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# Development and Evaluation of the Cultural Consultation Service

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In this chapter, we describe the development, implementation, and evaluation of the Cultural Consultation Service (CCS). We begin with some background on the development of intercultural services in Montreal. The next section describes the rationale for the CCS approach and the steps involved in setting up the service. The third section provides an overview of the cases seen by the service in the first decade of its operation, including sources and reasons for referral, as well as sociodemographic and clinical characteristics. This provides a sense of the portfolio of cases from which vignettes are drawn throughout this book to illustrate key issues in cultural consultation. The remaining sections summarize findings from qualitative process and outcome evaluations of the service.

## Background

McGill University has a long history of involvement in cultural psychiatry, dating back to the 1950s when the Division of Social and Transcultural Psychiatry was established (Prince, 2000). In the early 1970s, under the leadership of H.B.M. Murphy at McGill and Guy Dubreuil at the Université de Montréal, an interuniversity research group on medical anthropology and ethnopsychiatry (GIRAME) fostered collaboration and exchange among social scientist (anthropologists and sociologists) and health professionals (psychologists, psychiatrists, doctors, and nurses) from universities in Quebec and other Canadian provinces. This group focused mostly on international research in psychological and medical anthropology, to promote, coordinate, and disseminate research and teaching concerning sociocultural factors in health (Bibeau, 2002). GIRAME published a bilingual (French/English) journal, *Santé/Culture/Health*, which included much work in culture and mental health. Toward the end of its life as a network, the scholars associated with GIRAME began to focus on the issues of providing effective mental health care for the population of Québec (Bibeau, Chan-Yip, Lock, & Rousseau, 1992; Corin, Bibeau, Martin, & Laplante, 1991). GIRAME reflected the geopolitical and ethnocultural specificities of Montreal, a place of encounter of the Latin and the Anglo-Saxon world, and highlighted the richness

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associated with the intermingling of European and North American academic and clinical traditions. The use of diverse languages and bilingual communication was at the center of GIRAME activities, in its conferences, seminars, and publications. This inclusion of diverse perspectives within an active interdisciplinary exchange is one of the important legacies of GIRAME for the Division of Social and Transcultural Psychiatry and the establishment of our clinical-academic programs including the CCS.

Montreal is a city of almost two million situated in the Province of Quebec in eastern Canada.[1] The city is located on an island in the St. Lawrence River. The greater metropolitan area, including many surrounding municipalities both on and off the island of Montreal, totals almost four million residents—almost half the population of the whole province. The population of greater Montreal includes a very diverse mix of people with about 21% of the population born outside Canada. A high proportion of those born outside the country (22%) are recent newcomers who arrived in the last 5 years, including both immigrants and refugees. The languages spoken at home include French for 70% and English for 19%, but about 22% are allophones, a local term used to designate those with languages other than French or English. The most frequent mother tongues are French (66%), English (14%), Arabic (3.5%), Spanish (3%), Italian (3%), Chinese (2%), and Haitian Creole (1%). About 16% of the city are "visible minorities," including 5% Black, 2% Latin American, 2% South Asian, and 2% Chinese. In terms of ethnicity, the majority of Montrealers describe their origins as Canadian or French with the remaining top ten identities including Italian, Irish, English, Scottish, Haitian, Chinese, German, First Nations, Québécois, and Jewish.[2]

Prior to the establishment of the CCS, Montreal was home to several specialized services directed to immigrants and refugees. These included the transcultural program of the Hôpital Jean-Talon (HJT), the Montreal Children's Hospital (MCH) program for immigrant and refugee children, a network of professionals involved in the treatment of individuals who have suffered organized violence (RIVO), and a provincial social service department for refugees, refugee claimants, and unaccompanied minors called SARIMM. This service was integrated into a community health center servicing immigrant neighborhoods, the CSSS de la Montagne, and changed its name to become PRAIDA. Because of the important mental health needs of its clientele, PRAIDA, which offers services to refugee families and has a supra-regional role, was an early partner of all of the transcultural programs including the CCS. In parallel, Montreal saw the emergence of programs and consultants offering training in intercultural work to professionals.

All of the services developed in response to demographic changes over the past 20 years in Montreal, which has seen a large increase in the cultural diversity of both the general and patient

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[1] The data in this paragraph reflect the census metropolitan area of Montreal. Data on language (mother tongue and language spoken at home) is from the 2011 census (Statistics Canada, 2012. Montréal, Quebec (Code 462), and Quebec (Code 24) (table). Census Profile. 2011 Census. Statistics Canada Catalogue no. 98-316-XWE. Ottawa. Released October 24, 2012. http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E). Data on ethnicity and immigration was not available from the 2011 census, and the 2006 census was used (Statistics Canada, n.d.). *Population by immigrant status and period of immigration, 2006 counts, for Canada and census metropolitan areas and census agglomerations -20% sample data* (table). "Immigration and Citizenship." "Highlight tables." "2006 Census: Data products." *Census*. Last updated March 27, 2009. http://www.statcan.gc.ca/pub/12-591-x/2009001/02-step-etape/ex/ex-census-recensement-eng.htm#a2 (accessed February 21, 2013).

[2] Statistics Canada. No date. *Visible minority groups, 2006 counts, for Canada and census metropolitan areas and census agglomerations -20% sample data* (table). "Ethnocultural Portrait of Canada." "Highlight tables." "2006 Census: Data products." *Census*. Last updated October 6, 2010. http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/hlt/97-562/pages/page.cfm?Lang=E&Geo=CMA&Code=01&Table=1&Data=Count&StartRec=1&Sort=2&Display=Page (accessed February 21, 2013).

populations in the city. The MCH and HJT responded to increased diversity among the specific populations served (e.g., 50% of children seen at the MCH are allophone and 33% of the Jean-Talon catchment area is allophone, i.e., non-English or French mother tongue). The Côte-des-Neiges area, where the CCS is located, is one of the most ethnically diverse neighborhoods in Montreal, with more than half the population born outside Canada. As such, the services are rooted in the recognition of diversity as an important issue for health care because of concern about inequities in access and in the delivery of culturally appropriate care. Indeed, there was evidence from our own work in this neighborhood for underutilization of mental health services due both to lower rates of referral from primary care and direct resort (Kirmayer et al., 2007). The CCS project was, in part, a response to this observation.

Each of the services was initiated by professionals with experience in cultural psychiatry, whose particular perspective shaped the orientation of services, along with input from other professionals and social scientists working with each group. Reflecting the different backgrounds of the clinicians and their institutional settings, the services have followed different models of care. Despite the different orientations of the services, their common goal has been to work within the broader frameworks of psychiatry and collaborate with existing services. While the conceptual models of the services were initially tentative and open, all services have changed significantly over time as they learned from and adapted to their milieu, patient populations, and institutional constraints.

## RIVO

In 1984, a group of Quebec health professionals who were involved in different Latin-American countries founded "L'association Médicale pour l'Amérique Latine et les Caraibes" which was a group of professionals committed to fighting health inequalities in Quebec and in Latin America. The mental health committee of this association began to work on appropriate services for refugees, which, at the time, were largely coming from Central and South America. Reaching out to community organizations that were providing first-line support to refugees, like the House of friendship founded by the Mennonite Church of Eastern Canada (http://www.maisondelamitie.ca), this group organized a network to provide care for the persons who had experienced organized violence in their countries of origin.

This network was formalized as "Le réseau d'intervention pour les personnes ayant vécu la violence organisée" (RIVO) with the following premises: (1) it explicitly avoided the notions of "victims" or "survivors" as a way of acknowledging that the experience of organized violence was not necessarily framed in those terms for those who suffer from it. In seeking alternate language, RIVO wanted to emphasize the agency and strength of refugees as persons, families, and communities and take a critical stance toward the dominance of trauma-centered approaches; (2) a politically committed clinical stance was central to its philosophy; (3) it was conceived as a broad network, bringing together professionals from different disciplines, in private practice or in institutions, with diverse clinical orientations, including practitioners of ethnopsychiatric, humanistic, cognitive-behavioral, and psychodynamic psychotherapies.

RIVO has provided a referral network for patients seen in the community or various institutional settings who required care that took into account their histories of exposure to violence, torture, and forced migration. The network has also served as professional support groups with peer supervision through case conferences and educational activities. Although the cultural dimensions of care were not at the forefront for all the clinicians affiliated with RIVO, the case discussion seminars always emphasized the interaction between traumatic context and the cultural background of patient and clinician. After a period of rapid growth during which RIVO was delivering therapy to more than 400 persons each year, cuts in funds for refugee health care by the federal government in 2012 have severely constrained and jeopardized its mission, illustrating the fragility of services which are not considered essential by the policy makers or mainstream health care institutions.

## The Hôpital Jean-Talon Transcultural Clinic

The Jean-Talon Hospital Transcultural Clinic (HJTC) was created in 1993 to respond to the needs of the large immigrant population in the hospital's catchment area. The clinic was established by Dr. Carlo Sterlin, a psychiatrist originally from Haiti, who had worked in the area of transcultural psychiatry since the 1960s, starting at McGill (Sterlin, 2006). The origins of this clinic stemmed from the observation that many patients of Haitian origin who attended the outpatient clinics of HJT spoke only Creole and had clinical manifestations that did not fit conventional psychiatric diagnostic frameworks. Despite the initial perception by others that the clinic focused solely on the Haitian population, the clinic grew into a well-established transcultural psychiatry service working with a broad diversity of immigrant and refugee patients. Six clinicians attached to the hospital formed the core staff. However, throughout its existence, the clinic has relied on volunteers, and three of the four active clinicians involved donated their services in return for the academic and professional stimulation of peer supervision and collegial support. The HJTC intervention model includes both consultation and clinical services. The service applied two models, one using a small group composed of a principal therapist and two or three co-therapists and the second involving a large group comprised of clinicians from different cultural backgrounds, culture brokers, and an interpreter, as well as members of the patient's entourage. The clinic also provides training and community prevention and mental health promotion programs.

The clinic's therapeutic approach was strongly influenced by the French ethnopsychoanalytic approach originated by Devereux (1970) and further developed by Nathan (1991) and Rose-Marie Moro (Moro & Rousseau, 1998; Sturm, Nadig, & Moro, 2011). According to Nathan, the rationale for the large group method includes at least four distinctive features (Nathan, 1991, 1994a, 1994b; Streit, 1997; Zajde, 2011):

1. It reassures families in crisis who come from collectivist or communalistic societies who may find the group less threatening than a face-to-face dyadic clinical encounter.
2. It is an effective method to limit the problems of personal and cultural countertransference.
3. Through the intervention of the interpreter, it reduces the risk of misunderstanding the family.
4. The different perspectives, questions, and interpretations of the multiple therapists provide a sort of "semantic bombardment" that unsettles the client, disengages them from their dominant systems of interpretation, and mobilizes their capacity to explore new modes of interpretation and action.

Despite this rationale, this group intervention strikes many as posing the threat of a power imbalance that could be unsettling to patients. Evaluations of this model to date have mainly involved detailed analyses of cases (Sturm et al., 2011; Zajde, 2011). In an effort to better understand the perspective of patients who received treatment at the Jean-Talon clinic with this extended group psychoanalytic model, the initial CCS project supported an initial assessment of the service (Sterlin, Rojas-Viger, & Corbeil, 2001). The goal was to identify the acceptability and impact of the intervention from the patient's point of view. This evaluation reviewed the experience of the HJTC with the 20 patients who had completed therapy at the clinic between November 1995 and September 2000. Most of the respondents appreciated the interventions and found the following aspects helpful: (1) it allowed them to express their suffering in their own language, (2) it was useful to hear proverbs that recalled their countries of origin (cf. Bagilishya, 2000), and (3) it was helpful to speak about their countries and personal history in an atmosphere of attentive listening and respect, which encouraged them to reflect on their past and consider how to refashion their future.

Although the clinical approach of the HJTC borrowed heavily from French ethnopsychiatric models—thus trying to bridge traditional/cultural interpretations with a Western psychoanalytic dimension—the approach has remained flexible. The emphasis is on presenting concepts that make sense to the patient, using only those definitions of "mental health" that fit the client's perspective. The HJTC team thus tries to incorporate psychodynamic intervention models with an anthropological approach that draws on the client's cultural interpretation of the problem by creating a space for the interaction of multiple discourses. The clinic continues to welcome families and is an interesting setting to train professionals interested in cultural intervention.

## The Transcultural Child Psychiatry Team of the Montreal Children's Hospital

The transcultural child psychiatry team of the Montreal Children's Hospital (MCH) was established by Dr. Cécile Rousseau, who was also instrumental in setting up RIVO, and whose long involvement and contacts with community organizations working with refugees at multiple levels linked this service to a broad grassroots network and partnership. Rousseau had worked as a general practitioner in Central America and participated in several large community research projects in Montreal, examining issues including racism, access to institutional support, and the social exclusion of immigrants and cultural minorities. As a child psychiatrist, Rousseau saw the need for specialized services designed to meet the mental health needs of refugee and immigrant children and their families, in particular (but not limited to) those having lived through organized violence. The most salient aspects of this service were its commitment to responding to refugee mental health needs in social and political context, integrating concern with socioeconomic issues and broader power dynamics with close attention to the experience of children and their families.

The MCH team began with a very open mandate and initially received referrals for a wide range of problems. Interventions included clinical assessments and ongoing therapy for refugee and immigrant children and their families. The model utilized a team approach toward clinical intervention. The team was confronted with numerous complex cases that they were not equipped to manage but which included cultural issues, for example, developmental disorders among immigrant children. Because the team soon became overloaded, the MCH revised and limited its mandate to cover a circumscribed patient population, in order to reduce patient load and increase efficiency. Referrals to the MCH came primarily from schools, lawyers, a CLSC, or another clinician. A priority was placed on refugee families, particularly those who have lived through organized or other forms of violence, though a large number of children with potential developmental and behavior problems (e.g., ADD) were also seen. In addition, the team worked closely with the psychiatric emergency ward and saw a number of patients with acute psychoses. Although the relevance of cultural issues in cases of psychosis was initially more difficult for clinicians to appreciate (see Chapter 14), the team was able to work as consultants to the inpatient ward at the MCH to develop interventions with these families.

The evolution of the MCH service from broader grassroots accessibility to integration within the hospital also meant changing its practices to adapt to the norms and constraints of the institution. For example, given the hospital's referral and triaging policies, the team had to shift from an informal word-of-mouth referral system from the community to the more formal process required by the psychiatry unit's triage system. Because of reluctance among patients to speak initially with someone from outside the team, an administrative coordinator was hired on the team to take referrals and triage cases. In addition to clinical services, the MCH Transcultural Team was involved in a number of other institutional activities, including providing training for outside institutions (e.g., Department of Youth Protection) as well as working on prevention programs in Montreal-area schools.

The MCH model utilized an eclectic and flexible clinical model that incorporated various theoretical streams in a hybrid "bricolage" of approaches including French ethnopsychiatry of Nathan (1994a, 1994b) and Moro (2000), North American medical anthropology, as in the work of Arthur Kleinman and Byron Good (e.g., Good, 1994; Kleinman & Good, 1985; Kleinman & Kleinman, 1996), and the political dimensions of collective and individual suffering recognized in some versions of Latin-American psychoanalytic thinking and social psychiatry, for example, Marcelo and Maren Vinar (1989) and Elisabeth Lira (Lira & Weinstein, 1984).

As in the case of RIVO and the Jean-Talon Clinic, the nonpsychiatric clinical staff of MCH transcultural clinic were supported through community fund raising efforts. This provided the program with some freedom from institutional constraints but also made it precarious. The community-oriented foundations of the MCH developed into important partnerships and team members eventually moved from the MCH to a comprehensive community clinic where they continue work in close partnership with community organizations, schools, health care institutions, and social service organizations like Youth Protection. The work of the MCH team is described in more detail in Chapter 4.

## Origins of the Cultural Consultation Service

The CCS was developed in response to gaps in services identified in earlier epidemiological work, a review of models of care, and a fortuitous research funding opportunity.

Earlier research in Canada identified important inequities in access to mental health services (Beiser, Gill, & Edwards, 1993; Federal Task Force on Mental Health Issues affecting Immigrants and Refugees, 1988). Studies in Quebec also documented the importance of culture as a determinant of mental health needs and service use (Bibeau et al., 1992; Rousseau & Drapeau, 2002, 2003, 2004; Rousseau, ter Kuile, et al., 2008). In Montreal, a community epidemiological study in 1995 examined help-seeking patterns and health care utilization among immigrant populations in the Côte-des-Neiges district (the catchment area of the Jewish General Hospital and the local comprehensive community clinic, the CLSC Côte-des-Neiges) (Kirmayer, Young et al., 1996). The study compared newcomers from the Caribbean, Philippines, and Vietnam with Canadian-born English- and French-speaking residents in the same neighborhood and found a high degree of unmet need for mental health services. In particular, the study documented underutilization of existing resources by new immigrants (Kirmayer et al., 2007). In many cases, this was attributed to the perception that they would be stigmatized by their community or would face barriers due to language, culture, religion, or racism and discrimination in conventional mental care settings. Other epidemiological surveys have confirmed the specificities of the needs of migrant and refugee communities in Quebec (Rousseau & Drapeau, 2002). Qualitative interviews revealed some of the complex issues of social stress and cultural meanings of symptoms that influenced help-seeking and referrals to mental health (Groleau & Kirmayer, 2004; Whitley, Kirmayer, & Groleau, 2006a, 2006b).

A site review of the Australian Transcultural Mental Health Network afforded the first author the chance to see a variety of models in action in eastern Australia, including programs in Sydney, Melbourne, and Victoria, and web-based resources (Kirmayer & Rahimi, 1998). This led to an overview of approaches to culturally responsive services that linked models of care to local demography, patterns of migration, and political ideologies of citizenship that singled out specific groups as "others" worthy of attention in designing health care services (Kirmayer & Minas, 2000; see Chapter 1). This comparison made it clear that the ethnic matching or ethnospecific clinic approach common in the USA did not fit the Canadian context well. In Canada, the high level of diversity and constant immigration undercut any sharp distinction between newcomers and established ethnocultural communities. The link between long-standing cultural and linguistic communities and newer waves of migration was solidified in the policy of multiculturalism, which suggested that cultural diversity could be acknowledged and respected in mainstream social institutions. The goal then was to find ways to improve the response to diversity across the mental health care system.

An opportunity to pursue this arose with a federal government program funding research aimed at improving continuity of care. The Health Transition Fund (HTF) was a $150-million fund administered by Health Canada (the federal Ministry of Health) from 1997 to 2001, which supported 140 projects across Canada to evaluate innovative ways to deliver health care services. These projects were expected to generate evidence that policy makers in government, health care providers, researchers, and others could use to make informed decisions that would lead to a more integrated health care system. The project "Development and Evaluation of a Cultural Consultation Service in Mental Health" (QC424) was funded from 1999 to 2001. This research grant provided the resources to develop the CCS and conduct a formative evaluation on its implementation and a review of the outcomes of the first 100 cases referred to the service. Further grants insured the maintenance of the CCS, but, as was the case for other cultural programs, funding cultural consultation within mainstream institutions has remained a challenge.

## Implementing the CCS

Implementing the CCS involved a bootstrapping process that built on existing clinical programs, research projects, and training activities in cultural psychiatry. The design and implementation of the project followed several steps as listed in Table 2.1.

**Table 2.1** Steps in implementation of the CCS

1. Assessment of need for the service
2. Selection of appropriate models for service delivery
3. Recruitment and training mental health professionals for intercultural work
4. Development of clinical procedures for consultation
5. Development of information resources for cultural consultations
6. Advertising and recruitment of patients
7. Evaluation of service

### Assessment of Need for the Service

In the process of preparing the grant proposal for the CCS project, meetings were held with key stakeholders in health and social services institutions and the community, including colleagues within the Department of Psychiatry of the Jewish General Hospital (the host institution), the Montreal Children's Hospital Transcultural Team and Multiculturalism Program, the Jean-Talon Hospital Transcultural Clinic, several CLSC's (comprehensive community clinics) located in ethnically diverse neighborhoods that had links with the JGH, the regional refugee clinic (based at the local CLSC), the office of the regional health authority responsible for the bank of interpreters and for issues of access to care for linguistic and cultural minorities, members of the RIVO, and community groups working with Caribbean and South Asian communities. These meetings identified specific needs for services, and the organizations provided letters of support for the grant proposal. This also served to strengthen existing partnerships and collaborations and to identify a steering committee for the project.

In the process of this initial assessment of local needs, a major issue identified was the underutilization of interpreter services. Despite the availability of a bank of interpreters trained and made available by the Montreal regional health authority, hospitals were observed to make little use of this service. Hospitals had to pay for these services out of their general budget, so cost may have been one important barrier. However, efforts to reduce the cost, offering a discount for a period, had limited effect. Another issue identified was general lack of familiarity with cultural issues and a desire for more in-service training at community clinics and organizations. McGill faculty affiliated with Division of Social and Transcultural Psychiatry had done presentations to community clinics and hospitals, but there was a need for more in-depth training to provide practical help with case management and skills to work with specific types of issues or cultural groups. These needs were identified as priorities and considered in the design, staff recruitment, and work plan of the CCS.

## Choosing the Appropriate Models for Service Delivery

As discussed in Chapter 1, a variety of models have been developed to meet the challenge of culturally appropriate care:

1. The simplest approach is to insure access to standard care for all patients. At a minimum, this requires readily available interpreter services. However, since many individuals from culturally diverse backgrounds are unaware of mental health services or experience significant barriers, access must include elements of community outreach education. Moreover, health care providers must be trained, and quality assurance standards must be in place, to insure they make appropriate use of interpreters (see Chapter 5).
2. A second approach relies on existing resources within cultural communities. In most communities of any size, there are professionals, religious leaders, traditional healers, elders, and other helpers who often deal with mental health problems. These people have intimate knowledge of the social norms and cultural history of their community. Their modes of intervention are culturally consonant and integrated in the community. They may enjoy greater legitimacy and authority than biomedicine or formal mental health services which may be associated with stigma or fears of coercive treatment. Conventional health care services may refer people to such practitioners or work in close collaboration with them, each providing complementary aspects of patient's care. However, for complex cases and major psychiatric disorders, community helpers may not have the requisite expertise and institutional resources to provide all aspects of care.
3. A third approach involves the development of specialized services to improve access and provide culturally appropriate care. This includes a wide range of models including ethnospecific clinics for specific populations (e.g., Hispanic clinics with Spanish-speaking staff). This model is practical in settings where there is a large population with shared cultural or linguistic background that can be addressed through matching. It has the advantage of making expertise readily available by concentrating it at one site and creating an organizational structure that can institute some form of community control. The disadvantages include a potential lack of influence on the wider health care system and increased stigmatization as patients from specific backgrounds are segregated at one location.

In the case of the CCS, the choice of an outpatient consultation model was based on several considerations related to the composition of the hospital catchment area, health care policy in Quebec, and the larger values of multiculturalism and interculturalism (see Chapter 1):

- The existing emphasis on primary care delivery of mental health services with psychiatry providing outpatient backup consultation or collaboration to strengthen the capacity of frontline services.
- The very high degree of cultural and linguistic diversity in the population making ethnospecific services impractical.
- The relatively small size of communities with a high proportion of newcomers so that for many groups, only limited services were available within the community.
- The cultural values of multiculturalism and interculturalism, which encourage interaction among ethnic groups in a shared social space rather than hiving off groups in specialized settings.
- The recognition that, despite the goal of inclusiveness through mainstreaming, the lack of specialized services means that minorities' issues are often ignored or misunderstood in clinical intervention planning. Hence, there remains a need for bringing together a critical mass of expertise in culturally responsive services both for adequate care and training of

professionals to improve their cultural competence and promote cultural safety throughout the health care system.

The CCS adopted an approach to clinical assessment and intervention that focused on knowledge transfer to primary care physicians or other referring clinicians. The aim was to use the consultation not only to address the needs for that specific case but also to transfer knowledge, attitudes, and skills that could be used by the referring clinician to approach similar cases in the future. At the same time, the CCS could serve as a training center for mental health practitioners (psychiatry residents, psychology interns, social work, and nursing students) and a research site for work on refining methods of cultural formulation and assessment.

## Recruiting and Training Mental Health Professionals and Staff for Intercultural Work

The CCS built on available expertise in the McGill Division of Social and Transcultural Psychiatry and the wider network of colleagues at other institutions in Montreal. The founders of the CCS were psychiatrists (LJK and JG) with much experience in intercultural clinical work, training, and research. LJK brought research experience in medical and psychological anthropology as well as clinical involvement in consultation-liaison psychiatry, behavioral medicine, and indigenous communities. He trained in psychiatry at University California, Davis, in Sacramento in the late 1970s, where psychiatrist Henry Herrera, anthropologist Byron Good, and sociologist Mary-Jo Good had developed an innovative consultation program working collaboratively with local healers (Good, Herrera, Good, & Cooper, 1982). JG brought extensive experience in family systems-oriented child psychiatry as well as psychoanalysis. Both took part regularly in the case conferences that provided models of systemic and cultural thinking for later work by colleagues and students.

The service recruited a clinical psychologist who functioned initially as the coordinator of the service. In addition to administrative support staff, other people recruited during the initial phase of the CCS included clinicians with consultation experience from the target disciplines (psychiatry, psychology, family medicine, nursing, and social work) to act as consultants and trainers, a webmaster, and an IT person to maintain computer databases and Internet website resources, an evaluation researcher to work with the team to conduct a process evaluation (DG), and research assistants to collect outcome data from patients.

Because the staff involved were unfamiliar with the cultural consultation model—which was, in fact, a work in progress—we used weekly meetings of the service to forge a team, address organizational issues, and create a shared understanding and approach to the work of the service. Although these meetings centered on cultural formulations of referred cases or consultation to organizations, they also devoted time to logistics, discussed problems and dilemmas in the functioning of the service, and identified potential solutions for implementation. This process helped to clarify the role of the CCS and the type of knowledge translation and clinical tasks within its purview.

Building on the existing network developed by the MCH, the CCS established a bank of 73 consultants, predominately psychologists, psychiatrists, and social workers. In fact, a small number of consultants were used repeatedly, both because of the specific background of referred cases and because of the high level of skill they evinced. Consultants integrated directly into the team (as staff at the JGH, postdoctoral fellows, or trainees) were used most frequently.

Culture brokers were recruited as needed for a specific case. Preference was given to bilingual, bicultural clinicians with expertise in cultural psychiatry or psychology. However, in most instances, brokers with all of these attributes were not available. As a result, the culture broker might be someone with limited mental health knowledge who was closely supervised by the CCS consultant throughout the process of data collection and formulation. In effect, training occurred through this experience of on-the-job supervision. The culture broker was required to prepare a cultural formulation report following the Outline for Cultural Formulation in DSM-IV-TR (American Psychiatric Association, 2000). This was augmented with additional topics to address other aspects of identity, migration history, developmental experiences, illness models, and social structural problems (see Chapter 3). The culture broker's work could then be assessed both by observation during the assessment interview process, by their presentation of cultural information during the CCS case conference, and through the quality of their written report. This allowed the CCS consultants to identify culture brokers who were skilled, who would be invited to continue to work with the service, and those who were less skilled or biased, who would not be employed again.

With the end of grant funding, the service scaled back to a more streamlined model with a clinical director working closely with an administrative coordinator who is also highly skilled in interpersonal relations performing intake, triage, and assigning consultants to cases. In addition to the CCS consultants, culture brokers, and referring clinicians, the service allows selected students and trainees from health and social science disciplines to take part in the weekly case conferences contributing diverse perspectives to the discussion and insuring a lively exchange.

## Development of Clinical Procedures for Consultation

The clinical procedures of the CCS were modeled on outpatient consultation, with patients referred by primary care or other frontline clinicians seen by the CCS team at the Institute of Community and Family Psychiatry (the location of the outpatient psychiatry clinics of the Jewish General Hospital). The referring clinician or organization was invited to take part in the consultation and subsequent cultural formulation case conference, though most clinicians were unable to attend because of their own schedules. On some occasions, consultants travelled to the referral site to see patients there or to present the results of the consultation to the referring team.

The key participants in the consultation included a CCS clinician (usually a cultural psychiatrist or psychologist), an interpreter (when initial triage suggested one would be needed), and, usually, a culture broker with specific cultural knowledge pertinent to the case. The CCS clinician played a supervisory role and usually took the lead in meeting the patient and organizing the assessment process. The culture broker played varying roles, sometimes taking part in the interview and on other occasions providing contextual information and comments on the case during the subsequent CCS case conference. In many instances, the culture broker prepared a written cultural formulation following an expanded version of the DSM-IV-TR Outline for Cultural Formulation (American Psychiatric Association, 2000; Kirmayer, Thombs, et al., 2008). A handbook was prepared for consultants and culture brokers working with the CCS team, which outlined basic procedures and provided guidelines for the cultural formulation and other resource materials (see Chapter 3).

## Development of Resources for Cultural Consultations

Cultural consultation requires mobilizing relevant resources for specific cases. These resources may include interpreters, culture brokers, community organizations, and clinicians or others with specific skills or expertise. To identify these resources, we canvased existing programs, services, and organizations to collect information on individuals and programs relevant to the work of the service. We created databases of community organizations, professionals, and resource persons with expertise in culture and mental health and a website for access to this data and related information in cultural psychiatry. These databases were maintained by the CCS coordinator and updated regularly.

To facilitate cultural consultations, referrals, and identification of appropriate clinical and community resources, we developed three database resources: (1) a community organization resource database; (2) a clinician, interpreter, and culture broker database; and (3) a bibliographic database and library of literature in culture and mental health (with about 1,500 books and 3,000 articles). These databases were made available to CCS consultants and clients in multiple formats: over the Internet, in printed form, and by telephone, fax, or e-mail from the CCS. The CCS website served as a portal with links to online resources for clinicians and consultants, including (1) information on professional training activities and conferences in intercultural mental health; (2) bibliographies and references to online texts and technical documents; (3) patient information handouts, pamphlets, and other documents for users in multiple languages; and (4) information on community resources. This site evolved into the Multicultural Mental Health Resource Centre (http://www.mmhrc.ca) with the support of the Mental Health Commission of Canada.

The community organization resource database was based on earlier work by Heather Clarke and collaborators at the Montreal Children's Hospital Multiculturalism Program who had produced a spiral-bound document of about 80 pages listing organizations that were run by and provided services for specific ethnocultural communities. We transformed this document into a searchable database on a desktop computer. We developed a questionnaire to update the existing database requesting information about community services being offered including the cultural populations served, availability of interpreters, social services (e.g., home visitors, support groups), and mental health-related services. The questionnaire was mailed to 87 organizations in the greater Montreal area and followed up with telephone contact to collect up-to-date information.

We also created a database of clinicians, interpreters, and culture brokers who were available to participate in cultural consultations. The database included contact information, areas of expertise (language, culture, specific patient populations, or types of clinical issues), and our own notes on previous experiences working with that individual.

## Advertising and Recruitment of Patients

To make use of the CCS, clinicians must be aware of the service, identify appropriate patients in their practice, and have a simple referral process. The CCS was devised as a regional service, with consultations available for patients from the greater Montreal area. The information resources and referral activities were available more widely, across the province of Quebec, by telephone, fax, or e-mail.

To make clinicians aware of the CCS when it was first launched, a brochure announcing the service was prepared and distributed to the mailing lists of the Quebec Corporation of Psychologists and the Quebec Psychiatric Association (see Fig. 2.1). The brochure described the service and stated: "a cultural consultation is best reserved for cases where there are difficulties in understanding, diagnosing and treating patients that may be due to cultural differences between clinician and patient. Such differences can occur even when patient and clinician are from similar background because of wide variation within social and cultural groups."

Initial referrals to the service were asked how they heard about the service. It appeared that few referrals came about as a result of this mailing. Instead, referrals tended to come from clinicians familiar with the core group of CCS consultants because of either previous work, in-service training, or presentations at hospitals and institutions in the region. As the usefulness of the service became apparent, further referrals came from the same sources and gradually spread by word of mouth to colleagues both locally and at other clinical, social service, and community centers. Hence, the referral sources grew in concentric circles geographically and by collegial links.

## Evaluation of the CCS

Evaluation is essential for any new service to determine its effectiveness and limitations and to provide a basis for refinement and justify its place in a health care system that faces ongoing

CULTURAL
CONSULTATION
SERVICE

THE CULTURAL CONSULTATION SERVICE (CCS) OF THE JEWISH GENERAL HOSPITAL DEPARTMENT OF PSYCHIATRY OFFERS CLINICAL CONSULTATIONS TO PSYCHIATRIC, MEDICAL AND MENTAL HEALTH PRACTITIONERS, AS WELL AS INSERVICE TRAINING IN CULTURE AND MENTAL HEALTH.

**WHAT IS CULTURAL CONSULTATION?**

A cultural consultation is a comprehensive assessment of the social and cultural factors influencing diagnostic, prognostic and treatment issues of patients with mental health problems.

**WHAT IS THE FUNCTION OF THE CCS?**

The CCS may provide specific cultural information, links to community resources or formal cultural psychiatric or psychological assessment and recommendations for treatment.

**WHAT CONSTITUTES AN APPROPRIATE CASE FOR CULTURAL CONSULTATION?**

Cultural consultation is best reserved for cases where there are difficulties in understanding, diagnosing and treating patients due to cultural differences between clinician and patient. Such differences can occur even when patient and clinician are from a similar background because of wide variation within social and cultural groups.

**WHO CAN MAKE A REFERRAL TO OUR SERVICE?**

Requests for consultation can be made by any physician or licensed mental health practitioner and will be screened to determine if they are appropriate.

**HOW DO I REQUEST A CONSULTATION?**

A consultation request can be made by contacting the CCS Monday to Friday between 8:30 to 4:30. At the time of the request, the consultee should be prepared to provide the reasons for the consultation as well as basic identifying information about the patient (e.g. date of birth, occupation, languages spoken, address, immigration or refugee status, medicare number).

**OTHER ACTIVITIES OF THE CULTURAL CONSULTATION SERVICE?**

- In-service training and workshops for health professionals.
- Internships and rotations for trainees in psychiatry and other mental health disciplines.
- Development of an internet database of resources on culture and mental health.
- International Consortium for Cultural Consultation

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**Fig. 2.1** Brochure describing the Cultural Consultation Service financial constraints. From its inception, the CCS has been a research setting and a variety of studies have been conducted that shed light on the implementation, impact, and effectiveness of the service. The following sections present the results from the initial evaluation of the CCS, which included a formative process evaluation of the implementation of the service and a basic outcome assessment. The goal of the process evaluation was to document the development of the service to identify facilitating factors and barriers to implementation. The process evaluation used a model of participatory action research with a research anthropologist (DG) working as a participant observer in close collaboration with the clinical teams.

The outcome evaluation of the services involved assessing the consultations in terms of (1) patterns of referral from specific institutions and professionals, (2) reasons for consultation, (3) sociodemographic and clinical characteristics of cases referred, (4) use of specific professional and community resources including interpreters and culture brokers, (5) consultation diagnosis and treatment recommendations, (6) themes in cultural formulations, (7) referring clinician satisfaction with the consultation, and (8) concordance with the recommendations. Efforts to assess patient outcomes in terms of symptoms and functioning and cost-effectiveness analysis were stymied by the great heterogeneity of the cases seen and the need to minimize intrusiveness in the consultation context, which sometimes did not involve seeing the patient but only meeting with the referring clinician. This is a common problem in evaluations of consultation services.

## Quantitative Evaluation

Over the 13-year period from 1999 to 2012, the CCS service received 636 requests for consultation and completed 491 consultations. Of these, 455 cases were directly assessed by a CCS consultant, and 36 cases were only discussed at a CCS case conference. The majority of consultation requests concerned individuals (86%), but some involved couples or families (12%). A few cases (2%) involved requests from organizations to discuss issues related to their work with a whole ethnocultural group or community. The CCS also received frequent requests for information and links to resources.

**Table 2.2** Sources of referral of CCS individual cases ($N=406$)[a]

| | *n* | % |
|---|---|---|
| *Referral source* | | |
| Community health clinic (CLSC) | 135 | 33 |
| Hospital outpatient psychiatry clinic | 84 | 21 |
| Hospital outpatient clinics (nonpsychiatric) | 37 | 9 |
| Hospital inpatient (medical and psychiatric) | 35 | 9 |
| Private practitioner | 48 | 12 |
| Government agency | 19 | 5 |
| Community organizations | 16 | 4 |
| Rehabilitation center | 13 | 3 |
| School | 7 | 2 |
| Hospital emergency room (including ER psychiatry) | 6 | 1 |
| Medical clinic (nonhospital) | 5 | 1 |
| Law firm | 1 | 0 |
| *Referring professional* | | |
| Physician (primary care, specialty medicine) | 126 | 31 |
| Social workers | 97 | 24 |
| Psychiatrist | 78 | 19 |
| Psychologist/psychotherapist | 67 | 17 |
| Nurse/mental health care nurse | 22 | 5 |
| Other health care professional (nutritionists, OTs, etc.) | 7 | 2 |
| Organization | 1 | 0 |
| Other (legal and lay persons, teachers, interpreters) | 8 | 2 |

[a] Only individual cases directly assessed by a CCS consultant are represented in Tables 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, and 2.9

Table 2.2 summarizes the referring institutions and professionals.[3] Referrals came from the whole range of health and social service professionals based at hospitals (40%) and comprehensive community clinics (CLSC, 33%). Smaller numbers came from private practitioners (12%), government agencies (5%), and community

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[3] Tables 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, and 2.9 present data on individual cases seen by CCS consultants; couples and families and cases not seen directly by a consultant are not included.

**Table 2.3** Reasons for referral and expectations for consultation ($N = 406$)

| | *n* | % |
|---|---|---|
| *Reasons for referral* | | |
| Clarify diagnosis or meaning of symptoms and behaviors | 320 | 79 |
| Help with treatment plan | 277 | 68 |
| Problems with clinician–patient communication | 90 | 22 |
| Help with refugee claim/immigration status | 75 | 18 |
| Problems with treatment adherence | 54 | 13 |
| Other cultural problems | 79 | 19 |
| *Expectations for consultation* | | |
| One-time consultation | 341 | 84 |
| Follow-up by CCS | 70 | 17 |
| Provide ongoing treatment | 27 | 7 |
| Help locating resources for patient | 138 | 34 |
| Other | 33 | 8 |

**Table 2.4** Sociodemographic characteristics of CCS individual cases ($N = 406$)

| | *n* | % |
|---|---|---|
| *Age* | | |
| 0–13 | 4 | 1 |
| 14–21 | 37 | 9 |
| 22–40 | 203 | 50 |
| 41–64 | 152 | 37 |
| ≥65 | 10 | 3 |
| *Gender (female)* | 210 | 52 |
| *Marital status* | | |
| Never married | 148 | 37 |
| Married | 145 | 36 |
| Living as though married | 18 | 4 |
| Separated | 39 | 10 |
| Divorced | 36 | 9 |
| Widowed | 18 | 4 |
| N/A[a] | 2 | 0 |
| *Education level* | | |
| No formal education | 13 | 3 |
| Primary | 33 | 8 |
| Secondary | 139 | 34 |
| Post-secondary | 147 | 36 |
| N/A[a] | 74 | 18 |
| *Employment status* | | |
| Unemployed | 224 | 55 |
| Employed/full time | 58 | 14 |
| Employed/part time | 11 | 3 |
| Student | 37 | 9 |
| Homemaker | 39 | 10 |
| Disability/sick leave | 13 | 3 |
| Maternity leave | 2 | 0 |
| Retired | 6 | 2 |
| Welfare | 6 | 1 |
| Other | 3 | 1 |
| N/A[a] | 7 | 2 |
| *Immigration status* | | |
| Refugee or asylum seeker | 167 | 41 |
| Landed immigrant/permanent resident | 85 | 21 |
| Citizen | 123 | 30 |
| Other (student visa, status Indian) | 15 | 4 |
| N/A[a] | 16 | 4 |
| *Year of arrival in Canada (of $N = 377$ not born in Canada)* | | |
| 1950–1959 | 4 | 1 |
| 1960–1969 | 3 | 1 |
| 1970–1979 | 10 | 3 |
| 1980–1989 | 39 | 10 |
| 1990–1999 | 104 | 28 |
| 2000–2009 | 205 | 54 |
| 2010–2013 | 10 | 3 |
| N/A[a] | 2 | 0 |

[a] N/A: Data that were not recorded at intake were categorized as "Not available"

organizations (4%). The majority of cases were referred by physicians, mental health practitioners, or other health professionals. Almost one in four cases was referred by social workers (24%). Most ($n = 223$, 55%) of the referring clinicians indicated at the time of referral that an interpreter would be required for the consultation. Of these, only 60 had used an interpreter with the index patient in the past.

As seen in Table 2.3, the most common reasons for consultation were requests for help with clarifying a diagnosis or the meaning of specific symptoms or behaviors (79%), treatment planning (68%), problems with clinician–patient communication (22%), requests for help with issues related to immigration status (18%), treatment adherence (13%), or other cultural problems (e.g., better understanding of culture of psychosocial factors, assess ability to return to work) (19%). Three quarters of all cases had multiple reasons for requesting consultation reflecting the complexity and interrelatedness of issues. Based on intake assessment, the majority of referrals were classified as either ASAP ($n = 167$) or Urgent ($n = 136$), comprising over 75% of the cases.

Sociodemographic characteristics of the cases are summarized in Table 2.4. The mean age of patients referred was 36.7 years. The overall educational level of patients was high with 36% having completed at least some post-secondary education. However, over half of the patients were unemployed at the time of referral. Of the patients who were born outside of Canada, 104 arrived between 1990 and 1999 and 215 arrived between 2000 and 2012. The earliest year of arrival was 1951. Non-Canadian-born patients had spent a mean of 7.5 years (range 0–58 years, median 4 years, mode 1 year) in Canada, between arrival and referral. A large proportion of the cases seen (41%) were asylum seekers or refugee claimants. This reflects the fact that the CCS is located near the regional refugee clinic, which is a federally funded service that provides basic medical care while claimants are awaiting determination of their status. Although they are very experienced in providing medical and psychosocial care for this population, staff at the clinic call on the CCS for help with complex diagnostic and management issues as well as help with assessments related to claimants' appearance before the Immigration Review Board (see Chapter 12).

The cases represented enormous diversity in terms of countries of origin, languages, ethnocultural groups, and religions as summarized in Table 2.5. Patients came from 70 different countries, with the largest numbers coming from India ($n=51$), Pakistan ($n=34$), and Sri Lanka ($n=25$). When grouped by region of origin, 147 patients (36%) originated from South-Central Asia, followed by 61 patients from sub-Saharan Africa. The rest were distributed between North Africa, the Middle East, East Asia, Latin America, Europe, Southeast Asia, the Caribbean, and North America. Paralleling this geographic origin, the largest set of ethnicity groups was South Asian ($n=128$, 31%), followed by Middle Eastern/North African (16%), sub-Saharan African (13%), and South or Central American (10%). Most patients self-identified as belonging to two major religions, Christianity ($n=144$, 35%) and Islam ($n=120$, 30%), with smaller proportions belonging to Judaism, Sikhism, Hinduism, Buddhism, traditional indigenous religions, or no religion. Separate branches or sects of each religion are not identified (e.g., both Sunni and Shia Muslims are included under the umbrella of Islam). Patients spoke a great variety

**Table 2.5** Ethnocultural characteristics of CCS individual cases ($N=406$)

| | *n* | % |
|---|---|---|
| *Region of origin* | | |
| South-Central Asia | 147 | 36 |
| Southeast Asia | 12 | 3 |
| East Asia | 19 | 5 |
| Middle East/North Africa | 51 | 12 |
| Sub-Saharan Africa | 61 | 15 |
| South or Central America | 39 | 10 |
| Caribbean | 32 | 8 |
| Europe | 15 | 4 |
| North America | 30 | 7 |
| *Ethnicity (geographic grouping)* | | |
| South Asian | 128 | 31 |
| Southeast Asian | 11 | 3 |
| East Asian | 25 | 6 |
| Middle Eastern/North African | 63 | 16 |
| Sub-Saharan African | 53 | 13 |
| European | 17 | 4 |
| Latin American | 35 | 9 |
| Caribbean | 28 | 7 |
| Aboriginal | 23 | 6 |
| North American | 1 | 0 |
| N/A[a] | 22 | 5 |
| *Religion* | | |
| Buddhism | 10 | 2 |
| Christianity | 144 | 35 |
| Hinduism | 27 | 7 |
| Islam | 120 | 30 |
| Judaism | 2 | 0 |
| Sikhism | 37 | 9 |
| Traditional indigenous | 7 | 2 |
| Other | 3 | 1 |
| None | 12 | 3 |
| N/A[a] | 44 | 11 |
| *Mother tongue* | | |
| African languages | 38 | 9 |
| Arabic | 27 | 7 |
| Chinese (Mandarin, Cantonese) | 19 | 5 |
| English | 38 | 9 |
| French | 13 | 3 |
| European languages (other than French or English) | 15 | 4 |
| Middle Eastern languages (other than Arabic) | 35 | 9 |
| Spanish | 46 | 11 |
| South Asian languages (e.g., Hindi, Tamil, Urdu) | 135 | 33 |
| Southeast Asian languages (e.g., Khmer, Vietnamese) | 8 | 2 |
| Indigenous languages | 3 | 1 |
| Other | 23 | 6 |
| N/A[a] | 6 | 2 |

[a] Data that were not recorded at intake upon referral were categorized as "Do not know"

**Table 2.6** Resources needed for cultural consultation ($N=406$)

| | $n$ | % |
|---|---|---|
| *Matching of consultant* | | |
| Ethnicity | 51 | 13 |
| Language | 18 | 4 |
| Religion | 4 | 1 |
| *Specific clinical skills* | | |
| Psychiatric (mental status examination, medication) | 251 | 62 |
| Social work expertise | 8 | 2 |
| Child and family therapy | 6 | 1 |
| Experience with refugees, trauma, and migration issues | 5 | 1 |
| Somatization | 2 | 1 |
| Other (e.g., drug abuse, medical complications) | 7 | 2 |
| *Interpreters* | 153 | 38 |
| *Culture brokers* | 198 | 49 |

of languages and dialects (76 recorded at intake), with the largest single number speaking Punjabi. When grouped by region, most patients spoke South Asian languages (33%), followed by Middle Eastern (e.g., Arabic, Farsi; 16%), Spanish (11%), African (9%), European (7%, including French), and East Asian languages (5%, mainly Chinese). Small numbers of patients spoke indigenous languages (e.g., Mi'kmaq, Lakota, Quechua) and other languages (e.g., Kreyol, Pidgin, and American Sign Language). Less than half ($n=167$) of all patients spoke at least a little French, and 40% (67/167) of these were fluent in French. Of importance for understanding potential difficulties in navigating the health care system, fully 47% ($n=192$) of patients had no French language skills at the time of referral. However, almost 75% overall had at least some English language skills and 26% ($n=106$) were fluent in English; 23% ($n=92$) patients could speak no English at all.

This culture and linguistic diversity demanded a wide range of resources in terms of consultants, interpreters, and culture brokers (Table 2.6). Some form of matching of the consultants' background (language, ethnicity, or religion) with that of the patient was needed in 18% of cases, and some specific clinical skills (psychiatric expertise, family therapy training, experience working with trauma, refugees, somatization) was needed in 69% cases. Because it was often not possible to find a skilled clinician with the requisite language skills and cultural background knowledge, it was necessary to use both interpreters and culture brokers to address the specific cultural and mental health issues raised by a case. Interpreters were employed in 38% ($n=153$) of cases, and culture brokers in 49% (198); 15% of cases (59) had both interpreters and culture brokers. For smaller ethnocultural communities or more recent immigrants, it was sometimes difficult to find a well-trained interpreter or appropriate culture broker to work with a patient or family. Patients were sometimes reluctant to meet with a culture broker or consultant from their own background because the small size of the local community made confidentiality difficult to maintain.

Table 2.7 summarizes the intake and final diagnoses of patients assessed by the CCS. The first column presents the initial diagnosis as reported by the referring clinician at the time of intake to the CCS. Patients had an average of 1.67 diagnoses at referral. The most frequent diagnoses at the time of intake were major depressive disorder, PTSD, psychotic disorders (including schizophrenia and psychotic symptoms NOS), and other anxiety disorders. The level of certainty of these diagnoses varied with the expertise of the referring clinician and the extent of previous evaluation. Of these intake diagnoses, on average 55% were confirmed by the consultation. For most diagnostic categories, the level of confirmation of intake diagnosis ranged from 40 to 76%, but low rates of confirmation were found for some psychotic disorders as well as anxiety, adjustment, and dissociative disorders. The CCS evaluation made new diagnoses in 73% of cases ($n=295$), with an average of 2.00 diagnoses per case (1.46 new diagnoses per case overall). The final column in Table 2.7 presents the proportion of final diagnoses in each case that were new. Fully 61% of the final diagnoses were produced by the CCS; put another way, 2/3 of the final diagnoses differed from the referral diagnoses. In particular, most diagnoses of psychotic, anxiety, adjustment, and personality

**Table 2.7** Intake and final diagnoses of CCS cases ($N=406$)

| | Diagnosis[a] | | | | | |
|---|---|---|---|---|---|---|
| | Intake | Confirmed | | New | Total | New/total |
| Diagnostic category | *n* | *n* | % | *n* | *n* | % |
| Affective disorder | 198 | 143 | 72 | 100 | 243 | 41 |
| Depression | 173 | 132 | 76 | 87 | 219 | 40 |
| Bipolar | 25 | 11 | 44 | 13 | 24 | 54 |
| Psychotic disorder | 154 | 70 | 45 | 101 | 171 | 59 |
| Schizophrenia/schizophreniform | 43 | 25 | 58 | 22 | 47 | 47 |
| Schizoaffective | 13 | 5 | 38 | 15 | 20 | 75 |
| Other psychotic | 37 | 12 | 32 | 39 | 51 | 76 |
| Psychotic symptoms | 61 | 28 | 46 | 25 | 53 | 47 |
| PTSD | 109 | 81 | 74 | 59 | 140 | 42 |
| Anxiety disorder | 48 | 17 | 35 | 30 | 47 | 64 |
| Adjustment disorder | 12 | 4 | 33 | 46 | 50 | 92 |
| Somatoform disorder | 24 | 14 | 58 | 14 | 28 | 50 |
| Personality disorder | 20 | 8 | 40 | 43 | 51 | 84 |
| Personality traits | 16 | 5 | 31 | 44 | 49 | 90 |
| Childhood disorder | 3 | 0 | 0 | 15 | 15 | 100 |
| Learning disorder | 7 | 3 | 43 | 13 | 16 | 81 |
| Eating disorder | 5 | 0 | 0 | 2 | 2 | 100 |
| Substance abuse | 16 | 10 | 63 | 26 | 36 | 72 |
| V-code | 20 | 5 | 25 | 43 | 48 | 90 |
| Other conditions | 6 | 0 | 0 | 8 | 8 | 100 |
| Cognitive disorders | 13 | 7 | 54 | 15 | 22 | 68 |
| Dissociative disorders | 7 | 1 | 14 | 2 | 3 | 67 |
| Factitious disorders | 2 | 0 | 0 | 0 | 0 | 0 |
| Impulse control disorders | 1 | 0 | 0 | 7 | 7 | 100 |
| Sexual and gender identity disorders | 2 | 0 | 0 | 1 | 1 | 100 |
| Sleep disorders | 1 | 0 | 0 | 2 | 2 | 100 |
| General medical condition | 15 | 5 | 33 | 20 | 25 | 80 |
| Total Diagnoses | 679 | 373 | 55 | 591 | 964 | 61 |
| Average Diagnoses per case | 1.67 | 0.92 | | 1.46 | 2.37 | |

[a] *Intake* = Diagnosis by referring clinician provided at intake, *Confirmed* = intake diagnoses confirmed by CCS evaluation, *New* = new diagnoses made by CCS evaluation, *Total* = Confirmed + New CCS final diagnoses in each category, *New*/*Total* = proportion of diagnoses in each category made by CCS evaluation

disorders as well as V-codes were made by the CCS. The increase in diagnoses of psychoses probably reflects the specific expertise of cultural psychiatry in differentiating psychosis, dissociative disorders, and cultural variations in illness experience (Adeponle, Thombs et al., 2012; see Chapter 14). The fact that the CCS was able to make diagnoses of personality disorders more frequently likely reflects the ability to collect more information about past patterns of behavior and cultural norms. The increased diagnosis of adjustment disorder and the use of V-codes stem from the careful attention to situational or contextual issues including migration, acculturation, family systems, and other social stressors and predicaments. Overall, this table indicates that the CCS plays an important role in basic diagnostic reassessment.

Of course, psychiatric diagnosis is only one aspect of clinical assessment, and the cultural formulations produced by the CCS identified many other issues or problems that required clinical attention. Table 2.8 lists the predominate themes in the cultural formulations many

**Table 2.8** Common themes in cultural formulations ($N = 283$)

| | $n$ | % |
|---|---|---|
| *Family systems issues* | 77 | 27 |
| Family and couple conflict | | |
| Changes in configuration of extended family | | |
| Intergenerational issues | | |
| Family honor and obligations | | |
| *Exposure to trauma and violence* | 66 | 23 |
| Impact of war, torture, and organized violence | | |
| Domestic violence | | |
| Effects of violence on development | | |
| PTSD, depression, and other sequelae | | |
| *Migration issues* | 71 | 25 |
| Stresses and losses on migration trajectory | | |
| Uncertainty of refugee or immigration status | | |
| Family separation and reunification | | |
| Homesickness and mourning for culture | | |
| *Cultural identity, acculturation, and adjustment* | 123 | 43 |
| Adjusting to life in host country | | |
| Shifting/hybrid cultural identity | | |
| Changing gender roles and relations | | |
| Changing social roles and community | | |
| *Cultural models of illness and healing* | 47 | 17 |
| Modes of symptom expression and idioms of distress | | |
| Illness explanatory models and causal attributions | | |
| Cultural influences on social determinants of health | | |
| Treatment choice and expectations for care | | |
| *Other social, economic, and structural issues* | 129 | 46 |
| Stereotyping, prejudice, and discrimination | | |
| Social isolation, marginalization | | |
| Poverty, socioeconomic uncertainty | | |
| Unemployment or underemployment | | |

of which influenced diagnosis, treatment recommendations, treatment adherence, or constituted clinical problems in their own right. These issues fall into several broad groups that are often closely related. The most frequent issues included:

- Variations in family systems and structures (e.g., patriarchal families), including changes in age and gender roles (e.g., significance of marriage, divorce, adolescence, or elder status for identity and social status of men and women) and notions of honor and shame as regulatory principles in family dynamics (see Chapter 7).
- The impact of exposure to violence and massive human rights violations (including civil war, genocide, torture and childhood and domestic violence), which may be experienced prior to migration, on the journey to safety or after resettlement.
- The impact of migration itself (e.g., issues of identity, fracturing extended families, changing gender roles, eliminating communal supports and mediators, and creating tensions between generations); the stressful impact of the uncertainty and complexity inherent to the application process, waiting period, and review board hearing for asylum seekers (see Chapter 12); and the impact of prolonged family separation and reunification (see Chapter 13).
- Issues related to changes in social roles, gender relations, hybrid identities, and new configurations of family and community.
- The impact of other social, economic, and structural issues including poverty, unemployment (or underemployment for migrants whose credentials are not recognized), as well as ethnic, religious, or racial stereotyping, prejudice, and discrimination, including everyday micro-aggression, institutional racism, and biases in provision of health and social services as well as interactions with mainstream institutions like the police, youth protection, and the justice system (see Chapters 11 and 13).
- The effects of cultural modes of expressing symptoms, models of illness, and expectations for treatment, including the prevalence of dissociative symptoms leading to misdiagnosis of psychosis, experiences with health care and healing practices in country of origin, and the value of religious practices in coping and healing.

**Table 2.9** Referring clinician evaluation of consultation outcomes ($N=134$)

| | *n* | % |
|---|---|---|
| *Recommendations* | | |
| Recommendations were clear | 124 | 93 |
| Recommendations were feasible | 102 | 76 |
| *Impact of cultural consultation* | | |
| Influenced the patient keeping appointments more regularly[a] | 9 | 12 |
| Influenced the patient's treatment adherence[a] | 16 | 21 |
| Improved the clinician–patient relationship[a] | 28 | 36 |
| Influenced the use of other services | 36 | 29 |
| *Referring clinician satisfaction* ($N=91$) | | |
| Satisfied with the consultation | 73 | 80 |
| Helped to deal with patient's problems | 58 | 64 |
| Recommend service to a colleague | 86 | 95 |
| Use service again | 85 | 93 |

[a] Data only available for 78 cases because of a change in questionnaire

**Table 2.10** Reasons for non-implementation of CCS recommendations ($N=287$)

| | *n* | % |
|---|---|---|
| Patient lost to follow-up | 75 | 26 |
| Patient refused or disagreed with recommendation | 64 | 22 |
| Clinician found recommendation inappropriate or irrelevant | 29 | 10 |
| New circumstances made recommendation irrelevant or inappropriate | 37 | 13 |
| Recommendation implemented but results unsatisfactory | 2 | 1 |
| Recommendation already implemented | 6 | 2 |
| Lack of systemic resources | 6 | 2 |
| Recommendation will be implemented in future | 10 | 3 |
| Patient unable to implement the recommendation | 4 | 1 |
| Clinician did not have opportunity | 7 | 2 |
| Third-party disagreed with recommendation | 4 | 1 |
| Recommendation too costly or difficult to implement | 4 | 1 |
| Recommendation arrived too late | 5 | 2 |
| Lack of communication with third-party needed to implement | 2 | 1 |
| Clinician forgot to implement or does not remember if implemented | 36 | 13 |

The cultural formulation was presented as a narrative that identified the salient issues and their interactions in an individual case. This was distilled into a brief clinical problem list that could be addressed with specific interventions, which was conveyed to the referring clinician.

To assess the usefulness of the CCS consultations, referring clinicians were contacted about 6 months after the consultation and asked to respond to a brief questionnaire. Each of the recommendations in the consultation report was read to the clinicians, and they were asked whether the recommendation had been implemented and, if not, why. The questionnaire also asked questions about the clarity and feasibility of recommendations in this case and the effect of the consultation on client adherence to treatment and health care utilization as well as on the clinician–patient relationship. Finally, they were asked about their overall satisfaction with the service.

Outcome data are available on 134 referrals from 91 clinicians (Table 2.9). For the great majority of cases, the referring clinicians found the consultation recommendations clear ($n=124$, 93%) and feasible ($n=102$, 76%). There was some evidence for impact on clinical care and service use, with 12% reporting the patient was better at keeping appointments and 21% finding that the patient was more adherent to treatment. Out of the total 701 recommendations made to these clinicians, 59% ($n=414$) were implemented, with a mean of 3.1 recommendations/case. Table 2.10 summarizes the main reasons for not implementing specific recommendations. The most common reason for lack recommendation concordance was patient lost to follow-up, which occurred for 26% ($n=75$) of recommendations. This was followed by recommendations that were not implemented due to patient refusal (22%). The clinician disagreed with the recommendation in 10% of the cases ($n=29$), and the recommendation became irrelevant in 13% of the cases ($n=37$). The clinician forgot to implement the recommendation or did not remember if the recommendation was implemented in 13% of cases ($n=36$). Patient-related reasons for not implementing a recommendation were reported in a total of 49% of the recommendations. In most cases, referring clinicians reported that they were satisfied with the consultation (80%) and indicated that it had helped in the management of their patients (64%). Nearly all who used the service said they would use it again (93%) and would recommend that their colleagues use it (95%).

## Formative Process Evaluation of CCS Implementation

Given the innovative nature of the CCS, the principal objective of the qualitative evaluation was to document the process of its implementation. To promote the active participation of the service's members in the evaluation process, the evaluator met with CCS clinical team on several occasions to determine the specific objectives of the evaluation, which included (1) developing a typology of intercultural clinical problems seen by the CCS, (2) identifying themes in the cultural formulations produced by the culture broker and the team, (3) identifying barriers and facilitating factors for the implementation of the service, and (4) describing components of the service which changed as a result of the process evaluation.

The evaluation used a multiple case study method with overlapping levels of analysis (Yin, 2008). In case study designs, the explanatory power derives from the depth of case analysis, not from the number of units analyzed. The formative evaluation was conducted during the initial grant-funded phase of the project and included the initial 52 cases seen by the CCS. The different levels of analysis used in the study were based on the perspectives and explanations of three members of the research team who included an anthropologist, two clinical psychologists, and psychiatrist. Two sources of data were used:

1. The CCS case files were reviewed to compile the following data: (a) the referring clinician's stated (explicit) reasons for the referral, (b) the case notes of the clinical coordinator and CCS consultants from triage through completion of the consultation, (c) the complete text of the cultural formulation and clinical recommendations for the case, and (d) the summary of clinical recommendations produced at the end of the consultation with the CCS team.
2. Participant observation during the clinical case conference provided information on the case and on the process of interaction among consultants, culture brokers, and referring clinicians. The evaluator and the clinical coordinator participated in these meetings and took process notes. The meetings were also audio-recorded and transcribed so that they could be reviewed if needed.

Post-case conference research meetings were held immediately following each weekly CCS case conference meeting. The meetings were chaired by the lead evaluator (DG), an anthropologist with graduate training in public health who was responsible for the evaluation. The other participants were usually the CCS clinical coordinator (a clinical psychologist) and a participating mental health practitioner with experience in qualitative research. We used the technique of triangulation of perspectives in order to maximize the internal validity of the qualitative results (Denzin, 1989; Green & Thorogood, 2004). This group reviewed the participant-observation notes and reflected on the assessment process and clinical conference interactions. During these meetings, these three participants aimed to address the specific research objectives by answering the following key questions:

1. What were the principal themes in the cultural formulation for the case?
2. Did the consultation process identify additional problems related to the case that were not initially recognized at triage?
3. Did the consultation process reveal implicit problems?
4. Based on participant observation during the clinical consultation, are there ways to improve the CCS process?
5. Did the consultation identify training needs?

Discussion among the researchers continued until consensus was reached on each question.

## Cultural Issues Motivating Clinician's Request for a Cultural Consultation

Referring clinicians' explicit reasons for requesting a cultural consultation recorded at the time of triage are summarized in Table 2.11. These reasons for referral were stated directly by the clinician or elicited with the help of the CCS coordinator during the triage process. Additional cultural issues that were uncovered later on during the consultation are labeled "emergent." Finally, some clinicians omitted to mention key reasons for referral that were clearly present at the time of referral and motivated the request but only became apparent during the course of the assessment. These unstated reasons for referral are labeled "implicit." Most cases had multiple reasons for referral, and thus the categories are not mutually exclusive.

The most common reasons for referral explicitly indicated by clinicians at the time of triage related to clinical issues they were experiencing with their patient such as cultural difference creating an uncertainty in the choice of treatment including medication choice (92%), uncertainty of diagnosis (50%), and experiencing problems with patient's treatment adherence (40%). The second most important category of explicit reasons presented at triage by referring clinicians involved problems related to clinical and interpersonal communication (communication 71% and interpreter 12%). Intercultural communication issues occurred between clinicians and patient or between clinicians and the patient's family. Interpreter issues usually involved issues of access or availability, but in some cases, there were communication difficulties between clinician and interpreter with misunderstandings or misalliances (see Chapter 5). Difficulties experienced by the referring clinicians themselves (e.g., feeling lack of skill or competence to deal with problem or emotionally overwhelmed by patient's trauma history) were the explicit reasons for consultation in about 1/3 of cases.

**Table 2.11** Reasons for referral to the CCS of initial 52 cases

| | Explicit | | Emergent | | Implicit | |
|---|---|---|---|---|---|---|
| | *n* | % | *n* | % | *n* | % |
| Treatment choice | 48 | 92 | 0 | 0 | 0 | 0 |
| Diagnosis unclear | 26 | 50 | 5 | 10 | 0 | 0 |
| Treatment adherence | 21 | 40 | 0 | 0 | 0 | 0 |
| Communication | 37 | 71 | 4 | 8 | 2 | 4 |
| Interpreter problem | 6 | 12 | 4 | 8 | 0 | 0 |
| Systemic problems | 12 | 23 | 10 | 19 | 7 | 13 |
| Inherent to patient | 0 | 0 | 2 | 4 | 0 | 0 |
| Referring professional | 18 | 35 | 0 | 0 | 1 | 2 |
| Total | 168 | | 25 | | 10 | |

The third most frequent category of problem we termed *systemic*. This involved issues related to bureaucratic procedures, practices, and demands of the health, social, educational, legal, or immigration systems. Systemic problems led in turn to other problems including the need for additional diagnosis, interpreters, and better intercultural communication. For example, a child who was having difficulty adjusting to the French school system (a provincial legal requirement for immigrant children in Québec) needed an educational assessment to determine if he was suffering from a learning disorder that would give clinical grounds to make an administrative appeal to allow him to attend school in English.

The consultation process itself sometimes revealed additional issues that had not been identified at triage that could account for the referral in about 1/3 of cases. These included issues the referring clinician was not aware of (termed *emergent* in Table 2.11) and those that the clinician likely knew but did not explicitly declare (termed *implicit*). These results suggest that in many cases, the specific reasons for referral were too complex to identify at triage and required more assessment. For example, a consultation request was identified at the moment of triage as a demand for clarification of whether the diagnosis of depression was accurate. The patient was the father of a family that had escaped an ongoing war in their country of origin. During the consultation process, the CCS team understood that the interpreter's lack of training in mental health had contributed to the diagnostic confusion because he had concealed information due to his concern that the patient's family would be harshly judged or stigmatized. Once the CCS consultant addressed the concerns of the interpreter, the information required to make a diagnosis was readily obtained.

While their reasons for consulting the CCS were genuine, some clinicians did not reveal some of the key reasons motivating their referral. These reasons became apparent as information was collected on the case or, in some instances, because of general knowledge about changes in the health care system or obvious gaps in available services. We estimated that close to one-third of the requests for consultation at the CCS were also motivated by implicit reasons involving a hidden agenda. In most cases, it is likely that referring professionals did not disclose these reasons because they knew the CCS only accepted cases that clearly suggested a cultural component and that it did not provide post-consultation treatment for patients. Among the cases presenting implicit reasons, the most frequent issues were associated with the referring professional or to the health care system. Problems associated with the referring professional involved situations where clinicians either lacked confidence in their own ability to treat the patient or questioned the competence of another professional involved in the case. These issues were difficult for the clinician to disclose at the time of referral because doing so would threaten their clinical authority or undermine professional solidarity. Other implicit problems associated with the referring clinician involved cases where clinicians were confronted with challenges to some of their own assumptions, stereotypes, or prejudices regarding the cultural group of their patient. Clinicians may have been reluctant to reveal such biases because they are contrary to ethics or the professional ideal of affective neutrality (Williams, 2005). A second distinct category of implicit problem involved systemic issues. In all of these cases where they arose, implicit systemic problems were related to problems of accessibility to mental health services, particularly for asylum seekers or for those needing services in a specific language.

For 63% of cases, no new reasons were identified during the consultation, suggesting that the triage process often was sufficient to help the referring clinician accurately identify and articulate the basic needs for consultation. New reasons for consultation—of which neither the referring clinician nor the triaging psychologist had been aware—were identified through the consultation process in the remaining 37% of cases. The most common type of new problem was systemic (10/19 cases), involving availability of services, continuity of care, or dilemmas created by specific institutional practices. The systems involved included health and social services, education, legal, and immigration.

The relative lack of recognition of systemic problems may have to do with the tendency to attribute difficulties to characteristics of the patient rather than the system and to become habituated to or normalize everyday difficulties with the system. In five cases, new diagnostic issues were raised, including the need for specialized medical or neuropsychological evaluation to rule out organicity or intellectual impairment. Multiple new reasons (2–4) were identified for 12 cases (23%), indicating the complexity of issues that might have gone unrecognized without cultural consultation.

Implicit reasons for consultation were identified in 15/52 (29%) of cases. The most common implicit reasons involved problems that concerned referring clinicians themselves (10/15) or systemic issues (8/15). Implicit reasons for consultation related to the referring clinician and usually involved their own lack of confidence, comfort, or competence in dealing with the patient. In some cases, the referring clinician's implicit concern was with the competence of another professional, and the cultural consultation was seen as a way to document inadequate care and mobilize an alternative. Subtler cases involved challenges to clinicians' implicit assumptions about including cultural differences in gender roles, religious values, and issues of racism. Implicit problems related to systemic factors (found in 8/52 or % of cases) differed from those we identified as new problems in that there was some reason for the clinician to downplay or hide them. Generally, this was because the referring clinician was hoping to transfer the patient or obtain services for the patient that the CCS was not set up to provide, i.e., psychotherapy, long-term treatment, or case management. These cases are clear indicators both of problems in accessibility to services, lack of use of interpreters, insufficient training in cultural competence for primary care or mental health practitioners, or other gaps in the health care system.

Cultural consultation often facilitated the therapeutic alliance between the referring clinician or team and the patient. The referring clinicians' effort to seek a consultation may have demonstrated to the patient an interest in understanding the patient in his or her own cultural framework. The cultural formulation produced by the consultation made sense of the patient's puzzling or disturbing symptoms and behaviors by placing them in social and cultural context. This clarified the patient's predicament and thus increased the clinician's empathy for the patient. These issues sometimes encouraged agencies or clinics to take an interest in knowledge transfer and training on cultural competence as an underdeveloped agenda and broadened the use of existing community organizations working with minorities or providing additional skills to refugees or immigrants.

Cultural consultation also revealed the complexity of the case, transforming clinician's frustration into an appreciation of the intellectual and professional challenges presented by the case and so increasing clinician's interest and motivation to remain actively involved. Even where patients were not seen, the advice and reinterpretation of events provided by the CCS team worked to improve and maintain the referring clinician's treatment alliance and refine their diagnostic and treatment approach.

## Conclusion

The CCS model uses outpatient consultation to support primary care clinicians and frontline mental health workers with the aim of improving the response to diversity in mainstream services. The CCS consultations to individual practitioners as well as case conferences and in-service training to clinics and organizations promote knowledge exchange. The CCS brought together local resources and, through a working group, developed an approach to cultural consultation built around the use of cultural consultants, culture brokers, and interpreters and organized in terms of a cultural formulation with specific recommendations to the referring clinician. The CCS assessment often results in changes in diagnoses and identifies important social and cultural issues that influence treatment and that may constitute important clinical problems in their own right. In general, referring clinicians find the service helpful for understanding complex cases, and there is some evidence the consultations can improve treatment engagement and adherence. Although it has not proved possible to conduct a rigorous outcome assessment at the level of patients health status owing to the great heterogeneity of patients referred and the time-limited intervention the CCS provides, as illustrated throughout this book, cultural consultation can have a dramatic impact on individual cases.

The analysis of cases seen in the Cultural Consultation Service and other transcultural clinics indicates that access to mental health care varies widely by linguistic and cultural background. In a significant number of cases, language barriers and the cultural complexity of the cases had prevented adequate assessment in conventional mental health care settings. The CCS was able to provide clinical reassessment and redirection of treatment in a substantial proportion of cases, and these interventions have been well received by referring clinicians. Although cultural consultations require substantial resources, in terms of specific expertise in cultural psychiatry as well as interpreters and culture brokers, the result of this intensive process is often a change in diagnosis and treatment plan with significant immediate and long-term consequences for patients' functioning, use of services, as well as clinician satisfaction.

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