Clinical approaches to cultural diversity in mental health care and specificities of French transcultural consultations: A scoping review.

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LAURA CARBALLEIRA CARRERA  laura.carballeira@gmail.com
Hopital Cochin
Corresponding Author
ORCiD: 0000-0002-1572-5616

Sarah Lévesque-Daniel
Universite de Montreal

Rahmeth Radjack
Hopital Cochin

Marie Rose Moro
Hopital Cochin

Jonathan Lachal
Hopital Cochin

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Abstract

Background: Cultural context substantially affects the experience and clinical expression of psychiatric diseases, while cultural factors limit both access to and the effectiveness of care, especially for migrant families requiring the construction of specific types of services. We review the international literature on mental health services that take cultural elements into account and use these data to uncover the specificities of the French model of consultations by a group of transcultural psychotherapists. Methods: Exhaustive review of the international literature through searches of PubMed and PsycINFO. The review includes 32 articles. Results: The specificities of mental health services for migrant families are linked to the host country's migration patterns and citizenship model. In English-speaking countries, specialized services for ethnic minorities offer ethnic matching of the therapist and patient. In Canada, indirect transcultural consultation services have existed since the late 1990s. Australia emphasizes the networking of consultation services and professional training in cultural competence, while the Nordic countries (Sweden, Finland, Norway, and Denmark) focus management on trauma. In France, psychotherapy services, with flexible numbers of therapists involved according to the situation, have existed since 1990. Discussion: Most initiatives place emphasis on training and supervision, in an indirect approach not specifically focused on the patient, or offer cultural matching of patient and therapist. The French transcultural approach, on the contrary, makes the family's culture and its cultural diversity an integral part of the therapy process. Scientific publications clearly demonstrate the clinical efficacy of this method.

Background

Julian Tudor Hart set forth his famous Inverse Care Law in the Lancet (1971) (1): “The
availability of good medical care tends to vary inversely with the need for it in the population served." That is, the people who need medical care most receive the least, while its availability is concentrated in the population groups that need it least. Migrants and ethnic minorities are the casualties of this systemic inequality in access to the healthcare system, especially to mental health facilities. Reports from the World Health Organization (2) and humanitarian groups such as Doctors of the World (3) reveal that the resources dedicated to mental health remain inadequate, are distributed unequally, and used inefficiently. These organizations therefore seek to promote the development of public policies to reverse this situation — indisputably needed in this ever more globalized world, where migrants currently account for hundreds of millions of the world's population (4).

At the macro level, this population faces problems including the lack of health insurance coverage, lack of knowledge of the healthcare system, and linguistic barriers. At a micro level, its members run up against the lack of understanding, prejudices, and negative attitudes of many professionals (5). A therapist, for example, may be less interested in and devote less effort to an intervention with a patient perceived as not cooperating or having a different system of values and with whom the therapist finds it harder to identify culturally. This affects the quality of the intervention, reproducing the Inverse Care Law (6).

This inequality in access to care has consequences at several levels. On the one hand, migrant families and ethnic minorities underutilize the primary healthcare system, at the same time as they overuse emergency departments. On the other hand, these issues can impede the professionals' understanding of the particular psychopathology and can lead to differences in the prescription of drugs, decisions about hospitalization, the availability of psychotherapy, and the patient's course under treatment (7,8).
Added to that are pre- and post-migration factors that act as social determinants of mental health: exposure to violence and traumatic migration experiences, the process of acculturation, situations of loss and mourning, adverse socioeconomic conditions, conflicts due to cultural differences, discrimination, and social isolation (3,8–10).

Finally, it is appropriate to note the major influence of cultural factors on the ways that diseases and their treatments are conceptualized. In every culture, the manner in which symptoms are experienced and interpreted is part of the systems of meaning, and these meanings will model the ways people in those cultures become sick, or cope with feelings of unease, or seek help (11).

There are two positions about how to work with the cultural diversity of families in the organization of health care. The first expects migrant patients to adapt to conventional care, by normalizing or ignoring the differences. The second position recognizes and seeks to remedy these differences by the development of culturally sensitive approaches and clinical practices. Unfortunately, culture is often mentioned only when there are misunderstandings or at least difficulties in mutual comprehension between the professional and the patient or lack of adherence to treatment. Culture then designates a thing that belongs only to the patient and that represents an obstacle to communication and cooperation (8).

Healthcare systems can adapt in several ways: using interpreters and cultural mediators, training professionals in cultural competence (Table 1) and supervision, making innovations in the therapeutic framework of general mental health services, and developing specialized clinics for ethnic minorities (8,10,12–19).

We propose to conduct an exhaustive review of original ways of providing healthcare services that offer a response that takes cultural elements into account and use it to uncover the specificities of the French model, developed from the school of Avicenne and
Methods

This is a scoping review of the international literature on clinical approaches to cultural diversity in mental health care. In October, 2018, we conducted an exhaustive search for articles identified in the PubMed and PsycINFO databases, with the aid of key words and synonyms: “cultural/transcultural/ intercultural/cross cultural”) OR (“migrants/ethnic minorities/cultural diversity) AND (“psychiatrist/ mental health”) AND (“care/services/treatment”). The principal investigator used the abstracts and titles to screen the articles provided by the search. We used the following inclusion and exclusion criteria:

Articles dealing specifically with clinical models for handling cultural diversity in psychiatric treatment and describing the modalities of care
Published between 1985 and 2018
In English, French, Spanish, or Italian.

The research was completed by an analysis of the summaries of the principal journals in the national and international transcultural field (L’autre, Transcultural Psychiatry). The references in the articles included in the initial research were also examined. Finally, international experts in the field were approached and asked about documents in the gray literature that met the inclusion criteria.

The articles were read and summarized by one author (LCC), and also read by two other authors (JL and MRM). The organization of the results was discussed during meetings of the research group.

Results

This review includes 32 articles. Table 2 presents the principal characteristics of the services and care described in the articles.

Different types of services developed across the world
The adaptation of mental health care to a context of cultural diversity began in English-speaking countries in the 1970s and in France in the 1980s (12,14). According to Kirmayer (20), the difference in the development of mental health services for immigrant populations is associated with countries' histories and patterns of migration and their citizenship models.

First we find countries such as the United Kingdom and France, which have had substantial immigration from their former colonies. These migrant populations very often faced racism and discrimination on their arrival.

In England, transcultural psychiatry began to develop at the end of the 1970s, with the creation of specialized services for ethnic minorities. Later, professionals were introduced to concepts such as cultural sensitivity, antiracist practices, and misdiagnosis (diagnostic errors due to the failure to take cultural factors into account). Multicultural and multidisciplinary advisory teams appeared, and professionals of varied cultural origins were recruited (12). More recently, the United Kingdom has developed an innovative model: the Cultural Consultation Service (CCS). This is an adaptation of the model developed at McGill University in Canada (and described more fully below), which uses an ethnographic methodology and is based on medical-anthropological knowledge. These departments aim to improve the evaluation, treatment, and outcome of immigrant families. They also seek to act on the structural determinants of inequality in access to mental health care and increase the cultural competence of professionals (17,18). Various practices are therefore recommended without any general consensus around a single model (12).

Some countries, such as the United States, Canada, and Australia, whose populations were shaped by successive waves of migrants, have a multicultural citizenship model. This model promotes the existence of multiple cultural communities within the society. These
countries thus tend to recognize cultural diversity and its stakes for health in general. 
There are also ethnospecific clinics (20).

The United States is a country that was built largely through immigration, but has also 
been deeply marked by its history of slavery and racism. Despite the existence of policies 
promoting assimilation, migration flows have led to the preservation of different cultural 
communities. The development of ethnospecific clinics is a response to this diversity. In 
these clinics, the professionals know the language and the culture of the community they 
serve (20,21). Ethnic matching of therapists and patients is also facilitated in general 
medical care (8,22). The USA is also where ethnopsychiatry and ethnopsychoanalysis were 
born, after World War II, at the Menninger Clinic (in Kansas until 2002, when it moved to 
Texas), which used anthropology and clinical practice complementarily and strongly 
influenced the principal French model (23).

In Canada, cultural identity is considered fairly positively, and the concept of "reasonable 
accommodation" is relatively widespread. The law encourages pluralism and diversity to 
preserve the language and culture of ethnic minority groups and to combat racism (20). 
Cultural psychiatry has attempted to meet the challenges presented by the diversity of 
the population in general healthcare facilities, beyond the development of ethnospecific 
services in some cities. At the beginning of the 1990s, combining the Canadian concepts 
of "multiculturalisme de convivence" (multiculturalism of living together, as opposed to 
that of dominance) with French ethnopsychoanalytic traditions, several plans for 
transcultural teams took form in the Montréal region (8,24,25). In 1999, to cope with the 
limitations of this system, the Cultural Consultation Service (CCS) of McGill University was 
created. It used a consultation-liaison model, which integrates the medical-anthropological 
approach and Western mental health care. Families are referred by a professional who 
considers that cultural factors are compromising the evaluation, treatment, or therapeutic
relationship. The CCS, with the aid of interpreters and cultural mediators, assembles the information necessary to understand the patients' narratives. The team then researches and drafts a cultural formulation (*Table 1*), which is submitted to the referring professional, accompanied by treatment guidelines and possible management strategies (8,26).

In Australia, various services have been developed to meet the needs of ethnic minorities and Indigenous communities. The choice for the Indigenous communities was to give them the control in the development and management of care services. Efforts for migrant families have primarily concentrated on language barriers (20). Accordingly, all states and territories in Australia have transcultural mental health resources, funded by the public healthcare system. They make up the Australian Transcultural Mental Health Network, whose function is to support mental health care nationwide, through research, professional training, and innovation in services. Its objective is to improve the accessibility, quality, and cultural appropriateness of mental health care for migrants. Specific innovations include the creation of jobs such as consultant in ethnic mental health and the recruitment of bilingual staff (16,19,27). Moreover, specialized services have been developed for the treatment of victims of torture and trauma to help refugees (28,29).

Countries that have not traditionally received large populations of migrants are also now attempting to respond to cultural diversity to provide greater social justice and appropriate care for all patients. In particular, the Nordic countries, which have been culturally homogeneous until recently (except for several indigenous minorities) have experienced an increase in the diversity of their populations. In Sweden, Finland, Norway, and Denmark, special focus has been placed on developing services to treat the sequelae of violence and trauma as well as on training in cultural competence in general healthcare
facilities. Mental health services specific for indigenous populations have also been set up (5,30–32).

In other European countries, isolated initiatives have been launched to respond to the increase in cultural diversity. Nonetheless no government policies have sought to improve the access of migrant families to mental health care. Italy, Germany, and Spain have set up teams aimed at providing transcultural training for mental health professionals (7,15,33,34). Italy has several transcultural care teams in departments of psychiatry and child psychiatry; not only do they offer consultation-liaison services, but they can conduct psychosocial and psychotherapeutic interventions in the most complex cases (7,15). In particular, Italy has developed cultural mediators, as in Milan (Crinali) (35). Germany and the Netherlands are trying to guarantee greater cultural openness in public mental health facilities (5,36), while in Belgium this initiative depends more on non-profit organizations (9).

The French model: transcultural psychotherapy services, with flexible numbers of therapists involved according to the situation

The French citizenship model tends to minimize the importance of cultural differences in individuals in favor of adherence to the shared values of the Republic. Traditionally, the multiculturalism established in France is one that might be called a multiculturalism “of dominance”, in which cultural identity can be expressed in the private sphere but is not recognized or valued in the public sphere. There is a widely shared fear of migrant communities. For the sake of integration, homogenization of these differences is expected in the public space (24,25). Therefore, health care in France is traditionally considered to be addressed to everyone, with no specificity linked to their cultural origins and without any recognition of the obstacles that might prevent patients from having access to these services, which are theoretically available to all.
Nonetheless, French psychiatrists and psychologists who see migrant patients must deal with the limitations of this concept of care. In the 1980s, the first foundations of transcultural psychiatry were laid in France, based on the ethnopsychoanalytic theories developed by Georges Devereux (37). According to Devereux, the basic mechanisms of mental functioning are universal, but the processes of an individual's socialization in their culture of origin must be understood to be able to access this universal dimension, since these cultural processes generate diverse and varied clinical events (10,14). From this paradigm, Tobie Nathan at the Avicenne Public Hospital created an innovative psychotherapeutic framework intended for migrant families: the ethnopsychiatry group. Marie Rose Moro, who became director of the program in 1989, modified some elements to adapt it to the children of migrants (the second generation). She insists on the importance of the process of cultural métissage (hybridization) and of decentering (Table 1) (14). A group of transcultural therapists is a central element of this flexible service offered to families, and its most original aspect. We will therefore analyze it now, noting that it does not summarize the model, which can also work in small groups or on an individual basis (with or without an interpreter).

This group-based model of transcultural service shares the factors common to all therapy, such as the construction of a narrative, the establishment of a therapeutic relationship, and a variety of specific theoretical and methodological factors (38).

Organization of transcultural therapy

Transcultural psychotherapy applies a therapy technique based on two complementary interpretations of symptoms rather than a simultaneous reading. Accordingly, anthropological and clinical psychoanalytic approaches are used. The clinical approaches rest on elements from psychoanalytic parent-children therapy, narrative therapy, and systemic and psychoanalytic family therapy, combined with techniques of cultural
mediation (14).

Most often, referrals for transcultural management arise during the treatment of children, when medical, social, educational, or other institutions consider that second-line treatment is needed after the failure of standard management. The indication is stated in terms of the complexity of the situation and of the clinical problem, when the team referring the patient considers a cultural clinical approach necessary. In some cases, these referring teams can be seen in an indirect consultation, that is, without the family, to analyze the interventions and help adapt the care strategies (10,38).

The first consultations are intended to construct the alliance and the treatment plan with the family. Once the plan is constructed, the usual follow-up is then organized in sufficiently long sessions (around 90 minutes), scheduled every 6-8 weeks.

Patients are invited to bring their families to these consultations. They are received by a group composed of several therapists of diverse cultural origins and an interpreter-cultural mediator of the same culture as the family, who can interpret successively in both directions (patient-therapist or therapist-patient). At least one professional from the referring team, who is managing and knows the patient, is also invited.

The group is multicultural and multilingual. It is directed by a principal therapist and relies on the trained co-therapists. For the management of children, one of the co-therapists becomes the auxiliary co-therapist for the child, by sitting down to play with him or her, in an area set up for this in the center of the group, with a table, crayons, and games to play. The group represents and embodies otherness and makes it possible to transform this otherness into a therapeutic lever. It thus serves as a support for psychological construction (39). The framework of the group functions as a transitional space in the sense used by Winnicott: a space for listening and receiving, enabling patients to talk about their cultural representations, protected from criticism and lack of understanding.
The group holds the family and the child — in Winnicott's sense of "holding" (40). It becomes a transitional space: in the face of the cleavage of migration, the group is a mediator that makes it possible to integrate the culture of origin and that of the host country (14). Finally, management by a group is congruent with the collective approach to care found in traditional societies (8,14,39,41).

The transcultural consultation is a flexible system, and the size of the group can be adapted to the situation. The classic large group includes around 10 co-therapists, as well as trainees. Over the years, the transcultural framework has progressively dealt with new domains, including questions of intergenerational transmission, family dynamics, and child development in the context of migration and even adoption (14,42). The referrals of unaccompanied minors or patients needing specific work around psychological trauma has required some modifications in the size of the group or the function of the co-therapists (10). Experiments with smaller groups have also been proposed according to the family's cultural origin, when large groups have no particular anthropological interest (in families from Southeast Asia, for example), contrary to the families from North Africa and West Africa, who accounted for most families at the time the group system was created and for whom the group has a protective valence that facilitates expression.

The presence of the interpreter is a key parameter in transcultural work, both at the linguistic level (understanding one another) and the symbolic level (recognizing the identity and singularity of the other). The interpreter enables each family member to speak their own native tongue and to recognize its value to themselves and their children, an element that facilitates the construction of their identity (38,43). It has been shown that this interpreter has a function as much for second generation children, speaking French, as for the first generation (43).

Therapeutic processes
The objective of transcultural therapy is to promote a creative dialogue and a co-construction of personal and family narratives that lean on the representations and experiences of the patients, whether they are individuals, families, or collective groups. The principal therapist gives the floor to participants and is always the person addressed. This mode of communication, which anthropologists call indirect, enables great emotional containment. During the sessions, the co-therapists speak at the principal therapist's request to propose their hypotheses, representations, or images, relying on their own attachments, history, and culture. They may evoke myths, history, traditions, etc. These references to personal experience open the door to a dialogue about cultural complexity and the different readings possible in situations of cultural métissage (hybridization) (10,14,38).

On this basis, the group enables the formulation of different conceptions of reality and of what the patient and the family are experiencing. It makes it possible to open the discussion to various — and sometimes divergent — daily realities. This hetero-narrativity of the group authorizes and supports the family members' self-narrativity. The group accompanies them in a reflexive process in which they can question themselves and transform their subjective representations. Each can thus attain a more flexible and complex self-identification and use all of their skills to find new ways of resolving their conflicts (10,14,38,42).

Finally, the framework enables the emergence of narratives that are difficult to share in the framework of individual therapy. These narratives deal, for example, with migration experiences, questions about cultural métissage, and transmission, but also etiological theories about the origin of both the disease and the distress (10) (Table 1). The etiological theories can thus serve as cultural containers that make it possible to ascribe a meaning to the symptoms and to the psychological distress.
The transcultural group opposes an ethnocentric perspective and promotes transcultural encounters. The viewpoint proposed is that of the wealth and multiplicity that results from situations of métissage. It thus becomes a space where the dominant cultural discourse can be questioned, with the suspension of the psychiatric diagnosis performed from western classifications (14,42).

The process of decentering is essential to allow this encounter. One of its techniques involves the analysis of cultural countertransference, defined as therapists’ explicit and implicit emotional reactions to the otherness of a patient who belongs to a different culture. Therapists try to be aware of these reactions, most often during work with the group, both before and after the consultation (10,14,39,42). This can also take place later, as part of group seminars where they try to describe and then analyze this cultural countertransference.

Discussion

Very diverse models lead to diverse methods of taking cultural diversity into account in mental health treatment. Nonetheless, most of these initiatives have stressed training and supervision — the approach to care is thus indirect and does not take the patient as its object — or the cultural matching of patient and therapist. The aim of these methods is to modify the framework of care, that is, the services provided, to search for a compromise between the patient and the therapist, etc.

The French transcultural approach is thus distinguished by its representation of the cultural elements of the patients’ attachments, which are not considered to be obstacles, but rather “active catalysts of the care relationship” (10). The patient's culture and various attachments are thus an integral part of the process of therapy.

The introduction of cultural rationales into therapy and the acceptance and attribution of value to non-Western representations of distress and disease become important symbolic
acts, because they belong to the families and to their history, and they can appropriate them or not, according to their desire and their pathway. The therapeutic relationship is thus rebalanced, more symmetric, because the family members put into this therapeutic relationship what they consider important and which gives meaning to what is happening to them. It is no longer the therapist alone who decides what makes sense. The group of therapists and the family co-construct the meaning. Accordingly, real therapeutic work can occur; in a situation where it was previously impossible because of the asymmetry inherent in receiving a patient of a minority culture in a facility that symbolizes the majority culture of the host country.

The therapists of the group are not experts in the patient's culture, but rather in the very concept of culture and cultural attachments. The therapeutic work, which involves understanding and reflecting about the notions of cultural diversity, authorizes the family, with the group's help, to co-construct ways to think about the distress and the disease and to resolve the conflicts. These ways of thinking will in fact be métissées or hybridized, since migrant subjects, whether born abroad or of parents born abroad, are necessarily a hybridization of two cultures, that of their origins and that of their host country (44). The preeminence of the "understanding of cultural diversity" over "cultural competence" is well illustrated in the literature (30).

Numerous scientific publications show the clinical importance of transcultural services and therapeutic processes (42,45-48). These publications reinforce the clinical observation of the effectiveness of the services, invented yesterday at Bobigny and Paris and deployed today in numerous French (Bobigny, Paris, Vitry-sur-Seine, Longjumeau, Bordeaux, Toulouse, Clermont-Ferrand, Dôle, and Nantes) and European (Luxembourg, Switzerland, Italy, Spain, Portugal) mental health facilities.

Conclusions
There are diverse models that lead to various methods of improving mental healthcare access for migrants. The French transcultural approach is the only one that places the concept of culture at the heart of therapy for migrant families.

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Not applicable

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Not applicable

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Not applicable

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The authors declare that they have no competing interests.

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Abbreviations

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Tables
Cultural competence

There are several definitions of this term in mental health care. A review of the literature (18) proposes that this concept refers to the combined skills that enable professionals to provide culturally appropriate care. This includes the consideration of differences due to language and to the influence of culture on the expression of distress and the ways of seeking help. Other aspects mentioned include respect for the patient's beliefs, as well as a disposition, even a real desire, to learn about other cultures.

Cultural formulation

DSM-5 introduced a cultural formulation interview. This evidence-based tool is composed of a series of questionnaires that assist clinicians in making person-centered cultural assessments to inform diagnosis and treatment planning.

Decentering

Decentering refers to the ability to distance oneself from oneself and from one's own cultural point of view (42).

Etiological theories

The etiological theories refer to the traditional explanations for the disease that are found in non-Western societies – imputed to nonhuman invisible beings (10). Transcultural psychiatry proposes to use these traditional etiologies as a therapeutic lever in their function as cultural containers. In situations of distress or disease, the subject looks to "make sense of the senseless" (49) or of "misfortune" (38). The use of etiological theories belonging to patients allows them to participate actively in the search for meaning and for a solution to the symptoms and their various forms of distress.

Table 1 - Definitions

| Type of service                  | Description                                                                 |
|---------------------------------|-----------------------------------------------------------------------------|
| Service for minority ethnic communities K | Transcultural Psychiatry Unit at Bradford, the Maudsley Outreach Support Home Treatment Service, the voluntary organization "Ipamo" |
| Cultural Consultation Service K | The CCS is an innovative model to promote cultural competence of clinicians and outcomes from care |
| Transcultural Mental Health worker K | Use of transcultural mental health workers as an alternative to interpreters to identify the communication barriers and improve the mental health care for black & minority ethnic patients |
| Ethnopsychiatric Group or Transcultural Consultation | An adaptation of the clinical framework, including working with an interpreter and transcultural approach |
| **Intercultural Consultation Service** | This consultation proposes short-term interventions for children and families with complex migration experiences. |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------|
| **Transcultural Centre**             | The Transcultural Centre in Stockholm supports health professionals by training, supervision and consultation, networking, knowledge transference and support of local clinical development. |
| **National Centre for Mental Health for the indigenous population** | The Sámi National Centre for Mental Health. |
| **Gross-cultural opening of the health care system** | - Cross-cultural competence training  
- Multicultural staff recruitment  
- Implementing culturally and linguistically specialized treatment programs |
| **Competence Centre for Transcultural Psychiatry** | A specialist outpatient clinic forming part of the Mental Health Services for trauma-affected refugees. Aims: to provide treatment, and research on transcultural psychiatry. |
| **Interculturalization of mental health services** | De Evenaar is a Centre for Transcultural Psychiatry that provides mental health services to migrants, refugees, and asylum seekers. The Centre offers either inpatient or outpatient care. |
| Psychiatry Assisting a Cultural diverse Community in creating healing Ties (PACCT) | Non-profit organization that provides mental health care for children and 
| | background |
| Transcultural Psychiatric Team | Specifically designed to ameliorate cultural competence through consulta 
| | primary care facilities, but also social services and voluntary organization |
| Servizio di Clinica Transculturale (Cooperativa Crinali) | A group of trained therapists and cultural brokers, psychosocial and psych 
| | with special regard for maternal and infant care. |
| Transcultural Psychiatry Program | Specialized team on a mainstream healthcare service, offering consultative 
| | training for professionals; mental health care for migrants |
| Ethnopsychiatry Clinics | Transcultural Clinic of Jean-Talon Hospital; Montreal Children Hospital |
| Cross Cultural Mental Health Services | A culturally responsible approach to diagnosis and treatment. Clients’ 
| | staff member that can speak the language and/or is familiar with the culti |
| Service                                    | Description                                                                 |
|-------------------------------------------|-----------------------------------------------------------------------------|
| Cultural Consultation                     | Various forms of cultural consultation, including direct assessment, secondary consultation and discussions with community organizations about cross-cultural aspects of mental health |
| Mental Healthcare for minority ethnic communities | Mental Health clinics for ethnic minorities or ethnic matching between clinicians and patients |
| Cultural Competence                       | National Center for Cultural Competence: to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity |
| Transcultural Consultation Program        | It assists mental health services through workforce training and service development with the aim of improving the quality of care provided to individuals and families from culturally and linguistically diverse backgrounds |
| Non-for-profit organization for refugees and migrants | It provides psychological services to refugees, asylum seekers, displaced persons, and trauma survivors before migrating to Australia |
| Service for the Treatment and Rehabilitation of Torture and Trauma Survivors | STARTTS: Service for the treatment and rehabilitation of torture and trauma survivors, and STARTTerS: Early Childhood Programme at the NSW Service for the Treatment of Torture and Trauma Survivors |
Psychiatry care congruent with local culture | Dispositif Itinérant d’Assistance Malades Mentaux (DIAMM) – Mobile Support Team for the Mentally Ill

Table 2 – Main characteristics of the international transcultural services

Supplementary Files

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