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ORIGINAL PAPER

Cultural Consultation in Context: A Comparison of the Framing of Identity During Intake at Services in Montreal, London, and Paris

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Abstract Cultural diversity poses a challenge to mental Health care systems in many settings. Specialized cultural consultation services have been developed in a number of countries as a way to supplement existing services. The objective of this paper is to compare and contrast cultural consultation services in Montreal, London, and Paris to determine how culture and society have shaped the evolution of these services to meet local sensitivities and imperatives. Historical contexts of the sites, their descriptions and origins, how they categorize cultural, ethnic, and linguistic diversity, and their intake procedures are compared and contrasted according to a standardized template of themes. Data came from site visits and participant observation at each site. For historical, political, and cultural reasons, categorization of diversity and intake procedures differ markedly by site: Montreal focuses on language categories and language proficiency; London enumerates ethnic diversity according to officially mandated categories; and Paris does not gather ethnic data on its patients in any form. The process of cultural consultation, specifically its triage and intake procedures, is profoundly influenced by local histories and social norms that are maintained by professional cultures of psychiatry in each setting. To properly place their patients in context, cultural psychiatrists must not only aim to understand the culture of the other, but also must consider the culture of the mainstream society and how it shapes the delivery of services.

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Introduction

Cultural diversity poses a challenge to mental health care systems in many countries. A variety of strategies have been developed to address this challenge, including ethnic match, cultural competence, and cultural safety (Kirmayer 2012; Bhui et al. 2007). The Cultural Consultation Service (CCS) in Montreal was founded in 1999 as an approach to address cultural diversity in primary care medicine and mental health services (Kirmayer, Guzder, and Rousseau, 2014). Its principal aim was to support clinicians in learning how to work with diversity in mental health through case-based consultation. The CCS model has been adopted by several sites around the world providing an opportunity to examine how local historical and political contexts influence the process of consultation.

This paper will compare and contrast the original program with two international adaptations, the London CCS in the United Kingdom and The Françoise Minkowska Center in Paris, France, to see what differences may have emerged in response to changes in context, health care systems, and local practices of identity. Although derived from the same model, we expected that the sites developed along different lines according to the historical, geographic, political, and cultural contexts in which they are embedded, including how they categorize diversity and corresponding administrative policies that have affected their triage and intake procedures. Here, we focus on clinical cultures of psychiatry as revealed through the gathering of clinical information by the services, the initial vetting of cases, and clinical vignettes that illustrate emergent differences. Comparisons with the Montreal CCS serve to show how culture and society have shaped the evolution of these services to meet local needs and imperatives, with Montreal emphasizing the language proficiency of patients, London focusing on assigning ethnic categories, and Paris striving to avoid ethnic or religious categories in any form. These differences across sites highlight the culture of psychiatry and psychiatric services and their role in shaping the delivery of mental health services in multicultural settings. A focus on context and clinicians is missing from most evaluations of health and social interventions where the focus is on the patient, as if that is where all pathology and challenges are located. This paper explicitly highlights the need for clinicians to take note of how service models may be adapted to each setting and in so doing fills a knowledge gap that will pave the way to demonstrate how cultural consultation can be optimized across countries and sites.

Cultural consultation employs linguistic interpreters and culture brokers to improve communication in clinical situations where there are differences of language and culture between patients and clinicians. As part of the work, facilitating the participation of the referring clinical team in the evaluation is of critical importance, making the consultation a form of knowledge transfer in which specific cultural knowledge and generic skills for cultural competence and safety are modeled for the referring team by the consultants. Cultural consultations consist of a psychiatric evaluation and a cultural formulation following a format similar to the DSM-5 Outline for Cultural Formulation (OCF) (American Psychiatric Association 2013, pp. 749–750; Lewis-Fernández et al. 2015). More specifically, the original Handbook of the Montreal CCS used an expanded version of the DSM-IV OCF, some of which was incorporated into the DSM-5 version of the OCF. Reports summarizing these evaluations are provided to the referring team and they have an opportunity to discuss, review, and modify conclusions at a clinical case conference, where diagnostic formulation and treatment recommendations are negotiated. The procedure is well accepted by patients and positively evaluated by referring clinicians (Kirmayer et al. 2003, 2014a, b). Services modeled on the CCS have been developed in several countries (see www.mcgill.ca/iccc).

Methods

In 2015, the lead author visited Montreal, London, and Paris to gather information about their consultation services. He attended meetings, met with service directors and personnel to clarify procedures and practices, and gathered historical information about the clinics and their operations. In London, over the course of 1 day, he interviewed two service staff, toured what had been the clinical site, and attended Culture Consultation "Club" rounds. There were no clinical activities to observe because these had been discontinued 2 years before due to withdrawal of funding by the National Health Service. Due to the fact that clinical services were no longer in place, the lead author received input from former team members and read publications of the London CCS to gain better understanding of the dilemmas the team and service had faced. From rough notes, a first draft of site description and procedures was written by the lead author and sent to the London team for their input and correction. In Montreal and Paris, a similar investigation took place. The main difference between these sites and the London CCS was that clinical activities were ongoing, so the lead author, as a clinician, was able to participate in routine team meetings and patient care. In Montreal and Paris this included participation in meetings for the triage of new referrals, clinical case conferences, team discussions, educational lectures, and routine clinical care. Information gathered from these various modes of participant observation provided the basis for broader reflection on the culture of psychiatry at each of the sites. As a member of the Montreal team, the lead author directly participated in clinical procedures over the last 15–20 years. Participation in Paris took place from June to September 2015. The lead author participated in ten team meetings and some patient evaluations as well. There were several interviews of members of the Minkowska team to understand their points of view with respect to the evolution of the services they were delivering. In all sites, input from the clinic team members was crucial to developing the background of the clinics and interpreting findings according to local cultures of psychiatry. Descriptive data about patients and clinical staff were not collected, as this was not the focus of the study. Two staff from each site, including the lead author, became co-authors of this paper, ensuring that the comparisons were grounded in local experience. In effect, in addition to site visits by the first author, the paper is based on participant observer methods, drawing from the extensive experience of each of the co-authors with their respective services.

A template of items emerged from these meetings and observations that enabled a systematic comparison (see Table 1), including the type of clinic, number and type of referrals, the clinic structure, historical context, attitudes toward categorizing diversity, intake procedures, and the dominant framework of each clinic. Intake forms from each of the sites (see Table 2) enabled comparison with respect to the kinds of information obtained by the clinics at triage and in the early phases of the consultation process. Historical context and attitudes regarding the categorization of diversity informed the critical assessment of intake procedures at each of the sites.

Results

Important differences emerged among the sites with respect to site description and origins, historical context, categorizing diversity, intake procedures, and the content of intake forms. A discussion of these items for each site follows.

Montreal

Site Description and Origins

The Montreal CCS is located in the outpatient psychiatry department of the Jewish General Hospital (JGH) which serves an inner-city catchment area of Montreal. The JGH is a McGill University teaching hospital and the CCS is affiliated with the McGill University Division of Social and Transcultural Psychiatry (www.mcgill.ca/tcpsych), an academic program devoted to research and training in culture and mental health. The need for culturally responsive services in Montreal was driven by the changing demographic profile of the hospital neighborhood in the 1980s and 1990s. The area, which had been composed of a mixed Jewish, Irish, and French Canadian population in earlier years, received a large influx of Asian (Filipino and Chinese), West African, Caribbean, South Asian (Tamil-speaking), Latin American, and Arab-speaking immigrants and refugees. The clinical dilemma of cross-cultural understanding motivated the need for a service that would address culture and language in the clinic.

Drs. Laurence Kirmayer, Jaswant Guzder, and Cécile Rousseau founded the CCS in 1999, and the service continues to conduct research and provide cultural consultations to primary care and specialty mental health practitioners to improve the care of immigrants, refugees, and minorities (Kirmayer et al. 2003, 2014a, b). The CCS conducts approximately 50 in-depth cultural consultations per year but does not provide follow-up care.

Table 1 Overall comparisons by clinic site

Characteristic/site	Montreal	London	Paris
Clinic name	The Cultural Consultation Service (Montreal CCS)	The Cultural Consultation Service (London CCS)	Centre Françoise Minkowska (Minkowska)
Year founded	1999	2010	1962 (for the Centre)
Type of clinic	Consultation service—no treatment of patients	Consultation service—no treatment of patients	Treatment center for immigrants and refugees
Health coverage for residents	Universal	Universal	Universal
Number of referrals	48.2 per year (total) on average from 1999–2017 (in-depth, detailed cultural consultation)	900 referrals over 18 months, with 50 per year in-depth, detailed cultural consultation	500 new patients in 2014 (a small proportion of these receive in-depth, detailed cultural consultation)
Type of referrals	Mostly immigrants and refugees	Mostly long time psychiatric patients with severe and persistent mental disorders	Mostly immigrants and refugees
Clinic structure	Research clinic with research and medical directors	Research clinic with a chief psychiatrist overseeing operations	The Minkowska Association manages finances, and the chief psychiatrist manages daily operations
Historical context	French–English language tension	Legacy of racism	Serial social trauma
Ethnic statistics permitted?	Ethnic statistics are permitted and collected but not mandated by the government	Ethnic statistics are mandated by the government	Ethnic and religious statistics are not permitted by the government
Attitudes toward categorizing diversity	Ethnicity is an essential characteristic of the individual so classification is meaningful, but the government does not mandate ethnic or racial classification in the health services sector	Ethnicity is an essential characteristic of the individual so classification is meaningful. To guarantee services to vulnerable populations, ethnic classification is mandated in the health services sector	Ethnicity is not an essential characteristic of the individual, but is a social construct, so ethnic classification is harmful—by removing ethnic terms from society, stereotypes and prejudices will disappear as well
Intake procedures	Intake by clinical coordinator, triage by medical director	Intake by cultural consultants working alongside referring staff from four community teams	Intake by Minkowska staff, triage by MÉDIACOR
Dominant framework	Multicultural mainstreaming	Multicultural mainstreaming	Person-centered transcultural Psychiatry
Shaping of services according to local context	Focus on use of language interpreters and culture brokers	Focus on educating clinicians about culture to legitimize culturally—sensitive services and reduce discrimination	Focus on person-centered care in the clinic without admitting ethnic or religious categories

Table 2 Comparison of patient intake questionnaires by site (Yes = present, No = absent)

Item/site	Montreal	London	Paris
Name of patient	Yes	Yes	Yes
Gender	Yes, three options: male, female, other	Yes, four options: male, female, transgender, prefer not to say	Yes, two options
Date of birth/age	Yes	Yes	Yes
Marital status	Yes, single line, open-ended	No	Yes, "family situation," with 7 options in addition to number of children
Immigrant status	Yes	No	No
Country of origin	Yes	No	No
Year of arrival in host country	Yes	No	Yes
Ethnicity	Yes, single line, open-ended	Yes, 18 options, pre-determined categories	No
Mother tongue	Yes	No	No
Speaks English or French?	Yes	No	No
Other languages spoken	Yes	No	Yes—languages spoken is the only item
Needs interpreter?	Yes	No	No
Already using interpreter?	Yes	No	No
If not, why not?	Yes	No	No
Education	Yes, 2 open-ended questions	Yes, 6 options, pre-determined categories	Yes, either yes or no with a subcategory called "professional activity, yes or no"
Occupation and employment status	Yes	Yes	No
Religion	Yes, Single line, open-ended	Yes, 9 options, pre-determined categories	No
Disability	No	Yes, 8 options, pre-determined categories	No
Sexuality	No	Yes, 5 options, pre-determined categories	No
Homeless, yes or no	No	No	Yes

Historical Context

Founded in the early seventeenth century, Montreal is the commercial and industrial center of the province of Quebec, and the second largest city in Canada, with over 4 million inhabitants in the greater metropolitan area. The people of Montreal are mainly French speaking (63%) with substantial English (11%) and "allophone" (non-English and non-French, 22%) minorities (Statistics Canada 2017). With a population of 36 million, Canada takes in some 260,000 immigrants and about

25,000 refugees each year of which 50,000 settle in Quebec, most in the greater Montreal region. In the city center, migrants approach 50% of the total population in some neighborhoods, with great linguistic and religious diversity. Immigration has a long history in Montreal, although the demographics of migration have changed considerably: while migrants from Europe formed the majority in the first half of the twentieth century, in recent years most migrants to Montreal have had non-European, mostly Asian, origins (Jarvis et al. 2011).

Montreal occupies a unique position within Canada, being at the crossroads of the English- and French-speaking peoples of the country. Given the larger English-language context of Canada and North America, issues of language are important in the city. Referenda on Quebec sovereignty, in 1980 and 1995, narrowly avoided endorsing political independence from Canada, and French language rights played a central role in these destabilizing events. As the language of one of the official founding peoples of Canada, French is accorded special status: Canadian federal laws must be written in French and English, and all services by the federal government in any province must also be available in French (Government of Canada 1985). Indeed, language is so crucial an issue to Canadian society that the Commissioner of Official Languages, Mr. Graham Fraser, once said that whereas race is at the core of American identity, and social class is at the center of being British, language is fundamental to defining Canada as a country (Fraser 2009). Canada was the first country to adopt a national policy of multiculturalism (Kivisto 2002; Mackey 2005). The government collects population statistics on country of origin and ethnicity and supports community activities aimed to strengthen and maintain the identity of ethnocultural communities. While federal multiculturalism theoretically includes French Canadians as a language and ethnic minority, the province of Québec, where French Canadians are in the majority, formally rejects this framework and has adopted *interculturalism* as its response to cultural diversity (Kirmayer 2019). Interculturalism in the Québec context refers to (1) dominance of the French language, and (2) integration of minorities to the French-speaking society in order to preserve and protect French language and culture (Bouchard and Taylor 2008). These priorities influence Quebec society at all levels, including the CCS for which language diversity is of primary clinical importance (Kirmayer and Jarvis 2019). For example, while in theory health services are available in French and English throughout the province, in practice clinicians are inconsistently fluent in both languages. Consequently, when planning CCS interventions, the languages that will be represented in the clinical evaluation will influence the kind of interpreter selected and how the clinical work is translated to patients, families, referring clinicians, and students in attendance.

Categorizing Diversity

There is no government mandate to collect ethnic statistics at the hospital or clinic level. Statistics Canada collects and publishes the national data according to specific categories of ethnic, visible minority, language and religious groups (Clarke et al. ∞2008). The Montreal CCS does not use these categories explicitly at intake, but gathers ethnic data from referring clinicians and asks patients to identify themselves along ethnic, religious, and language lines. In cases where a CCS patient disagrees with the clinician with respect to ethnic classification, the patient's perspective is accepted, although some claims to ethnicity may be puzzling. Hence, the categorization of diversity that takes place in Montreal is somewhat fluid in nature and categories may change over time. Language, on the other hand, is of more serious concern in Quebec society. Patients are broadly categorized into three groups according to mother tongue: French ("Francophone), English ("Anglophone"), and other languages ("Allophone"). These language categories are unique to Quebec and have clinical consequences. While French- and English-speaking interpreters are easy to find, interpreters for patients speaking other languages are unevenly available, although the provincial government maintains a bank of professional interpreters from which clinicians may draw if booked in advance. Payment for these interpreters varies across institutions, with some giving language services a high funding priority and others choosing not to hire professional interpreters and placing the onus on patients to find the means to speak to their physician, usually through their family members (Brisset et al. 2014).

Intake Procedures

The CCS coordinator receives referrals, gathers intake information by contacting the referring clinician, and records this on a form (available on request). Intakes are reviewed with the medical director to assess suitability, plan follow-up, and decide which team members should be assigned, including interpreters and culture brokers (Kirmayer et al. 2014a, b). As part of routine intake, the service coordinator asks referring clinicians about the ethnicity, religion, and mother tongue of the patient being referred. Many clinicians have not considered these questions before and must get more information; the intake coordinator follows up to clarify this by telephone or after receiving information by fax or mail. During subsequent clinical evaluations, patients are rarely directly asked about their ethnicity. Rather, this information is gathered by talking with the patient and family over the course of the evaluation about where they come from, what languages they speak and prefer in health care or other settings, and their religious affiliations and practices. From this information, the interviewer derives an ethnicity that may differ from the one suggested at intake. Ethno-racial labels such as "Black," "Asian," or "Latin American" usually are not used unless the patient insists on such a term in their self-description, which happens on occasion. The greatest emphasis is on patient's language proficiency and preference. The first determination is always whether the patient speaks French or English fluently enough to speak without an interpreter during the evaluation. When a third language is preferred or deemed necessary, an interpreter is provided if possible unless the patient prefers to use French or English. Generally, attempts to provide services in the patient's preferred language are accepted by the referring clinical teams, and by the patients, even if such efforts have not been part of past interventions.

London

Site Description and Origins

The London CCS is located at the Wolfson Institute of Preventive Medicine, Queen Mary University of London. The CCS was developed for the local specialist mental health services that provide care for people with complex and serious mental illness. The need for a culturally sensitive mental health model arose out of the history of British colonization, history of racism, and especially the significant immigration to the U.K. since the end of the Second World War, when people from the former colonies began to relocate for economic and political reasons to the mother country. After making application to the local National Health Service (NHS) commissioner, the CCS was given a three-year commission (2010–2013) to triage and accept referrals from the staff of four community teams in the London borough of Tower Hamlets. This neighborhood has a high level of immigration and poverty, so the CCS was mandated to work with specialist mainstream mental health services to improve the delivery of culturally competent care (Owiti et al. 2014, p. 817) and to foster race equality by reducing health care disparities through direct clinical work and the provision of training (Bhui, Ascoli, and Nuamh 2012, p. 186). The focus was on consultation, without follow-up care, within the multicultural mainstream rather than by referral to ethno-specific services.

The London clinic founder and team leader was Professor Kamaldeep Bhui, a research psychiatrist who oversaw CCS operations. Dr. Bhui and his team demonstrated that CCS interventions improved the self-assessed cultural competence of clinicians (Owiti et al. 2014, p. 824), reduced the cost of care per patient, and improved clinical outcomes (Bhui et al. 2015a). Despite these positive results, and receiving 900 referrals, the NHS decommissioned the service after 18 months due to perceived low priority of culturally competent services in a climate of shrinking health budgets and urgent priorities elsewhere in the system. Currently, the London CCS operates with a more academic mandate. It has continued its activities in training, research, organizational consultancy, and policy-making but provides no direct clinical services. A cultural consultation “club,” built on the principles of the CCS in Montreal, has been running for over 10 years, and continues to offer clinicians and academics an opportunity to review case material or clinical and public health dilemmas in which the role of culture needs unpacking and understanding.

Historical Context

The United Kingdom is a constitutional monarchy and ruled the largest colonial empire in world history in which overseas slavery and other forms of oppression were commonplace. The country experienced a dramatic influx of immigrants after World War II, mostly from former colonies. Consequently, cultural and ethnic diversity in London reflect the colonial history of the UK, although in more recent years the freedom of circulation and work within the European Union has also influenced the ethnic composition of the population. A country of 65 million, the

U.K. accepts approximately 250,000 immigrants per year, receives 33,000 requests for asylum, and accepts 15,000 of these (Office for National Statistics, 2017, 2018; Eurostat 2018). Immigration has long been a source of controversy and debate in the UK (Powell 1968; Goulbourne 1998), which has been reflected in health services. For several decades, concerns have been expressed by service users, care providers, and the non-statutory sector about inequities in the access to and outcomes of mental health care, over-representation of ethnic minorities under the Mental Health Act (involuntary treatment), and institutional racism within public services. Research conducted in this area in the past three decades, as well as the outcomes of public enquiries in some high profile cases of death of young black men due to racial stereotyping (David Rocky Bennett and Steven Laurence, to name the most well known), generally supported these concerns (Morgan et al. 2005; Bhui, Ullrich, Kallis, and Coid 2015b). Individual and systemic racism and the lack of cultural competence within the workforce were identified as the roots of the problem. Proposed solutions have evolved from the recruitment of a culturally diverse workforce and the development of culturally and ethnic-specific services (in an attempt to ensure ethnic matching between patient and clinician), to massive efforts to train the general workforce in "cultural capability" (Bhui et al. 2012; Ascoli et al. 2012; Owiti et al. 2014). The Cultural Consultation Service in London emerged in the context of this effort.

Categorizing Diversity

In the U.K., the government mandates the collection of ethnic statistics in health care services. In 2003, the British National Statistician said,

> "Defining and measuring ethnicity and national identity has never been easy, especially as what the term embraces is constantly evolving. However, it is vitally important that we do measure ethnicity and national identity and that we do so in a way that is sound, sensitive, relevant and useful. We also need this to be consistent over some period of time, so that we can build up a clear picture of contemporary Britain and how it – rather than the measure of ethnicity and national identity – is changing" (National Statistics 2003, p. 4).

Of former European colonial powers, only the U.K. has created an official ethno-racial categorization reflecting the migration of former colonized peoples (Simon 2008a, p. 158). However, ethnic categories are constantly changing, with changing patterns of immigration; terms for non-European migrants to the U.K. have included "negro," "colored immigrant," and "Commonwealth colored immigrant" in the 1950s–1960s; "New Commonwealth and Pakistan ethnic origin" in the 1970s; and "West Indian," "African Asian," and "Indians and Pakistanis" in later years (National Statistics 2003). Ethnicity is one of the first things asked of people when they arrive at British hospitals. Ethnicity is self-defined by the service user at the point of access and fitted to official census categories in which race, ethnicity, religion, nationality, and citizenship all feature, including, for example, White, Black, Mixed, Asian, Somali, Chinese, and Irish (Office for National Statistics

2011). The practical result is that counting ethnicity matters, and not to be counted is not to exist, according to a special news report (BBC London News, 2011).

Intake Procedures

Referrals to CCS London were followed by an initial team discussion to interpret the reasons and motivations for the referral, an initial meeting with the referring clinician for exhaustive case discussion, and an initial joint meeting with the clinician and patient (Owiti et al. 2014). During this initial meeting, the CCS consultant asked the patient the questions on the intake form, and the patient would choose from among the various options for ethnicity and religion, such as Asian/British Indian, Asian/British Pakistani, Asian/British Bangladeshi, Other Asian Background, Chinese, Vietnamese, and Mixed White and Asian; and Black/British Somali, Black/British African, Black/British Caribbean, Black/British Other, Black/British Other African, and Mixed White and Caribbean, among others. Religion options included Buddhist, Christian, Hindu, Jewish, Muslim, Sikh, No religion, Prefer not to say, and Other religious beliefs.

Procedures at the London CCS reflected the way that consultants formed ongoing relationships with potential referring clinical teams. Specifically, the CCS was commissioned to work alongside four community multidisciplinary teams within mainstream services, covering a catchment area of an inner-city region, with 94% of referrals belonging to ethnic minorities, 38% requiring an interpreter, and high levels of social deprivation and inequality (87.8% were unemployed and 88.6% reliant on state benefits) (Bhui et al. 2015a). As a result of this liaison process, the referring clinical team knew about CCS London and could immediately enter into a focused discussion regarding the case. The aim of the CCS was to provide clinical cultural consultation, based on the cultural formulation model, as well as training to staff, which occurred through formal training events and the experience of working with the CCS cultural consultant.

The U.K. government mandated collection of ethnic identity data on the CCS intake questionnaire (available on request), and a similar effort to categorize patients is done at intake in any medical or hospital setting. The London CCS began with a short intake form, but changed after approximately one year because the NHS commissioners funding the project wanted to capture more extensive demographic information (Owiti 2015). Interestingly, the short form that was discontinued asked about the patient's mother tongue, languages spoken, the need for an interpreter, and the patient's preferred language—items similar to the Montreal CCS intake, but these were dropped for reasons of space from the second version as the team sought to comply with government mandated variables on the expanded form. Given the environment of collaboration and government mandated intake questions, establishing ethnic and religious categories was generally expected and accepted by referring clinicians and patients alike.

Paris

Site Description and Origins

The Centre Françoise Minkowska is located in the 17th arrondissement and is certified by the Haute Autorité de Santé. Minkowska is an independent clinic founded expressly to provide services to immigrants and refugees. In 1978, an institutional five-year plan was put in place to situate Minkowska in the regional health care system. The clinical activity of the Center has evolved along with the diversification of immigration to France and initially was organized around seven geo-linguistic teams specializing in clients from “Black Africa,” South and Southeast Asia, Maghreb, Portugal and Portuguese-speaking countries, Spain and Spanish-speaking countries, and Central and Eastern Europe. Patients were assigned to therapists according to their spoken language and culture of origin. It was soon apparent that this organization of clinical activities was stigmatizing for patients and clinicians. In the 1990s, in the aftermath of the debates surrounding French ethnopsychiatry (Fassin 2000; Fassin and Rechtman 2005; Sargent and Larchanché 2009), and under the direction of Dr. Rachid Bennegadi, Christophe Paris, and Marie Jo Bourdin (the directorship of Minkowska), clinical practice was reconfigured to follow a person-centered, integrative approach informed by medical anthropology (Bennegadi et al. 2008, Larchanché 2015a).

The orientation and practice of the Centre Minkowska is influenced by the ideals of French republicanism in the broader social context: equality of all citizens of France, without respect to country of origin, religion, or ethnicity (Bowen 2017). In the republican vision, separating patients into ethno- or geo-linguistic groups ghettoizes individuals based on superficial characteristics pertaining to the private domain and that should not be taken into account by public institutions where such categories could be used to stigmatize or discriminate. When Alexandre Minkowski, the son of the founders, assumed leadership of the Association in 1972, the funding he sought from the government was tied to adherence to these republican values. However, this approach was counter to the principles of ethnopsychiatry, which had come to be the dominant paradigm at the Center by the end of the 1970s. The ethnopsychiatry paradigm—as it was implemented in France—considered exploring culture to be the principal way to understand “immigrant suffering” and to provide appropriate therapeutic care, but this emphasis risked the long-term possibility of stereotyping clinicians and their patients (Sargent and Larchanché 2009; Larchanché in press). To remedy this dilemma, by the late 1990s the Directorship of the Minkowska Center advocated a new approach influenced directly by the Montreal CCS model that aimed to honor republicanism and avoid stereotyping patients while preserving a space for cultural representations in routine clinical work. Due to heavy demand for services from the Paris region, in 2009 Minkowska developed a triage system (MÉDIACOR) that processed approximately 500 new cases per year through *Médiation* (mediation), *Accueil* (reception), and *Orientation* (orientation) (Centre Minkowska, 2014).

Historical Context

France is a unitary semi-presidential republic, with a former colonial empire second in size only to that of the U.K. and an extensive history of overseas slavery (Jenkins 2011). Paris, as the largest city, is the cultural and economic hub of the country. Serial social traumas during the twentieth century, such as the World Wars and colonial misadventures in Algeria and Vietnam, have left their scars on the national psyche. The Fifth Republic (1958) sought to reinforce republican ideals with respect to minorities, especially in light of atrocities against the Jews in World War II and against the people of Algeria during the War of Independence (1954–1962). As a result, republican ideals continued to have an enormous influence on professional practice and research at all levels in France. Given this context, Minkowska has operated within a framework of republican values in which ethnicity was not an officially recognized characteristic of the individual, ethnic classification was deemed to be harmful, and collection of statistics on the ethnic and religious status of patients was not permitted.

The country has a long history of immigration, much of it from former colonies. With a population of almost 67 million, France received approximately 200,000 immigrants per year from 2004 to 2012 (Brutel 2014) and received just over 100,000 asylum applicants in 2017, with a refusal rate of 73.2% (Ministère de L'Intérieur, 2018). Approximately 40% of new arrivals to France settled in the Île-de-France (Paris) region (Beauchemin et al. 2010). While French laws, derived from the Constitution of the Republic, do indeed forbid enumerating persons by ethnicity and religion, some have felt that many issues relating to minorities in France remain unexplored, with the result that country of origin and immigrant status have been reported in official statistical publications in recent years (Fassin and Simon 2008, p. 286; Brutel 2014; Beauchemin et al. 2016).

Categorizing Diversity

As already discussed, the recording of ethnic categories in research has been a sensitive matter in France. Also, there have been debates around job discrimination linked to residence in "sensitive neighborhoods" (L'Horty et al. 2011), which led the Senate to add residence as the 20th discrimination criterion in proposed legislation (Le Monde 2014). The commission nationale de l'informatique et des libertés (CNIL) produced ten recommendations that restrict the use of ethnic statistics in France and protect the confidentiality of personal information gathered by the government, institutions, and research protocols. Overall, the CNIL recommendations continue to be followed (Commission, 2007). Despite these regulations, in practice, clinicians may make notes that include ethnic and cultural material germane to individual cases. In addition, certain words or phrases may allude to patient characteristics without stating them explicitly. For example, the word "difficulty" applied to clinical service access or assessment may imply an ethnic issue; a reference to a "sensitive residential environment" may be code for an immigrant suburb; a person's "communication abilities" may refer to a foreign accent; emphasis on family structure as a problem may refer to polygamy; and a patient referred for “cadre de culture mal vécu” (a poor living environment), may also imply problems deriving from the patient’s ethnic origin (Larchanché in press, pp. 90–97, 2015b, p. 6; Jarvis 2015). Whereas in Canada and the U.K., ethnic and religious terms are used openly, in France there is a tendency to hide or remove words from everyday speech, a practice that has intensified since World War II (Miles and Torres 2007, pp. 67–68). The concern seems to be that racism in France has such a lengthy and controversial history that it remains too sensitive for the country to face head on at this time without serious consequences for national unity (see Simon 2008a, pp. 153–154). For many people, the French Republic comes first, and therefore the choice to ignore issues of race and racialization is more acceptable than the potentially divisive effects of talking about the problems of ethno-racial communities (Simon 2008b, pp. 9 and 13, 14–16). At the same time, there are grass roots effort and work by social activists and artists that seek to draw attention to issues of race and ethnicity: for example, the advocacy work of national associations like CRAN (Representative Council of Black Associations) or AFIP (Association for the Promotion of Professional Integration), or the display on racial profiling presented at Place de la République and the Internet program “Too Black to be French” (Boni-Claverie 2015), have gained considerable visibility but remained marginal to mainstream attitudes.

Intake Procedures

Referrals to the Minkowska Centre are initially triaged by support staff that ask the patients directly for information on the form entitled Fiche MÉDIACOR version modifié 28-02-2014 (available on request). The form outlines core activities of the triage and assessment process for members of the Minkowska team. This is the form referred to in Table 2, and although brief, it represents the first contact with the patient to gather basic clinical information, such as name, age, gender, date of arrival in France, spoken languages, homelessness, and literacy. Clinical trainees or staff carry out the next step by using a more detailed form to gather information on country of origin, language fluency, and patients’ understanding of the illness according to their culture of origin. This information is not for assigning the patient to ethnic or religious categories, but to triage each case and plan ahead for treatment options. The Minkowska clinicians review available documentation about the patient and may contact the referring clinicians to gather additional details. This information is presented at MÉDIACOR meetings, where the team decides how the patient will be followed. In these meetings, cases are briefly summarized, usually without explicit mention of ethnicity or religion. Once assigned to a team, additional information is added to the dossier, with sections on citizenship status in France, language fluency, language of evaluation, and languages that require interpretation. Since 2016, an intake form (Fiche de présentation MEDIACOR version 2016) is available online for professionals to use. This was implemented to ensure that professionals provide more comprehensive information regarding their referrals and to prepare for the MEDIACOR treatment planning meetings.

In general, in France, matters of ethnicity and religion are sensitive subjects and patients may feel uncomfortable disclosing such personal information. Hence, clinicians are careful to avoid explicit categorization of their patients along ethnic and religious lines, and use oblique references, as described above, such as a "sensitive" or "delicate" situation, to alert others that the issues at hand are of an ethnic or religious nature. The overriding imperative is not to apply explicit ethnic labels but to explore these aspects of identity on an individual basis using a person-centered approach.

Comparison of Intake Questionnaires

A comparison of the preliminary intake questionnaires reveals several differences among the sites, which are summarized in Table 2.

Language

The Montreal site has an abundance of intake items having to do with language and interpreters. Examples of items include mother tongue, English or French fluency, other spoken languages, need for an interpreter, history of interpreter use, and reasons for use of an interpreter or for not using one. The London CCS intake form does not have any language items at all, while Minkowska asks what languages the referred patient speaks—the only language item at this early stage of the assessment process.

Ethnicity and Religion

The Montreal and London sites have items for ethnicity and religion, although with important differences: In Montreal, the item is open-ended and brief, simply saying "Ethnicity," with a blank to be filled in by the intake coordinator based on the referring clinician's report and subject to modification after the full evaluation. In London, the item consists of 18 pre-determined categories loosely based on the 2011 U.K. national census (Office for National Statistics 2011). Patients choose the category that describes them, which is recorded by the person doing the intake. The situation is similar for the religion item, only there are nine options on the London form. A person may declare an "other" ethnicity or religion if they wish, which occurred in 18% of the patients (Bhui et al. 2015a). Minkowska does not gather information on patient ethnicity or religion.

Other Items

The Montreal CCS has items for health care insurance, immigrant status, and country of origin, while the others do not. Montreal and Paris have an item for year of arrival in the host country. Minkowska asks relatively in-depth information about marital status (7 options for "Family Situation"), something not appearing at all on the London form. Montreal has a single, open-ended item for marital status. The London CCS extensively covers Education (6 options), compared to the other sites. Only London asks questions about disability (8 options) and sexuality (5 items). Minkowska is the only site to ask if patients are homeless.

Discussion: Culture, Context, and the Framing of Identity

For historical and cultural reasons, categorization of diversity and intake procedures differ markedly by site. While Montreal focuses on language categories and language proficiency, London enumerates ethnic diversity according to officially mandated categories, and Paris avoids assigning patients to ethnic or religious categories in any form. Each of these positions risks othering patients in different ways, which may lead to intensification of the patient's experience of alienation. Clinical examples from each site are discussed in the following sections.

Montreal

Negotiating Language in Clinical Meetings

The dominant language of the evaluation must often be negotiated in Montreal. Take, for example, the following scenario.

> A young man is referred to the CCS for evaluation. At intake, the mother tongue is recorded to be Cantonese, so an interpreter is hired. Once the assessment begins, it becomes clear that the situation is more complicated than anticipated. The patient's grandmother speaks Fujianese and Cantonese. The patient prefers to speak Cantonese but tries to express himself frequently in French as the consultation begins. The interpreter speaks Cantonese and English, while the culture broker speaks Mandarin and English but no Cantonese or French. In the end the family and clinical team decide together that the patient and his grandmother will speak in Cantonese to the interpreter, who will then translate into English. During the interview, the patient, his sister, and his grandmother frequently converse together in Fujianese, which conversations remain untranslated.

In this example of language negotiation, the patient tried to assert his knowledge of the French language early in the interview. When this did not fit comfortably with the English microcosm of the hospital (where some staff and students speak French poorly), the negotiated language of the meeting (English) undermined the patient's attempts to adapt to the French language mainstream. Consequently, he retreated into Fujianese communication with his family to maintain a zone of familiarity or safety against the negotiated choice of English for the interview.

Code Switching in Clinical Meetings

Given the language diversity in many cultural consultations in Montreal, patients and staff often switch the language they are using for various reasons and with unintended consequences, as in the case that follows.

> From the intake, it was assumed that the patient would need an Albanian-speaking interpreter. In a pre-consultation team meeting, the CCS staff reviewed the patient's file in English. As soon as the referring clinicians (child

> welfare workers who only speak French) joined the meeting (they arrived late) there was a shift from English to French. At the beginning of the evaluation, the psychiatrist asked the patient for her language preferences, and she replied that she speaks English. The interpreter replied that he prefers French. The patient started to speak Albanian and the interpreter translated into French. At one point the patient started speaking English, so the psychiatrist replied initially in English and then switched into French, so the patient resumed speaking in Albanian. This sequence was repeated five times during the meeting. The psychiatrist spoke to the patient once in French and she replied in English. Many times, the patient spoke in English, particularly when she described what happened in Kosovo during the war before she came to Canada. Sometimes the interpreter translated from English into Albanian.

During this consultation, there was pressure to speak in French because the referring clinical team from child welfare services could not speak English. When the interpreter preferred French as well, the patient switched to Albanian but attempted to speak English to the psychiatrist again several times during the interview. In this setting, the patient's attempts to speak English (her preference) were submerged by French language hegemony, which was upheld by the (English-speaking) psychiatrist.

In these two examples, patient language preferences were trumped by other language priorities. To avoid these circumstances, and to uncover the patient's preferences, language proficiency was given a high priority by the Montreal intake coordinator (as for all patients referred to the CCS) even if clinical realities undermined those efforts.

London

Racial Discourse in the Clinic

The following case was chosen as an illustrative example in one of the London CCS publications on the culture of care within psychiatric services (Ascoli et al. 2012).

> A middle aged man of Caribbean origin with mental illness has refused any kind of engagement with services and treatment for years. He lives in a constant state of severe self-neglect and total social isolation…he reaffirms his refusal to engage with any suggested worker on the grounds of race, ethnicity, religious belief, gender, age and professional seniority or orientation, claiming that his needs as a middle aged male of Caribbean descent cannot be met or understood on these various grounds and labelling each attempt at intervention as *racist, oppressive,* discriminatory and custodialistic. The treating team finds itself trapped and paralysed as the majority of staff accepts this narrative and therefore their potential interventions become identified with discrimination and oppression, leading to therapeutic impasse (Ascoli et al. 2012, p. 6 of 8)

Ethno-racial categories and identities, such as Caribbean, were central to the clinical dilemma of treatment refusal due to perceived racism. Hence, as race and racism were invoked, first by the patient as he refused to allow treatment for reasons of racism and second by the hospital staff as they allowed racial discourse to undo their treatment efforts, the patient was at risk of being discharged without essential care. The CCS team concluded:

> Although work around race, culture and ethnicity often emphasises over treatment or inappropriate diagnoses, the following account shows that this negation of race, culture and ethnicity can lead to under-treatment. The passive acceptance of the patient's narrative on race, culture and ethnicity lead to the incapacity to recognise disability. Culture, race and the racial discourse were therefore used to justify an ideology of therapeutic nihilism and lack of intervention. (Ascoli et al. 2012, pp. 5–6 of 8)

Hence, the unintended effect of creating lists of forced choices into which patients must fit in an attempt to combat health care disparities may unwittingly reify and perpetuate the very racist categories and stereotypes the government was trying to eliminate, a kind of self-fulfilling prophecy. The attitudes of the health care team and patients alike may become racialized by such categories with the effect of aggravating differences and undermining health care delivery.

Paris

Avoiding Generalizations

At intake meetings, which are only for clinicians and clinic staff, the Minkowska team works hard to avoid stereotypes and premature conclusions about patients, which may take the form of ascribed ethnic or religious classifications.

> A therapist refers a patient from Senegal and hopes that Minkowska will hear and help because he has neither the time nor the ability to follow up. There are some sleep problems and traumatic recollections due to a problem in the country of origin. The patient speaks French well, which may mean a relative life of privilege in Senegal. During the discussion, religion, ethnicity and racism were not addressed beyond country of origin and language capacity – at one point, the lead clinician says that we are obligated to avoid stereotypes, not to use clichéd discourses of individuals based on the skin color, religion, or social class…we need to do person centered care and avoid generalizations – at this point we examine the countertransference.

As with the Paris intake form, the triage discussion was remarkable for the absence of reference to ethnic or religious variables. The focus instead was on the person in front of the clinician and what his or her needs may be in the absence of premature closure and prejudice. This approach attempted to create an open, undecided attitude toward the patient—a choice to ignore issues of ethnicity and religion in favor of higher, republican values. Some of the meeting was spent warning the team about possible pitfalls.

> No language barrier, cultural problem – [the patient] may have been referred for ‘exotisme’. The patient may not be well understood by the referring clinicians given that he is an immigrant from Senegal… some people think that immigrants are not suitable for analysis, there is terrible prejudice, the immigrant is subhuman, his brain is not developed sufficiently – so we say an individual is not ready for psychoanalysis. Or, some may say that immigrants do better in group therapy because they feel more free to speak when they are in groups… If we resemble the patient physically, he may have higher expectations of us. The cultural is not in the other, but in us. Remain flexible and able to change your opinion of this patient – he may say totally different things in the first face-to-face interview.

The concern raised in these passages was that in French society at large as well as among professionals there may be a particularly raw form of racism or intense anti-immigrant sentiment that must be avoided altogether. Hence the careful containment of racial, ethnic, and religious discussions in the public clinical sphere was limited to simple statements of country of origin and level of French fluency—along with an explicit effort to focus on the needs of each patient as a person, whose privacy and dignity must be protected at all costs.

Conclusion

Despite facing challenges at multiple levels, cultural consultation as a model of mental health care delivery to diverse populations has proved adaptable to varied social and cultural contexts, with services implemented in several countries. However, comparison of intake practices at cultural consultation services across Canadian, British, and French contexts revealed the extent to which the process of framing identity in referral for cultural consultation itself is a culturally mediated enterprise maintained by professional cultures of psychiatry in each setting. In Montreal, the principal focus of intake evaluation was on mother tongue and access to interpreters. In London, the principal focus was on officially assigned ethnicity and other sociodemographic variables which health services are mandated to obtain. In Paris, the focus was on avoiding ethnocultural labels altogether, partially in response to government proscription of ethnic statistics, but also due to an idealistic motivation to respect person-centered values of confidentiality and personal privacy. These differences were the products of local histories of national identity maintained by health service practices in each setting. Patients’ predicaments reflected these local histories and current politics, which may become intertwined with their mental health. Hence, psychiatrists working in cultural consultation, who aim to understand the culture of the other, must also understand the culture of the mainstream society and how it shapes service delivery. Understanding local history and context is essential to compare variations across sites, to identify the transportability of specific practices and to devise culturally safe and appropriate practices to facilitate access to mental health services. In addition, if local history and culture affect the mode of psychiatric explanation and the understanding of cultural identity, then differences between sites may emerge that are more fundamental than mere clinical procedures, including differences in the ways that identity is construed in cultural formulation. A next step would be to explore this possibility by comparing cultural formulations from the three sites, while considering the patient's contribution to the process of intake and categorization of diversity.

Although psychiatry has international institutions and evidence-based standards of care, local cultures of psychiatry and modes of practice vary substantially. The ways in which identity is configured in cultural consultation reflects policies of health and social systems that foreground some aspects of identity and hide others. Determining which elements of identity are relevant to understanding and responding to the mental health needs of patients depends on having a broad view of dimensions of identity that can be obtained by comparative work across settings. At the same time, since patients must adapt to local practices, making sense of the local politics of identity is essential to provide appropriate services and help patients and clinicians deal with tensions and contradictions that may be highly charged and in rapid flux in current geopolitical contexts.

Compliance with Ethical Standards

Conflict of interest The authors have no conflicts of interest to declare.

Ethical Approval This article does not contain any studies with human participants or animals performed by any of the authors.

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