placing interpretation services at the forefront of care is crucial because research shows that language barriers reduce access to care and combined with ineffective interpretation can greatly affect the health and well-being of clients, due to misdiagnosis, incorrect treatment and wrong referrals.

In mental health, where diagnosis relies heavily on words, the importance of properly trained interpreters is crucial, says Dr. Jose Silveira, a psychiatrist and clinical director of Portuguese Mental Health and Addiction Services at Toronto Western Hospital. "It is absolutely critical that patients be treated in their own language," says Silveira. "Currently, we do not have any objective tools that help us to confirm or refute a hypothesis we have about what somebody is experiencing, so we are completely dependent on the patient being able to convey their internal world to us. The vehicle through which that happens is language."

More than just translating words, skilled interpreters serve as cultural brokers, conveying subtle nuances and explaining cultural customs, says Stella Rahman, co-ordinator of Cultural Interpretation Services at the Centre for Addiction and Mental Health (CAMH) in Toronto. She says interpreters' perspectives on mental illness and addiction are just as important as language skills because they may affect the way they interpret.

But the availability of interpreter services alone does not guarantee high-quality client care. Health care practitioners need to be

### 10 TIPS FOR WORKING WITHOUT AN INTERPRETER

- 1 Speak slowly, not loudly.
- 2 Face the person and use non-verbal communication.
- 3 Avoid difficult and uncommon words.
- 4 Be aware of frequently misunderstood words.
- 5 Don't complicate communication.
- 6 Organize what you say for easy access.
- 7 Repeat when you have not been understood.
- 8 Rephrase and summarize often.
- 9 Don't ask questions that can be answered with a "Yes" or "No."
- 10 Greet the client in the client's own language to establish a rapport.

Source: *The Healthcare Professional's Guide to Clinical Cultural Competence*, ed., Rani Srivastava, 2007, Elsevier Canada

trained to work with interpreters. “It’s one thing to have a tool available to you; it’s another thing to know how to use it,” says Silveira. “Many health care providers have no idea how to use an interpreter.”

Rahman has personally interviewed each of the more than 130 freelance interpreters on her roster. Since the service was created in 2001, she has seen requests for service increase from 12 per month to more than 200 per month in 2007. Rahman’s interpreters need to prove they have completed competency exams in English as well as the targeted languages they would like to interpret, through the Interpreter Language Interpretation Skills Assessment Test, the Cultural Interpreter Language Interpretation Skills Assessment Test or those offered by the Ministry of the Attorney General and the Immigration Refugee Board.

Marie Serdynska, co-ordinator of the Multiculturalism Program at Montreal Children’s Hospital, has also seen a steady increase in requests from clinicians at the hospital, reporting 7,686 interpretations within the hospital’s most recent fiscal year, a 14 per cent increase over the previous year, and a 30 per cent increase in the last three years. In existence for two decades, the program has a bank of about 35 trained interpreters, but like Rahman, Serdynska will use an outside agency if needed.

In Toronto, Montreal and Vancouver – where almost two-thirds of the country’s immigrant population resides – interpreter services are in place, but standards vary across institutions, ranging from ad hoc interpreters to trained professionals who specialize in medical and mental health interpreting. British Columbia has a long history of community organizations providing interpreter services. In 1994, the province established health care interpreting standards. In 2003, it added a province-wide interpreter service through the PLS that has 400 interpreters – including 75 trained in mental health – within the PHSA and responds to more than 20,000 requests annually. The PHSA’s language access policy specifies that when a communication

barrier exists between health care provider and client, a professional interpreter or language support should be called in.

“The PLS has been set up to meet the language service needs of the health system,” notes Barclay. “But not all health authorities are using our services. There is still work to be done to ensure that the five provincial health authorities implement a co-ordinated response rather than an ad hoc response.”

Throughout Canada, several colleges, including Vancouver Community College and Seneca and Niagara colleges in Ontario, offer language interpreter training certificate programs that cover such topics as ethics, cultural sensitivity and standards of practice. In Montreal, talks are underway between Dawson College and health care providers to offer a certificate program this autumn.

While there has been a patchwork approach to policies and standards throughout Canada, the National Standard Guide for Community Interpreting Services, released in November 2007, offers a framework on which to build the standards of spoken language interpreters, providing clear definitions of the competencies and skills required to ensure a consistent service. Creators of the guide, which include HIN, Critical Link Canada, the Language Industry Association and the Association of Canadian Corporations in Translation and Interpretation, see it as the first step towards the establishment of standards and accreditation of community interpreters in Canada.

Still, federal funding is needed for implementation, says Barclay. “Every group is trying to do that by cobbling little bits of funding together, but we do not have any national sources of funding that could really help us,” she says, adding that the federal Primary Health-care Transition Fund that gave provinces and territories some money to introduce new approaches to health care delivery between 2000 and 2006 has dried up. The fact remains that interpreters need to become as integral a part of the health care system as diversity is a part of Canadian society. ■

## INTERPRETING IN ACTION: TIPS FOR WORKING WITH INTERPRETERS

### During the pre-session:

- introduce yourself and briefly get to know the interpreter;
- identify the objectives of the interview, topics to be covered and time available;
- provide a brief summary of the client;
- ask the interpreter if he or she has any cautions, concerns or issues regarding this client or the situation;
- remind the interpreter to interpret everything using the first person;
- ask the interpreter to share his or her cultural insights with you as the health care provider, but to differentiate these from the interpretation itself;
- reinforce confidentiality.

### During the interpretation session:

- face the client directly;
- always speak in the first person as if talking directly to the client;
- introduce yourself and the interpreter to the client or clients;
- describe your role and the purpose of the session;
- speak slowly, clearly and directly to the client, not to the interpreter;
- while the interpreter is speaking, observe the client’s non-verbal communication;
- verify interpretations of any non-verbal behaviour (“I notice you are tapping your foot – is this something you do when you are nervous, or is there something else ...?”);
- use simple language and short, straightforward sentences.
- be patient; remember that the interpreter may require much more time to interpret something than you needed when you spoke in English;
- ask open-ended questions as needed to clarify what the client says or to hear what the client may wish to convey;
- observe and evaluate what is going on before interrupting the interpreter;
- always ask that the client repeat instructions.
- provide written information (preferably in the client’s language) for instructions, appointments and contact information;
- provide information as to how the client may access an interpreter (preferably the same interpreter) in the future.

Source: *The Healthcare Professional’s Guide to Clinical Cultural Competence*, ed., Rani Srivastava, 2007, Elsevier Canada

# Challenging borders and barriers

## Cultural competence must embrace anti-oppression frameworks

BY AVRIL ROBERTS

There is an ever increasing body of research linking racism and mental health problems. “Racism has many different impacts on people’s health,” says Dr. Kwame McKenzie, senior scientist in the Social Equity and Health Section at the Centre for Addiction and Mental Health (CAMH) in Toronto. “It is linked to factors such as poverty that increase the risk of developing illness. Some consider racist attack and abuse to directly lead to health problems.”

Add to that micro-aggressions, the kinds of incidents described in a 2005 study of the strategies black Caribbean students attending Montreal community colleges use to achieve academic success: “I was with a group in the metro and we were waiting for someone who was going to meet us there,” recounted one student. “Automatically it was assumed that we were troublemakers and we were told to leave.” Repeated experiences grind people down: “It eats you up morally,” reported another student. “It’s very hard to get through.”

“The students felt that systemic racism is an issue and that they have to use the anger that is engendered by racism as a motivation to succeed,” says Dr. Myrna Lashley, lead author of the study and a psychology professor at John Abbott College in Montreal. “We are creating a generation of very angry young people.” In her private practice where she does psychological assessments for the courts and social services, Lashley deals with these young people. “I notice that

quite a few have mental health difficulties. They have social issues that make them feel they don’t belong.”

Lashley says that clinicians must consider broader social issues when working with such clients. “Society, not just clinicians, has been unable to accept what systemic discrimination does to people. It changes how you view the world and yourself. It attacks your self-esteem and makes you more cautious.”

This systemic discrimination is often mirrored in the mental health system, which may not acknowledge racism, discrimination and

oppression and their impact on mental health. “Some institutions welcome this discourse, but others forbid it,” says Dr. Jaswant Guzder, head of child psychiatry at Jewish General Hospital in Montreal.

Guzder says that mental health and addiction clients often have to contend with “a collusion of professional blind spots, beginning with our institutional stance that is unwelcoming or that denies cultural axis issues. If an institution doesn’t facilitate the building of a therapeutic alliance that takes into account both a person’s experiential cultural map and previous racism encounters, this clinical setting is taking an approach that reflects either overt racism or an implicit racism related to ignorance, lack of acknowledgement or sheer oversight, a situation that constitutes institutional racism,” she says.

Related challenges include:

**Limited access to language interpretation services.** “These services are considered a luxury, not a necessity,” says Guzder. Too often, non-professional staff are enlisted to provide on-the-spot interpretation, setting the stage for misinterpretation, misdiagnoses and mismanagement of mental health issues.

**Cultural misinterpretation.** For example, there is a generalization that people from some ethnocultural backgrounds are non-verbal or somatizers and are therefore unsuited to psychotherapy, when, in fact, they may come from cultures where direct confrontation or disclosure of feelings is discouraged.

**Clinician neutrality.** Or, as Guzder calls it, the “delusion of neutrality – the notion that we, in the healing professions, are so neutral that we view all human suffering in the same way and don’t bring prejudices of our own.”

**Inadequate training.** Do health care education and training discuss the fact that ethnicity might make a difference to health-seeking and care? Is social exclusion as a determinant of health examined?

**Over-reliance on Eurocentric therapies and models of care.** Adherence to limited notions of health and wellness fails to consider more culturally appropriate types of care.

**Emphasis on evidence-based practice.** “If we decide we want to use this mantra, then if services are going to be equitable, the evidence needs to be equitable,” says McKenzie. “There are two problems with this. One is that we need more information and research on different ethnocultural groups. The second is that we may need new methodologies that allow us to make sense of the data we get from research on small ethnocultural groups. At the moment, our system of care is built on knowledge that is mainly monocultural. This is unlikely to meet the needs of a multicultural population.”

**Scarcity of funding for ethnoracial services.** “Mainstream money feeds into mainstream organizations for care, but for the groups that have the highest need, money is often diverted into community organizations that mean well but that may be less able to offer comprehensive care,” says McKenzie.



Factoring in the structures, philosophies and impacts of the organizations that intersect with the mental health system such as schools, child welfare services, settlement agencies, police and the criminal justice system, it becomes glaringly evident that cultural competence must expand beyond its traditional focus on individual clinical competence.

“If we want to be serious about producing non-discriminatory, balanced services, we must take a systemic approach,” says McKenzie. “We must be advocates. We have to put money into the right places, think of the big picture and unfreeze services so they can be innovative and fast-moving to adapt to the needs of cultural communities.”

McKenzie is optimistic that Canada can be a leader in delivering equitable care: “There is a chance for Canada to develop service models that could be the envy of the world because there is so much diversity here and it is a relatively new country. However, this means challenging old ways of thinking and people will have to start thinking differently.”



One service model that pushes the traditional boundaries of cultural competence and puts systemic issues of racism and oppression at the centre of care operates through Across Boundaries, an ethnoracial community mental health centre in Toronto. The agency opened its doors in 1995, as the only community mental health agency in Ontario, possibly in Canada, to build its foundation on an anti-racism, anti-oppression approach that drives the organizational structure, hiring, training and education and service delivery.

Walk into the agency and you will notice that everyone – staff and clients – is a person of colour. If you are a current or prospective client you will be invited to sit in the open area or, if you like, in a separate room. The program co-ordinator will come out and greet you, introduce you to everyone and offer you coffee while you wait to attend your program or interview. While you sit there, you may notice that some of the artwork on the walls reflects systemic issues like racism.

“Mental health already has too much stigma,” says Sulekha Jama, who has worked on the agency’s front lines. “When you come into a place where everybody looks like you, where you don’t know who is staff and who is client until they introduce themselves, that helps a lot. We also name racism. The minute you name it, it opens the door for people to actually talk about it. It’s a comfort for people when they come through the door, knowing that they can just be who they are. That’s what they tell us.”

All of the clients in Across Boundaries’ programs are people of colour with severe mental illness. During the intake process, if a client mentions experiencing racism, the case worker assigned to the client at the first meeting asks if the client would like to talk about it. If the client hasn’t raised any race issues, the case worker explains that Across Boundaries operates from an anti-racism framework and is open to discussing related issues whenever the client would like.

According to Jama, immigration is a major topic. “Clients talk about what they went through at the airport when they claimed refugee status, being separated from the other passengers, being searched, having customs officers make fun of them, laughing at them because of their English,” she says. “We’re able to tell them that

other people have gone through the same thing. They are relieved to find out it’s not just them. It gives people the sense that this is a place where they can talk about it.” So many clients from Afghanistan, Iran and Iraq have had such humiliating or traumatic experience that they have formed a support group facilitated by a case manager who speaks Persian. The group of about 14 people has been meeting weekly for the past five years.

A Tamil support group that started shortly after the tsunami hit Sri Lanka in 2004 is still going strong under the direction of a Tamil-speaking staff member. About 16 people meet weekly in Scarborough, an area of eastern Toronto that is home to more than 7,000 Tamils who fled Sri Lanka’s civil war.

At the Jane-Finch Mall, in the heart of a diverse neighbourhood in northwestern Toronto facing many social issues, youth aged 16 and older in the Y-Connect program drop in for two hours every Tuesday evening for Real Talk, a freewheeling session where they meet with two youth workers and chat about what is going on in their lives.

Across Boundaries provides space for two psychiatrists to offer services on site – one is the only Somali psychiatrist licensed to practice in Ontario. A doctor of traditional Chinese medicine offers acupuncture at the mental health centre once a week and a doctor of Ayurvedic medicine (a medical system from India) visits once a month.

The agency’s staff have completed formal and informal anti-racism training that informs their attitudes and behaviours with clients. Many have deep roots and connections in the cultural communities they serve, so their awareness of cultural beliefs and practices helps them advocate on their clients’ behalf when dealing with mainstream agencies, for example, helping a depressed Somali mother find community day care for her four rambunctious preschoolers so that as a single mother with a mental illness she would not get caught up in the Children’s Aid system.

Beyond clinical care, Across Boundaries conducts community-based research about pressing issues such as the experience of trauma from war, abuse or migration and its impact on mental health.

Martha Ocampo, co-director and one of the founders of Across Boundaries, says, “The whole idea behind Across Boundaries was to develop a model, have the mental health system look at our model and see how effective it is, then use it to appropriately serve a very large population so that at some point we would disappear.”

But Across Boundaries has not disappeared. Far from it. The agency served 480 clients in 2007 and still seems to be unique in its approach to mental health services. “Perhaps some organizations are not ready yet to operate in an anti-oppression framework,” says Ocampo. “If they haven’t had the anti-racism education and training, people don’t understand why there is a need for a paradigm shift or a change in the way they have been doing business. It is important that organizations go through a process of organizational change, starting with governance.”

Ocampo raises these key questions: Who is governing the organization? What needs to change? What kind of policies have to be developed? How will the policies be implemented? What programs or services will be appropriate for people coming into the programs? What kind of outreach can you offer? Who needs the help most? Who are your partners? With these questions in mind, mental health and addiction agencies can begin to work toward developing models of cultural competence that recognize systemic issues like racism and oppression. ■

# Spirit or scalpel

## Partnering western medicine with faith communities to bring healing

BY KIM GOGGINS

**T**HE BABY WAS CONCEIVED DURING A brutal rape, and his young Congolese mother, a Christian, kept her shame locked within her war-torn community. Both are now in Canada, where the mother is receiving mental health services to help her deal with the trauma. It is also through the mental health agency that her son's baptism is arranged – a ritual that will provide the opportunity for mother and child to bond and begin to heal.

“In the case of African Christians, child baptism is like a second birth ... making it a child of God,” says child psychiatrist Dr. Cecile Rousseau, a professor in the Division of Social and Cultural Psychiatry at McGill University in Montreal. “I remember a mother who wanted to rename her troubled son Jacob to reflect the struggle between Jacob and the angel in the Old Testament. In a way, she saw her boy as a wounded child but understanding this as God's will helped her to face it. The baptism was very important for her to establish a bond with her son.”

Incorporating a client's faith tradition, such as this baptism, into mainstream mental health services can play an important role in treatment and recovery, says Rousseau. Religion and spirituality affect one's worldview. They shape how we understand and explain illness. People from cultures that turn to traditional healers such as shamans or other faith healers may distrust and reject the beliefs and practices of mainstream western medicine.

Religious rituals played an important role in the treatment of illness

throughout the centuries, but the growing role of science in healing virtually severed the link. “If we look back to how the healing process started, in western medicine and non-western medicine, the healer, the physician, the pharmacist was someone with spiritual involvement, regardless of the culture,” says psychiatrist Dr. Soma Ganesan, medical director of the Department of Psychiatry at Vancouver General Hospital and University of British Columbia Hospital.

Ganesan says that rather than complicating mental health care, a client's faith or spirituality can play a critical role in care. “Science cannot provide the whole answer,” he says. “People always turn to other things – what they feel comfortable with, their philosophy of life.”

Disregarding a client's religious or spiritual beliefs can lead to miscommunication, misdiagnosis and inappropriate care. Dr. Eric Jarvis, director of the Cultural Consultation Service at Montreal's Jewish General Hospital, says that clients who have a religious way of speaking and understanding the world, for example, speaking with God, may be misdiagnosed with a psychotic disorder.

At the Jewish General Hospital, faith and spirituality and traditional therapies may be integral parts of treatment. “We don't believe that because something is culturally acceptable it cannot be harmful or is necessarily helpful, but we try to understand it,” says Jarvis. “We would invite a member of that community or the healer to a session to better understand what is going on.”

Although science has weakened the link between faith and healing, psychiatry, more than other medical specialties, recognizes the importance of religion and spirituality. A recent U.S. survey published in the *American Journal of Psychiatry* found that although psychiatrists are less religious than other physicians, 90 per cent agreed that it is appropriate to ask clients about their religious faith or spirituality, compared to only 53 per cent of other doctors.

Mental health services are beginning to acknowledge that faith practices can help, not hinder, treatment. Spirituality and religion are engrained in the model of care at

the Centre for Addiction and Mental Health in Toronto, says Michael Taylor, manager of Spiritual and Religious Care Services. “When people are here for the first time, it may be very difficult for them and sometimes faith or faith practices are important,” says Taylor, who received more than 4,000 requests for services last year. “Prayer, reading a sacred text or speaking to someone of a similar faith community may help.”

This belief is reflected at Vancouver General Hospital and the University of British Columbia Hospital, which have 24-hour on-call pastoral care, as well as a cross-cultural psychiatry outpatient clinic. Ganesan says that a decade ago, medical staff reacted negatively when a spiritual practitioner was requested, but now, clinicians have a list of faith specialists to draw from and they even seek their feedback.

“We had a psychotic patient who wanted to see a Buddhist priest,” recalls Ganesan. “A Buddhist monk was brought in and after a session with the client and family, the monk invited us to join. His message to the client was very clear: ‘Spirituality is one part, but you are now sick; you need treatment; you have to listen to your doctor.’ That was a positive experience,” says Ganesan.

Connecting the beliefs of ethnoracial minorities with western models of care can help clients make sense of their illness and provide comfort; yet some clients may be hesitant to discuss their faith. Rev. Grace McBride, director of Spiritual and Religious Care at the Royal Ottawa Healthcare Group, says that it is important to be aware of the attitudes and issues around mental health within the client's culture and to ensure that it is acceptable to bring in someone from a religious community.

“If the community believes that the client is possessed by devils or spirits or that this is punishment for some wrong, people will not reach out for help because of the fear of being shamed,” says McBride. “The most important thing is to respect the differences, to be aware and to ask. The role of the multi-faith chaplain is to be the bridge between community beliefs and the institutional realities; you can only do that by listening.” ■

## Family responses to alcohol problems

*Familial Responses to Alcohol Problems* presents a collection of articles that review knowledge and approaches to addiction treatment and prevention across the lifespan and address other issues related to family coping and functioning. The first set of articles focuses on children, youth and older adults; the second set looks at family systems, with a focus on couples and family response and the last two articles examine co-morbidity and spirituality within a family context. The book includes perspectives from several different treatment and prevention approaches.

The first article reviews the findings of the first 12 years of the Michigan Longitudinal Study, which provides interesting insights into risk factors for the development of alcohol problems in children. The breadth of data is impressive and allows the authors to generate some ideas about identifying children at risk and developing prevention measures. “Family Response to Adolescence, Youth and Alcohol” looks at the efficacy of family intervention for youth substance abuse and reviews three models of family treatment. Multi-systemic therapy and brief strategic family therapy are older models, while multi-dimensional family therapy is somewhat newer. All three models are described as effective but the article does not really address differences or drawbacks. The

article about older adults provides a good summary of the difficulties in identifying and treating alcohol abuse in this population and discusses a family approach to this challenging problem.

The second section of the book focuses on family responses to addiction. The first article looks at the ARISE (A Relational Intervention Sequence for Engagement) model for helping family members get a loved one into substance use treatment. The model is linked to motivational approaches and is embedded in the stages of change concept. The subsequent articles are more associated with traditional 12-step treatment models. “Family Response to Adults and Alcohol” looks at augmenting individual treatment with the couples reciprocal development approach to improve outcomes and family functioning. Another article presents concrete tools and exercises to help family members cope with the different stages of recovery and may be useful to abstinence-based therapists.

The last two articles focus on different issues. “Treatment of Comorbidity in Families” describes common concurrent mental health and addiction problems and ideas around treatment approaches. The author notes that attention to family, children in particular, can help to promote better treatment outcomes in co-morbid

situations and may have a preventative effect for the children. The final article examines ways to incorporate spirituality into the family context as part of recovery. The article is broad and inclusive in defining spirituality, embracing family ritual, meditation and community service, as well as prayer and religious affiliation. It is refreshing to see a topic that is often examined only in individual terms addressed at a family level, and that is seen as a potentially beneficial force for all family members, including the substance user.

The editors fall short of their goal to provide “state of the art endeavors” in this book; most of the articles focus on fairly established approaches, and the references are mainly from the 1990s and earlier. However, although there may be more recent developments in the area of family approaches to addiction, this book provides a thoughtfully chosen overview and a good introduction to the idea of family intervention.

*Familial Responses to Alcohol Problems.* Judith L. Fischer, Miriam Mulsow and Alan W. Korinek, eds. Haworth Press, New York, 2007, 179 pp., \$25US.

**Joanne Shenfeld** is the service manager of Family and Youth Addiction Services at the Centre for Addiction and Mental Health in Toronto.

d o w n l o a d e d

SHEILA LACROIX

## Tools for inclusive health promotion

Here are some web-based tools and guides to assist you in tailoring health messages and programs for ethnically diverse communities.

### **Culture Counts** (CAMH) [www.camh.net](http://www.camh.net)

Visit the CAMH website for a look at the **Culture Counts** resources. See the Project Background and Description page for links to the various resources, including the full text of the best practices manual *Culture Counts: A Roadmap to Health Promotion*. The strategies in the manual, such as “work with community partners” and “translate and adapt” emerged from earlier work, studying readiness and needs of seven ethnocultural communities. As a part of the **Culture Counts** initiative, culturally sensitive public information materials relating to alcohol, identified as a need within the communities, have been developed or adapted from existing resources (see links). This process will undoubtedly continue to encompass other drug and mental health-related issues.

### **Count Me In!** (OPC) [www.opc.on.ca](http://www.opc.on.ca)

The Ontario Prevention Clearinghouse (OPC) offers *Count Me In! Tools for an Inclusive Ontario*, published in 2005 and funded by the Public Health Agency of Canada and the Laidlaw Foundation. It supports a project called *Developing a Social and Economic Inclusion Toolkit for Ontario Communities*. A practical workbook enables you to work through a framework based on four basic questions: Who? (your group and specific factors that influence your group); What? (determinants of health); Where? (ways to measure belonging) and How? (strategies and targets to promote inclusion). Examples are provided that clarify the process. There is a web site specifically for this program, [www.count-me-in.ca](http://www.count-me-in.ca), which has links to additional resources and information about forums on inclusion and engagement.

## Should Aboriginal healing practices be integrated into conventional medical care?

BY CLIFFORD CARDINAL

There is a longstanding debate within Aboriginal health circles about whether traditional healing and conventional medical approaches should be integrated to provide better care for Aboriginal clients. Some argue that integration would lead to the appropriation of traditional healing practices by the very society that has oppressed Aboriginal peoples for centuries. As a traditional Cree healer on the medical school faculty at the University of Alberta, I argue that conventional medicine has much to learn from traditional healing practices and that these practices should be shared. If traditional knowledge and wisdom are to remain intact and alive, our people must open their doors to dialogue about practices that historically have not been documented.

The argument that access to traditional knowledge, for example, around healing practices, should be restricted to Aboriginal people, overlooks the fact that people may know about healing knowledge but that they are not necessarily holders of healing knowledge. The keepers of traditional healing knowledge have more than knowledge. They are well known within our communities and exemplify an unusual capacity for humility.

Knowledge serves no one if it is not used. Healing ceremonies are meaningless if there is no need for healing. But we know that mortality and morbidity rates remain high among Aboriginal people. Aboriginal people need physicians who are trained as healers of their own kind to document what little is left of the sacred health knowledge and to carry that knowledge into the future.

We need this knowledge in order to practice medicine appropriately. But what are the conditions for sharing? Should an elder provide a CV to document his or her qualifications? Or do we engage with them on their own terms and in their own territory? Our knowledge keepers have not felt the urgency of documenting their knowledge because they have focused on living it, not on professing it.

Much academic writing has been done by our people, written with the hope that the purity of the ideas of traditional knowledge will be respected. It may be difficult to understand this writing as a unified body of thought, perhaps because it is difficult to express knowledge and wisdom that have been preserved and perpetuated through centuries of oral cultural tradition. A wealth of ideas comes from academic theories, disciplines and representations of aboriginal ways of thinking. The disciplines have their own protocols. Traditional medical knowledge also has its own exclusive protocols. How do we navigate through academic and traditional inquiry, respecting all the appropriate protocols?

When knowledge is documented or shared by a trusted teacher, it is believed to be entrusted to people with moral fibre who will use it to enrich their lives and those of people around them. Consider, for example, the pipe ceremony. Each ceremony is adapted to the needs of its participants, but the central message remains unchanged. Through the permission of the conductor of the ceremony, others in the circle can learn these ways provided they are willing to walk the road. Many of our youth are interested, but have no teachers in their communities. The scope of the knowledge specific to the pipe ceremony is their inherent right by way of their belonging in the circle. As circles create other circles the scope widens and the act reverberates, just as a pebble thrown into a pool of water causes ripples and waves outwards.

Knowledge must be used daily to survive. To restrict or inhibit the practice of traditional knowledge is like an old man who never shares his knowledge, dying with what was given to him.

Recently, several practising healers asked me about preserving the traditional medicine recipes they had collected over their lifetimes. I suggested that the recipes be documented through modern means, for example, by using pictures of plants and written instructions for making herbal medicine. The healers were unsettled by this suggestion. At a

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sweat ceremony one month later, the same healers declared, "It is about time this happened." The spokesman of the group would never see this transpire because he died soon after, never having shared his "recipe book." In fact, the morning of his passing one of his relatives asked me whether he had shared any of his medicine recipes with me.

Knowledge of traditional healing practices is best shared by someone with a history in healing, rather than by someone who has objectified it, compared it and analyzed it purely from an academic perspective. The past has shown us that force and coercion have stripped us of our identity; this is the opportunity to practise what we do in an appropriate context.

At the university, it is a pleasure to see a medical student ready to receive his first pipe, blessed by healers. I am proud to see a first-year medical student participating in a healing event with traditional teachers, and to hear her say, "This will affect the way I practise."

The need for our young healers in medicine to know traditional medicine is great. How can we tell them to learn two systems of healing skills in separate "culturally appropriate" venues? The hope lies in developing collaborative relationships between traditional healers and conventional health providers. Learning healing knowledge in two viable traditions, blessed by elders in medical school, is the solid cultural practice of learning the appropriate things in the appropriate place. It may be a hard road to walk but our medical students have started on this journey.



**Clifford Cardinal** is a traditional Cree healer and an assistant professor in the Department of Family Medicine at the University of Alberta.

## CANADA

### 3rd National Biennial Conference on Adolescents and Adults with Fetal Alcohol Spectrum Disorder

April 10–12, Vancouver, British Columbia  
toll-free tel 1 877 328-7744  
fax 604 822-4835  
www.interprofessional.ubc.ca

### American Society of Addiction Medicine 39th Annual Medical-Scientific Conference

April 10–13, Toronto, Ontario  
Contact: ASAM, 4601 N. Park Ave., Upper Arcade, Ste.101, Chevy Chase, MD 20815 USA  
tel 301 656-3920  
fax 301 656 3815  
e-mail email@asam.org  
www.asam.org/AnnualMeeting.html

### Centre for Health Evaluation and Outcome Sciences Conference: "Cracked But Not Broken – Shaping New Knowledge into Treatment for Amphetamine and Crack Dependent Youths"

April 18–20, Vancouver, British Columbia  
Contact: St. Paul's Hospital, 620B – 1081 Burrard St., Vancouver, BC V6Z 1Y6  
tel 604 806 8678  
fax 604 806 8674  
e-mail cheos@cheos.ubc.ca  
www.cheos.ubc.ca/news/conference-april18-20.html

### The Human Condition Series 2nd Annual International Multidisciplinary Conference: "Terror"

May 2–3, Barrie, Ontario  
e-mail humanconditionseries@gmail.com  
http://humancondition.wordpress.com/call-for-papers-terror-2008

### World Psychiatric Association Section of Epidemiology and Public Health Meeting: "From Epidemiology Toward Mental Health Planning"

May 11–14, Saskatoon, Saskatchewan  
tel 306 966-1840  
e-mail karen.mosier@usask.ca  
http://medicine.usask.ca/psychiatry/wpa2008

### 2008 National Conference on Collaborative Mental Health Care

May 15–17, Victoria, British Columbia  
e-mail CollabMHCCConf@viha.ca  
www.shared-care.ca

### 2008 World Congress for Psychiatric Nurses

May 22–24, Regina, Saskatchewan  
Contact: Registered Psychiatric Nurses' Association of Saskatchewan, 2055 Lorne St., Regina, SK S4P 2M4  
tel 306 586-4617  
e-mail rabyj@shaw.ca  
http://worldcongress.rpnc.ca

### 2008 National Social Work Conference: "Human Rights in a Global Community"

May 22–25, Toronto, Ontario  
Contact: Ontario Association of Social Workers, 410 Jarvis St., Toronto, ON M4Y 2G6  
tel 416 923-4848  
fax 416 923-5279  
e-mail info@oasw.org  
www.socialworknationalconference2008.org

### 16th Annual David Berman Memorial Concurrent Disorders Conference

May 26–28, Vancouver, British Columbia  
toll-free tel 1 877 328-7744  
tel 604 822-2801  
e-mail ipconf@interchange.ubc.ca  
www.interprofessional.ubc.ca/16th\_David\_Berman.htm

### Gender Matters: Meeting the Challenge – Moving Best Practices Forward for Women in Ontario's Substance Abuse Service System

May 27–28, Toronto, Ontario  
tel 905 476-2394  
e-mail gendermatters@jeantweed.com

### Addictions Ontario 40th Annual Conference"

June 2–3, Mississauga, Ontario  
Contact: Norma Medulun, Addiction Programs and Services, Niagara Health System, 8 West Hampton Rd., St. Catharines, ON L2T 3E5  
tel 905 682-6411, ext. 63121  
toll-free 1 800 682-6411  
fax 519 673-1022  
e-mail Norma.Medulun@niagarahealth.on.ca  
http://addictionsontario.ca

### Canadian Psychological Association Annual Convention

June 12–14, Halifax, Nova Scotia  
Contact: CPA, 141 Laurier Ave. W., Ste. 702, Ottawa, ON K1P 5J3  
tel 613 237-2144, ext. 330  
toll-free 1 888 472-0657  
fax 613 237-1674  
e-mail conventionmanager@cpa.ca  
www.cpa.ca

### 3rd North American Conference on Spirituality and Social Work

June 19–21, Fredericton, New Brunswick  
e-mail Jcoates@stu.ca  
www.spiritualityandsocialwork.ca

### 2nd Biennial Conference on Brain Development and Learning: "Making Sense of the Science"

July 12–15, Vancouver, British Columbia  
Contact: UBC Interprofessional Continuing Education, Room 105, 2194 Health Sciences Mall, Vancouver, BC V6T 1Z3  
tel 604 822-6156  
toll-free 1 877 328-7744  
e-mail devcogneuro@gmail.com  
www.interprofessional.ubc.ca/bdl.html

### 49th Annual Institute on Addiction Studies

July 13–17, Barrie, Ontario  
Contact: Linda Hood, Box 322, Virgil, ON L0S 1T0  
toll-free telephone 1 866 278-3568  
toll-free fax 1 888 898-8033  
e-mail info@addictionstudies.ca  
www.addictionstudies.ca

### 58th Annual Meeting of the Canadian Psychiatric Association

September 4–7, Vancouver, British Columbia  
Contact: CPA Head Office, 141 Laurier St. W., Ste. 701, Ottawa, ON K1P 5J3  
tel 613 234-2815  
fax 613 234-9857  
e-mail conference@cpa-apc.org  
www.cpa-apc.org

### Psychosocial Rehabilitation Canada Conference 2008: "Breaking through the Barriers to Recovery"

September 17–19, Winnipeg, Manitoba  
e-mail DorayJ.Sutton@mts.net  
www.psrpscana.ca

## UNITED STATES

### Nicotine Dependence Annual Conference

April 28–30, Rochester, Minnesota  
tel 507 284-2509  
toll-free 1 800 323-2688  
e-mail cme@mayo.edu  
http://ndc.mayo.edu/mayo/research/ndc\_education/conference.cfm

### 20th Annual Convention of the Association for Psychological Science

May 22–25, Chicago, Illinois  
Contact: APS, 1010 Vermont Ave. NW, 11th flr, Washington, DC 20005-4918  
tel 202 783-2077  
www.psychologicalscience.org/convention

### College on Problems of Drug Dependence 70th Annual Meeting

June 14–19, San Juan, Puerto Rico  
e-mail ebjeller@temple.edu  
www.cpdd.vcu.edu

### 116th Annual Convention of the American Psychological Association

August 14–17, Boston, Massachusetts  
Contact: APA, 750 First St. N.E., Washington, DC 20002-4242  
tel 202 336-6020  
e-mail convention@apa.org  
www.apa.org

### 11th International Conference for Philosophy and Mental Health

October 6–8, Dallas, Texas  
tel 214 648-4960  
fax 214 648-4967  
e-mail Linda.Muncy@UTSouthwestern.edu  
www.utsouthwestern.edu/psychiatryandfreedom

### Annual Meeting of the American College of Neuropsychopharmacology

December 7–11, Scottsdale, Arizona  
e-mail acnp@acnp.org  
www.acnp.org/default.aspx?Page=Upcoming-Meeting

## ABROAD

### 5th UK/European Symposium on Addictive Disorders

May 8–10, London, United Kingdom  
e-mail enquiries@ukesad.org  
www.ukesad.org

### International Harm Reduction Association 19th International Conference

May 11–15, Barcelona, Spain  
Contact: Harm Reduction 2008, Conference Consortium, 34 Bloomsbury St., London WC1B 3QJ UK  
tel 44 207 462 6997  
fax 44 207 462 6999  
e-mail info@ihraconferences.com  
www.ihra.net/Barcelona/Home

### EUROPAD 8 Conference

May 29–31, Sofia, Bulgaria  
e-mail maremman@med.uniipi.it  
www.europad.org

### World Psychiatric Association Thematic Conference on Depression and Relevant Psychiatric Conditions in Primary Care

June 19–21, Granada, Spain  
tel 34 902 430 959  
e-mail info@wpa2008granada.org  
www.wpa2008granada.org

### 6th International Congress of Cognitive Psychotherapy

June 19–22, Rome, Italy  
Contact: FEDRA Congressi S.A.S., Via Achille Barilatti, 61, 00144 Rome, Italy  
tel 39 652 247328  
fax 39 652 05625  
e-mail info@fedracongressi.it  
www.iccp2008.com

### 7th European Conference on Gambling Studies and Policy Issues

July 1–4, Nova Gorica, Slovenia  
e-mail conference@easg.org  
www.easg.org

### A Climate for Change: An International Summit on Addiction

July 10–12, Melbourne, Australia  
tel 642 75721115  
fax 617 4091 6491  
e-mail summit@pacificcmc.com  
www.pacificcmc.com

### 3rd International Conference on Teaching Psychology

July 12–16, St. Petersburg, Russia  
e-mail info@ictp-2008.spb.ru  
www.ictp-2008.spb.ru

### 8th International Conference on Grief and Bereavement in Contemporary Society

July 15–18, Melbourne, Australia  
Contact: Australian Centre for Grief and Bereavement, McCulloch House, Monash Medical Centre, 246 Clayton Rd., Clayton, Victoria 3168 Australia  
tel 613 9265 2100  
e-mail conference@grief.org.au  
www.icgb08.com

### 14th European Conference on Personality

July 16–20, Tartu, Estonia  
Contact: Secretary General of the ECP14, Department of Psychology, University of Tartu, Tiigi 78, Tartu 50410, Estonia  
tel 372 7375902  
e-mail iaccp2008@jacobs-university.de  
www.iu-bremen.de/iaccp2008

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