Cultural Competency in Clinical Consultation at the Alberta Children's Hospital: How to Deliver Equitable, Effective, and Adequate Health Care to Minority People

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Abstract

The need to provide culturally competent health care and social service has become a major concern for social workers, health professionals, and researchers. Many researchers suggest ways to implement culturally competent programs and services, such as diversity training for staff, the building of cordial relations with the communities around the service centers, implementing culturally responsive service policies, and hiring from the communities to create a workforce that reflects the diversity of service users. Others advocate the need to introduce programs such as interpretation service to eliminate language barriers. They also emphasize the development of practice guidelines which should include self-assessment, enquiry about a client's cultural background, and the need to acquire cultural knowledge.

Although, the above suggestions see the need for changes in the traditional way of providing health care and social service, there has been little examination of the link between culture, illness, and healing. It shows that many practitioners do not see the importance of implementing culturally competent services and programs within the health care and social service settings. Further, much of the current debates on cultural competence focus on services and programs provided by mental health practitioners and nurses, but very little research has been conducted from a social work perspective. The Child and Women's Diversity Program at the Alberta Children's Hospital tries to correct these deficiencies in cultural competence by providing a cultural based consultation to social workers, physicians, and psychologists.

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Acknowledgements and Dedication

Dedication

I want to dedicate this to my mother who always supported and motivated me in all my endeavours – especially in my education.

Acknowledgement

I would like to thank my advisors Glen Schmidt PhD, Judy Hughes PhD, and my practicum supervisor Linda Kongnetiman MSW for their invaluable directions and support. I would also like to express my appreciation to my committee member Eleanor Wint PhD for taking time to work with me during this practicum.

Introduction

Practicum objective

According to Kelly (1995), the number of visible minority adults in Canada is expected to triple to more than six million by 2016 (p.8). This means that the minority population is growing faster than those of Euro-Canadian ancestry. Thus, Canada has become one of the most ethnically and racially diverse countries in the world. This poses challenges to traditional case management models because the diversity will require more culturally competent workers.

However, the current social services delivered by case managers do not reflect the values of ethno-cultural service users because their values, norms, and experiences are different from those of European decent. Thus, "social workers working with" service users "and their families, in particular those needing assistance with activities of daily living, are directly confronted with questions of values, meanings, norms, and attitudes concerning such themes as sickness, dependency, care, family dynamics, and gender relations" (Guberman & Maheu, 1999, p. 127).

In this practicum report, I will make some comparisons between traditional case management models and cultural competence in a health care setting. I will show that the traditional case management models are Eurocentric – the practice was formulated for the mainstream society. Therefore, the models have failed to provide equitable, efficient, and adequate health care and social services for the ethno-cultural groups in Canada.

In the second section of this report, I will argue that health care and social service providers need to be culturally competent in order to counter the challenges posed by ethnic and cultural diversity in Canada. I will examine cultural dimensions of health care and social services for ethno-cultural minority groups

I will evaluate cultural competence from a social work perspective and how culture impacts illness, diagnosis, healing, and access to social and health services. Also, I will examine how cultural beliefs and values shape illness expression, illness behavior, and access to social assistance. I will highlight how these cultural factors serve as barriers to equitable and efficient services and programs for ethnocultural children in the mainstream health care and social assistance system. Issues, such as, traditional healing, natural versus supernatural causes of illness, and biomedicine will be emphasized to draw a link between culture, healing, and illness.

In order to illustrate the practical aspect of cultural competence practice, I will provide detailed accounts of my practicum experience with the Child and Women's Diversity Program at the Alberta Children's Hospital. Therefore, I will use a case study to illustrate my experience with culturally competent clinical consultation. The accounts will highlight how the program implements culturally competent services and programs through clinical consultation. The illustration will explain culturally competent clinical consultation and how it benefits practitioners. In the final section of this report, I will make recommendations and evaluations.

Literature Review

What is culture?

With the growth of an ethnic population in Canada, it is hardly surprising that the concept of cultural competence has attracted the attention of health care professionals and social workers. However, practitioners believe that it is important for them to understand the concept of culture before they can promote cultural competence in health care and social service. The reason is that practitioners perceive a correlation between culture and illness because they believe that it has influence on a patient's health care and social needs. Therefore, the past decades have seen contemporary practitioners struggling to find a working definition for the concept of culture and cultural competence. Unfortunately, practitioners have not been able to develop their own definition of culture because they rely on those provided by anthropologists and sociologists.

Consequently, the effort to concoct a homogenous definition has not been difficult for practitioners because they rely on the numerous definitions by sociologists and anthropologists. For example, Singh, Williams, and Spears (2002) define culture from an anthropological perspective by saying culture includes ideas, values, customs, beliefs, artifacts and language of a group of people. From a broader perspective, Singh, Williams, and Spear (2002) explain that culture consists of all elements and ideas within a community, including folklore, nationality, language, spirituality, sexual orientation, politics, or any other elements that bind people together in a community. Therefore, culture involves elements of unification and sharing of a common heritage (p. 37).

Also, the American Institutes for Research (2005) did not depart from the traditional definition of culture by sociologists and anthropologists. The Institute's definition consists of similar elements found in Singh, Williams, and Spears's (2002) definition. It includes "religion and spiritual beliefs, race, socio-economic class, age, sexual orientation, and group history" (p. 7). Brophy and Crago (2003) make a similar assertion by associating culture with elements that represent a common heritage and unify people in a community. These include "knowledge, beliefs, morals, customs, capacities, and habits acquired by members of a particular group" (p. 397).

Somewhat in contrast to the above definitions, Holladay and Quinones (2005) make an effort to depart from the traditional anthropological and sociological definition of culture. The authors provide a narrow definition of culture by describing it as a programming of the minds of people within a society (p. 531). Literally, this definition conveys the notion of mind control, training of the mind to think positively, or adopting new behaviours. Metaphorically, it means members of a community learn their culture and transmit it from one generation to the next.

However, Holladay and Quinones's (2005) definition clarifies Singh, Williams, and Spears's (2002) definition which asserts that culture involves shared values. It helps to understand that people from a community have shared values because they have been taught to think and behave the same way. Holladay and Quinones, (2005) describe this process as mental programming. Consequently, the mental programming causes members of a community to have similar/same perception of things. That is, members of a community have shared values because they have been taught to accept certain values, traditions, and practices over others.

The authors offer good definitions, yet culture is one of the concepts with different interpretations. Thus, each definition is inadequate to depict the full meaning; therefore the authors (Singh, Williams, & Spears, 2002; the American Institutes for Research, 2005; Brophy and Crago, 2003; Holladay & Quinones 2005) underscore different characteristics of culture as the most important.

Despite the differences in the definition of culture among the writers, certain characteristics and themes are emphasized by them. Generally, the authors share common views that all aspects of culture have impact on communities. For instance, ideas, language, artifacts, traditions, norms, rules, and symbols of societies have influence on people's behaviour and perception. Another common view in the definitions is that people are not born with culture. It is acquired by people through socialization. Holladay and Quinones (2005) describe this process as mental programming and for the American Institutes for Research (2005) culture is "learned behaviors and values that are shared among members of a group" (p. 7). In other words, programming of the mind can be interpreted as learned behaviors in the Institute's definition. This implies that for Holladay and Quinones (2005) and the American Institutes for Research (2005) human beings are born without culture or values. People's attitudes, beliefs, and values are instilled by the community. Thus, human developmental stages of feeding, sensory capacities, motor ability, and talking are taught by a person's community.

Relationship between culture and illness

Briggs, Briggs, and Leary (2005) take the argument a step further to depict a relationship between culture and illness. For Briggs, Briggs, and Leary (2005) practitioners need to understand culture because it shapes an individual's perception about illness, treatment of illness, and response to illness. Briggs, Briggs, and Leary (2005) go on to explain that culture determines successful assessment, diagnosis, and curing of mental illness because it influences how people identify themselves (p. 77). The authors assert that problems may occur in cross-cultural treatment when the client and the practitioner do not share the same cultural background.

In extensive analysis of the relationship between culture and illness, Aries (2004) looks at how health care managers, service users, and providers in large metropolitan hospitals comprehend the influence of patient and workforce diversity on health care in hospitals. The author's concern for this inquiry was prompted by the growing cultural diversity in the United States. Aries' (2004) study shows that frontline workers are divided about their understanding of the link between culture and health care delivery. One group does not see the link between culture and health care and how service providers are supposed to combine both. The other group, according to the author, argues that a patient's cultural background was a vital factor in the delivery of health care. They felt it was mandatory to learn what they could do to help the patients for whom they were providing health care service (p. 175).

According to Aries (2004), ethnocultural patients prefer service providers from the same cultural background. He goes on to argue that ethnocultural patients were confused and disappointed when health care does not reflect their cultural beliefs because many of the new immigrants do not share similar Western cultural beliefs, values, and health care practices. His study also identifies a language barrier between the patients and health care providers because many of the patients do not speak and understand the English language. Consequently, he deems these cultural differences as a challenge and problematic to the health care workers because it is very difficult for them to understand the patients' needs.

Aries (2004) concludes that an individual's cultural beliefs, values, and traditions impact the way the person sees health problems, seeks medical help, and accepts the medical rules.

In other words, the diversity can impact how the patient follows up with the medical treatments and medicinal instructions. Thus, he argues that since these factors differ among groups, there will always be conflicts between health care providers and patients.

Finkler (1985) conducted anthropological research on traditional healing in Mexico. The research result also shows a link between culture and illness. It shows that the traditional belief system shapes Mexicans' perceptions of illness etiologies. According to Finkler's research (1985), Mexicans believe that supernatural forces such as witchcraft and other unseen spirits are responsible for illnesses that cannot be cured by biomedical treatments. For example, they believe that illnesses such as mental disorder and chronic pain are caused by supernatural forces. The research shows that Mexicans believe that these forces are vagabond spirits of persons who died unnatural death. A victim of a perceived incurable illness seeks treatment from either a traditional healer or spiritualist.

Research by Ovuga, Boardman, and Oluka (1999) on traditional healing practice in some African countries also confirms Finkler's (1985) analysis of the link between illness and culture. According to Ovuka, Boardman, and Oluka (1999), about half of the research participants in Nigeria maintained that all physical illnesses were instigated by evil spirits or witchcraft (p. 277). Similar to Finkler's (1985) research findings in Mexico, Nigerians also attribute mental illness to evil spirits, witchcraft, or curses because they believe that it cannot be cured by biomedicine. The result of Finkler's (1985) research suggests similarities with Ovuka, Boardman, and Oluka (1999) that cultural beliefs about illness determine where, how, and when an individual seeks treatment. For example, like Mexicans, Nigerians believe that mental illness can only be cured by a powerful spiritualist who can negotiate with the evil spirits or witchcraft that caused the illness (p. 277). This shows that both cultural groups hold a similar belief about illness etiology.

Also, Abrahamson, Trejo, and Lai (2002) make similar assertion that cultural beliefs dictate how individuals behave, find answers, share, and adjust to problems during crisis such as illness. Particularly, in mental health, culture influences how patients manage mental health crisis. Cultural factors, such as beliefs, world view, values, and norms affect the overall treatment of illness and success of assessment. According to Abrahamson, Trejo, and Lai (2002) because culture influences illness, practitioners such as psychiatrists and other health care providers need to understand their clients' culture. Therefore, Abrahamson, Trejo, and Lai (2002) call for the need for cultural competence in health care.

What is cultural competence?

Dogra, Vostanis, and Frake (2007) postulate that a clear understanding of cultural competence would help practitioners to become culturally competent service providers. Therefore, they take the challenge to define cultural competence. For Dogra, Vostanis, and Frake (2007) culturally competent health care service involves the ability of practitioners to work effectively within the context of different cultures. The definition depicts cultural competence in health care as a practice model that incorporates systems, agencies, and professionals with the ability to react to the exceptional needs of groups whose cultures are different from the mainstream's culture (p. 138).

The definition implies that the effort to promote a successful culturally competent service involves not only practitioners, but also systems such as institutions and government's agencies. That is, a service is described as culturally competent if the providers and the systems work together to provide equitable and efficient services for minority groups. Thus, cultural competence is not an independent entity - it needs institutions, agencies, or practitioners to be operationalized.

Sue (2006) writing from a medical perspective offers a narrow definition of cultural competence. He defines it as having cultural understanding of a specific culture and abilities to provide efficient interventions to members of that culture (p.237). The author argues that the definition has been adopted by the American Psychological Association's Multicultural Guidelines and it serves as an ideal framework for health care providers.

However, the author underscores the dilemmas of using the definition as a framework for cultural competence practice. Paradoxically, Sue (2006) asserts that the definition is philosophical and it is yet to evolve into practice or a research-oriented stage. Meaning the definition is philosophical because it does not have what he describes as an operational specificity. Sue (2006) goes on to explain that the traditional definition of cultural competence does not address issues such as characteristics of cultural competency, how different cultural competencies can benefit different ethnocultural groups, the feasibility of measuring cultural competency, and the issues of multidimensional versus one-dimensional cultural competency (Sue, 2006, p. 238). According to the author, these issues cannot be ignored in the discussion of cultural competency. They are important elements in understanding cultural competence and help us to measure the levels of cultural competence.

Sue (2006) describes cultural competence as a "multidimensional phenomenon" which involves "scientific mindedness, dynamic sizing, and culture skills" (p. 239). In terms of scientific mindedness, the author explains that a therapist uses hypothesis to draw premature conclusions about a client with a different cultural background. From the context of generalization or stereotype Sue (2006) asserts that the therapist is involved in a dynamic down sizing and tactically knowing when to apply a broad view and be involved and when to individualize and be isolated in working with clients (p. 239). It involves flexible generalization in a credible manner. Moreover, a good therapist has cultural-specific skills if he or she has knowledge about the client's culture.

Sue (2006) goes on to underscore the dilemma with these characteristics by arguing that these characteristics (scientific mindedness, dynamic sizing, and cultural specific expertise) are procedures and it is impossible for a practitioner to be proficient in none, some or all three (p. 239). Sue (2006) offers three strategies that can be used in achieving all three characteristics.

These include:

- Self-awareness: therapists need to assess their cultural values, beliefs, biases, and to recognize the differences between them and their clients.
- Assessment of client: therapists need to understand the level of acculturation of the client, country of origin, race, culture, the degree of the client's experience with discrimination in the society etc.
- Pre-therapy intervention: helping the client to become familiar with Western psychotherapy through orientation programs for the treatments.
- Hypothesis testing: forming a systematic hypothesis about the client
- Attending to credibility: therapists must try to achieve credibility with the client by giving the best treatment that would yield benefit.
- Understanding the nature of discomfort and resistance (therapists must use their discomfort with the client to understand the client's emotional experience).

- Understanding a client's perspective (therapists need to understand the client's perception in the context of treatment goals, ways of resolving problems, and cultural understanding of mental health problems).
- Strategy or plan for intervention (therapists must take into consideration the client's culture, goals for treatment, and ways of achieving goals, in planning for intervention).
- Assessment of session (therapists must evaluate themselves after the end of each treatment session).
- Willingness to consult (therapists must consult and collaborate with cultural experts to find out if the behavior of the client conforms to his or her cultural norms).

Primm, Osher, and Gomez (2005) offer a much broader, but less philosophical, definition of cultural competence. According to Primm, Osher, and Gomez (2005), cultural competence is an embodiment of a practitioner's behaviour, attitude, and policies in the agency to provide to effective service in a multicultural community. The authors argue that the combination of these elements to provide culturally competent service will depend on the practitioner's ability to accept diversity, perform self-assessment, handle the dynamics of differences, obtain and institutionalize cultural knowledge, and become accustomed to diversity and the cultural contexts of the ethnocultural service users they serve (p. 566).

Yee's (2002) definition also highlights the importance of the combination of the practitioner's effort and the institution's policies to promote cultural competence in health care service. Like Primm, Osher, and Gomez's definition (2005), Yee (2002), also highlights the combination of practitioners' behaviours, attitudes, and policies that work together in a society, agency, or among practitioners to promote equitable and efficient service to ethnocultural groups.

James's (2008) definition narrowly emphasizes the ability of practitioners to work with ethnocultural groups. For James (2008), the combined human and institutional efforts are less important in promoting cultural competence in health care and social service. Rather, his definition emphasizes the practitioner's skill to work efficiently with ethnocultural groups or in communities where many different cultures reside. This involves having the ability to comprehend the language, culture, and behaviours of the people and groups, and to make proper suggestions. James (2008) goes on to explain that cultural competence also involves developing cultural awareness (by accepting the value of diversity in population), acquiring knowledge about other cultures, and having skills to work in a cross-cultural setting.

A much different analysis by Reich and Reich (2006), shows that there is no homogeneous definition for cultural competence. Reich and Reich (2006) compare different definitions of cultural competence to draw this conclusion. For example, they cite definitions by other authors such as Stuart (2004), Cross, Bazron, Dennis, and Isaacs (1989) and Lynch and Hanson (1998). Reich and Reich's (2006) analysis of Stuart's (2004) and James's (2008) definitions show that the authors share a common view that a practitioner's ability to understand a client's culture is the most important aspect in promoting cultural competence in health care and social services.

However, according to Reich and Reich (2006) other definitions show dissimilarities. For instance, the definitions by Cross, Bazron, Dennis, and Isaacs (1989) highlight an agency's or individual's behaviors and attitudes, and the ability of those working with ethnocultural communities to recognize the value and shortcomings of the sociocultural environment in which these interactions transpire. Although, Reich and Reich (2006) try to show dissimilarities and inconsistencies in the definition of cultural competence, they fail to realize that these definitions have one thing in common. That is, they focus on the ability of practitioners to work congruently with other service agents to provide effective services to people from diverse cultural backgrounds.

Disparities in health care

Taking the argument to a further direction, Betancourt, Green, and Carrillo (2002) argue that the attempt to find working definitions of cultural competence show that practitioners are keen in promoting equitable and effective services to ethnocultural groups. Moreover, Betancourt, Green, and Carrillo (2002) argue that, these working definitions commonly show that ethnocultural groups have less access to effective and quality health care. The lack of accessibility to equitable health care is compounded by language barriers, sociocultural differences, and different perspectives on health, medical care, and beliefs about diagnosis and treatment (p. 3). For these reasons, Betancourt, Green, and Carrillo (2000) imply that the various definitions are homogenous because they recognize the diversity in the health care and social services.

Betancourt, Green, and Carrillo (2002) go on to contend that the lack of diversity in health care leadership and work force, inadequately designed health care system for minority patients, language barriers between health care providers and patients, are some of the reasons why cultural competence is needed in health care system. For instance, figures presented by the authors show that although minorities represent 28 percent of the U.S. population only 3 percent have access to the medical school faculty, 16 percent in public health school faculty, and 17 percent are county health officers (p. 3). In order to provide equitable service for minority groups, Betancourt, Green, and Carrillo (2002) advocate for the need to increase diversity in medical schools, public schools, and other public service sectors. This would eliminate one-size-fits all approach to health care and social services.

Apparently, Betancourt, Green, and Carrillo, (2002) are optimistic that cultural competence will diminish racial and ethnic differences in health care. They argue that the recognition of the link between cultural competence and the need to increase diversity in the public service sector is imperative. Moreover, the need to reduce ethnic racial and ethnic disparities in health care is also imperative in promoting a successful cultural competence services. They contend that the few who see the relation between cultural competence and the disparities in health care are working hard to improve services at the systemic and clinical levels.

Pumariega, Rogers, and Rothe (2005) make similar assumptions about the importance of cultural competence in reducing disparities in health care. They argue the current disparities in mental health care and the growth in cultural diversity call for the need for cultural competence in health care. For Pumariega, Rogers, and Rothe (2005), the current growth in ethnic populations requires practitioners to become culturally competent in their services to clients/patients. However, the authors argue that despite the growth in minority populations, particularly among children and youth, the ethnic population does not have equal access to mental health services and programs.

Pumariega, Rogers, and Rothe's (2005) analysis of mental health programs for ethnic minority children and youth shows that they have minimal or no access to mental health services because they belong to members of the population with low socioeconomic status, lack of community service facilities, lack of health education and activism, and insufficient culturally competent services and programs that can meet their particular health needs within the context of their cultural backgrounds (p. 539). Also, practitioners from the mainstream population lack cultural competence training. The authors describe these factors as population barriers, provider factors, and systemic factors. According to the authors, these factors should be seen as barriers to adequate, efficient, and effective mental health care service to minority children and youth.

The authors identify misdiagnosis of ethnic minority youth with psychiatric disorders as one of the consequences of these barriers. They argue that more African-American youth were diagnosed with behavioural and mental problems, fewer diagnosed with mood and anxiety disorders, and substance abuse disorder than youth from the mainstream society. (p. 543). They emphasize that misdiagnosis is a result of the failure to implement cultural competence in the health care system. Without cultural competence programs and training, practitioners will not see the cultural differences between the mainstream and minority population.

According to the authors, human psychological development is influenced by culture. Therefore, mental health practitioners or service providers need to become culturally competent. They argue that, cultural norms define developmental stages, such as toilet training, manifestation of sexuality and intimacy, and the readiness to become independent from parents. (p. 540). Also, explanations of problem behaviors and psychological strategies vary among cultures. For instance, whereas hyperactivity in male children is considered normal by some cultures, it is seen as a behavioral problem for other cultural groups (Pumariega, Rogers, and Rothe, 2005).

Importance of cultural competency training

Combs and Luthans (2007) argue that training or educational programs are important but not enough to promote cultural competence. Thus, they propose an additional effort called diversity self-efficacy. The authors offer separate definitions for diversity and self-efficacy. A broad definition of diversity emphasizes cultural dissimilarities among populations. These differences consist of race, ethnicity, sex, ability, beliefs, and age. Similar diversities are found in many organizations or agencies. (p. 91 - 92).

Combs and Luthans (2007) go on to contend that these dissimilarities challenge organizations and states to operate in fairness and in an equitable manner. They cite South Africa as a typical example of a state that is being challenged to promote equity for its diverse ethnic groups and Sweden and France for gender equity. Also organizations such as multinational corporations are being challenged to promote fairness and equity to increase their profit.

As a result, organizations have adopted diversity training as an instrument against these challenges. The training offers knowledge and direction to employees so that they can promote peaceful work environments and encourage interactions with other colleagues at workplace (Combs & Luthans, 2007, p. 92).

In terms of self-efficacy, the authors go on to argue that the fruitfulness of diversity training depends on the trainee's self-efficacy. This involves the trainee's effort or capability to convey diversity training back to the agency (p. 92). In this context, self-efficacy involves a trainee's belief, confidence, perception, and judgment that he or she has the ability to accomplish a goal. The authors use the term diversity self-efficacy to coin these characteristics. They assume that diversity training can only become a transferable concept if the trainees have self-efficacy. In other words, self-efficacy is a motivational force for action: It shapes a person's mind and gives him or her desire to achieve intended goals. Thus, they assume that the effectiveness of any diversity training depends on the trainees' self-efficacy.

However, they also acknowledge some barriers to diversity self-efficacy. These include the psychosocial influences, such as individual biases and stereotypes toward others, that control diversity behaviors and may hinder diversity self-efficacy (p.93). These elements, according to the authors, are covert – thus hard to visualize.

Combs and Luthans (2007) go on to draw a link between self-efficacy and intention. They argue that intentions can predict the future behavior of an individual and have been generally used in research as a substitute for and an instrument for determining future behaviors. Health sciences literature emphasizes this theory by asserting that efficacy beliefs have a direct link with the intentions to promote the best health care practice (p. 96). It involves the trainee's objective or goal. Thus, the trainee, in addition to self-efficacy must have the intention to transfer diversity training to the workplace. The authors conclude that diversity training must be designed to include self-efficacy so that it would have an impact on the trainees' intentions to actively promote diversity at the workplace.

However, Crewe (2004) argues that an effective culturally competent training begins with the school of social work. According to Crewe (2004) increase in the diversity population calls for the need for professionals, particularly schools of social work, to skillfully address the challenges imposed by the new diversity in the country.

One of his reasons is that living in a multicultural society does not sufficiently equip us to understand the complexities of other ethnocultural groups and provide culturally competent services and programs for them. Moreover, the increasing disadvantage ensuing from the disparities created by a separate and uneven society requires greater needs for culturally competent practice and services (Crewe, 2004, p. 46).

At this juncture, Crewe (2004) contends that the responsibility of achieving culturally competent practice rests with social work education. Core curriculum of social work education/training must include some components of cultural competence. It is the responsibility of professors, supervisors, and agencies to prepare future social workers with adequate cultural knowledge to provide culturally competent services and programs to ethnocultural groups.

The adequate knowledge would include a patient's cultural background, ethnicity, race, gender, historical experiences, and socioeconomic status. This approach would help social workers to become experts in both internal and external magnitudes of cultural differences among and between different ethnic groups.

Crewe (2004) goes on to assert that, the new diversity will compel social workers to recognize the commonalities and differences between cultural groups. He goes on to explain that, it would be erroneous for social workers to narrowly look at the external characteristics, such as people, country of origin, linguistic background, cuisine, arts, and clothing to design programs or services.

Social programs or policies derived from these external characteristics alone are conceivable to one-size-fits all services. In order to prevent one-size-fits all services, Crewe (2004) suggests the need to include cultural study in social work educational curriculum. This would help social workers to understand other cultures. Also, it would help social workers to understand their clients' behavior, their societies, and acknowledge the potentials that exist in all cultures. However, Crewe (2004) suggests that it is not enough to provide knowledge of the other culture. Rather, health care policies, programs, and services that social workers work with must also focus on facilitating culturally competent practice.

The College of Nurses of Ontario (2005) provides 6 requirements for cultural competence practice for nurses and other health or human service practitioners. These include self-reflection, acquiring cultural knowledge, facilitating client choice, communication, developing an approach to care, and quality practice settings and culturally sensitive care.

Self-reflection involves the need for a practitioner to assess his or her own culture and practice setting. In terms of culture, the association emphasizes that the individual practitioner must understand the beliefs, values, and biases which he or she has learned and how they affect his or her world view of other ethnic groups. It underscores the importance of self-reflection by saying that it helps the practitioner to recognize the values and biases that emphasizes her/his method and interventions, and their effect on the client (p. 4).

However, the association acknowledges some challenges involved in the process of self-reflection. That is, a practitioner with similar cultural background of a client may intentionally or unintentionally impose his or her values on the client. This may be due to the false assumption that they both share the same or similar cultural values.

The second requirement on the list is the need for practitioners to acquire cultural knowledge. According to the association, although it is impossible for a practitioner to acquire total knowledge of all cultures, it is important for them to at least have a broad comprehension of how cultures influence people's beliefs and behaviors (p. 5). This process begins with the need to realize that behaviors and responses differ in every cultural context. Thus, the association asserts that, in terms of health care individual beliefs and values about health, illness, death, meaning of suffering, and perception about health care providers are affected by culture.

The need to facilitate a client's choice comes third on the guidelines. According to the association, this process involves the need for the practitioner to recognize that the client has different explanations for health and treatment goals. Thus, in order to promote culturally competent care, the association suggests that practitioners must help clients to achieve their particular goals. This demands that the practitioner explore a client's perceptions and try to understand the meaning he or she attaches to the requests and goals.

The fourth guideline is communication. The association sees communication as an important process in providing culturally competent care where there is a language barrier. The role of the practitioner in this process involves using verbal and non-verbal communication to inform the client and his or her family about the caring process. The association suggests an interpretation service as one of the ways of eliminating cultural barriers. Health care providers can use trained interpreters to achieve this goal. Although, the Association prefers the use of trained or medical interpreters for the service, they encourage practitioners to use professional colleague, family members, or community members when they cannot access professional interpreters. Overall, the association prefers professional interpreters and professional colleagues rather than family members and friends. However, it continues to argue that a professional colleague can provide a better interpretation than all the other sources because he or she understands the terminology used in the care service. The association also emphasizes the importance of ensuring confidentiality when using interpreters. That is, the practitioner must remind the interpreter of the need to protect the client's information.

The fifth requirement for culturally competent practice, involves the need to gather in-depth information about the client's culture through open-ended interviews. This would allow the client to give relevant information. The practitioner needs listening skills to absorb the information and, moreover, he or she must be nonjudgmental and must respect the client's cultural beliefs and values.

This guideline suggests that practitioners need to evaluate their client's country of origin, family system, genogram of the family, social class, sex roles, immigration history, and cultural background. The evaluation would help the practitioner to acquire and understand how the clients perceive the problems, their ways of solving problems, and what type of goals they want to achieve. Having completed the evaluations, the practitioner can then hypothesize how different client's beliefs or culture are different from the assumptions of the practitioner. It will force the practitioner to consider the client's culture, goals for the treatment, and ways of achieving the goals.

The final requirement for culturally competent practice is quality practice settings. According to the association, practitioners can provide culturally competent service or programs when there are quality practice settings. Quality practice settings will make diversity the core of policymaking, committees, cultural competent educational materials, provide access to equitable resources, and create linkages between the service providers and service users (p. 12).

Interpreters

Hsieh (2006) argues that although the use of interpreters can help to reduce cultural barriers, as the College of Nurses of Ontario (2005) argues, especially in the health care service, we should not overlook the challenges involved in employing their services. She explains that the use of interpreters in medical settings is challenged by conflicts such as "others' communicative practices, changes in participant dynamics, institutional constraints, and unrealistic role expectation" (p.721).

Hsieh (2006) describes the traditional role of a medical interpreter as a passage for conveying messages between patients and health care providers. The author describes interpreters' role as a conduit because it forces the interpreter to act in an unbiased, authentic, and machine-like way. The conduit role involves interpreting in one language literally what has been said without any alteration (Hsieh, 2006, p. 721). However, interpreters find it very difficult to adhere to the conduit principles as they sometimes find themselves supporting providers when patient-practitioner conflict arises. According to the author, interpreters perceive the conduit principles as a straitjacket because it constrains them from performing their appropriate roles. Hsieh (2006) assumes that the impartial performance is triggered by interpreters' efforts to overcome the conflicts in their role performances. (p. 722).

Hsieh (2006) underscores some of the dilemmas in the use of communication or interpretation in implementing cultural competence. For instance, when the patient-provider encounter produces an emotional environment it becomes difficult for the interpreter to conceal his or her compassion for the patient. Thus, the interpreter is removed from the position of empathy and sympathizes with the patient. This may force the interpreter to assume an advocacy role. The author traces these conflicts/dilemmas to four main factors such as an individual's "communicative practices, participant's and dynamics participant dynamics, and high expectations" (Hsieh, 2006, p. 723).

Hsieh (2006) explains that others' communicative practices are when a patient or provider's communication behavior becomes inconsistent with the interpreter's expectation.

For the interpreter, an effective interpretation or communication is when all statements and expressions are directed to the other speaker before it is relayed by the interpreter (p. 723). However, sometimes, the provider or patient directs his or her statement directly to the interpreter. This is done with the expectation that the interpreter will edit the information or delete any confidential information or unrelated information before transmitting it to the other speaker. This situation, according to the author, creates a dilemma for the interpreter because it challenges the impartial role of the interpreter. The author describes this event as an incompetent behavior of participants and asserts that it can lead to dilemmas/conflicts for the interpreter to adopt a conduit role. She also explains that, cultural factors can make a speaker appear incompetent and less eloquent (p.724).

Furthermore, Hsieh (2006) explains that changes in participants' dynamics can create deviation in an interpreter's conduit role. She also asserts that participation of a second provider or a member of the patient's family in the consultation process may alter the conduit role of an interpreter. This may shift the focus of the discussion from the patient's illness to unrelated issues. Consequently, patient-provider discussion could reduce to provider-provider or family member-provider communication. Thus, the discussion may not be directed to the patient or the provider. This might exclude a participant from the conversation. For the interpreter, interpreting this information is a violation of the professional's code of ethics to protect the client's confidential information (p. 724).

For instance, sometimes a patient may share confidential information with the interpreter during consultation, but may not want it to be disclosed to the doctor. The interpreter loses the patient's trust if he interprets the information to the doctor. Simultaneously, failure or refusal to interpret the information to the doctor is a violation of interpretation principles which require the interpreter to disclose all information. Also, the interpreter loses the doctor's trust if he or she refuses or fails to share the information.

Nevertheless, the Hsieh (2006) realizes that her assumption could be mistaken because the success of interpretation does not depend on only the interpreter's role, rather it depends on the communicative behaviors of the patient, the practitioner, and the interpreter. (p. 722). In addition to these factors, the author asserts that, other external factors such as the institutional policies, culture, and patient-provider relationship can also influence the success of interpretation. For instance, an organization's or an agency's code of ethics and policies can prevent interpreters from execute their duties accordingly (p. 723).

Hsieh (2006) describes these factors as institutional constraints. Institutional culture usually regards a provider's time as a scarce commodity. It expects the interpreter to be conscious of the provider's limited time during clinical consultation. Simultaneously, the provider must adhere to the limited time set by the employer so that they can save the limited financial resource for the program. The conflict here is that, the interpreter finds himself in a situation where the provider is in a hurry to leave and a patient who wants to continue to talk. The author explains that, "in these situations, the provider and the patient may have very different expectations for the interpreter, which create challenges to the interpreter's choice of role performances" (p. 726).

Practicum Setting

Practicum Formalities

Prior to the commencement of my practicum at the Alberta Children's Hospital, I went through some of the formalities for new practicum students and employees. I was invited for an interview with my practicum supervisor and her co-worker three weeks before the practicum date after they had reviewed my resume. The field supervisor took the opportunity to explain her role (as a cultural consultant) and the role of her department. She explained that the department's practice is based on family-centered care for ethnocultural children and their families.

According to her, this is achieved through interpretation service for patients/clients who have low English proficiency. She was also planning to create a language based website where ethno-cultural groups with language barriers could access available resources and bilingual telephone services. Her role in this area involves assisting physicians and other health care providers to provide culturally competent services to patients.

The first day of my practicum started with an orientation session with my practicum field supervisor. I arrived at the Alberta Children's Hospital at 7:15 am (about 1 hour and 45 minutes earlier) for the orientation. The orientation began with formal greetings from the field supervisor. She introduced me to other staff, at the department, and had a name tag and security card made for me. The supervisor also reviewed my learning contract and made some suggestions to remove certain contents and add new ideas to it. She signed the revised version and a copy was sent to my academic supervisor. Furthermore, she assisted me to narrow the focus of my research to specific issues such as evaluation of culturally competent clinical consultation and comparisons between traditional case management models and cultural competence in health care setting.

My practicum began with assignment of two projects in the second week of my practicum. This included updating and adding additional chapters to the 'Enhancing Cultural Competency: A Resource Kit for Health Care Professionals. It contains about 180 pages of information on different cultural practices and beliefs of the major ethno-cultural groups in Calgary. For instance, it provides cultural information on Cambodians, Chinese, Somalis, and South Asians, etc. It was prepared by the field supervisor and with the assistance from former practicum students and other staff at her department.

Why was CWHDP created?

In order to accomplish the objectives of this practicum, I decided to do the required 560 practicum hours with the Child and Women's Health Diversity Program (CWHDP) at the Alberta Children's Hospital in Calgary. CWHDP is a program under the Southern Alberta Child and Youth Health Network (SACYHN). The program was initially funded by British Petroleum –Canada (BP-Canada) in 2002 in recognition of the growing demands for services and programs for the ethno-cultural population at the Alberta Children's Hospital. The initial concern of the Diversity Program was to enhance interpretation services and provide cultural competence training for staff at the Emergency Department and Inpatient Units at Alberta Children's Hospital. Presently, the Diversity Program provides support to health care professionals for culturally competent services and programs to visible minority people.

The objectives of the Diversity Program are:

- To increase awareness of cultural competency among staff within the Child and Women's Health Portfolio and South Alberta Child and Youth Health Network (SACYHN) partners.
- To improve knowledge of culturally competent health care among staff within the Child and Women's Health Portfolio and SACYHN partners
- To enhance skills in the provision of culturally competent health care among staff with the Child and Women's Health Portfolio and SACYHN partners
- To maintain and strengthen relationships with community organizations (Paget & Berzins, 2007, p. 9).

CWHDP is located within the Family and Community Resource Centre of SACYHN on the second floor of the Alberta Children's Hospital. "This extended the Program to support health care professionals in providing culturally competent services to patients and families from culturally diverse backgrounds across southern Alberta" (Paget & Berzins, 2007, p. 8). CWHDP achieves these objectives through the following strategies:

- Collaboration with Calgary Health Region Services
- Provision of Staff Support
- Research and Quality Improvement
- Education and Training Sessions
- Community Partnerships (Paget & Berzins, p. 14).

Structure of SACYHN

The structure of SACYHN consists of a steering committee, working groups, and regional groups. The steering committee is the nucleus of SACYHN and it consists of two groups called key partners and charter affiliates. These groups are drawn from different government organizations whose primary interest and focus are on child and youth health and well-being. For instance, the key partners comprised nine public institutions such as the Alberta education, health, justice, child and family services, and a government corporation. Also members of the charter consist of 19 public and private organizations.

The working groups carry out important projects that support SACYHN. Members of the working groups include members from the steering committee, parents, youths, and the organizational staff who support SACYHN. The components of working groups are communication working group, education working group, evaluation working group, Family Support for Disabilities Act working group, and Family and Youth Participation working group.

The regional groups consist of health care workers from various regions across the province. Serving as coordinators, these members "facilitate the integration of regional priorities with those of the Steering Committee and create a broad sense of ownership and participation within SACYHN" (South Alberta Child Youth Health Network, 2005). There are two representatives from each health region in Alberta: Chinook Health Region in Lethbridge, Palliser Health Region in Medicine Hat, Calgary Health Region in Calgary, and David Thompson Health Region in Red Deer. Serving as coordinators, these members "facilitate the integration of regional priorities with those of the Steering Committee and create a broad sense of ownership and participation within SACYHN" (South Alberta Child and Youth Health Network, 2005, p. 6).

Primary goals of SACYHN

SACYHN is built on collaboration among its members to bridge the geographic distance and disparity in service delivery to service users. The Network serves as a round-table for members to discuss disparities regarding child, family, and youth health and wellbeing in Alberta. SACYHN is committed to the following goals:

- Develop and adopt a shared vision and purpose
- Identify and create opportunities for positive change in service delivery
- Involve families and service providers in significant ways in planning and service delivery
- Build and sustain inter-regional, cross-sector, and clinical connections
- Develop, improve, and utilize electronic linkages (Southern Alberta Child and Youth Health Network, 2005, p. 1).

The mission of SACYHN is to promote "high quality, coordinated programs and service for children, youth and families" (Southern Alberta Child and Youth Health Network, 2005, p. 1). In order to achieve its mission the Network is committed to these ten principles:

- Child friendly, youth focused, and family centered
- Considers all phases of children's development
- Value diversity
- Recognizes the unique health needs of Aboriginal families and ethno-cultural population
- Engages all sectors and service providers relevant to children, youth, and families
- Supports services that are accessible and as close to home as possible
- Promotes successful transitions between services
- Strengthens community responsiveness to the needs of families
- Acknowledges the range of factors that determine health and well being

- Uses research and education to guide planning (Southern Alberta Child and Youth Health Network, 2005).

SACYHN collaborates with other key partners such as agencies, research community, commissions, family services, school boards, health care professionals, and government organizations to successfully achieve its mission.

Practicum Activities

Participation

I achieved my learning objectives through participation in several clinical consultations, updating cultural competence information for practitioners, and attending meetings on child and women's health and well being, and creating cultural information on West Africa for culturally competent practice. I also had several discussions on cultural competence clinical consultation with Linda Kongnetiman (my field supervisor).

As a cultural consultant, Linda serves as a liaison, provides cultural direction, mediates, and acts as a catalyst for change. She has knowledge in health values, beliefs, and practices among many diverse cultural groups. Thus, she serves as a communicator and liaison between the service users and health care providers. She provides cultural directions to the Alberta Children's Hospital so that it can promote culturally competent services/programs. The direction helps to incorporate culture, language, beliefs, values, and traditions into health care services. The directions also facilitate creation of educational materials that would assist practitioners to learn more about their patients. The training and advice she offers helps to reduce the stereotypes and mistrust that many ethnic minority groups have experienced in the mainstream health care and social service setting. She also serves as an agent of change because she has the skill to initiate change in the health care setting by creating opportunity for collaboration between practitioners and ethno-cultural service users.

Committee meetings.

I had the opportunity to attend three of the Child and Women's Health Diversity Program committee meetings to plan for a conference on cultural competence to be held in Calgary in 2010. I was an observer in the first meeting and a participant in the subsequent meetings held at the Alberta's Children's Hospital during my practicum. As an observer, I did not participate or contribute to the discussion. It allowed me to watch the proceedings and learn about the objectives of Child and Women's Health Diversity Program. The agenda of the meeting included a discussion on, cultural competency, update of aggressive behavior in schools and creating innovation services for children and youth. Twelve people who represented various key partners of Child and Women's Health Diversity Program attended the meeting. Organizing members included health care staff/professionals, community members, parents, youths, mothers, and public servants.

The conference will on focus issues such as development of cultural competence in child and women's health and representation of diverse members in mental health care. The committee members discussed how these issues could be addressed at the conference and how it could be used to attract international, regional, provincial, and professional participation. In order to achieve these objectives, the committee members agreed on the need for the planning committee to be comprised of people from different professional backgrounds. They also called for the need for sponsors from the educational department, youth, United Way, and Culture and Immigration Canada.

As a participant, in the subsequent meetings, I made a few suggestions in the last meeting before the end of my practicum. The discussion was based on finding a theme for the conference. Participants came up with several good suggestions but we agreed on a theme, which embraces the objective of the conference. I suggested to the members to include service users on the keynote speakers' list to reflect inclusion of the conference. Although, a few members nodded their heads while I was explaining my point, I was not sure if those who did not show such gesture agreed with me. However, at the final stage of the meeting, other members highlighted my suggestion.

Preparing and updating of cultural competency resource kit.

The Cultural competency resource kit contains about 180 pages. It provides information on cultural beliefs, values, traditional healing practices, and family systems of the major ethno-cultural groups in Calgary. It is one of the resources created by the Child and Women's Diversity Program for health care professionals at the Alberta Children's Hospital for reference on clients' cultural backgrounds.

My first assignment was to review and update the information that has been documented in the kit. Some of the updates include statistics on immigrant population. Having read through the whole chapters, I realized there were no chapters on Sudanese and on West African countries' cultures. Thus, with permission from my field supervisor, I initiated a chapter on West Africa and completed a version on Sudanese which had already been started but not included in the Kit. The process involved researching for general and common cultural information of West African countries and Sudan. The two chapters were added to the existing volume before the end of my practicum. My name has been added as a co-author of the Kit.

Clinical consultation.

I also participated in seven different culturally competent clinical consultations during the 560 hours of my practicum with different team members. The team members of the cultural competence clinical consultation I attended, consisted of psychiatrists, social workers, psychologists, and my practicum field supervisor. An evaluation report prepared by the Diversity Program, before I started my practicum, shows that "71 formal clinical consultations were provided to the Alberta Children's Hospital staff and their families from April 2003 to March 2004. For the fiscal year of April 2006 to March 2007, 72 formal clinical consultations were provided . . . these numbers do not include informal consultations with staff or phone and email consultations" (Paget & Berzins, 2007, p. 15). Practitioners decide when or if they need clinical consultation. A practitioner normally makes a request for clinical consultation when a case regarding diagnostic, care, or treatment issues of a client involves cross-cultural beliefs.

Professionals may request clinical consultation if cultural barriers hinder their services for a client. In other words, practitioners bring cases involving cross-cultural issues to clinical consultation to be discussed with the cultural consultant. I attended my first clinical consultation as an observer. This role helped me to observe the proceedings and focus on the main issues involved in clinical consultations. It lasted for about 45 minutes. "Clinical consultations vary in length from 30-45 minutes to multiple interactions over several days, depending on the individual situation and the time required to explore options" (Paget & Berzins, 2007, p. 15). Therefore, this was one of the longest consultations for the team. The team had met for this particular case prior to the last one I attended.

Generally, all the clinical consultations I attended involved issues such as worldviews, values, language, beliefs, traditions, culture, and customs of the client's ethnic group. These commonalities show that ethnocultural patients/clients are confronted with the same barriers to the mainstream health care and social services.

Sometimes the team may identify one or more of these factors as barriers between the client and the health care providers. Usually, we make recommendations after cultural assessment is done to determine barriers. For instance, when language barriers are identified, the cultural consultant may recommend that the team member/members should provide a professional interpreter for the next appointment with the client. Some recommendations encouraged the practitioners to consult other resources, including the cultural competency card, multicultural competencies practice tool, and a map of community resources for immigrant families developed by the Child and Women's Health Diversity Program.

I assumed a full participant's role in the subsequent cultural competence consultations. For instance, in one of the consultations, where the team members included two psychologists, I was there as a participant–therefore, I had the opportunity to make recommendations and participated in the discussion. Since cultural competency clinical consultation usually involves ethnocultural clients, the team normally tries to identify the ethnicity of the family. This is an important part of all consultations because it helps the team to understand the client's worldviews.

We usually commence every consultation by asking the practitioners about the client/patient ethnicity or cultural backgrounds. The practitioner who is working on the case normally provides information. Since practitioners bring the client/patient's files to the consultation we also have access to other relevant data that may help the team to make a cultural assessment. This means that the practitioners read the report before we begin with the assessment.

However, in a few cases, the practitioners were not able to provide such information. Therefore, it was very difficult to make a cultural assessment. For instance, since we could not identify or link the client's ethnicity to either his mother or father it was difficult for us to identify his cultural background. Thus, we could not make any cultural assessment of the case. The client has half brothers and sisters with darker skin. His father is white and mother is black. This means that the mother has other children from her previous marriage with a black man. We could not identify his mother's cultural background or ethnicity. We could not relate the boy's problems to his mixed cultural backgrounds. However, the cultural consultant suggested that the team could look at the boy's mixed race to see if this could impact his behavioral problem. That is, we needed to consider how the boy fits into both the white and black race. We also needed to know if he felt welcome to by both races, one race, or not welcome by either race? The cultural consultant explained that people with mixed race sometimes experience racial oppression from both sides of their racial backgrounds.

Each consultation was concluded with recommendations, for the team members, to correct the situation. For instance, if language is identified as a barrier to services and programs, the cultural consultant may recommend that the practitioner should employ an interpreter's assistance in his or next contact with the client. In a consultation involving postpartum depression, the cultural consultant recommended that the psychologist needs to explore if the mother has performed all the ritual practices that need to be observed by a new mother as required by her ethnic groups. However it was important for the worker to find out about the mother's belief toward those rituals before encouraging her to adhere to them. This is important because people from this cultural group believe that failure to observe certain rituals after birth can lead to misfortunes.

Debriefing.

Each clinical consultation was followed by a debriefing period with my field supervisor who would usually ask for my cultural assessment or comments regarding the case discussed earlier. Debriefing sessions, with the field supervisor, served as a practice moment for me because it gave me the opportunity to assess the consultation procedure, evaluate the other team member's approach, make a theoretical assessment of the approach, and make recommendations in the absence of the team members. Debriefings took place only between the supervisor and I after a consultation has ended and the team members have gone. Sometimes, the field supervisor would ask me to assess a case from a theoretical perspective.

It also gave me the opportunity to analyze and share my thoughts about every case. I used this moment to apply theory to practice. Linda also used the debriefing periods to elaborate and discuss related issues, ask questions, seek my opinions and answers regarding cases discussed at the consultations.

Case Study

I developed the following case study from one of the clinical consultations I participated in during my practicum at the Alberta Children's Hospital. It illustrates my experience with cultural competence in clinical consultation and the importance of implementing culturally competent health care and social services.

Method

This practicum was with the Child and Women's Diversity Program at Alberta Children's Hospital in Calgary. The man objective of the program is to promote culturally competent health care to ethnocultural groups through cultural competence training and consultation for practitioners in Southern Alberta.

I did not conduct any form of interviews with the clients and participants. Data were gathered from observation and participation in clinical consultations and Child and Women's Diversity Program meetings, review and update of cultural competency resource kit, debriefings with my field supervisor, and informal discussions with my supervisor on cultural competence in health care, direct observation, collective discussions, and analysis of personal documents generated within the group. The participants informally accepted my presence as a full member without formal informed consent.

The participants consist of a multidisciplinary team. This includes social workers, psychologists, psychiatrists, nurses, and a cultural consultant who voluntarily submit cases involving cultural barriers to health care and social services for discussion. In non-clinical consultation sessions, such as meetings, the participants include educators, board members, and other senior public servants.

Data collected include how the practitioners conduct cultural competency clinical consultation involving ethnocultural patients and clients, interactions between the consultation team, specific information concerning health, and cultural and psychosocial barriers to health care. All data, including my daily activities were recorded in a journal, kept in a secured place, for analysis. For the purpose of confidentiality, information on the clients' record at my disposal was not included in this report. The case study is a retrospective description based on memory and consultation notes. Data collected for the case study did not disclose the actual names of the client, country of origin, and other relevant information that may reveal her true identity.

Clinical Consultation process

Amina is a single mother, with five children from Nigeria. She is 25 years old and was married when she was 14 years old. The husband sponsored her to Canada about 8 years ago and they live in Calgary. They divorced the year after her younger child with Down Syndrome was born. She is unemployed and lives in a subsidized house and receives income support from the government and her husband. Amina and her ex-husband brought their younger child to the emergency at the Alberta's Children's Hospital for what she thought was a breathing problem. The child was diagnosed with Down Syndrome.

According to a report sent to the social workers at the hospital, Amina was very aggressive toward the nurses at the emergency: She scolded and raised her hands at the nurses when they attempted to take the child for treatment. Amina and her ex-husband were very angry when they were told to leave the trauma room and attend to their other four children who were in the waiting room alone. However, she insisted on taking the children with her to the trauma room. According to the report, the nurses could not allow the children to accompany her to the trauma room because it is a high-risk area for children. Moreover, children could not be left alone in the waiting room since there were no volunteers to look after the children. She told the nurses that she would never bring the child to the hospital again for treatment.

The two social workers involved in the case tried to control the mother's behavior by talking to her and including her in every point of decision-making regarding the child. Their efforts did not solve the problem. They contacted the cultural consultant (my field supervisor) for ideas and suggestions for appropriate intervention. The request led to clinical consultation with the two social workers.

The consultation began with cultural analysis of the mother's behavior. The team's analysis of the situation shows that the mother's behavior was perhaps caused by: (1) language barriers; (2) different cultural perspective of illness; (3) mistrust of the health care system; (4) lack of culturally competent trained practitioners; (5) misinterpretation of her behavior. The team acknowledged that it was important to deal with the situation in the intervention process.

Cultural Values.

At the consultation, the cultural consultant provided information about the cultural values and beliefs of the family. This helped the team to assess and understand the mother's behaviour from her cultural perspective. Therefore, the team concluded that cultural differences between the nurses and Amina might have caused the misunderstanding. They also agreed that the mother's behavior had to be interpreted from her cultural context before they could correctly describe her as an aggressive woman. The team also identified a language barrier as another cause of the misunderstanding between the family and the nurses. The cultural consulting assisted the team to assess Amina's behaviour from her cultural perspective.

Recommendations.

Also, recommendations were made for home visits by a health care staff to educate the family about the Canadian health care system and a professional interpreter should assist Amina at her future appointment with a social worker or health care workers.

The mother was reluctant to use an interpreter, but the team insisted on arranging one for her and insisted on appointing one for her. Overall, the consultation reflects issues such as cultural competence, oppression, anti-oppression, and family-centred care.

Relationship between culture and illness

Apparently, the team members acknowledged the importance of becoming culturally competent before they could provide equitable and efficient interventions for the client. They also realized that they needed to acquire some knowledge about the culture of the client. These realizations led to the clinical consultation. The cultural consultant provided brief information on some of the cultural beliefs and practice of Amina's ethnic group. She also encouraged the team members to refer to other materials by Child and Women's Diversity Program that provides information about the cultural background of the client. This is important because before we could understand the concept of cultural competence we needed to know the meaning of culture, the link between culture and illness. Also, we needed to see the link between culture and health care and social services.

Morgan (1997) describes culture as a phenomenon and traces its usage to the pre-industrial era when agriculture was the backbone of economic growth of many states. He asserts that the term culture was "derived metaphorically from the idea of cultivation: the process of developing land" (p. 120). Today, culture does not convey the idea of cultivation and development of land. Rather, it is broadly used to refer to the development of knowledge, ideology, values, laws, and daily rituals. "The concept of culture does not necessarily carry this old evaluative stance, being used more generally to signify that different groups of people have different ways of life" (Morgan, 1997, p.120).

Also, Morgan (1997) identifies the relationship between culture and organization. He describes organization as a cultural phenomenon because it is a determinant of a group's behavior. That is every organization has its own culture or way of doing things. For instance, "daily life in an organizational society is full of peculiar beliefs, routines, and rituals that identify as a distinctive cultural life when compared with that in more traditional societies" (Morgan, 1997, p. 121).

This analysis is applicable to social work and health care settings. Hospitals and social service agencies are organizations, with their own culture that shapes the life of practitioners. For instance, a practitioner's conduct is guided by the organization's codes of ethics which is determined by its culture. This implies that "organizational structure, rules, policies, goals, missions, job descriptions, and standardized operating procedures perform a similar interpretive function, for they act as primary points of reference for the way people think about and make sense of the contexts in which they work" (Morgan, 1997, p. 144).

Bonder, Martin, and Miracle (2001) define culture from an anthropological perspective by saying "culture is, that which is shared by people," (p. 35). In other words, "culture is the totality of learned, socially transmitted behavior. It includes ideas, values, and customs of groups of people. It embraces all learned behavior and values" (Schaefer, Lamm, Biles, & Wilson, 1996, p. 31 & 46).

The definition characterizes culture as a learned behavior that is transferable from one generation to another; it is shared through interactions between people and develops from the repetition of same behavior. The repeated behavior becomes the society's norm and expectations, culture is evaluative (values are the element of culture – thus it is the determinant of people's behavior), and culture has continuity with change (cultural identity is eternal, except a person's cultural knowledge undergoes changes when he or she encounters new ideas and situations) (Bonder, Martin, & Miracle, 2001, p. 36).

Also from a broad perspective, culture could be defined as "an integrated pattern of learned beliefs and behaviors that can be shared among groups. It includes thought, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs" (Betancourt, Green, & Carrillo, 2002, p. 1). This means that, culture involves beliefs and behavior that we learned through imitation or socialization. Thus, culture is not a natural phenomenon. It implies that the way we think, talk, form relationships and opinions, and our values are learned behavior from a community or group. Moreover, factors, such as race ethnicity, nationality, language, and gender determine a group's culture (Betancourt, Green, & Carrillo, 2002).

Therefore, the team assessed the situation from Amina's cultural background because it realized that perceptions of illness and disability are profoundly affected by culture. Even such matters as expression of pain have cultural dimensions . . . while there is significant evidence that biological pain reception is identical across ethnic groups, great social variability exists among groups in the extent to which pain is expressed . . . individuals who are experiencing significant struggles to cope may or may not report those difficulties, depending on the cultural value system in which they operate. (Bonder, Martin, & Miracle, 2001, p. 37).

The implication here is that culture shapes illness expression. The argument does not explain how cultural components such as beliefs and practices influence our perception of illness and treatment. Therefore, the question that arises from the author's argument is, how does culture influence illness and treatment?

Finkler (1995) answers the above question by saying, "a people's explanations of illness origins shape illness expression and illness behavior, and they reflect premises about the relation of human beings to the environment, to other human beings and society, and to themselves" (p. 48). In this context, illness expression and illness behavior is determined by cultural beliefs. We need to examine a person's cultural belief before we can understand his or her behavior toward illness. This would allow us to make the link between illness and culture. For instance, Finkler (1995) makes the link from her research on the beliefs Mexicans attach to illness and how it affects their choice of treatment and diagnosis. Finkler's (1995) account shows that:

> Witchcraft . . . is linked with illnesses that are not curable biomedically. It is commonly believed that when an illness is not curable by physicians, it must surely have been caused by witchcraft . . . because biomedicine fails to cure or alleviate an array of dysfunctions, numerous illnesses fall under the category of caused supernaturally. This includes psychotic episodes . . . characterizing persons who don't know what they are doing, who respond inappropriately to given situations, and who have lost their five senses (p. 51).

Also, many societies in Africa believe in the existence of the ancestor spirit. These societies believe that serious illness is caused by an ancestor spirit and it is curable only by a traditional healer. They believe that, "serious illness or other misfortune can result if a descendant should fail in his or her obligations to the ancestor spirit" (Okpako, 2006, p. 239).

Thus, people whose illness cannot be cured by biomedicine seek healing from traditional healers. Traditional medicine in Africa uses plant and animal parts for medicine.

Also, belief plays a role in the choice of diagnosis. Divination and incantation are used for examining the causes of illness. Divination involves consulting a fetish priest to find the obscure cause of illness.

Okpako (2006) makes the following argument to explain the importance of divination in African traditional healing:

> If divination reveals ancestor spirit anger, exposition of the hidden misdemeanor for ritual treatment is a necessary part of managing the illness. The rituals accompanying the use of herbal medicines are referred to as incantation. Incantation is medical poetry. It is a collection of carefully chosen words used to bring out the healing effect of the medicine (p. 239).

Incantation is used for removing "emotional contradiction from the mind of the patients and his or her relatives, and assuring them that everything possible is being done in the cultural context to heal the sick person" (Okpako, 2006, p. 239). This is similar to cognitive theory, which focuses on behavior that bothers persons and people around them. Like incantation, the therapy focuses on changing the client's behavior by removing the problem from his or her mind (Payne, 2005).

Incantation medicine is prepared from plants and animal parts. These plants include those used for minor illness and for serious illness. For example, a person experiencing minor illness such as headache, bruises, fever, will resort to plants meant for minor illness. This kind of treatment does not require incantation or divination. A person experiencing "life threatening illness where supernatural agents are believed to be the cause" may employ "plants used for serious illness" (Okpako, 2006, p. 240). This means that, beliefs in supernatural causes of illness influence people's decision to seek cure from traditional medicine through either spiritualists or herbalists instead of biomedicine. This may explain why some ethno-cultural minorities groups in Canada are reluctant to seek medical advice or follow doctors' treatment programs.

What is cultural competence?

Various definitions

As mentioned earlier, having a clear understanding of culture, the link between illness and the client's cultural background helped the team to provide culturally competent care and services for Amina. "Cultural competence . . . describes the ability of systems to provide care to patients with diverse values, beliefs, and behavior, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt, Green, & Carrillo, 2002, p. 5). The definition assumes that cultural competence promotes equitable, efficient, and adequate health care services and programs to ethnocultural minoritized groups. This means that cultural competence provides services and programs that take into consideration a client's/patient's cultural background.

Cultural competency is typically used in the context of clinical encounters or relationships between practitioner and clients, physician and patient, health professional and service recipient . . . Cultural competency sometimes is used in the context of just race or ethnicity, but the concept is also frequently used more broadly to include references to gender, sexual orientation, disability, and class. (Geron, 2002, p. 41)

That is, cultural competence defines the relationships between service providers and ethnocultural service users. The type of relationship the author is implying is respect for cultural differences – that is, a relationship devoid of ethnocentrism. Thus, cultural competency prevents practitioners from examining their patients' or clients' cultures through the eyes of their own culture. It involves overcoming the tendency to perceive other cultures from their own cultural perspective. Also cultural competence is defined as a "set of congruent behaviors, attitudes, and policies found in a system, agency, or a group of professionals that enables them to work effectively in a context of cultural differences" (Cross, Bazron, Denis, & Isaac, 1989, cited in Pumariega, Rogers & Rothe, 2005, p. 546). The definition assumes that cultural competence is applicable in every system, agency, and professional organization that provides services or programs to minorities.

For Sue (2006), cultural competence is when a practitioner has gained cultural knowledge and the skills for delivering equitable and efficient care for ethnocultural groups. These include cultural awareness and beliefs, (providers must acknowledge his or her cultural biases), cultural knowledge (having knowledge of the client's cultural background), and cultural skills (the practitioner's ability to provide intervention that is culturally relevant). This definition assumes that:

> Equipping service providers with knowledge about the culture of various ethno-racial communities, in the belief that ignorance and prejudice about cultures different from one's own can lead to culture insensitivity and discrimination . . . Many within social work practice hold the view that if one can better understand the behaviour, culture, and perspectives of an ethno-racial group, then cultural respect, validation, and acceptance should follow. (Yee & Dumbrill, 2003, p. 98).

The definitions fail to provide a whole picture of cultural competence. For instance, Betancourt, Green, and Carrillo's, definition (2002) focuses on the need to improve and equip the system to provide equitable services and programs for people with different cultural backgrounds. His assumption is that, cultural competence is when the system (an agency/organization) is able to provide equitable and effective services and programs to ethno-culturally minoritized groups. The definition looks at cultural competence from a macro level perspective and places the responsibility to implement cultural competence on the system.

Geron's (2002) definition overlooks the role of policies or system in implementing cultural competence. His definition focuses on the clinical relationship between practitioners and clients. Thus, a service or program is culturally competent if there is an established relationship between a practitioner and his or her client. This relationship is created through the practitioner's respect for the client's culture. Also the definition broadly looks at cultural competence by considering all marginalized persons such as gays, and lesbians.

Pumariega, Rogers, and Rothe's (2005), definition implies that cultural competence is when policy makers and service professionals are tolerant toward cultural differences. However, Sue's (2006), definition offers the process of cultural competence. The process involves learning about a client's culture, self-assessment of the practitioner, and developing skills to apply them. Thus, cultural competence is when a practitioner has fully completed these processes.

If we want to get the whole picture of cultural competence we need to formulate a new definition that would include all the different parts of cultural competence provided by the authors. Therefore, cultural competence is when a practitioner has fully acquired the knowledge of his client's cultural backgrounds and the skills to apply them, when the system is improved to provide equitable services for all marginalized people, involves culturally established relationship between a practitioner and his or her client, and when policies and a practitioner's behavior and attitudes are culturally tolerant. Working with one definition can lead to deficiency in providing culturally competent service.

Why do we need new cultural competence strategies?

There are concerns that ethnic minority groups are not given the same quality care as the mainstream population. These concerns show that there is a deficiency in the cultural competence strategies. For instance, the underserved, undervalued, or minority groups have difficulty getting appropriate, timely, high-quality care because of language barriers and that they may have different perspectives on health, medical care, and expectations about diagnosis and treatment. Achieving cultural competence in health care would help remove these barriers, supplanting the current one-size-fits-all approach with a system more responsive to the need of an increasingly diverse population (Betancourt, Green, & Carrillo, 2002, p. 3).

Also, Pumariega, Rogers, and Rothe (2005) provide evidence for the failure of the current cultural competence practices. They assert that there are barriers to efficient and effective mental health care for minority children and youth. These include socioeconomic disparities, poor health education, service locations, and systemic factors. (p. 542). Minority groups, such as African Canadians from Nova Scotia, also score very low on the health care scale. Kumanan (2004) makes a similar assertion to show that women from this group have the highest incidence of pre-term labour and low birth weight babies. This community also faces higher risk for disease such as diabetes, hypertension, and sickle cell anemia, all of which can cause complications in pregnancy and result in unhealthy babies and children (p. 1).

Failure of case management models

Traditionally, the role of social workers in health care settings is case management. The current case management practice represents the values of the mainstream Canadian culture. Consequently, health care providers and social workers working with ethnocultural families are "directly confronted with questions of values, meanings, norms, and attitudes concerning such themes as sickness, dependency, care, family dynamics, and gender relations" (Guberman & Maheu, 1999, p. 127).

The case management role may include clinical specialist or clinical case manager. It constitutes a variety of services provided by different practitioners with various healthcare training. Each practitioner has his or her specific functions. A practitioner may perform several functions as a member of the team. Thus, the description of the roles or functions of a social worker as a case manager is an uphill-task. Berkman, Gardner, Zodikoff, and Harootyan (2005) make the following assertion:

Clinical specialists teach older adults about health and health promotion, counsel and advocate for individuals and families to help them better manage health conditions and treatment, and collaborate with multidisciplinary health care teams around psychosocial issues, patient and family management, treatment adherence, and ethical issues" . . . whereas, "clinical case managers engage in education, counseling, social brokerage is designed to guide . . . individuals and their families through the health care system and gain access to essential resources (334).

However, it is very difficult to draw distinctions between clinical specialist and clinical case manager because their roles overlap. Both function as educators, counselors, and advocacy for individuals and their families. The distinction between clinical case management and clinical specialist and the numerous roles played by case managers are ambiguous. Peterson, Drone, and Munetz (1997) argue that "case management suffers from a lack of consensus regarding its definition, essential components, and appropriate application. Meaningful comparisons of various case management models await such a consensus" (p. 245). Hromco, Lyons, and Nikkel (1997) make a similar assertion that the concern for "case management for persons with severe mental illness has been the lack of consensus and clarity regarding the role of case managers This ambiguity is problematic for planning, monitoring, and evaluation of the case management service" (p. 415). The authors go on to lament that private the service sector which has no direct clinical contact with patients has also adopted case management to describe its roles.

Hepworth et al (2006) argue that the proper way of understanding the role of case management is to perceive it from micro and macro levels. According to the authors, "as a macro strategy, case management functions to locate, organize, coordinate, monitor, and evaluate services at systems level" (p. 450). In health settings such as long-term care, macro functions of case management will include "utilization review, program management, and locating and coordinating a defined group of services for a specific group of people" (p. 450). On the micro level, case managers' roles involve the following:

Acting as an advocate, broker, and mediator. In some instances, case managers may be involved in direct practice. The case manager's role focuses on work at the interface between clients and their environments. In recent practice models, the case manager has moved to the forefront of direct social work practice as providers have recognized that the needs of increasing numbers of clients with major disabilities (e.g., frail elderly developmentally and mentally disabled persons) were not being met because these people could not negotiate the complex and often uncoordinated human services delivery systems (Austin, 1990, cited in Hepworth el al, 2006, p. 251).

Stanard (1999) provides us with a clear traditional definition of case management. According to him, "the term case management is used to describe a variety of interventions that yield differing client outcomes. The definition and purpose of case management is largely dependent upon the model under discussion" (p. 170).

Analysis of these definitions show that, the general roles of a case manager may include assessing a client's needs, ensuring that a client receives good services, and coordinating with other service providers for a client's needs. These functions are carried on through locating care providers, providing information on services to clients, and making referrals. However, despite the lack of clear description or definition of case management, it is a widely accepted tool in social work and health service practices. Service providers have adopted different, but related, interventions under the traditional description of case management. Thus, case management consists of a variety of interventions but with a single focus on continuity of care.

The mental health community has proposed numerous theoretical models of case management for severe mental illness . . . while most models include service system management as an important component, they most often differ on whether the case management is seen primarily as systems coordinator or a therapist" (Hromco, Lyons, & Nikkel, 1997, p. 416).

The authors' emphasis is that different interventions have led to different models of case management – meaning the type of service determines whether the model is focused on service delivery or therapy. Peterson, Drone, and Munetz (1997) identify the full support, personal strengths, rehabilitation and expanded broker as the four models of case management used by many professionals. Holloway and Carson (2001) make a similar classification of case management. The authors' list includes assertive community treatment (ACT), intensive case management (ICM), strengths and rehabilitation models. Bedell, Cohen, and Sullivan's (2000) models of case management include full service, broker, and hybrid. However, all the models have common broad goals. That is, to promote a continued health care for long-term care users, accessibility, accountability, efficiency and to prevent a prolonged hospitalization. (Holloway & Carson, 2001, p. 22).

"Broker case management provides very little direct service to patients. Rather, services needed by the patient are arranged from among those available in the community" (Bedell, Cohen, & Sullivan, 2000, p. 181). Stanard (1999) echoes a similar assertion by saying that broker case managers link patients to services that he or she needs. For seniors in long-term care, this method focuses solely on services that meet a client's health needs. The service may be given at the medical clinic or in the community.

A case manager working within the brokerage model acts as an enabler, system coordinator and broker of services. Within this model functions to be carried out are the assessment of client need, the development of a comprehensive care plan for the client, the arrangement of service delivery, the monitoring and assessment of services, and evaluation and follow-up (Holloway, 1991, cited in Holloway & Carlson, 2001, p. 23).

The full support model combines teaching of coping skills with clinical management and the provision of support to clients in the community. A treatment team consisting of specialists in critical areas, as well as case managers provides service. Treatment planning and services are determined by the treatment team as opposed to the client (Robinson & Toff-Bergman, 1989, cited in Stanard, 1999, p. 170).

Within this model, the case manager provides direct services for seniors receiving long-term care. Thus, the case manager is responsible for both the senior's physical and social needs. Apart from the senior's medical needs, the case manager is concerned with the client's material needs such as housing, social benefits, "transportations, families and social networks" (Holloway & Carson, 2001, p. 23).

Holloway and Carson (2001) identify a fifth model called The Care Program Approach (CPA) which is popularly practiced in England. They lump these functions under five categories: They include, "an initial . . . (engagement, assessment and planning), environmental interventions (linkage with community resources, consultation with caregivers, maintenance and expansion of social networks, collaboration with physicians and hospitals, advocacy), patient-intervention, and patient environment interventions" (p. 23).

Bedell, Cohen, and Sullivan (2000) describe this model as hybrid case management. The key mission of care program approach is to ensure that patients in long-term care who are receiving secondary mental health services are given thorough assessment, care planning, and follow-up. This is to ensure that clients are prevented from falling through the cracks. In terms of its position among the other four models, "the CPA lies somewhere between brokerage and clinical case management. The keyworker . . . provides some direct care and coordinates the overall mental health care package." (Department of Health, 1999, cited in, Holloway & Carson, 2001, p. 23).

Examples of the hybrid model include, "Intensive Case Management, Expanded Broker, Family Case Management, Personal Strengths, Rehabilitation, and Clinical Case Management" (Rubin, 1992; Solomon, 1992; Chamberlain, & Rapp, 1991, cited in Bedell et al. 2001, p. 181). In other words, hybrid case managers provide some direct services and may broker other services at the same time. Although, most authors agreed with Bedell's analysis, they do not lump them under one classification as he has done.

"The strengths model focuses on the client's strengths rather than pathology. Interventions are based on client-determined goals, the importance of the relationship between the client and case manager is emphasized and there is a strong belief that" seniors experiencing severe mental sickness "can grow and change" (Holloway & Carson, 2001, p. 25). The main focus of this model is finding and enhancing client strengths and providing resources that would enable the client to integrate into the community with the goal of improving the quality of his or her life. The model opposes emphasis on a client's disability. Rather, it holds a perception that clients have strengths that can be used in overcoming disabilities.

The rehabilitation model underscores the urgency of helping a client define his or her goal, "incorporates rehabilitation assessment and the remediation of deficient instrumental and social skills, coordinating and linking patients with community services, monitoring of progress and advocacy" (Holloway & Carson, 2001, p. 25). Its focus is not only identifying and enhancing client's strengths, but also recognizing and assessing disabilities and remediating them. In other words, the main focus of intervention plans are on strengths and deficits of the clients.

"Typically, a single form of case management, or at most two, is available within a particular agency" (Peterson, Drone, & Munetz, 1997, p. 246). Unfortunately, these models do not make any references to the importance of cultural competence - they do not consider the importance of clients' cultural backgrounds. "The dominant group, most often without realizing it, projects its experience and culture as representative of all humanity. Our social institutions are based on the culture and experiences of the dominant group, and our educational system, the media, the entertainment industry, literature, and advertising reinforce this notion of a universal culture" (Mullaly, 2002: p. 46).

This means case managers provide one-size-fits all services to service users. Moreover, service users are deprived of appropriate services because there are only one or two models of case management available for them. For instance, a client or patient receiving a service from a broker case manager receives indirect services for only his health needs. Service users are deprived of direct services for their physical and social needs provided by a full support case manager because the service provider does not provide particular services. Consequently, this may lead to inequitable, inefficient, and inadequate service for the client. The models overlook the fact that clients/patients are not homogenous in their culture, values, and norms.

Proportion of immigrants in Canada

The number of ethnocultural groups in Canada is increasing, and this is challenging the health care and social assistance delivery in Canada. Prior to the lifting of the discriminatory immigration policy in Canada, most immigrants in Canada were European. Lately, the minority population is growing faster than those from Europe. For instance, the main source of immigration has moved from Europe to Africa and Asia. Immigrants from these regions are likely to confront barriers such as cultural differences from health care and social service providers. “A higher proportion of this population is made up of children and youth and in addition, a higher proportion of immigrant adults are in their childbearing years – about 50 percent versus 31 percent in the general population in 2000” (Kumanan, 2004, p. 1).

This makes Canada one of the most ethnically and racially diverse populations in the world. As a result, the population is becoming more ethically diverse. The present delivery systems need to be redesigned to manifest the diversity of Canada’s population. Therefore, it is imperative for practitioners to explore delivery strategies that provide equitable and efficient services by addressing issues of diverse cultural values, norms, beliefs, and experiences of the ethnic minority groups in Canada.

The result of lifting the discriminatory immigration policy was seen in the 1980s. Between 1981 and 1996, 2.1 million immigrants arrived in Canada from non-European continents such as Asia and Africa. "The average annual inflow of immigrants increased from just over 100,000 during the first half of the 1980s to 235, 000 per year during 1991 to 1995" (Citizenship and Immigration Canada, 2001). The increase has made Canada one of the highest immigrant receiving nations among the OECD countries.

Detailed analyses of the 2006 Census on immigration and citizenship show the growth of the immigrant population and the composition of the various language groups in Canada. The 2006 Census shows that 6,186,950 of the Canadian population are foreign born. This number accounts for 19.8 percent of the population in Canada – the highest in 75 years. "Between 2001 and 2006, Canada's foreign born population increased by 13.6 percent. This was four times higher than the growth rate of 3.3 percent for the Canadian born population during the same period" (Statistics Canada, 2007). According to the report, 1,10,0000 immigrants arrived in Canada between 2001 and before the end of 2006. These new immigrants made up of 17.9 percent of the foreign born population and 3.6 percent of total population in Canada.

The largest proportions of the newcomers were from Asia – 58.3 percent of the total new immigrants who arrived in Canada in 2001. Comparatively, "in 1971, only 12.1 percent of recent immigrants for this period were born in Asia" (Statistics Canada, 2007). European newcomers have declined from 61.6 percent, in 1971, to16.1 – making it the second largest group of newcomers in Canada

The composition of non-Europeans newcomers shows that in 2006 about 10.8 (increase from 8.9 percent in 2001) percent of new immigrants come from Central and South America and the Caribbean and 10.6 (increase from 10.3) percent were from Africa. (Crewe, 2004, p.45)

This diversity will require more culturally competent social workers and health care practitioners because these immigrants arrive here with their cultural beliefs, values, norms, and practices. (Bonder, Martin, & Miracle, 2001).

Immigrants from these countries are more likely to face language barriers and cultural differences from their health care providers. A higher proportion of this population is made up of children and youth, and in addition, a higher proportion of immigrant adults are in their childbearing years, 50 percent versus 31 percent in the general population in 2000 (Kumanan, 2004, p. 1).

Psychologists, social workers, and other health care professionals, the movement to make professional education and services more culturally competent is seen as a professional opportunity and imperative . . . to correct the incomplete and often inaccurate presentation of people of color and other historically underserved and undervalued populations that has heretofore characterized research, scholarship, and professional education. (Geron, 2002, p. 39)

Oppression

As a recent immigrant, member of the ethnic minority, single mother, dependent on social assistance, and unemployed, Amina is subjected to many forms of oppression. Mullaly (2002) defines oppression as the “domination of subordinate groups in society by powerful (political, economically, socially, and culturally) groups” (p.27). For Gil (1998), “oppression refers to a mode of human relations involving domination and exploitation - economic, social, and psychological - between individuals; between social groups and classes within and beyond societies; globally, between entire societies" (1998: p. 10). The key themes conveyed by both definitions are unequal distribution of societal wealth, domination, exploitation, inhumane treatment of other groups, and superiority and power over other groups. In this context, the oppressed are the underserved and undervalued populations. They include ethnic minority groups, such as Africans, Asians, and Natives population who reside in Canada. These groups are characterized as the underserved, undervalued, dominated, exploited, and subordinated. Amina is among the following category of immigrants in Canada who earn less than $10, 000 a year or no income:

> Four out of ten . . . recent immigrants, 38 percent of men and 39 percent of women, experience low income . . . they live in families with income less than one-half of median family income, or, if they do not live in a family, have income of less than one-half of the median income of unattached individuals. (Citizenship and Immigration Canada, 2001)

Policy of discrimination

For Christensen (2003), the current experience of oppression by minority groups in Canada, can be understood from the past laws and theories which he describes as policies of exclusion. These include Darwinism, the Indian Act of 1876, the Code Noir, and the Immigration Act of 1923. He argues that the policies of exclusion were strategically designed by policy makers to oppress minorities while giving special privileges and status to the "British and French" (Christensen, 2003, p.76). For example, the forefathers supported "the prevailing racist ideology of Manifest Destiny based on social Darwinism" (p. 76). They considered themselves as superior beings and with moral responsibility to civilize other racial groups through assimilation policies. “This served as a rationalization for colonial exploitation by the French and the British, and shaped attitudes and social policies that affected racialized groups” (Christensen, 2003, p. 76).

The oppression of the Aboriginal people was enforced by the Indian Act of 1876. The Act served as an instrument of subjugation, discrimination, assimilation, and deceit of the Aboriginal people. For instance, it empowers the Department of Indian Affairs to take “control of the land and resources, relegating the original peoples to reserve Crown lands, which they could not sell. Suffice it to say that the results left Aboriginal people, for the most part, in conditions of abject poverty” (Christensen, 2003, p. 77).

In terms of African-Canadians, Christensen contends that the Code Noir was intended to subjugate them. Although, they were one of the first people to come to Canada from the United States, they have been subjected to discrimination for centuries.

> In 1689, Louis X1V of France gave legal assent for Black slaves to be provided for the fisheries, mines, and agriculture in the French North American Colonies. . . the Code Noir, a social policy . . . also protected Whites from slave revolt . . . In the Canadian colonies, government-supported social policies ensured that Blacks remained unequal, living in segregated communities, and occupying a caste-like status outside of the opportunity structure . . . they were subject to race riots and the destruction of their homes and were denied land ownership, food rations . . . fair wages, and employment opportunities. (Christensen, 2003, p. 77)

Also, the Chinese and Japanese immigrants, who arrived later in the 19 the Century, were kept in ghettos and restricted to “cheap, and casual labour to perform specific menial tasks, such as working on the railroad or in the mines” (Christensen, 2003, p. 78). They were subjected to various forms of intimidation from both levels of government and the public. The oppression of Chinese and Japanese immigrants was supported by the Immigration Act of 1923. The earlier "Immigration Act of 1869 excluded undesirables, such as criminals, the diseased, Asians, and Blacks. In 1884, the Royal Commission on Chinese Immigration reported that the people of British Columbia wanted legislation restricting the province to people of the European race" (p. 78).

In his description of oppression, Mullaly (2002) gives us a vivid picture of oppression by asserting that "what determines oppression is when a person is blocked from all opportunities to self-development, is excluded from full participation in society, does not have certain rights that the dominant group takes for granted, or is assigned a second class-citizenship, not because of individual talent, merit, or failure, but because of his or her membership in a particular group or category of people" (2002; p. 28). He describes these groups as people of colour, women, poor people, gays, lesbians, etc.

According to Mullaly (2002), oppression includes exploitation, marginalization, powerlessness, and violence. Due to limited space set for this discussion I will discuss only two of them.

Marginalization: marginalization is when whole groups of people are excluded from "useful and meaningful participation in society, and this, in turn, may lead to severe material deprivation" (2002; p. 43). It also benefits those against whom it is not directed, by affording certain privileges. That is, for every qualified minority who is denied a position because of his or her gender or physical characteristics, there is a majority group member who is awarded that same position because of his or her colour.

Powerlessness: Mullaly (2002) describes powerlessness as “a lack of decision-making power” (p. 44). Powerlessness is a result of being at the bottom of the social ladder and it can lead to inhumane and disrespectful treatment. The groups who are generally powerless are people of colour, women, disabled, and low paid workers. Amina was powerless because she is a woman, unemployed, and a person of colour. In order for her to gain decision-making power, she must fully be assimilated into the mainstream cultural.

Assimilation is an essence of monoculture. I concur with both conflict and functional theorists that monoculture serves to maintain the privileges of some groups while keeping others in a subservient position. Monoculture or assimilation, therefore may offer reasons (justifications) for unequal social arrangements.

Hepworth et al. (2006) makes the following assertion:

> The profession of social work is devoted to empowerment so that people can make their own decisions because it is founded on humanitarian and egalitarian ideals. Social workers believe in the intrinsic worth and dignity of every human being and are committed to the values of acceptance, self-determination, and respect of individuality. They believe in the obligation of all people, individually and collectively, to provide resources, services, and opportunities for the overall benefit of humanity. The culture of individuals, families, groups, communities and nations has to be respected without prejudice. (p. 34)

The underlying view of Hepworth et al. (2006) is that in order to enhance human well-being and help meet the basic needs, social workers must empower people like Amina (people of colour, women, disabled, the unemployed, and low paid workers).

Intervention

Definition of intervention

The primary objective of all the clinical consultations I participated in was to find appropriate intervention for the clients. Therefore, the two social workers and the cultural consultant, who were present, at the consultation were concerned with finding appropriate/culturally competent intervention that would remove the cultural barriers between Amina and the health care providers. Appropriate intervention would facilitate access to equitable, efficient, and adequate services to Amina's child.

"Intervention is the action that the social worker and client take toward solving the problems. Intervention flows from the assessment and the established goals" (Heinonen & Spearman, 2006: p. 159). The definition is based on the assumption that intervention provides treatment and prevention of a problem. The two different kinds of preventions mentioned, by the author are primary prevention (effort to block a problem before it occurs) and secondary prevention (trying to stop a new problem while working on current one).

Mullaly makes a similar argument to relate social work to oppression, by saying that "the work of the social services sector is to treat, ameliorate, and/or attempt to eliminate the causes and consequences of social problems such as poverty, crime, alienation, homelessness, child abuse/neglect, spouse abuse, runaway adolescents, and so on" (2002; p. 3).

Anti-oppressive practice

"Anti-oppressive social work involves intervention that is not confined to individuals but that spans the social structural level of society. It involves critical reflection about oppression and its harmful effects on clients and action based on learning from such reflection" (Heinonen & Spearmam, 2006; p.141).

Social workers' approach to anti-oppressive practice involves critical thinking and examination of clients who are being oppressed. This allows them to assess the "oppressive conditions, process, and practice that exists at the personal, cultural, and structural levels" (Heinonen & Spearman, 2006; p. 142). According to Payne, the main foci of anti-oppressive practice are to "reduce inequalities and marginalization by policies and practices that promote social inclusion" (Barry & Hallett, 1998, cited in Payne, 2005; p. 271).

In order to promote effective anti-oppressive social work practice, Turner suggests that social workers must move from the traditional Eurocentric social work practice to what he calls inclusive social work practice. "Inclusive social work practice acknowledges the fact that social workers need to draw upon a range of knowledge, skills, and methods to achieve an understanding of others' situations" (Turner 2002, p. 57). It requires assessment of our perception and thought about others. Inclusive social work practice tends to promote practices that are respectful of others' worldview, values, culture, and customs. At the policy level, inclusive social work practice needs to focus on policy, research, administrative practices that tend to discriminate other groups within our society.

Today, practitioners and educators in the social work field have adopted a variant of anti-racism practice commonly known as anti-oppressive practice. Anti-oppressive practice embodies a person-centred philosophy; and egalitarian value system; and a methodology focusing on both process and outcome . . . often, now, the rhetoric of anti-oppressive practice presents a politically correct code word that has become a method of practice that assumes equality, equity and social justice. (Dominelli, 1996, p. 3, cited in Yee, 2002, p. 90)

However, "anti-oppressive practice embodies not just anti-racism practice: in-depth analysis shows that some features of the anti-oppressive approach reflect influences of Marxist, socialist, and radical ideologies, structural/sociological understanding of intersecting oppressions, and emancipator, and feminist perspective (Dominelli, 2002; Payne, 1997, cited in Sakamoto & Pitner, 2005; p. 436). Sakamoto and Pitner (2005) go on to assert that "based on these theories and perspectives, eradication of oppression through institutional and societal changes is seen as an ultimate goal. In fact, these features are the cornerstones of anti-oppressive and anti-discriminatory perspective" (p.436).

The practice is based on the assumption that "society is generally oppressive and that the social workers must do their best to offset this . . . anti-oppressive practice is about minimizing power differences in society and maximizing the rights to which all people are entitled" (Dalrymple & Burke, 1995; Dominelli, 2002, cited in Wormer, 2005: p. 4). In other words, anti-oppressive practice is committed to social justice, social change, emancipation, and taking the side of people who have been subjugated by structural inequalities such as poverty, sexism and racism and seeking to assist them in their desire to reverse the position they are in (Wilson & Beresford, 2000: p. 554).

However, some of the current anti-oppressive approaches and antioppressive acts have failed to alleviate oppression. Some of the anti-oppressive practices have failed to focus on broad societal concerns and social conditions that create and sustain problems experienced by individuals or groups. That is, the social worker has a professional duty to assist his or her clients to externalize problems and conditions beyond the individual level. Focus groups should be convened to explore issues related to oppression within a particular location. This approach usually occurs at the macro-level.

By definition, macro practice has its focus problem solving around situations or problems at the systems rather than the individual level . . . social work practice on the macro level is the practice of helping people solve social problems and make social change at the community levels . . . social work unlike any other profession has accepted as its mandate a focus on person-in- the -environment, social justice, oppression, and equality. (Hepworth et al., 2006; p. 410).

The mandates place social workers in a position to advocate for anti-oppression. Pollack (2004) argues that anti-oppressive practice attempts to look at clients' problems within social context in order to understand them. This approach endeavors to move away from professionalism/expert "model of service delivery toward one that is more inclusive of clients' experiences and that incorporates recognition of coping and resistance to oppression" (p. 693). The approach allows service users to assess written works or practices and contribute to the volume of knowledge and structures that determine and encompass anti-oppressive ideas and practice. The approach also includes the following:

Theories, models, ideas, proposals and demands which have been developed by the movements of social care service users . . . such knowledges are increasingly being documented by service users and their organizations and are to be found in a large and growing canon of commercially and independently produced literature and other materials, including textbooks, reports, newsletters, web sites, internet listings, media programs and documentaries. (Wilson & Beresford, 2004: p. 561)

Cultural competency clinical consultation

Many researchers suggest ways to implement culturally competent programs and services. For some practitioners, culturally competent care can be implemented through diversity training, for staff. The training should "relate to clinical context whilst being mindful of the political frameworks" (Dogra, Votanis & Frake 2007, p. 140). The potential and self-efficacy of the trainees to apply the training at the job are considered important.

For others, culturally competent programs and services should involve building cordial relations with the communities around the service centers, making culturally responsive service policies, and hiring from the communities to create a workforce that reflects the diversity of service users (Aries, 2004). For Hsieh (2006), implementation of culturally competent services and programs should include elimination of language barriers, by providing interpreters for service users who do not speak English. These will help ethno-cultural patients/clients to access resources and promote efficient and equitable health care. In addition to the need for training and building cordial relations, other researchers focus on creation of ethno-cultural guidelines. That is, practitioners rely on written guidelines for culturally competent practice at their agencies or departments. These include self-assessment, enquiry about a client's cultural background, and the need to acquire cultural knowledge, (College of Nurses of Ontario, 2006; Crewe, 2004).

Dogra, Votanis, and Frake (2007) explain that agencies, practitioners, and systems must have the capacity to implement culturally competent service. They argue that many organizations have designed numerous training materials and workshops to equip mental health workers with the capacity needed for culturally competent service. However, they argue that "to date there has been little evidence that cultural diversity training makes much, if any, significant change in the quality of service provision" (Anderson et al., 2003; Beach et al., 2004; Dogra & Carter-Pokras, 2005, cited in Votanis & Frake, 2007, p. 139).

Votanis and Frake (2007) give three main reasons for the failure of diversity training. They assert that the training equips service providers with the capacity for respecting diversity, but it does not emphasize a family-centered approach and it is "framed in political rather than educational terms" (p. 140). They conclude that, this has reduced diversity training programs to principles and statements and they lack effective mechanisms to assist service providers in the delivery of adequate, efficient, and equitable care. However, Votanis and Frake (2007) suggest that culturally competent services and programs can be implemented through training approaches that "pursue an educational agenda" and "relates to clinical context whilst being mindful of the political frameworks" (p. 140).

For the Child and Women's Health Diversity Program, culturally competent clinical consultation is anti-oppressive practice because it promotes equitable and efficient service delivery to ethnocultural service users. It also encourages practitioners to learn about their clients' cultural backgrounds through cultural information and training provided by the cultural consultant. The purpose of providing cultural competency clinical consultation by the Child and Women's Health Diversity Program is to "increase access to, and enhance the delivery of, culturally competent care to patients and families from diverse cultural backgrounds" (Paget & Berzins, 2007, p. 15). That is, it is used as an intervention strategy to assist social workers and health care professionals to provide culturally competent services and programs for ethnocultural service users.

It provides cultural information regarding health care and social needs of a client to practitioners so that they can provide comprehensive and culturally and linguistically appropriate services and programs for people from different cultural backgrounds. The information from cultural clinical consultation includes cultural beliefs, traditions, customs, political, and religious backgrounds of a client that impact assessment and diagnosis. Generally, culturally competent clinical consultation is not an option for the mainstream health care and social services. Rather, it equips practitioners with cultural knowledge and understanding in order for them to provide equitable and efficient services to ethnocultural clients.

Practitioners at the Alberta Children's Hospital are not mandated to attend cultural competence clinical consultation. They attended consultations when they felt the need to do so. The reason for attending culturally competent clinical consultation varies. These may include the realization that the exiting mainstream tools and theories, which are based on Eurocentric perception, to diagnose the patients do not meet the needs of the clients. Briggs, Briggs, and Leary (2005), note this realization in mental health care and argue that if ethnocultural patients/clients' "behaviors are viewed through culturally altered prisms, distortions will occur in the way of their behaviors" (p. 78). The authors go on to say that using Eurocentric diagnostic tools can have a negative effect on the interaction between the health care professionals and their clients and the way the patients see themselves.

The number of practitioners that attend culturally competent clinical consultation varies. The highest number of practitioners in the consultation in which I participated was three. The low number of team members allowed us to focus on cultural specific issues relevant to the client's social and medical needs. As mentioned earlier, the purpose of culturally competent clinical consultation is to provide cultural information about a client so that practitioners can deliver equitable services and programs. The information provided at the clinical consultation was about specific client's cultural backgrounds. They may include information such as, belief, social, and family system. This is based on the assumption that practitioners "should possess cultural knowledge and skills of a particular culture to deliver effective interventions to members of the culture" (Sue, 2006, p. 237).

Since I did not conduct any form of interviews with consultation team members for this report, it is very difficult for me to say exactly how the practitioners used the information they acquired from the consultations or the outcome of each consultation. However, I assumed that they used the information for the assessment of clients. They used the information for assessment in order to understand their clients better.

Moreover, since it appears that practitioners gained some understanding of their clients' cultural backgrounds, they were able to perceive how their clients' conceptualize their illness and social problems, understand the methods of solving their problems, and the goals they want to achieve. This is important because "clients differ in their definitions of health, well-being, and quality of life, as well as their goals for treatment and who they consider appropriate providers of care" (College of Nurse of Ontario, 2005, p. 6).

The practitioners also used the information and knowledge to explore the discrepancy between their clients' values and the assumptions of the mainstream health care and social service systems. The information helps the practitioners to "think about the client, cultural factors, objectives of the consultation and method of implementing cultural competence health care and social services for their clients" (Sue, 2006, p. 243). This means that the information and knowledge the practitioners gained from the clinical consultation enabled them to assist their clients to achieve their goals. The practitioners used the information as a tool for "exploring the client's view and attempting to understand the meaning behind a particular request, as well as the client's overall goals for treatment" (College of Nurses of Ontario, 2005, p. 6).

Moreover, the clinical consultations provided knowledge on "socio-demographic, racial/ethnic population differences . . . as well as how ethnic, cultural, social, environmental, and historical facts" (Crewe, 2004, p. 47) determine one's access to quality services and programs. I assume that social workers and health care workers, who attended the consultations, became experts in their client's, internal and external cultural dynamics. That is, the consultation helped them to identify differences within and between ethnocultural groups because they will be able to avoid using factors, such as race, language, ethnicity, and cuisine as the only factors to provide services or programs for ethno-cultural clients - as this leads to one-size-fits all service.

Theoretical orientation of cultural competency clinical consultation

The cultural competency clinical consultation teams, at all the consultations I participated in, are based on systems theory. The team always considered both internal and external factors that may influence the child and his/her family experience. In some cases, the team assessed external factors such as health facilities at the hospital, cost of parking, transportation problems, and access to services. They may also assess internal factors such as family dynamics, and cultural backgrounds. The theory connote that:

Treatment of minority children must be contextual, addressing psychosocial and cultural needs. The clinician must evaluate and mobilize familial, neighbourhood, and community resources, address environmental factors that contribute to behavioral problems, and enhance strengths the child and family bring to address the problem. The clinician should support parents in developing practical behavioral management skills consonant with their cultural values and beliefs . . . they must respect . . . family role functioning . . . at the same time foster family flexibility in dealing with their bi-cultural offspring. (Pumariega, Rogers, & Rothe, 2000, p. 548).

The authors' argument underscores the importance of the family role in achieving effective cultural competence services and programs. It also explains the need to understand system theory.

Although, all the culturally competent clinical consultations, I participated in at the Alberta Children's Hospital dealt with children the focus was on the whole family of the child. This means that the Child and Women's Health Diversity Program employs family-centered care. The Program acknowledges the role of the family in providing effective services and programs to the child. Although, the programs and services are designed for the child it requires family efforts to make them effective. This acknowledgement shows that "cultural competency is a key component of family-centered care; therefore the Diversity Program has become integrated in all service delivery models within the Child and Women's Health Portfolio and SACYHN" (Paget & Berzins, 2007, p. 8). It encourages practitioners to include all family members in the treatment plans.

I observed from all the consultations I participated in that instead of focusing mainly on one person (the child) in the family, the culturally competent clinical consultation team were concerned with the individual and his or her environment. The environment in this context is the family and others whom the child interacts with outside the family unit. Interaction in this perspective means interdependent. Therefore, the team does not see the child existing in isolation from the family, "other human beings, or apart from networks of social relationships. The difficulties manifested by an individual, therefore, are viewed by the team as stemming from sources larger than the person" (Nichols & Everett, 1986, p. 1). Black (1988) emphasizes this point by saying that "the idea can be expanded into an even more complex meaningful system, composed of individuals, family, and larger systems, who exist in a wider social context that shapes and guides mutual expectations, specific interactions, and outcomes" (1988, p. 1).

Family therapy is not something brought about solely by clinicians. Particularly with regard to marriage problems, a major part of the initial concern for help came from the public itself, as couples demanded assistance with their troubled marriages. On the other hand, when families have considered a single member to be the problem, clinicians and others have had to persuade such families that working with the family unit is more effective than dealing only with that individual (Nichols & Everett, 1986, p. 4).

Ecosystem

The major idea that family treatment introduced to the field of child treatment was the use of systems theory for understanding the context of the problematic behaviour of the child. This theory allows social workers to search for external influences that may be the cause of the child's behaviour. Turner, 2002, p. 171)

In other words, the theory helps practitioners to understand "the interactional patterns in a family system . . . beyond the nuclear family and into the family of origin and larger kinship system (Turner, 2002, p. 172). That is, a social worker, working with this theory, must extend the focus of his or her investigation into the extended family or outsiders who interact with the child. Thus, using this theory, invites most, if not all, members of the family and others to become participant in the treatment.

The theory also sees friends as an important instrument in the treatment. Turner (2002) goes on to contend that “other members who are part of the larger fabric of the nuclear family . . . are important reference points for sharing difficulties, normalizing problems, and offering support” (p. 176). This means that inclusion of friends into the treatment brings support, confirmation, an alternative view, and different activities into the treatment session. This means that family-centered care derives from ecosystem theory. Ecosystem is based on the ecological concept, which stipulates “the interrelationships between living organisms and their environments” (Dubios & Miley, 1992, p.58, cited in Heinonen & Spearman, 2006, p. 182). The concept derives from ecology or biological idea that sees interdependency between living organisms and their environments.

Social work uses the biological concept of ecology as a framework. The ecological perspective makes clear the need to view people and environment as a unitary system within a particular cultural and historic context. The perspective emphasizes the unity of the person within his or her environment, and focus of practice is on the interface between persons and their environment. (Heinenon & Spearman, 2006, p. 183)

The central theme of the ecological perspective is the idea of balance or connection between the person and his or her environment. The authors go on to assert that “the ecological perspective makes clear the need to view people and environments as a unitary system within a particular culture and historic context” (Germain & Gitterman, 1995, p.816, cited in Heinenon & Spearman, 2006, p. 182). This means that a client is inseparable from his or her environment. That is, understanding of the interaction with the family and between people and their environment is paramount in understanding an individual’s problems.

Human problems and needs are caused by their interaction with their environment and with other people, "and through a process of continuous reciprocal adaptation, humans change and are changed by their physical and social environment" (Dubois & Miley, 1992, p.59, cited in Heinenon & Spearman, 2006, p. 183). The key theme of the ecological perspective according to the authors is the "concept of goodness of fit between the person and the environment" (Wakefield, 1996a, p. 3, cited in Heinenon & Spearman, 2006). Thus, people confront problems when they are incompatible with their environment.

The central theme of the theory is interdependent of individuals within a community or society. Proponents of system theory argue that it is possible to apply biological laws of interdependent living organisms to "other areas, from the human mind to the global ecosphere" because the survival of living organisms depends on "mutual interaction of its parts . . . A system can be composed of smaller systems and can also be part of a larger system, just as a state or province is composed of smaller jurisdictions and also is part of a nation" ((Nichols and Schwartz, 1991, p. 101). A system, in this context, is a set of elements or individuals who can only survive through interaction. In this context, system means something that is joined together in such a way that whatever affects one part of it affects other parts. In making a link between system theory and family-centered practice, Nichols and Everett (1986) argue that "organismic world view introduced such relevant concepts for family therapy as systems, organization, ecology, open systems, complexity, positive feedback, and negative feedback" (1986, p. 69).

Evaluation

Autonomy

The decision of the team to appoint an interpreter to assist Amina, in spite of her objection, raises the issues of dilemma in autonomy. Autonomy, in this context, means that the ethno-cultural clients or patients have potentials to find their own needs, decide how the needs should be met, and supervise the quality of services they receive. That is, service users should be allowed to make decisions and manage available services and programs offered to them. It involves freedom for the minority person to exercise the same rights as other citizens.

Although, the objective of culturally competent clinical consultation is to promote autonomy I realized from my participation that practitioners sometimes must violate clients/patients' autonomy in order to provide equitable and effective services. For example, the appointment of an interpreter for Amina against her will shows that the team need to violate her autonomy so that it can effectively provide service for her child. Moreover, the decision also shows that there is a limit to clients' autonomy.

Cultural competency clinical consultation at the Alberta Children's Hospital underscores the importance of collaboration and consultation with the clients and patients. For instance, it encourages participation of clients, family members, and health care professionals in the decision making process. However, it acknowledges that these players are not necessarily always in agreement.

In this situation, participants may not concur on which values should be given priority when health care decisions are made . . . as a result . . . they are not being listened to or are restricted in determining their future care if the differences in decision making principles and values are not forthrightly examined by the involved parties . . . 'clients' often felt rushed and restricted in their control over the choices and become hyper-vigilant during the decision making process. (Nakashima, Chapin, Macmillan, & Zimmerman, 2004, p. 82-83)

Need for inclusiveness.

However, some service users like Wilson and Beresford (2000) interpret this as a violation of a client's rights for self-determination. According to Wilson and Beresford (2007), violation of a client's self-determination weakens the fundamental objective of an anti-oppressive approach. It leads to exclusion of knowledge, ideas, and experiences of the oppressed. Speaking from their own experience as former service users, Wilson and Beresford (2000) make the following argument:

Movements like the survivors' and particularly the disabled people's movements do not generally see themselves in terms of social welfare. They have challenged the medicalization of their experience, their narrow conceptualization in health and welfare terms, and the making of such provision to meet their needs. The disabled people's movement defines itself in terms of the oppression its members experience through the disabling reaction of society to their individual impairments. (2000, pp. 556-557)

Generally, a similar dilemma is recognized in the health care service. Health care practitioners determine their patients' needs, are the narrators, mediators, and the authors of clients' health experience and needs.

By giving no voice to the oppressed, Wilson and Beresford (2000) contend that "anti-oppressive theorists and practitioners may themselves be contributing to oppressive constructions and definitions of service users and their problems" (p. 558) because some social agencies tend to define their client's needs from a narrow perspective. This means that service users are excluded in evaluating research, providing cultural knowledge, and reports that claimed to represent their experience.

> The power to define what constitutes anti-oppressive practice . . . remains with practice teachers, tutors, and other academics, rather than service users . . . this raises a number of issues, the key one being the authority of knowledge in this area and who is qualified or authorized to determine what counts as anti-oppressive. (Wilson & Beresford, 2000: p.561).

Practitioners ignore the fact that service users have the potential to play an active role in the development of anti-oppressive practice. Unfortunately, social work professionals and their agencies, "have failed to pay significant attention or give clear recognition to" (Wilson & Beresford, 2000, p. 563) the needs and ability of service users.

The objective of cultural competency clinical consultation was to make the current anti-oppressive model effective by providing cultural information to health care practitioners. The connotation here is that the cultural information provided at the culturally competent clinical consultation, although might not represent an individual client's beliefs and values, it creates awareness of the need to provide services within one's cultural beliefs and values.

Diversities within a cultural group.

Cultural competency clinical consultation is provided within the individual client's cultural backgrounds but the process recognizes the uniqueness of all clients. For instance, general information, on the client's cultural backgrounds, was provided to practitioners/members of the team to reduce one-size-fits all services. The consultation encourages appropriate services and programs that suit their individual cultural beliefs and it leads to equitable services and programs for them.

However, the Child and Women's Health Diversity Program recognizes that members from the same cultural backgrounds are not homogenous in their beliefs and values. Members within a cultural group are beset by social, economic, political, and religious experience. For instance Nigerians are beset by tribal, ethnic, religion, and language differences. Moreover, those within the same ethnic groups are also beset by social status, economic, and religious differences. This means that people from one ethnic group do not see themselves as homogeneous in terms of medical needs, aging process, psychosocial, and environmental conditions, and health. Therefore, services have to be tailored to fit individual pathological and service needs.

Many health care programs and services assume that minority groups are homogenous in their need. This assumption leads to one-size-fits all social services and programs for the community. For instance, a practitioner may assume that all non-English speaking clients have language barriers and need an interpreter's service. This kind of assumption denies ethnocultural service users the right to self-determination and it may compound the social, economic and political inequality which cultural competence is tended to eradicate.

Recommendations

Language Barrier

The team perceived that the misunderstanding between the nurses and the Amina was caused by a language barrier. It assumed that Amina's English (speaking and comprehension) skills were not proficient enough for her to understand the medical needs of her child. They also argued that even if she had English proficiency, she might not have been able to understand the medical terminologies involved in her child's illness. This may hinder her child's access to equitable and efficient health care services.

The team goes on to explain that it would serve in the best interest of the child to provide an interpreter for the mother. As mentioned earlier, the team's recommendation for an interpreter to assist the family is based on its assessment that Amina has limited English language skills.

Link between language and service.

My initial question, at the debriefing with my field supervisor, was what is the link between language, equitable, and efficient health care or social services? I also argued, that if medical terminology is a barrier to equitable and efficient health care services, then all Canadians whose mother tongue is English, but do not have medical training should be assisted by a trained medical interpreter when they consult a physician.

However, my field supervisor explained that language differences lead to poor diagnosis and medical care, and wrong medications or hospitalization of immigrant children. A trained medical interpreter has vast knowledge of medical terminology and proficiency in a client's language.

This explanation is supported by Thomas, Silver, and Waitzkin's (2001) assertion that:

> when language and cultural barriers are present, the probability is further increased that patients might misunderstand or miscommunicate their perceptions of risks and benefits of treatment options. In addition to the problems associated with conveying information about diagnoses or medications, a language barrier impedes the effective use of information for encouraging compliance (p. 1344).

Thomas, Silver, and Waitzkin's (2001) research shows that language or communication barrier is rated the highest among other barriers such as health insurance, transportation, and long waiting period for consultation.

> All communication between physicians and non-English-speaking patients is concerned with symtomatology to the exclusion of feelings, causes or patient questions . . . Western medicine, which relies heavily on technology, often treats symptoms independent of their context . . . immigrants may still have difficulty understanding the physician's logic and be hesitant about following a regimen received as addressing only a portion of the problem. (Thomas, Silver, & Waitzkin, 2001, p. 1344-45)

These assertions explain the importance of language in providing equitable and efficient service to non-English speaking clients/patients. Language proficiency eliminates language barriers – thus, a physician can make an appropriate diagnosis. It helps the patient to give adequate information about his or her illness.

Illness etiologies

As mentioned above, the purpose of the cultural competence in clinical consultation at the Alberta Children's Hospital is to provide knowledge about individual patient's/client's beliefs or practice regarding illness and treatment. That is, in a situation where social workers or physicians encounter cross-cultural beliefs or practices not well understood by them they may request a culturally competent clinical consultation.

In Amina's case, we discussed some of the family's cultural beliefs they might have regarding illness and treatment. Also, in other cases involving patients from Asia, the broker emphasized the importance of acquiring some knowledge and understanding of the patient's beliefs about illness and treatment.

The cultural broker suggested that the social workers should explore the client's cultural beliefs regarding Down Syndrome. This implies that, the social workers' assessment of Down Syndrome should include the client's cultural beliefs. The recommendation was based on the general belief of the client's culture. This allows the social worker to understand the client's experience with Down Syndrome from the patient's cultural perspective. The cultural broker advised the social workers to find out the meaning of Down Syndrome from the parents' cultural perspective. The cultural consultant explained that having a child with disability is a taboo in some cultures, and this could lead to cultural barriers. The explanation led the team to assess Amina's cultural beliefs regarding causes of illness (particularly Down Syndrome) and how it is related to her behavior with the nurses and the medical setting at the Children's Hospital.

I learned from this particular consultation that it is important for practitioners to have knowledge about their client's cultural belief regarding causes of illness. The reason is that "how illness is explained often varies medically from culture to culture. Likewise, the methods considered acceptable for curing illness in one culture may be rejected by another" (O'Neil, 2006, p. 1). Having this information will help the practitioner to understand the client's explanations of illness. This is important because explanations of beliefs shape a patient's illness expression and illness behavior. Furthermore, they reflect premises about the relation of human beings to the environment to other human beings and society, and to themselves (Finkler 1985, p. 48).

Since Amina belongs to one of the ethnic groups in Africa that believes in supernatural causes of illness, the cultural consultant encouraged the practitioners to assess her behaviour from a non-biomedical perspective. Biomedicine is concerned with symptomatology. (Thomas, Silver, & Waitzkin, 2001).

According to Finker (1985) biomedicine is a:

> Reductionist and dualistic, attributing disease to attacks on the organism by pathogens, to endogenously produced malfunction or attenuated endogenous defenses . . . It has no room within its framework for the social, psychological, and behavioral dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic . . . or neurological physiological process. (1985, p. 54).

> The Western World mostly relies on a naturalistic explanation of illness . . . the naturalistic explanation assumes that illness is only due to impersonal, mechanistic causes in nature that can be potentially understood and cured by the application of the scientific method of discovery . . . naturalistic medical models link causes of illness to organic breakdown or deterioration, obstruction, injury, imbalance, malnutrition, and parasites (O'Neil 2006, p. 1).

He asserts that health care students in medical school are trained in naturalistic explanation. This means, most medical and nursing students have no or less knowledge in non-western explanation for causes of illness. On the contrary, for most non-western society – especially among many ethnic groups in Africa, explanation of the causes of illness is based on personalistic medical systems.

> Illness is seen as being due to acts or wishes of other people or supernatural beings and forces . . . Adherents of personalistic medical systems believe that the causes and cures of illness are not to be found only in the natural world. Curers usually must use supernatural means to understand what is wrong with their patients and to return them to health. Typical causes of illness in personalistic medical systems include intrusion of foreign objects into the body by supernatural means, spirit possession . . . bewitching. (O'Neil, 2006, p. 2)

These spirits are classified as the ancestors' spirits, foreign spirits, the distressed spirits, and the spirits of witchcraft. Members of the ethnic group attribute all illness to at least one of these spirits. For instance, the ancestors' spirits provide protection for living relatives against "disease and disaster" . . . and "can punish as well" by causing "sickness and even death to those who disregard or forget" to honor them (Gelfand, 1977, p. 33). In other words, certain sickness or mishaps are attributed to the anger of ancestor spirit. "An immoral act, example, incest, it is believed, can trigger ancestor spirit anger and result in serious illness" (Okpako, 2006, p. 239).

The foreign spirits are the result of those who died by accident in a foreign community and did not have a proper burial. Consequently, these spirits take possession of a living person's body and "confer a special talent on the person they select; it may be a talent for healing, for hunting, prophecy, . . . is never responsible for a death, it only causes sufficient illness to draw attention to its selection of a particular host" (Gelfand, 1977, p. 41).

Gelfand (1977), describes a witch as "a person endowed with the power to manipulate the forces of nature to the detriment of mankind" (p. 43). Finkler (1985) describes the power of witchcraft as supernatural or exogenous forces. Generally, Africans link witchcraft to illness that cannot be cured by biomedicine. That is, "when an illness is not curable by physicians, it must surely have been caused by witchcraft . . . because biomedicine fails to cure or alleviate an array of dysfunctions, numerous illnesses fall under the category" of illness caused by supernatural forces (Finkler, 1985, p. 50).

Lemelson (2004) makes a similar assertion in his anthropological analysis of Bali (Indonesia) traditional healing. He concludes that the Balinese attributes illness to unseen intrusions such as "sorcery, magic, violations of religious and moral norms . . . and spirit intrusion, imbalance, or disharmony in the patient's environment" (p. 58). In order to implement effective culturally competent services and programs in the health care setting, practitioners must try to understand and interpret illness from a patient's perspectives. Lamelson (2004) suggests four different perspectives through which practitioners can understand and interpret clients' experience with illness.

The first is the meaning and construction of the syndrome from the sufferer's perspective. Individuals differ in their situated understandings and interpretations of symptomatology. The second is the prevailing cultural models used to understand and find meaning in the symptoms. The third perspective is that of local experts, often belonging to but not restricted to such categories as traditional healers, religious, or ritual specialists who provide explanatory models for the disorder. The fourth perspective entails framing these symptoms in light of theories on the nature of the client's culture and its relation to individual experience. (p. 53). This recommendation calls for the need for practitioners to explore patients/clients' cultural belief systems and explanations for illness.

Treatment

The above discussion shows that a person's explanation of causes of illness determines his or her decision to consult treatment from either biomedicine or a traditional healer. For instance, a person who believes in naturalistic explanation of illness will, perhaps, rely on biomedicine for cure. Also, a person who has a strong belief in personalistic explanations of illness may seek healing from supernatural powers. Forcing a patient to seek cure from a model he or she does not believe or understand would thwart the success of the treatment. In some cases the patient may refuse to follow the healer/doctor's prescriptions.

This may explain the reason why some ethnocultural families refuse to follow biomedical treatment programs and interventions or are reluctant to seek treatment from a physician. In one example, the social worker reported that the client was not following through with a food program for her child who has Down Syndrome. However, the practitioner acknowledged that the child appears to be healthy without adhering to the program.

The team assumed that the mother was perhaps using a traditional feed as a surrogate for the formula prescribed by the program's pediatrician. One of the recommendations, made by the cultural consultant was that the social worker should try to find out what the parents are feeding the child. The assumption is that, perhaps the family does not believe in naturalistic explanation of Down Syndrome. Therefore, the family may have resorted to a traditional Chinese treatment.

My recommendation was that the family should be allowed to use traditional medicine or healer or combine them if it works for her. I agree with Pumeriega, Rogers, and Rothe (2005) that "the integration of consultation and intervention by traditional healers and ceremonies from diverse cultures is an important component of culturally competent care. Such practices should only be pursued if they are acceptable and desired by the child and family" (p. 548).

Also, Amina's refusal to cooperate with the nurses, at the emergency, could be related to her misunderstanding of naturalistic explanation of her child's illness and lack of confidence in biomedicine. Apparently, since the nurses did not have any information regarding Amina's cultural backgrounds, they concluded in the report that she was aggressive because they where not aware that many Africans consider certain serious illnesses as the cause of supernatural forces. Thus, people consult traditional healers who use supernatural methods, such as divination and incantation to diagnose their patients and provide remedies.

"Divination, the consultation of an oracle, is the diagnostic mechanism used in traditional African medicine to discover a hidden sin . . . If divination reveals ancestor spirit anger, exposition of the hidden misdemeanor for ritual treatment is a necessary part of managing the illness . . . The ritual accompanying the use of herbal medicines are referred to as incantation . . . it is a collection of carefully chosen words used to bring out the healing effect of the medicine. (Okpako, 2006, p. 239)

That is, healing is a combination of medicinal plants and the appeasement of supernatural forces. Unlike, biomedicine where the chemical component of medicine is regarded as the curing agent of illness, in traditional African medicine, the curing agent is spirit. Thus, incantation is necessary to appease the spirit that has caused the illness. The application of the herb assures the patient that his or her illness is being taken care of by the healer. Some traditional healing in Africa required the patient to wear an amulet around his/her neck, waist, or wrist to drive anticipated evil spirits away.

The essential feature of plant use in the management of serious illness is that the application of the remedy is accompanied by esoteric evocations addressed to the spirits and the plant itself. Here the objective is holistic treatment, the emotion being an important therapeutic target. (Okpako, 2006, 240)

This implies that Africans use some plants purposely for severe life-threatening sickness where supernatural agents are believed to be the cause. Only spiritual healers in the community know these types of plants. Plants for minor healing are usually known to every household and can be employed for treatment such as headache, bruises, and pains.

Efficacy of traditional medicine

The effectiveness of biomedicine is almost easy to measure. This could be achieved through a series of scientific testing on animals and human beings. However, the efficacy of traditional medicine does not go through any scientific testing process. Therefore, how can we measure the effectiveness of traditional medicine before patients use them? Or how do traditional healers determine the right plants to use for treatment? Traditional healers learn the right plants to use through their predecessors who have used them for centuries. For example, "numerous examples of fish poisons, arrow poisons, ordeal poisons used to detect witchcraft, or poisonous mushrooms are known in African communities and traditional healers do not use them as medicines" (Okpako, 2006, p. 240).

Albeit traditional medicine lacks a scientific test of it effectiveness, I would recommend that we need to respect the traditional knowledge of others about illness and treatments. Lemelson (2004) argues that "traditional healing is at least effective and frequently more so than modern medical and psychiatric approaches for a variety of disorders, including various mood disorders, psychosomatic and somatoform syndromes, acute or reactive psychotic states, and alcohol and drug dependence" (p. 52-53).

Adequate information

Amina, like many new immigrants, arrive in Canada with limited or no information about the health care system and biomedicine. Thus, service providers should provide adequate information to their clients. Adequate information would enhance the patients/clients' "ability to clearly understand their situation and incorporate many sources . . . into their decision-making process" (Nakashima, Chapin, Macmillan, & Zimmerman, 2004, p. 88). Moreover, service providers should provide options or alternative services and programs that meet the new immigrants cultural beliefs.

The current services exclude ethnocultural and other minority groups from decision making because the traditional notion of autonomy is narrowly based on the informed consent by a mentally competent and physically unimpaired person who is confronting the challenges of making decisions regarding a specific service and temporary treatment strategies. This means that a mentally incompetent and physically impaired person is excluded from decisions that affect his or her well-being.

In order for culturally competent services/programs to include other minorities, such as mentally incompetent and physically impaired persons, in the decision making process "social workers need to develop new ways for working with the impaired partner rather than focusing solely on the well" (O'Connor, 1999, p. 91) family member for decisions. In a situation where a person's potential to make a decision has reduced, social workers must find ways to include him or her in the decision-making.

Moreover, in order to promote effective culturally competent services and programs, culturally competent clinical consultation must continue to encourage practitioners to move from the traditional Eurocentric practice to inclusive practice. “Inclusive . . . practice acknowledges the . . . need to draw upon a range of knowledge, skills, and methods to achieve an understanding of others’ situations” (Turner 2002, p. 57). It requires assessment of our perception and thought about others. Inclusive social work practice tends to promote practices that are respectful of others’ worldview, values, culture, and customs. At a policy level, inclusive social work practice needs to focus on policy, research, and administrative practices that tend to discriminate against other groups within our society.

Conclusion

Implication for Social Work Practice

Three important issues in the case study have implications for social work: That is, who is the client, client's autonomy, importance of language, family-centered care, and the role of interpreter/interpretation in promoting cultural competence services and programs.

The question that the team's decision raises is: Who is the client in this particular case – the mother or the baby? For the team, the child is the principal client. This is supported by section 1.3.3 of the Guidelines for Ethical Practice for social workers (Canadian Association of Social Workers Code of Ethics, 2005, p. 4). In terms of encouraging client's self-determination, the section postulates that "social workers who have children as clients determine the child's capacity to consent" (Canadian Association of Social Workers Code of Ethics, 2005, p. 4). The section says that a child can be deemed as a client – therefore, in Amina's case, the child is the client. However, in section, 1.4.1 of the guidelines, it recognizes that a client, such as a child, does not have the ability to exercise self-determination or make its own decision (p.5). Section 1.5.5 advice social workers to ensure the rights and protection of a client's, such as a child, as they would do for adult clients (p. 7).

Ethical dilemma in social work practice

The dilemma here is that, in the same section, the guidelines postulate the need for an informed consent when working with "children as clients and others whose competency is in question." Thus, the child in the case study falls within this principles because he is a baby. He has no capability to make a decision regarding his treatment. The ethical dilemma here is that section 1.5.5 requires informed consent of clients before information can be disclosed to parents. However the same code postulates that a child or a person with mental disabilities is not fit to give consent for his or her treatment - thus, a parent or guardian must give such consent. This section gives the parents the sole responsibility to make decisions for the child. In this context, it appears the team violated the parent's autonomy when they decided to provide an interpreter for Amina.

The team could have minimized the ethical dilemma if it had considered the family as a whole (the client) rather than seeing the child as the only client. Having said this, we must also realize that each member of the family is important - the father, mother, child, and the other members of the extended family. Moreover, since it appears that children are treated by the guidelines as minors, the principal decision-making rests with the family. However, treating the mother as the principal decision maker may put the child's life in a dangerous position. The cultural consultant argued that the mother's refusal to accept an interpreter's assistance is detrimental to the child's health. This implies that, in such instance, the social workers will have to assume the role of principal decision making for the child or mentally incompetent person.

Family-centered care

Also, the Child and Women's Health Diversity Program approach to cultural competence has an implication for social work. It encourages family-centered care and services for clients/patients. In the above case, the team recognized that the child is culturally bound like the parents - his health care, social needs, and behavior are better understood if the practitioners understand the parent's cultural backgrounds. Also, the team acknowledged that effective culturally competent services and programs should involve a theoretical framework of family centered. Therefore, the goal of establishing a family-centered service system requires promoting cultural competence in children's . . . health" (Briggs, Briggs, & Leary, 2005, p. 78) care and social services.

This means that an effective culturally competent intervention in children's health care and social services is based on family-centered practice because the team expressed its respects, acknowledgement, and became grounded in the family's system, beliefs, customs, and values at the end of the session. Apparently, the team acknowledged "the roles of the family as arbiter of health practices and primary caregivers are influenced by relational value orientations" (Pumariega, et al., 2005, p. 541). It also realized that the illness of a single person in a family affects other members around him or her.

The team focuses on the interactional whole of a family and individual members of the family. It believes that examining the interactional patterns of the family can alter a problem or situation. Finding the hidden positive resources in the family's interactional whole accomplished this. Nichols and Everett (1986) assert that family-centered practice provides intervention that focuses on the whole family.

> Rather than focusing solely on the individual, family therapists are concerned with the person in his or her more significant context of living and coping. The family in both current and historical senses is the focus of family therapy . . . particular orientation to family practice. A family therapist does not see people existing in isolation from other human beings, or apart from networks of social relationships. The difficulties manifested by an individual, therefore, are viewed by family therapists as stemming from sources larger than the person. (Nichols and Everett, 1986; p. 1)

Therefore, from a family-centered care perspective, the team examined both the mother's behavior and the child's illness from the interactional pattern of the family, the family's cultural beliefs, values, and social and economic situations.

Equal voice

Moreover, the Child and Women's Health Diversity Program encourages equal voice for ethnocultural service users of the Alberta Children's Hospital through cultural competency clinical consultation. Each consultation provides training and information for practitioners to understand the clients' cultural background. For some researchers and practitioners, understanding of clients' culture may help them to provide equitable and efficient services for their clients. According to Yee and Dumbrill (2003) some social science researchers and multicultural social workers use common characteristics to group people within a society. Thus, race, ethnicity, nationality, and class, which are used interchangeably, are used to categorize people with different cultural backgrounds.

For instance, in the chapter on Sudanese that I completed for health care professionals, malaria, tuberculosis, leprosy, cutaneous and visceral lieshmaniasis, HIV, and schistosomiasis were listed as prevalent diseases found among Sudanese. Although, this information is intended to provide general information about medical problems among Sudanese, it may also promote stereotypes of Sudanese in Calgary. Consequently, it may persuade some health care professionals to send their Sudanese patients to be tested for these diseases even if they do not show symptoms for any of them. The question that arises at this point is: Are all Sudanese affected by these deadly diseases?

Other shortcomings of multicultural social work practice are that it sees all ethnocultural groups as homogenous in their needs. This false assumption can lead to one-size –fits all services and programs because it does not recognize the differences between and within ethnocultural groups. As mentioned earlier, the development of social work knowledge for multicultural social work and cultural competence training, social policy, and the type of service delivery remain under the control of leaders from the dominant population.

It makes little sense, therefore, to examine the differences of ethno-racial communities without first examining the group that defines these communities as different power that enables this group considers itself the norm. Multicultural social work practice cannot be fully engaged in by social work practitioners unless an examination of Whiteness occurs. The problem of dominance cannot be dismantled in society unless an emphasis and focus on ethno-racial communities shifts to the invisibility of the privileged in shaping the experiences of the oppressed. To name Whiteness in social work practice penetrates the insidious nature of discriminatory practice. To do otherwise means colluding with the oppressors and continuing to struggle in area of diversity at superficial levels without creating real change. More specifically, one could argue that Whiteness – the basis upon which Canada's social service delivery system developed – is responsible for unintentional and intentional forms of discriminatory practices inherent in the wider Canadian society. Understanding of the concept of Whiteness unmasks the way the dominant culture shapes the norms and values of Canadian society and reproduces various forms of oppression such as racism, classism, sexism, and other isms in the delivery of social work services. (Yee & Dumbrill, 2003, p. 100, 101).

For some multicultural social workers, categorization of people serves as "practical purposes of understanding the particular needs of specific communities" (p. 100). However, categorization needs to be used diligently and with a good purpose to avoid stereotype.

Apparently, the clinical consultation team were aware that categorization in culturally competent practice or training may encourage stereotype and generalization. Cultural competency clinical consultation, at the Alberta Children's Hospital, encourages practitioners to assess an individual client's cultural beliefs for appropriate service.

Also, the information used for understanding a client's cultural background highlights the power differences between the knower and the known. Yee and Dumbrill (2003) clarify this point by stating "can one assume that writers who come from the ethno-racial group they are writing about offer a more credible authentic knowledge about the particular culture than someone from the dominant culture could?" (Yee & Dumbrill, 2003, p. 100). Being a member of an ethnic minority group in Canada, I would argue that I can provide more authentic information of my group's experience than a member of the dominant groups whose source of knowledge is derived from text or research done to satisfy Western perception.

The information provided by a member of an ethnocultural group, about his or her culture is based on lived experienced. However, it would be wrong to assume that all ethnocultural persons can provide impartial information about their groups' experience. In order to acquire information about a client's lived experience, the Child and Women's Health Diversity Program encourages equal voice between the health care practitioners and their patients/clients. Most of the clinical consultations encouraged practitioners to facilitate direct communication with their clients. This allows practitioners to ask questions, to be taught, and to find related answers from their clients that might help them to provide an effective diagnosis.

In order to acquire impartial information, the cultural consultant encourages the consultation team members to use the cultural competency resource kit and other information available at the family resource centre to enhance their understanding of their clients' lived experience. This means that a combination of a client's live experience and research completed by an outsider can facilitate adequate and impartial information for effective health care services.

Moreover, the cultural consultant encourages equal voices by promoting the use of cooperative power. Co-operative power is based on the principles of partnership between the health care worker and the clients (families, professionals, communities, and other agencies).

> These relationships must recognize the real imbalances of power, authority, and access to resources that may exist between different parties - and there must be explicit permission for such issues to be talked about openly. There would need to be a space for support and challenge between users and practitioners - with workers valuing and learning from the standpoint knowledge of service users . . . while able to contribute frameworks of understanding and problem resolution based on their professional training. (Beresford, 2000; Beresford & Croft, 2001, cited in Tew, 2006; p. 46).

How my practicum objective was achieved

My main objective in this practicum was to understand cultural competency clinical consultation and how it is practiced. This was achieved through meetings, discussions, clinical consultations, and the review and update of the cultural competency kit. It has enhanced my knowledge about social work and the relationship between culture and illness. The review and update of the cultural competency kit was a challenge and learning process in my practicum. It helped me to acquire some knowledge about different cultures in both countries. Also, I have gained a lot of knowledge regarding the type of information practitioners need to become culturally competent providers. These include family system/structure, acculturation issues in Canada/Calgary, language, illness beliefs, traditional health care practice, and religious background. Practitioners need the ability to incorporate these knowledge with their practice to understand the client's/patient's health needs. In other words, it serves as tools for assessing the behavior and understanding of the clients/patients' cultural perspective. The lesson here is that in order to make appropriate diagnosis and understand a client's behavior, practitioners must try to assess a problem or behaviour from the patients/clients' cultural belief.

I learned from the cultural competency clinical consultations in which I participated that language was the common barrier to health and social resources for ethnocultural clients/patients. For instance, a family was unable to access available resources such as counseling, social assistance, and health services because the family has limited English proficiency. Moreover, I realized that language barriers create lack of proper communication between health care providers and patients. In some of the clinical consultations, I realized that some social workers could not link their clients to social services because the clients did not speak or understand English. In other cases, I noticed that a language barrier could lead to mistrust and antagonism between patients and service providers. In Amina's case, she did not cooperate with the nurses because of language barriers. They did not speak each other's language. The nurses saw the mother as a threat to them and simultaneously, she also considered them as a threat to her child and family. The cultural consultant normally provides general information on the clients' cultural background in relation to the situation presented by the practitioners. The information may include the client’s cultural beliefs regarding health, illness, healing, and rituals.

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