Language, Culture and Access to Health Care

Laurence Kirmayer
McGill University, Montreal, Quebec

What I thought I would do at this opportunity to address issues of language in healthcare was to go over with you some of the important findings and reflections that have come out of a variety of kinds of research and activity in this area that we've been engaged in, some are in association with this program, and this is what I'm going to try to do, it's quite ambitious but at least I'll touch on these issues briefly since I think we have a lot of opportunity for discussion today.

The first is just a brief reminder, and again you had this yesterday, but I'll come at it from a slightly different angle on sort of the facts of linguistic diversity in Canada and Quebec, in particular touching on what these issues mean for indigenous peoples, for immigrants and refugees, and for established ethnocultural communities. And then, through that really honing in on what is the impact of language on healthcare as a social determinant of health in and of itself, and as a major contributor to barriers to care or to facilitating access to care, and not only engaging in appropriate care, but getting an accurate response from others. And then in particular, I'll talk about strategies for trying to address linguistic difference, rather than erasing it to engage it in some kind of active way, and then end with what for some of you are some of the most interesting aspects of that, which is what are some of the implications in the long term. We can all accept, I hope accept that in the immediate situation in healthcare, in acute healthcare, people who are in trouble, we need to meet them where they are in some ways just to provide basic humane care. But there are larger issues, obviously this is where it gets much more politically contentious, about what kind of society we want to live in, and what the role is of linguistic diversity in society as a whole. So that's what I'm going to try to end with.

The context that I come from was already mentioned, it's a program here at McGill that started in the 1950s, it's the oldest program in the world that's devoted to looking specifically at culture in mental health. And originally it was driven by international concerns, people coming from elsewhere in the world, from the Commonwealth countries to train here, and raising questions about how relevant what they were learning was to things in Africa or Asia or elsewhere. We realize now when we walk out on the street the world is here in our own home, chez nous, and so these same issue are pertinent to everyday practice, and that's very much the driver these days in our discussions.

Culture, and I'm using culture here, I won't take the time to define or impact culture, suffice it to say it's what Ian Hacking calls an elevator word, it covers a lot of terrain, and it certainly includes within it as one of the central pillars and vehicles of transmission of culture, language itself. Much of what I'm saying you can use the two almost interchangeably; they don't cover precisely the same territory, but there is a huge area of overlap in what we're talking about. This is a slide that usually just says "Culture in Health" I just said "Culture & Language in Health", and that applies across the board, that is to say there is a set of scientific issues, what does it mean to be multilingual, how

does it change your brain, how does it change your ways of responding to the world, there's a lot of interesting empirical research on this coming from psychology, from cognitive neuroscience, other disciplines, linguistics. How does culture shape the social landscape to identify different groups and position them differently in society, with consequences for their access to care, for the way they are perceived by other people. We know in Canada's part of the legacy of colonialism, if you're an English speaker you respond to peoples' accents very involuntarily. People who have a British accent generally sound more intelligent to us, whether it's warranted at all. People who have a southern U.S. accent generally sound less intelligent. There are plenty of TV programs that exploit that kind of kneejerk reaction that we have. This is simply kind of engraved on us as part of social hierarchies that we're embedded in, it's a bit muted here compared to going to Britain where people can precisely locate somebody in terms of where they're from and what their social status is and even perhaps what their education itinerary was, but we certainly have some of that here. So that's an example of how social position is stratified and signaled through language.

There's a crucial set of clinical issues, and this is a lot of what I'll be talking about today, that is to say that the extent to that the helping professions depend on communicating with people to understand what their predicament is, and to offer them things that make sense to them, were deeply embedded not just in language but in all of its nuance and all of its complexity, because we're trying to understand peoples' emotions, we're trying to understand their worldviews, and we're trying to convey things to them in ways that make sense to them that are convincing, compelling, and so on. There's a set of ethical issues, because people frame their problems in different ways, and those are connected then to these human rights and political issues. The extent to which people need their languages, they need their languages to live fully, to be able to problem solve, to think creatively, to feel recognized and understood by others. So, this is the reason why we have in fact, at an international level, cultural and linguistic rights that people have in various contexts.

Some of my work I will be talking about a couple of different settings and projects, some of my work curves in the context of work in Indigenous health, I direct a national network for aboriginal health research. And it's worth beginning with this for many reasons, one of them is political, to sort of acknowledge the First Peoples and the extent to which in recent years because of some increasing recognition of their status and centrality to our society, their efforts to raise certain fundamental issues have been drivers for other groups and in the case of refugees lets say, who I'll talk about a little bit later, they have very little voice in terms of policy and so on, they're in such a precarious position that they don't often feel they can come forward and talk about vital issues. So the issues that indigenous people are raising become a kind of vanguard, a kind of way of putting issue on the table that actually apply to many other people. And we have in Canada 100+ year history of trying to eliminate aboriginal languages through very aggressive most would say violent policies, and the residential school system was a major vehicle for this. Canada supported the churches in establishing 100+ schools across the country, where aboriginal children were taken, sometimes sent by their parents in the hopes of getting a good education, getting ahead in life. And in those schools they were

forbidden to speak their languages; moreover their languages were denigrated, they were told there's nothing worthwhile there, you are savages, and so on. I was just in Saskatoon two days ago, and an aboriginal elder gave a talk about his own experience as a residential school survivor, and the deep humiliation and the kind of crushing that went on in that school system, which is belied by these photographs that I think were meant to show how nice and orderly the whole machine was.

What are the consequences of this, we have now several generations later, in fact there are plenty of people alive who went through this system, mainly we're interacting with their children and grandchildren, we have in some indigenous communities across the country very serious health problems, and very serious mental health problems. As you may know the suicide rate on average in aboriginal communities across the country is 4-6 times higher, particularly for young people, and it's an interesting issue as to why.

So one of the most interesting pieces of research has come out of the work of Michael Chandler a developmental psychologist at UBC, they did a study correlating some community level factors with the rates of suicide in different first nations communities in British Columbia. There are enough different communities and enough diversity that you can do this kind of correlational study at a community level. These are the indicators they looked at, did the community have self-government? Was it involved with land claims? Did it have its own education program? Did it have control of some health services? Some cultural services? Its own police and fire services? Those communities that had all of these factors had almost no suicides in the community. Those communities that had none of these factors had an astronomical rate of suicide. The suicide was usually reported in numbers per 100,000. So it's an extrapolation, but it's an astronomical figure, the highest rates you'll find anywhere in the world and in any groups of people. So this is a striking finding, this is probably the single most cited piece of work in indigenous health with policy implications, because it makes a correlation or shows an association, it's not really a correlational study, it's all the available data and just here's the pattern, but it has implications for health policy and it's been widely used.

They did a subsequent analysis where they looked at an additional factor which was language, and they said specifically, let's look at communities in which at least half of the band members have conversational knowledge of their own native language. What you can see is that for those communities that had that, and they're only a small number in the actual data here, but for those communities that had that, there are no suicides, even if they have none of these other factors. So what it shows is not only is linguistic knowledge of your own tradition important for mental health, it is so protective for mental health that you can have a lot of these other indicators of community organization, coherence can be absent, you can have other kinds of problems in your community, and there will be a protective or a buffering effect of having this kind of cultural knowledge. So this is a very compelling bit of evidence, it's hard to collect this kind of evidence, hard to show it in this way, but we have to perhaps not overvalue this but take it quite seriously in thinking about it.

We've been involved in another project with indigenous people for about 5-6 years looking at indigenous concepts of resilience, how do people from indigenous communities understand their own ability to do well despite adversity, that's how we defined resilience in an everyday way in talking with people. What's interesting, we've worked in Kahnawà:ke, in the North, with Cree, Inuit, Métis communities, out west, in Mi'kmaq communities out East, and across all these communities we've been looking specifically about what's distinctive about resilience amongst indigenous peoples. We assume that the general resilience literature that comes from inner-city youth in the U.S. or children of parents with severe mental illness, we assume that many of those factors are relevant as well to indigenous people, but we wanted to ask a question, is there anything specific, given they have specific adversities, and they have unique configurations of communities, and this unique history I've already mentioned, what is distinctive?

One of the things that has come out across these traditions has been the importance of stories. These are primarily oral traditions. People prior to European contact transmitted their cultural knowledge by story-telling and by enactment of stories through ceremonial ritual life, the notion of stories as being a privileged way of knowing and a way of transmitting knowledge across generations is absolutely essential. And those stories are full of specific words and specific concepts. And when you lose the language you lose a whole layer of that story. So it's not surprising to discover that even though many indigenous languages were wiped out and most are fragile, that there is a serious effort to regain and rebuild languages in many communities. So in addition to Inuktitut and Cree who are doing reasonably well, Mohawk for example, many middle-aged people are going back to school and studying language. And this has been a phenomenon that has been successful in other places. Just to mention the Maori in New Zealand have managed to create language nests for young children, and have really brought the language back. And as you may know, New Zealand is now officially a bilingual bicultural nation, in which children of European descent all study Maori language in school. You can imagine what that does for the collective sense of identity and well-being for Maori in New Zealand.

So just to cap this little part of my talk with this book that I recommend to you, those of you nodding encountered this, John Ralston Saul who makes the argument that if you look back at the early political language in Canada and trace it forward, a central metaphor in all of that language is the notion of fairness. We often assume that our political language has come from British and French political systems, there was some kind of a blend of these notions of civility and equality and so on, but he argues that you do not find the language of fairness in those political systems, you find equality, you find a variety of other things. The language of fairness came explicitly from the treaties with First Nations peoples. So he argues that we are fundamentally in our identity a Métis nation, that is to say we are engaged in a kind of cultural hybridization and engagement with indigenous cultures, and we should become more aware of that in our collective identity. If you go to Pointe des Callières and see the sound and light show before you descend in to the depths of the archaeology of Montreal, you get a nice little bit of revisionist history where things start off the way I learned them in textbooks in Quebec

about all of the settlers, the Coureurs du Bois, and suddenly the indigenous face intrudes and says, wait a minute, that's not quite how it happened. I think that this is a very important message for us, I think looking at the indigenous issues which we have all acknowledged these days are ethical and human rights issues, and we need to attend to them, is not only central to improving and repairing the relationship between those of us who are descended of settlers or immigrants or refugees, and indigenous peoples, but I would argue points the way toward a different vision of a kind of tapestry of society.

So to shift now to the issue of migration, Canada is a nation of immigrants. Over the last 100 years, we've had constant influx of people, actual numbers have fluctuated on average at any given point in time, between 15-20% of people living in Canada have been born elsewhere. So that's a very fundamental fact about our identity and our sense of self, which you can feel if you walk out on the street in Montreal. And we usually portray this I think in a very self-congratulatory way, and indeed many people look at Canada from the point of view saying this is this fabulously successful experiment in diversity, look at how people are living together and mostly not killing each other. We had a conference here years ago, where my friend Gordon Sheppard presented some of his book *HA!*, which I recommend to you, he was describing some of the English-French tensions in Quebec, and our American visitors were completely blown away with the idea that we could live with this level of tension in society. Their idea was this should be inevitably complete chaos and insurrection. I think it's interesting that we have that tension, and it's a creative tension. So that's the backdrop.

However, the reality is that despite our self-congratulatory view, we have had highly discriminatory immigration policies and frank racism built into the system. This is just a quick list, in 1914 you may know the story, the Komagata Maru, a ship that came carrying a lot of Sikh immigrants, was kept in the harbor for many weeks while people died because Britain and Canada were terrified of the idea that all of these dark-skinned people would come in to Canada. The most popular song on the radio in 1914 was a song called the White Canada, which was not about snow.

So, it's been a hard one process to extricate ourselves from some of the fundamental racism that is part of the human condition I would say, we don't have to beat ourselves too hard for it, but we have to work on it and change it. And again just to realize that the redress and the recognition of these issues in most cases is extremely recent, it's a phenomenon of the last few years. So we were in the midst of a different kind of political response to these issues, a different kind of trying to hold ourself to a different standard, and I think that's very encouraging. One of the reasons it's so incredibly important is because those bits of migration history I showed you which are about Chinese, about South Asians and so on, represented a marginal phenomena in the past. Most immigrants prior to 61, this is kind of what the distribution looks like. Post 61, this is what the distribution looked like. So we've had a profound change, and this is ongoing, from migration mainly coming from Europe, from different peoples in Europe, who in a sense are different variations on a theme, even linguistically with the exception I guess of a few kinds of special linguistic groups, the Finns and Hungarians and so on. In general, are variations on a theme, and there's a lot we can understand about each other both in terms

of language and in terms of how we figure the world, and there are much greater differences with people who are coming now, and this is 2006 just to show you where migration is coming from. So in Canada the top 3 languages, we have Chinese and Arabic among the top 4 languages. So recent migration in general just very crudely we get about 250,000 a year, 20-25,000 refugees a year, so we have this 10 to 1 or 9 to 1 ratio which again is distinctive. There are other countries, Scandinavian countries who only take refugees at this point, and there are countries that take more or less immigrants.

Immigration is going to be a fact for the foreseeable future, and we certainly need immigration to maintain our own collective wellbeing. There's also going to be a lot of pressure for migration and global warming. One consequence of global warming is going to be incredible pressure for migration. So we need to be thinking through these issues, and what kind of space are we creating that can integrate people, that can allow people to co-exist peacefully, and language certainly plays a role in this. I think that in Canada we tend to be very self-congratulatory, and there are probably some good reasons for that. This is some data from a few years ago from a world values survey, it's an interesting from a comparative point of view in terms of public surveys of attitudes, and you can see that Canada fares among the very best when you ask people, would you not like people of a different race? Very low levels of overtly acknowledged racism, the real feelings are maybe a bit more complicated, but in terms of what's socially acceptable, this is giving us a sense of social norms.

Similarly for people of a different religion, keep watching where the U.S. is vis-à-vis Canada, because this is the moral of this story. And then if you look at immigrants and foreign workers you see a difference. In the U.S. this represents the pressure from the South and the fact that you have this interesting split in the U.S. between people who are of Latino or Hispanic descent who are established as an ethnocultural community, who distinguish themselves from newcomers. Years ago we were proposing a book looking at work that I'll tell you about in a moment, the reaction from a U.S. publisher was, oh but you're talking about migrants, whereas culture is different, culture is about these ethnoracial blocks. So it's interesting then, in the U.S. those two different groups, the politics are quite different, whereas in Canada I think we have such a continuum so that everybody in a sense is a hyphenated Canadian of some sort, whether they care to declare it or not, and mostly it's not a big deal to declare it, so that changes our attitudes. Most interestingly, attitudes towards someone who speaks a different language. You see a huge gap if we're using the U.S. as a society that is in some respects similar to us, there's a very different attitude towards language.

This is the reality of our immediate local environment, this is again data from half a dozen years ago, but this is the proportion of people who are recent immigrants, in the past five years or so ago, in Montreal. You see people congregate in certain neighbourhoods but not just one neighbourhood, in many different places. This is where the Jewish General Hospital and Saint Mary's hospital are located …the CLSC Cote-des-Neiges. I want to tell you briefly about a study we did well over a decade ago looking at access to care, we were interested in access to care, modes of expressing distress. Partly because there's international literature in cultural psychiatry saying that westerners

express their suffering in emotional and psychological terms, and everybody else, which is to say Asians, Africans and so on express their suffering in bodily terms. We didn't believe this, so we set out to look at this clearly, so we did a survey of 2400 people in the Cote des Neiges area, and we were able to oversample certain census tracts where there were high proportions of newcomers so we ended up with groups of people born in the Caribbean, Phillipines and Vietnam. What we found was that when you compare healthcare utilization in those groups, that people make comparable use of primary care. So this is good news, it means our socialized medicine system and our local community clinic and the emergency rooms are accessible at a very basic level to people. But when we looked a mental healthcare we found huge discrepancy. We found in fact people are 1/3 as likely to make use of mental health care. Some of that might be healthy immigrant effect, in Canada if you are a voluntary migrant, immigrant, you are in general likely to be healthier than the general population. If you're a refugee, it's another story. But we controlled for the level of emotional distress and life events, stressful life events, level of bodily distress, and even when we did that, we found that Vietnamese and Filipino made significantly less use of mental health services, and this is both on their own and being referred from primary care. Then we thought, well maybe it's because they're using other forms of healing, that's often the reaction. Well they're not coming, so that's great, they're going to their own internal resources. That's often a relief for policymakers, they can say they're taking care of themselves. In fact, what we found was the opposite, that is the more likely you were to be using your own resources within the communities, churches, temples, whatever, the more likely you were to make use of mental health services. So it was not accounting for this discrepancy. We did a qualitative component to this study where we asked people who had distress you told me that you've had these symptoms of distress but you didn't go for help, why did you not go for help? There's a series of reasons people proposed, the first one of which I'm going to focus on for a few moments, which we called, based on a factor analysis, ethnolinguistic match. It had items: my culture would not be understood, my language would not be understood. Here you can see the difference between immigrants and non-immigrants, and all of these factors, again I'll just draw your attention to the ethnolinguistic factor, which is including both culture and language, but you see that in terms of the difference between native-born people and people born outside the country, and I should say that the native-born people are also culturally diverse, of course, in the Cote-des-Neiges area, there are all kinds of people, the children in many cases of people who themselves come, these are now people who were born outside the country, for the Filipinos about five years ago, for the Vietnamese 10 years ago, Caribbean 15 years ago on average, representing different waves of migration. You can see that language makes a difference in this context.

Here's a very recent study from the U.S. with a large sample, about 7000 visits, looking at people who needed interpreter services and people who didn't need interpreter services in healthcare, and showing that those who did need interpreter services were more likely to make many visits to the ER. That is, when you look at the number of visits to primary care I should say. When you look more closely at what the differences are between these groups, it turns out, similar to our study, that there were lower rates of people being diagnosed with mental health problems, and greater rates of people being diagnosed with common somatic symptoms that are often poorly characterized, poorly understood, and

poorly treated. So there is a process going on here, which I'll try to clarify for you, where people are expressing their distress in the form of pain, fatigue, other common symptoms, and they're getting some kind of treatment for that, but the question remains, to what extent are other things being missed, social problems, health problems, are other things being missed that would be a more definitive diagnosis and intervention.

So behind that, and part of the study again, the qualitative part, we selected people from each of the five groups we're looking at: English-speaking Canadian born, French-speaking Canadian born, Filipino, Vietnamese, and Caribbean, we selected 20 people from each of these groups of 200+ that we had as random samples who had physical symptoms for which no explanation had been found. So this is this kind of somatization problem. We interviewed them in depth with something called the McGill illness narrative interview, which gives people a chance to really narrate their suffering. These interviews lasted anywhere from 1-3 hours. These were very lengthy interviews around these symptoms. I'll case the Vietnamese, what came out in these interviews was very interesting, a number of people said, well my problem, I'm having aching in my joints. This is a problem we call *phong thấp* which translates essentially as rheumatism, but when you talk to people more, the reason we have this is because cold winds cause this. These are not literal winds, these are a kind of, in ethnophysiology, a way of understanding the kinds of energies that affect the body and must remain in balance. And you can get those cold winds, for example, if you're a young woman and you have a baby and you don't have the proper postpartum rituals to close your pores, you can get those cold winds because of the climate as well, and there's a whole bunch of narratives about this, that people then expose to us. In the process of doing this, they told us more and more stuff about the stresses they were going through, about the nuclearization of their family, that is to say that their kids, they come here as boat people, they settled, their kids have moved off to Toronto now, they're living as older people in isolation, so there's a whole sort of social story there, and in fact when you spend enough time talking with people they would start telling you traumatic stories about their migration, about the violence they experienced on the boats coming out of southeast Asia. This is a conversation that went on with an interpreter in Vietnamese with a French-speaking researcher, and with a kind of back and forth. With that facility to be able to talk at length, not just in their own language but also with enough time, we got this many-layered story. The other thing that came out was an idiom we could call *wat wok* which translates as indignation essentially. This is what happens to you when some of our informants said, you wouldn't understand this, it's a very sophisticated idea, but I'll try to explain it to you as a Canadian. If a person undergoes a lot of humiliation in a status hierarchy that they can't challenge, they have to swallow that. If you come from a Confucian society, we have to respect that hierarchy, you have to swallow it, and it can cause a lot of internal turmoil and can lead to illness. It's a kind of sociosomatic theory. And again what they told us was, "I can tell you about this because you're an outsider, I could not tell someone within the community." So it's an interesting issue again of recognizing the need, not only to find ways to bridge with people and to communicate with them, but to allow them the social space of living in a pluralistic society, and encountering others who then afford them new opportunities. All the more reason to look at how we can communicate with each other.

A couple of other examples now, coming more directly from the clinical service. You'll be hearing I think in the next session from my colleague, Eric Jarvis, who directs this cultural consultation service at the Jewish General Hospital. This is a program that we started some years ago, to try to, based on the research I showed you already, showing the unmet need in the neighbourhood, to see, is there a way that we can address cultural linguistic issues in everyday care? So we set up a program in which people could be referred. At the Jewish General Hospital, the figures there are the proportion of immigrants, up to 65% of the population are people who were immigrants. The process of what we do is to try to look in depth, at patients that are referred to us from primary care, look in depth to try to understand the cultural and social dimensions of their mental health problems, which are generally not given a lot of attention in standard mental healthcare. And so I'll just show you briefly some results from about 500 cases that we've seen over the years, and just to mention first of all the diversity, 70 different languages represented. So it's not an issue of me saying today I'm learning Khmer, like my colleague Devon Hinton in the U.S. who works in a neighbourhood where he works primarily with Cambodian refugees, he is fluent in Khmer, it's not an option for healthcare practitioners in this neighbourhood. We have to find different strategies to address this hyperdiversity. You see here that we use in about 1/3 of the cases we make use of interpreters in this process. I won't belabour this, people come from many different places here it's mapped linguistically, you can see where the kinds of languages we're dealing with, sort of grosso modo, here are the top ten languages from some earlier data.

What we do really is we employ interpreters and cultural brokers who are people who are able to translate cultural context rather than language per se, sometimes an interpreter can do that job although it's not formally within their job description. Often there are other people, again Eric will tell you more about this no doubt. We use that information to try to do what in DSM-IV, the official nosology of the American Psychiatric Association, buried in the back of the book is an outline for cultural formulation. The good news I should say is in DSM-V which is about to come out in about a month, anyone who is a mental health has already been inundated with offers to buy the book, which is going to make incredible piles of money for the American Psychiatric Association, but the good news is that DSM-V has a cultural formulation interview in it, so it's kind of demystifying this process and showing how you can go about collecting this kind of information. We use, this is more recent data, we use interpreters in about 38% of cases, there are issues in using interpreters, when people come from small communities, the likelihood that they feel exposed by an interpreter being there is greater, they may know that person. There are complexities because the kind of linguistic match that we're doing is often very crude, and there are other issues, religious, political, that may intersect in ways that make things awkward for people. Nevertheless, the consequence of getting this additional information is that we make huge numbers of re-diagnoses of people. People coming from our own healthcare system. Very high percentage of people where we do not agree with the referring diagnosis, from a family doctor or mental health practitioner, from a psychiatrist, sometimes people who have been in treatment for years. Many cases, we uncover new problems that were not recognized before. If you ask, what's the single most significant intervention in many of these cases, it's the use of an interpreter. To our

great shock and dismay, we see all kinds of people who have been in the healthcare system for a long time, who have never been assessed with an interpreter.

There are many reasons for that, here's an extreme example, typical, not typical, extreme emblematic of the scenario, it's actually a patient that I saw briefly in the ER at one point who a colleague of mine had already seen, and he found her mute and unable to speak at all, and was sort of stymied in doing much of an assessment, and he recommended a sodium amatol interview, which is like a blast from the past, they did this in the 2nd world war for shell shock, the idea is that you get sort of intoxicated from the barbituate and then you become disinhibited and you start speaking if you have a conversion symptom your paralysis disappears and so on. In any event, when this woman was interviewed with a Tamil speaking interpreter, it was discovered without her husband present, who had been doing all of the interpreting up to that point, it was discovered that this was a case of severe domestic abuse. You could imagine that it's a very unhelpful, bordering on malpractice to be assessing domestic violence through the perpetrator, it's just not the way to do it and not the way to be helpful. But this is typical, unfortunately, or common in our healthcare system.

Here's another case seen by the cultural consultation service, incidentally you see the reference, we're very pleased that just last week we sent off the manuscript for this book that will be describing in great detail the experiences of the service, so I've got the references in press, soon to be available from this book. These are some vignettes. So this is a situation again where the skill of the interpreter, and in this case the ability to speak a particular language, and one of the interesting issues is that for all the diversity of Canada, saying oh we had 70 languages in this neighbourhood, we're actually one of the least linguistically diverse places in the world. If you go to Indonesia and Southeast Asia, there are much more linguistically diverse places. So this is just a global fact, and our strategies for dealing with this are important to everyone. So I think this last phrase from this patient is very important, she finally says, for 15 years I could not speak, finally I can. It's not uncommon that we find situations where there is a family member who because of their work experience, going in and out of the home, has developed a certain facility in local languages, English or French. But there are other members of the family, who because they're confined to the home, and the nature of everyday family life, have not developed that facility, and any kind of interaction with institutions, healthcare institutions, assessments, they're voiceless, absent, we end up with a very distorted picture of what's going on, sometimes with very dramatic effects.

This is an example of a child case where the child was functioning as the interpreter and culture broker in everyday life for the family, which is not uncommon for migrant families. He was developing severe problems, eating disorders, suicide threats, oppositional behaviour, he was hospitalized for some length of time at the Children's Hospital. Eventually, when he was finally assessed, the family was assessed with someone who could speak their language, it was discovered this whole interaction was going on, and the family were flabbergasted that professionals had been taking the son's narrative as the accurate portrait of what was going on in the family, which had led to all sort of catastrophes, involvement of child protection services and all kinds of other

things. We have all of these stories from the cultural consultation service, I think it's very instructive for all of us to think about these things.

This is the problem again, I've tried to outline it in 2 spheres, the question is what are our strategies for dealing with this? This is a summary from a few years ago, looking at different countries that have high levels of diversity, that are wealthy, that have lots of resources, that can try to come up with creative responses. The interesting thing first of all is that they tend to take very different approaches. In Australia years ago, the issue of cultural diversity was framed as NESB: non-English speaking background. The assumption was that you need interpreter services. When you came to Australia as a migrant, you got a card that says I only speak Khmer, and here's an 800 number where you can get services. So if you go to see your doctor, there's no complexity right now as we experience here, how to find the interpreter, how to make an appointment, how to work this out. It's just available immediately, that was understood as a basic service need in the country. Along with that in the University of South Australia, they had a master's degree in mental health interpreting. So it was taking seriously that this is actually something that you could devote some serious time to getting really expert at. Unfortunately, that created people who nobody could afford to fund in the healthcare system. I suspect we would have much the same dilemma if we went that route. But in any event, it points out how when you look at these issues, diversity in Australia has a lot of similarities with Canada in terms of migration, you can approach this very differently. Just to take the Australia-Canada comparison for a moment, it's interesting to compare, and the reality being that in Canada, language services have lagged far behind Australia, we've had much less serious attention to this, both within healthcare and more broadly. It's not hard to understand why, it reflects the politics of language in our country, we do recognize languages but we recognize 2 languages. All of the other languages, those are all the allophones who are this big problem, we don't quite know what to do with. In a sense we have pre-empted the language issue, it's highly politicized, there's a lot of energy that goes into it, there's not a lot of energy left for these other issues. When you go to the Children's Hospital in Parramatta in Sydney, at every corner of every corridor are directions to the departments in 15 different languages, why is that not the case in Montreal? It's outrageous.

I don't have time to talk about the other strategies in other places, I'll just say that in general the assumption, this is very much the Canadian assumption overall, people should learn the system, that's part of social integration, we don't want to delay that process, people should just move along, and they'll get care according to their ability to navigate the system. You only have to face your own health problem, to be in a car accident in rural Poland or Vietnam or somewhere, to begin to realize how cruel that is, or have a child with a serious health problem, and so on to realize how inappropriate that response is. Use of interpreters is a basic strategy for addressing this kind of difference. As I say it leads on to other issues of culture brokers. I'll say a few words about the other approaches.

The approach we take, the strategy we're going to come up with, reflects a lot of local issues. The demography, our recognition of certain kinds of difference that are more

salient for us, that are worthy of attention, that are worthy of some kind of positive response. Underneath that are ideologies of citizenship; who really counts, what does it mean to be a citizen, and what is the relationship of your participation in society to your cultural and linguistic background. We have now a Mental Health Commissionin Canada, which is in the difficult position of trying to provide frameworks for improving mental health services, against the backdrop of provincial control of services. In any event, they've tried to put some issues on the table, you'll see here one symbolic representation of Canadian diversity. Always a hard issue of how to represent diversity without creating stereotypes. In the 7 or so dimensions, there are issues that come up with up as strategic priorities for reforming mental health care in Canada, 2 of them address diversity. One is directly related to aboriginal peoples, First Nations, Métis, the other is related to the broader diversity in society, which includes ethnocultural ethnolinguistic groups, but also includes people of different sexual orientation, different levels of ability, and so on. These are different kinds of diversity that also need to be attended to, and the idea that we would be addressing those things. If you look here, the goal overall is to find ways to address these within the healthcare system.

There are two broad ways that this gets framed, one is in terms of cultural competence. The cultural competence of institutions, the cultural competence of individual practitioners, and that means knowing how to explore cultural linguistic issues, it means having specific skills, it means also very much knowing where you're coming from, what your own background is, what your relationship is to these issues, and how you're perceived by other people that you're encountering. There are strengths and weaknesses to each of these approaches, but because of the critique of cultural competence, and the notion that it does not sufficiently address structural issues.

The Mental Health Commission of Canada borrowed and endorsed an idea that actually comes from New Zealand, from the work of Maori nurses in New Zealand, of a framework that they've called cultural safety. The idea of cultural safety shifts the discussion toward the fact that because we are societies with histories of colonization, with institutionalized racism and so on, if you are from certain minority groups, you face a kind of structural violence. The situation in health care or other settings is inherently unsafe for you, or you're likely to perceive it that way. There have to be active measures by institutions, by health care providers to make the encounter safe. If things are not safe, of course, you react very defensively, and you shut down. It's easy enough to extrapolate this to the healthcare context, and think about what that might mean. I think this is a very important initiative in Canada to try to unpack these ideas, it's coming mostly from indigenous people, but it's equally relevant to thinking about the situation for newcomers or other minority groups, racialized groups and so on in healthcare.

Basic strategy for making things safe is having good communication and doing what you need to facilitate that, and having an interpreter is a basic part of that process. Mental health interpreting is more challenging than medical interpreting. The models we have in interpreting come primarily originally from politics and from business, law, are not adequate for medical work, they don't get at the nuance and the emotional levels, the relational levels and so on that we need to be focusing on, so there's additional training.

Nevertheless, these clinical vignettes, there is a real reluctance to make use of interpreters, a real underutilization of interpreters, it's only a few months ago our hospital after working in this area for 10 or 15 years, publishing on this, pushing on this, sending around a memo to everyone to encourage, please don't use interpreters. Strictly because of budgetary issues. We cut work, we minimize the cost in healthcare because we're all strapped. We're fighting against some powerful structural issues, there are issues also in professionals own attitudes and training, and patients' attitudes.

What can we do to address those? We need to make institutional investments, we need to put aside the time and money to do proper healthcare, we need to have accreditation standards and monitoring of institutions so that they are liable and they're found not up to scratch if they're not providing these basic services. We need to train healthcare providers; these are some guidelines that we've produced recently for the Canadian Psychiatric Association on training for mental health practitioners that include the notion that all practitioners should be trained in working with interpreters. Certainly when I trained and even more recent generations there wasn't a hint of how to do it, so it's all very mysterious and overly complex in peoples' minds. And we need to make it easy. So we've been working on a project for the Mental Health Commission of Canada building a website that allows people to get access to basic information, and to health information in many different languages, so you can hand somebody an information sheet on different kinds of things, you can just take it off the shelf. Instructions on how to work with interpreters and culture brokers, and information on where to find such people. Our hope is that if you have easy access to these materials, you have a mandate, in fact a requirement from your own professional association, from hospital accreditation organizations, and from society as a whole to make use of these resources, then it's possible to implement these things. The consequence is not just better health care, less misdiagnosis, better relationships with patients, and so on, which of course while it's hard to calculate, this likely has a very significant cost going forward. We've seen cultural consultation services people who have been misdiagnosed and mistreated for many years. The cost of that is enormous, both at a monetary level and a human level for people. But also a kind of vision of society, which I think Canada has stood for very much in Quebec as well, notwithstanding the sort of rejection of the metaphor of multiculturalism in favor of interculturalism, we still have a defacto multiculturalism, which is to say we have a certain level of valuing of diversity, a sense of the richness of it, people have no problem acknowledging it at the level of food, and music, the arts, we need to recognize that it goes much deeper in terms of people's understanding of human problems. We have a conference coming up in June on mindfulness in cultural practice in mental health, acknowledging the fact that in recent years, in psychology, psychiatry, people have been borrowing ideas from Buddhism as a kind of strategy for how to deal with certain mental health problems. It's clear that we have a kind of global arena where there is great richness and diversity embedded in languages and cultural worlds, and the goals should not be to just turn this into a kind of sameness and blandness, but to find meaningful strategies in which we can live together in diversity.