Development and Evaluation of a
Cultural Consultation Service in Mental Health

Final Report

Project No. QC424

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Development and Evaluation of a Cultural Consultation Service In Mental Health

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Preface

This working paper presents the final report of Project QC424 funded by the Health Transitions Fund of Health Canada. The project involved the development and evaluation of cultural consultation as a specialized service in mental health. The principle objective of the service was to improve the accessibility and cultural appropriateness of mental health services for the multicultural population of Montreal, including immigrants, refugees, and ethnocultural groups, as well as Aboriginal peoples. It is our hope that the work summarized in this report provides a useful model for others developing services to meet Canada's cultural diverse population.

We are very grateful for the support of our home institutions, particularly the Department of Psychiatry of the Sir Mortimer B. Davis Jewish General Hospital, the Department of Psychiatry of the Montreal Children's Hospital and McGill University Health Center. The staff of the Transcultural Psychiatry Service of the Montreal Children's Hospital and the Culture and Mental Health Research Unit assisted with the preparation of this report. Thanks especially to Kay Berckmans for her hard work on this project.

For more up-to-date information on the activities of the Cultural Service as well as dowloadable copies of this report visit our website: www.mcgill.ca/psychiatry/ccs

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Development & Evaluation of Cultural Consultation Services in Mental Health

Executive Summary

Purpose of the Project

This project involved the development and evaluation of cultural consultation as a specialized service in mental health. The principle objective of the service was to improve the accessibility and cultural appropriateness of mental health services for the multicultural population of Montreal, including immigrants, refugees, and ethnocultural groups, as well as Aboriginal peoples. This new program can serve as a model for similar services in other Canadian cities.

Target Audience

The findings of this study will be useful to clinicians, planners and educators involved in developing models for the delivery of culturally appropriate and effective mental health services.

Activities

The project had three main activities corresponding to our major goals:

I. Development and evaluation of cultural consultation services
A new Cultural Consultation service was established at the Sir Mortimer B. Davis—Jewish General Hospital (JGH). This service was assessed along with already existing Transcultural Clinics at the Montreal Children's Hospital (MCH) and Hôpital Jean-Talon (HJT). This allowed us to identify gaps in services and to compare different models of service.

II. Development of information resources for cultural consultations
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.

III. Training mental health professionals for intercultural work
We reviewed training models and developed a series of teaching materials and in-service training activities for health and social service professionals. In collaboration with the Regional Board of Health and Social Services, this program also aimed to improve the capacity of clinicians and interpreters to work together in mental health and to develop a cadre of culture-brokers.

Methodology

The quantitative evaluation of the JGH and MCH services involved assessing the outcome of consultations in terms of: (i) types of cases referred and evaluated; (ii) use of specific professional and community resources; (iii) types of interventions and recommendations; (iv) consultee satisfaction, and (v) recommendation concordance. Efforts to assess patient outcomes and cost-effectiveness 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.

The qualitative component of the evaluation used a model of participatory research with participant-observation by research anthropologists working in close collaboration with the teams. At the Jewish General Hospital, a protocol was used to summarize case conferences and interview consultees and consultants, to document: the process of consultation and its outcomes. At the MCH series of cases of refugees with histories of severe trauma (related to organized violence) and adolescents with first episode psychoses were intensively analyzed by interviewing the clinicians involved in their long term care, reviewing records and analyzing case conference discussions. At the HJT, a series of patients were followed up with a semi-structured interview protocol to assess the impact of the large group intervention.

Findings

The analysis of cases seen in the cultural consultation services and transcultural clinics indicates that access to mental health care varies by linguistic and cultural background and that racism diminishes access to mental health care or undermines the relevance and reception of conventional care. 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 cultural consultation services were able to respond to these needs in a substantial proportion of cases and their interventions were well received by referring clinicians. They required substantial resources in terms of specific expertise in cultural psychiatry as well as interpreters and culture brokers. Evaluations often involved teams of 2-3 or more interviewers and multiple or lengthy contacts with patients and their families. However, the result of the intensive process was 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.

The review of training models and programs indicates that there is insufficient development and integration of transcultural training in most professional programs as well as little or no training in working with interpreters and culture brokers.

Recommendations and Policy Implications

The findings from this project are important because (a) they indicate significant unmet need for mental health services for Aboriginal peoples, immigrants, refugees and asylum seekers and (b) because they suggest some effective means of responding to these needs both by developing additional services and through ongoing training and support of clinical institutions and personnel.

1. There is a clear need for specialized multidisciplinary teams or services that bring together clinical expertise with cultural knowledge and language skills essential to work with patients from diverse cultural backgrounds.

2. Specialized cultural consultation services can play a major role in education of clinicians and in developing innovative strategies for intervention, which can later be transferred to practitioners in primary care settings.

3. There is a need to increase awareness of cultural issues in mental health and corresponding clinical skills at the level of primary care and social service institutions through in-service training.

4. There is a need to support community services and improve liaison with professional mental health care to develop the role of culture brokers who can work closely with clinicians to mediate during clinical encounters and identify appropriate resources to assist with the social care of patients.

5. There is a need to strengthen training of mental health practitioners in concepts of culture and strategies of intercultural care. This should include recognition of the value of clinicians' own linguistic and cultural background knowledge as added skills.

6. There is a specific need to train mental health practitioners to work with interpreters. This should become a standard part of graduate training programs in psychology, psychiatry and family medicine residencies, and the education of other mental health and social service professionals.

7. There is a need for additional training of interpreters to increase their expertise in mental health. Interpreters also need ongoing supervision and support to work with potentially distressing or traumatizing situations.

8. Quality assurance and accreditation standards for cultural competence must be further developed and applied to both training and service programs.

9. Finally, there is a need for a national network in transcultural mental health that can act as a clearinghouse for models of intervention, clinical resources and training materials.

Development and Evaluation of Cultural Consultation Services in Mental Health

Objectives

This project involved the development and evaluation of cultural consultation as a specialized service in mental health. The principle objective of the service was to improve the accessibility and cultural appropriateness of mental health services for the multicultural population of Montreal, including immigrants, refugees, and ethnocultural groups, as well as Aboriginal peoples. This new program can serve as a model for similar services in other Canadian cities.

The specific objectives of the project were:

- to identify gaps in existing services to ethnocultural minorities, immigrants refugees and Aboriginal peoples;

- to develop and evaluate a multidisciplinary cultural consultation service which specializes in mental health evaluation and treatment;

- to facilitate access to cultural expertise in mental health by developing a network of clinicians, databases and internet resources.

- to offer ongoing professional training and to promote the development of competency in intercultural intervention among mental health practitioners, particularly those who offer front line or primary care services;

Rationale

The reports of the Federal Task Force on Mental Health Issues Affecting Immigrants and Refugees and of the Comité de Santé du Québec indicated the need to develop culturally sensitive health care for all citizens (Bibeau, Chan-Yip, Lock, Rousseau, & Sterlin, 1992; Federal Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988). Despite the policy of equal access to care for everyone, significant barriers to care continue to exist across Canada for Aboriginal peoples, immigrants, refugees and ethnocultural minorities by reason of language, culture and ethnicity (Beiser, Gill & Edwards, 1993; Jacob & Blais, 1992).

Culture shapes the experience and expression of emotional distress and social problems in myriad ways (Kirmayer, 1989). In order to accurately diagnose and treat patients from diverse backgrounds, therefore, it is essential to consider the cultural meaning of somatic symptoms, and explore the social context of distress (Kleinman, 1988; Mezzich et al., 1996; Rogler, 1993, 1996). A variety of models have been developed to meet this clinical challenge. These range from ethnospecific mental health services or clinics (e.g.

an Indochinese Refugee Mental Health Clinic; Kinzie et al., 1980), to the use of culture brokers and specially trained mental health translators, to the training of clinicians in generic cultural competence. Despite the apparent utility of many of these approaches, to date there have been no studies to demonstrate their efficacy and cost-effectiveness. In a climate of constrained resources for health care and steadily increasing cultural diversity, the development and evaluation of models of care has become an urgent priority.

Beyond the need for basic research on models of care for culturally appropriate and accessible mental health services, there is a need to improve the process of diagnosis and treatment in cross-cultural psychiatry (Rogler, 1996). This is not simply a matter of devising a cultural formulation of a case, but requires the development of assessment instruments, new strategies and techniques of intervention and research to better understand the interactional processes of interviewing, interpreting, assessment and treatment in the larger context of the changing demography of our society.

Models of Care

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. Our own research in the Côte des Neiges area (Kirmayer, et al., 1996), clearly documented under-utilization of existing resources by immigrants from certain ethnocultural communities. 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 and racism in conventional mental care settings.

2. A second model involves the use of helping resources and people within cultural communities. In most communities of any size, there are professionals, indigenous healers, elders and other 'natural' helpers who have traditionally dealt 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 may enjoy greater legitimacy and authority that biomedicine or formal social services in responding to mental health problems. Conventional health care services may refer people to such practitioners or work in close collaboration within them, each providing complementary aspects of patient's care. However, for complex cases and major psychiatric disorders, they may not have the requisite expertise and institutional resources to provide all aspects of care.

3. A third model involves the development of specialized services. These has followed different directions in different countries (Kirmayer & Minas, 2000,) In the United States, this has taken the form of ethnospecific services, e.g. Indochinese, Hispanic or African-American Mental Health Clinics (Cheung & Snowden, 1990; Kinzie et al., 1980; Mason,

et al. 1996; Primm, et al., 1996; Sue et al., 1991). A similar model has been tried in Toronto with the Hong Fook Mental Health Clinic. In Britain, an attempt has been made to provide psychodynamic psychotherapy in an "anti-racist clinic" for people from visible minorities (Fernando, 1995; Kareem & Littlewood, 1992). In contrast, in Australia, efforts to provide improve access and provide culturally sensitive care have been integrated into the mainstream with an emphasis on the ready availability of interpreters (Minas, Silove & Kunst, 1993; Gardner, 1997; Kirmayer, 1998).

Clearly, these models are not mutually exclusive. Each has a potential role to play. In particular, there is indirect evidence form cultural psychiatric research and client satisfaction studies to suggest that specialized services have an important function in improving the quality and accessibility of mental health care for ethnocultural minorities (Sue, 1992). These services are intended to provide support for mental health work in primary care as well as social service and psychiatric settings. In this way, they can be a useful adjunct to the overall effort to shift psychiatric care to the primary care sector.

Up to the time of the present study, there have been no comparative evaluation studies of the merits and limitations of any of these models, so that it is difficult for planners to justify investment in the development and maintenance of specialized services. The CCS Project was designed to evaluate the impact of cultural consultation, to clarify its role and effectiveness, and to compare different models of implementation.

2. Project Activities

The project had three main activities corresponding to our major goals:

I. Development and evaluation of cultural consultation services
A new Cultural Consultation service was established at the Jewish General Hospital. Specialized cultural consultation services were then evaluated and compared at the Montreal Children's Hospital, the Jewish General Hospital, and Hôpital Jean-Talon.

II. Development of information resources for cultural consultations
A database of community organizations, professionals and resource persons with expertise in culture and mental health was prepared and a website for access to this information was created.

III. Training mental health professionals for intercultural work
A comprehensive review and systematic comparison of training programs in culture and mental health was conducted and training activities devised for specific groups of practitioners.

In what follows, we describe the specific objectives, methods, and major findings or results from on work on each of these axes.

Partners and Collaborators (Appendix G)

This project involved partners from the Division of Social & Transcultural Psychiatry of McGill University, affiliated teaching hospitals, and community clinics as well as the regional board of health and social services. The main partners were:

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I. Development and Evaluation of Cultural Consultation Services

This section describes the development, functioning and evaluation of three specialized cultural consultation services at the Jewish General Hospital (JGH), the Montreal Children's Hospital (MCH), and Hôpital Jean-Talon (HJT).

All three services developed in response to demographic changes over the past 10-20 years in Montreal, which has seen a large increase in cultural diversity.

Each clinic was initiated by a psychiatrist with extensive experience in the area of transcultural psychiatry, whose particular perspective shaped the orientation of services, along with input from the other professionals and social scientists working with each group.

1. The JGH has used a consultation-liaison model and emphasized integrating the perspectives of medical anthropology with conventional psychiatric, cognitive behavioural and family systems perspectives.

2. The MCH has emphasized a pluralistic approach and focused on providing flexible services for immigrant and refugee children, especially those who have suffered organized violence. It has worked closely with schools and community organizations to integrate community resources and perspectives.

3. The HJT has adapted an ethnopsychoanalytic model that uses a multicultural group of clinicians and people accompanying the patient to reframe the problem from multiple points of view, and mobilize the cultural frames of reference of the patient and his or her entourage.

Despite the "specialized" nature of the services, their common goal has been to work within the broader psychiatric structure and collaborate with existing services. While the conceptual models of the services were initially broad, tentative and open, all three services have evolved significantly over time as they learn from and adapt to their various milieus, collaborators and patient populations.

The Cultural Consultation Service of the Jewish General Hospital
(Appendix B)

The Cultural Consultation Service (CCS) of the Sir Mortimer B. Davis—Jewish General Hospital was designed and implemented expressly for the current research project. The function of the CCS was to provide specific cultural information, links to community resources or formal cultural psychiatric or psychological assessment and recommendations for treatment. This section presents the systematic evaluation of the service.

Cultural consultations took one of two forms:

1. A direct assessment of patient by a cultural consultant and or culture broker preferably with the participation of the referring person (complete assessment usually involved 1 to 3 meetings with patient, a brief written report, transmitting recommendations, and usually a clinical presentation at the end of the process to give the entire team an opportunity to discuss the case).

2. The second major form of consultation occurred strictly between the referring person and the cultural consultant, without the patient being seen directly. Typically, the consultee to presented the case and their concerns during a clinical meeting in which the CCS team members and the invited consultant discussed the issues and made recommendations.

Objectives

The specific goals of this evaluation were:
1. to document the process of developing the service to identify the types of problems seen, types of resources needed, recommendations made, as well as facilitating factors and barriers to implementation;
2. to identify gaps and barriers to care in the general health care system through analysis of cases referred to the CCS;
3. to identify the types of cultural formulation used by consultants;
4. to evaluate the client (consultee) satisfaction, recommendation concordance and clinical outcomes of the intervention.

Methods

Quantitative evaluation. The quantitative evaluation of the service involved assessing the outcome of consultations in terms of: (i) types of cases referred and evaluated; (ii) use of specific professional and community resources; (iii) types of interventions and recommendations; (iv) consultee satisfaction, and (v) recommendation concordance using

questionnaires that are appended to this section of the report. Although the original plan was to evaluate patient outcomes and cost effectiveness, this proved impossible for two major reasons: (i) the great heterogeneity of cases, which spanned the gamut of psychiatric conditions, sociodemographic characteristics and social predicaments; and (ii) the intrusiveness of the consultation process, which did not always involve direct contact with the patient, or else involved a series of elaborate group meetings in which the priority was making structural or strategic therapeutic interventions. (Details of the methods are presented in Appendix B1).

Qualitative evaluation. The qualitative component of the evaluation used a model of participatory research with participant-observation by a research anthropologist working in close collaboration with the team. A protocol was used to summarize case conferences and interview consultees and consultants, to document: (i) the type of intercultural problems referred to the CCS; (ii) types of persons and institutions who utilize the CCS (iii) types of cultural formulations and their influence on interventions; (iv) types of clinical and community recommendations proposed; (v) barriers to service implementation (e.g., legal and ethical barriers for refugees) and how they are overcome; and (vi) intrinsic and extrinsic factors that facilitate or hinder the implementation of the CCS recommendations. (Details of the methods are presented in Appendix B2).

Findings

Over the 12-month period of formal data collection, the CCS service received 102 requests for consultation. These came from the whole range of health and social service professionals based at hospitals and community clinics (CLSCs). The majority of consultation requests concerned individuals but almost 1/3 involved couples. Four cases involved requests from organizations to discuss issues related to their work with a whole ethnocultural group or community.

Most clinicians requesting consultations had heard about the service through word of mouth, and the rate of referrals gradually increased over the course of the project as consultees who had found the service useful spoke of it to others or asked for help with a new case. Presentations to clinical services by CCS team members also increased awareness of the service and its usefulness.

The cases represented an enormous diversity of countries of origin, languages, ethnocultural groups and religions. This demanded a wide range of consultants, interpreters and culture brokers. It precluded developing ethnospecific services. Indeed, we were aware of some ethnocultural communities that did not make a significant number of referrals simply because they were aware that we did not have consultants who spoke the appropriate language available; contrariwise, certain ethnocultural communities are probably over-represented in our sample because our team had multilingual, multicultural clinicians from that group available.

The most common reasons for consultation were requests for help with clarifying a diagnosis or the meaning of specific symptoms or behaviours (58%), treatment planning (45%), and request for information or a link to organizations and resources related to a specific ethnocultural group or issue (e.g. refugee status (25%). Half of all cases had multiple reasons for requesting consultation giving some indication of the complexity and inter-relatedness of issues.

About half of all requests to the CCS could be resolved with telephone contact and informal exchange of information or linking to specific resources. In about 1/5 cases the clinical coordinator felt that there was no need for a cultural consultation. Some of these cases represented inappropriate referrals in which basic medical and social services had not yet been arranged or employed, others involved an effort to refer a difficult case that had no indication of a cultural component in the hope of obtaining additional services. Of the 52 cases where a consultation was recommended, in 1/5 the consultation occurred entirely through discussion with the referring clinician and the patient was not seen.

The specific resources needed for consultation involved interpreters for about half of all consultations. Some form of matching of the consultants' background (language, ethnicity or religion) with that of the patient was needed in 2/3 of cases, and some specific clinical skills (psychiatric expertise, family therapy training, experience working with trauma, refugees, somatization) was needed in 1/3 cases.

Building on the existing network developed by the MCH, the CCS established a bank of 73 consultants (see Appendix E), 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 and they evinced. Consultants integrated directly into the team (as staff at the JGH, postdoctoral fellows or trainees) were used most frequently.

Because it was not usually possible to find a skilled clinician with the requisite language skills and cultural background knowledge, it was often necessary to use 2 to 3 consultants to address the specific cultural and mental health issues raised by a case.

It was possible to find appropriate resources to conduct the consultation in most cases. However, ethnic matching was very approximate and it was particularly difficult to find psychiatrists and child psychiatrists with skills needed to work with specific patients. As well, 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 impossible to maintain.

Most clinicians (86%) reported they were satisfied with the consultation and that it had helped in the management of their patients. All who had used the service said they would use it again and would recommend that their colleagues use it.

More detailed information on the reasons for consultations comes from the qualitative process evaluation (Appendix B2). This went beyond the statements made during the initial telephone contact to consider all of the available evidence as to the consultee's explicit needs as well as hidden or implicit requests in the case. The latter were determined through observation of the case conferences where the consultee would often present, as well as by taking into account the perspectives of all the consultants involved with the case and the clinicians, culture brokers and social scientists on the CCS team. This process also lead to the identification of new problems that had not been part of the clinician's reasons for referral, or identified at the time of triage, but which constituted additional valid reasons for cultural consultation.

Based on the process evaluation, the most frequent explicit reason for consultation was for help in planning, reformulating or obtaining appropriate treatment for the patient (92% of cases). The next most common reasons for consultation involved interactional problems between the consultee and the patient or other care providers (67%). This involved explicit acknowledgement by the care provider that the problem resided between the patient and himself/herself. The remaining explicit reasons for consultation were: diagnostic questions (50%); problems with patient treatment compliance (40%); difficulties of consultee's themselves (e.g. feeling lack of skill or competence to deal with problem or emotionally overwhelmed by patient's trauma history) (35%); systemic problems (e.g. with gaps in services, continuity of care, expectations of other professionals, or administration of health care and social service institutions) (23%), and specific issues with interpreters (e.g. lack of availability, misunderstandings, misalliances) (12%).

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 system. In 5 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 to 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 consultees themselves (10/15) or systemic issues (8/15). Implicit reasons for consultation related to the consultee, involved the consultee's own lack of confidence or or feeling of incompetence in dealing with the patient. In some cases, the consultee'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 consultee 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 poor accessibility to services or gaps in the system and the limitations of the consultation model to resolve them.

Cultural consultation often facilitated the therapeutic alliance between the referring person and the patient. The consultee's 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 the patient's puzzling or disturbing symptoms and behaviours by placing them in social and cultural context. This clarified the patient's predicament and thus, increased the clinician's empathy for the patient.

Cultural consultation also revealed the complexity of the case, transforming clinician's frustration into an appreciation of the intellectual and professional challenge presented by the case, and so increasing clinician's interest and motivation to remain actively involved.

A wide range of issues were raised in cultural consultations to provide the social, cultural and political context for patient's symptoms and behaviour and guide diagnostic assessment, treatment planning and service delivery. The most frequent issues raised concerned:
• variations in family systems and structures (e.g. patriarchal families)
• variations in age and gender roles (e.g. significance of marriage, divorce, adolescence or elder status for identity and social status of men and women)
• notions of honor and shame as regulatory principles in family dynamics
• the impact of migration (e.g. issues of identity, fracturing extended families, changing gender roles, eliminating communal supports and mediators, and creating tensions between generations)
• the impact of exposure to violence (CCS consultants often faced incredulity from clinicians on the level of violence that patients had been exposed to in their home countries)
• the stressful impact of the application process, waiting period, and review board hearing for asylum seekers
• the effects of subtle racism or other biases on provision of services to patients
• the prevalence of dissociative symptoms leading to misdiagnosis of psychosis, personality disorder or malingering
• experiences with health care and healing practices in country of origin

- the value of religious practices in self-soothing and psychological containment of grief and anxiety.

Even where patients were not seen, the advice and re-interpretation 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.

A number of important challenges and potential obstacles were faced in the process of conducting cultural consultations:

1. While some clients welcomed the opportunity to be seen by a clinician or culture broker from a similar cultural background other clients expressed reservations or concerns that being seen by someone from their own community might compromise the privacy of their problems. Some cultural communities are very small and mental health problems highly stigmatized so that their concerns were realistic. Reassuring patients about rules of confidentiality may be necessary but not sufficient.

2. The same concerns about confidentiality applied to the use of interpreters during the consult. Given that the CCS strictly used interpreters from the Régie régionale, the rules of confidentiality were clearly in place. Patients needed to be reassured about what this would mean.

3. Similarly, sometimes clients who were seeking asylum expressed concern about how information gathered during a cultural consultation might affect their application for a refugee status. Again, clarification of the CCS's role to these patients was essential.

4. We needed to clarify repeatedly with consultees that we functioned strictly as a consultation service and not a treatment service. Clinicians often made demands of the CCS that went beyond consultation, requesting emergency intervention, comprehensive primary care, or transfer of the case for long-term treatment or case management. We had several consultations in which, once the process began, the consultee became inaccessible or discontinued treatment with the patient, presumably on the assumption that the CCS would become responsible for the patient's subsequent care.

5. The cultural consultant was sometimes placed in a difficult position, called upon to balance the demands of developing an alliance with the patient based on cultural understanding while still negotiating the rules, norms and standards of traditional psychiatric care. The demands of these two positions were sometimes in complete opposition. As a result, the skill level of the consultant and their relative comfort in negotiating this position was important in any consultation.

6. The CCS was very active in promoting the use of professional interpreters in hospital and other mental health settings. The recommendation to use an interpreter was frequently made as part of a consultation but also as a phone intervention even when a consultation was not pursued. Despite the increased use of professional interpreters

in the hospitals, difficulties and resistance to their use was still noted particularly in the case of hospitals that still tend to rely on staff members to act as interpreters.

The Transcultural Child Psychiatry Consultation & Treatment Clinic of the Montreal Children's Hospital (Appendix C)

The ethnocultural profile of the population of children on the island of Montreal is changing rapidly. In 2000, more than 50% of children enrolled in schools in the metropolitan region were allophones. Health and social services as well as scholastic institutions have attempted to adapt to this demographic transformation but much remains to be done. Beyond the initial sensitization to cultural differences, there are few places of specialized practice that can serve the as training sites, consultation resources, and places to develop innovative practices.

The Transcultural Clinic of the Montreal Children's Hospital (MCH) has the triple mandate of training a diverse group of professionals form different disciplines (psychiatrists, physicians, psychologists, art therapists), clinical consultation and treatment, and ongoing research to rethink and renew clinical theory and practice through a critical examination of some of the implicit assumptions of conventional mental health care.

Objectives

The overall goals of the evaluation of the MCH program were to draw out the specificity and limits of a transcultural approach in child psychiatry and to outline the eventual contribution and the transferability of this specific vision to intervention in health, social service and school milieus. The specific goals were:

1. to describe the clinical population of the Transcultural Clinic and document the evolution of treatment modalities and outcomes;
2. to analyze the modes of conceptualization and intervention employed in complex cases of trauma and first episode psychosis followed by the clinic.

Methods

The evaluation of the MCH Transcultural team comprised three main elements:

1. An analysis of the characteristics of families requesting services and of the evolution of the clinical relationship. The clinic's clientele was described in terms of sociodemographic profile, reasons for consultation, referral sources and pre-migratory and post-migratory histories. The evolution of cases in terms of modalities of treatment and outcome was documented.

2. A qualitative retrospective analysis of the characteristics of the interventions of the MCH Transcultural Team focusing on case series with trauma or psychosis

3. A prospective evaluation of new cases, with longitudinal follow-up. Given the limited duration of the FASS project, the collection of data for this last component is not complete and will be the subject of later publications.

Quantitative Analysis of Cases

A quantitative analysis of 239 cases seen by this service between July 1996 and December 2000 was performed. Variables examined included the age and gender of the referred patient and their country of origin, and their reasons for referral and the referring source. Events considered to be specific to this patient clientele were documented. Finally, therapeutic process and modalities were noted, as well as outcome, as judged by the therapists involved.

Qualitative Analysis of Cases of Trauma or Psychosis

This aspect of the project used in-depth qualitative analysis of the clinical narratives of professionals and care providers about a limited number of cases in treatment for which the evolution over the last two years was known.

We chose 14 cases involving either trauma or psychosis, two types of diagnostic problems, frequently encountered by the team that are associated with contrasting assumptions about the relative contributions of environmental and constitutional factors. Trauma represents the impact of an adverse environment on the family and the child. In the case of families referred to the team, the role of organized violence is often major. We therefore find ourselves faced with problems where the macrosocial determinants (war and persecution) directly influence the microsocial reconstruction (family and community relationships) of the person. In the case of psychosis, professional models emphasize the role of genetic factors and constitutional vulnerability. The environment and the culture are often considered secondary, serving as a background for the reconstruction of meaning disrupted by the psychotic episode.

For both types of problem, we collected data from three sources: (1) an interview with the clinician responsible for the case; (2) a group interview including all members of the team involved in the follow-up and, if possible, with the outside care provider also involved in following the family; and (3) a review of the subsequent evolution of the cases studied as they were discussed in weekly team meetings over the period of the study.

Findings

Children from over 70 countries were seen by the clinic. Their countries of origin were diverse. A large proportion of referrals was received for children who had arrived form countries with recent and/or ongoing conflicts, including but not limited to Central and West Africa, North Africa, Central America, South and South East Asia and the former Soviet Union. The team also saw Canadian children from Aboriginal (First Nations and Inuit) communities. Transcultural issues relating to Aboriginal Canadian children's referrals included the experience of cultural upheaval by these communities and difficulties in providing culturally responsive services to these children by conventional health and social service providers.

In terms of the age of children referred, approximately one-third were between the ages of 5 to 9 years, one-third were between the ages of 10 to 14 years, 22% were between the ages of 15 to 18 years, and less than 15% were under 4 years of age. Two-thirds of the referrals were received for male children.

The three greatest numbers of referrals for boys were for externalizing and internalizing symptoms (29.8%), followed by internalizing symptoms (25.1%) and then externalizing symptoms (15.9%). Internalizing symptoms made up almost half of referrals for girls (48.9%) followed by internalizing and externalizing symptoms at 15.9% and then externalizing symptoms and psychosis, each at 6.8%. The variety of internalizing and externalizing symptoms were diverse. Questions for referral were formulated in terms of concerns about Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder and learning problems, as well as depression, suicidality and poor social adjustment manifested either by withdrawal or aggressive behaviour. Certain types of referral reflected specific issues that posed particular challenges in the migrant population including requests for the evaluation of developmental delays and medical symptoms, as well as the evaluation and treatment of psychotic disorders and other symptoms, with the concomitant use of traditional treatment modalities. Referrals from primary care providers were specific to this clinic's patient population, and concerned the patient or their family's experience of catastrophic events including genocide, whether or not the children were symptomatic.

Certain aspects of the referral sources and methods of accessing the clinic were instructive. The clientele were less likely to be self-referred than to be referred by a helping professional already involved with the family (86% of cases). Referrals were received from multiple sources, including schools and health and social service providers in primary care clinics (CLSCs). The largest source of requests from within the hospital came from the hospital's Multicultural Health Clinic, with 21.3% of referrals originating from this clinic. This medical clinic has been established in order to respond to the needs of newly arrived children and adolescents in Montreal, defined by a length of stay in Montreal of less than two years. In addition, religious, health, legal and social service agencies who had developed an expertise in addressing the needs of this particular patient population also requested referrals. Finally, children were referred directly from the emergency room, as well as from outpatient clinics and from hospital wards. Efforts were made to meet referred patients at their inpatient wards within the hospital in order to help ensure follow-up.

The chief factor associated with continued follow-up appeared to be related to the family's means of accessing services. Families who were provided the clinic's name were more likely to follow-up if they called the team themselves and were able to discuss their request for services with the team secretary. At the initial evaluation an interpreter was present, who acted both as language interpreter and culture broker and as such was a key member of the treating team. Once the family had attended their first appointment, almost 3/4 remained in treatment.

Treatment offered differed in some aspects from conventional child psychiatric care. Often multiple treatment were proposed, with over a third of patients being offered two or more treatment modalities; this might include, for example, individual play or art therapy, medication for the child, family therapy, as well as mediation with schools, other health and social service providers and the Refugee Board. Aspects of the treatment approach distinctive to the team included the use of symbolic interventions based on a reformulation of the representations of individual and collective experience.

In general, treatment outcome was considered an ongoing process, with the child's symptoms being influenced by the resolution of ongoing stressors including the reunification of families, the accordance of refugee status or conversely, the elaboration of alternative living plans by the family, and the child and his family's adaptation to the host country and their formation of new social ties. As such, while clientele no longer received services and treatment was ended upon favorable outcome, the families were assured continued access to services if future needs arose. This also occurred for children who reached the age of majority and therefore no longer were eligible for children's services. As a result of their ongoing tenuous circumstances efforts were made to remain available to these families in consultation to the adult service providers to whom they were referred. Similar efforts were made to remain available as consultants to primary care providers.

Outcome, as judged by therapist, was largely good (40% of cases) or moderate (24%). In some cases, treatment ended as a result of a refusal of a patient's request for asylum in Canada (6%). In 30% of cases where consultations were provided of where patients did not follow-up, there was no information available to judge outcome. Finally, poor outcome was noted in a small number of cases. In general, cases with poor outcome shared in common a burden of catastrophic stressors, with the additional component of a worsening of behavioral problems by the youth involved. This often occurred in the context of severe difficulties for the family and host country institutions in establishing a climate of trust and a shared vision of the child's best interests, with the transcultural team failing in their attempts to act as mediators between the family, their culture of origin and the host country institutions and values.

Analysis of Trauma Cases

The analysis of trauma histories revealed the coexistence of multiple versions of the traumatic history, which reflect different perceptions and interpretations of daily reality in the host country. This multiplicity of histories offered by the families (which may be provided by different members of a family or at successive moments of interaction) confronts the tendency for clinicians and host country institutions to search for a single authoritative truth, which has a reassuring rationality, and is conflated with the need for a coherent account for psychological reconstruction of the self.

The analysis of the evolution of cases allowed us to identify several elements that promote reconstruction after trauma:

1. One key element is the capacity for care providers and teams to support uncertainty and to orient themselves with partial truths, without trying to attribute to one or another version of the patient's history the full weight of "reality", but instead allowing some movement or fluidity between different histories, recognizing that each has the capacity to contain a dimension of experience. As well, our analyses suggest that too great a tendency to emphasize the pre-migratory traumatic experience of the family can minimize or hide other important problems that are ultimately related but more immediate. Shifts in the roles and dynamics of power in the family system often provide keys to the therapeutic process. Such opportunities can be quickly lost, however, when they are obscured by a traumatic history that, by its power to evoke horror and suffering, captures all the attention.

2. A second element is the necessity to put the notion of disclosure of trauma and victimization in social and cultural perspective. Disclosure of trauma is essentially perceived as positive and curative in the Euro-American mental health literature. Our results suggest that too great an emphasis on disclosure can be damaging and that respect for the rhythm of the individual and the family is preferable. This has direct implications for evaluation, which must be considered as a gradual process. The initial meeting between the team and the family establishes the possibility of a therapeutic alliance and a basis for further collaborative work. In no case can it provide complete understanding of the experience of the child or the family.

3. In the case of immigrant families, and particularly refugees, the articulation between therapeutic and political realms of experience is crucial to the possibility of any therapeutic alliance. The experience of discrimination and exclusion is common among people with minority status. In the case of refugees, the risk of deportation, the difficulty of continuing one's life in a social and legal vacuum, and the anguish associated with the decision making process of the Commission of Immigration for the Status of Refugees, gives primary importance to the political dimension.

The clinical team's firm commitment to the right of asylum was a necessary precondition for therapeutic interaction. This position challenges the neutrality that is often claimed by professionals. All would agree that the first step toward the resolution of trauma is ending the traumatizing situation and reducing the risk of its repetition. The recognition of the potential for trauma in political contexts that transcend the therapeutic frame represents

an important step in the therapeutic process. The "neutrality" of the therapist, on the contrary, may reinforce the status quo, that is to say, the situation of mistrust in which the refugee must constantly prove that he has legitimate reasons to seek asylum.

Analysis of Psychosis Cases

In the case of psychosis, the transcultural team was involved first as consultants to the crisis team responsible for the care of hospitalized adolescents, and later at the level of direct outpatient follow-up treatment with families.

A review of cases of psychosis made it clear that transcultural intervention allowed the emergence of the plurality of explanatory models that coexist around a first psychotic episode. Since the hospital context tends to relegate non-medical explanatory models to a second level, families censure themselves. The establishment of an alliance that values pluralism and relativizes medical knowledge, facilitates the emergence of other discourses. The religious world, traditional knowledge, political relationships of domination in the host society, and the gap between biomedical values and those of the families' culture of origin, are then used to make meaning of psychotic disorganization and allow the family and community to support the afflicted person.

Being open to this plurality of perspectives also allowed the clinicians to grasp the importance of having recourse to multiple models of treatment, including non-medical approaches. Our data reveal, in particular, the increasing importance of transnational networks in providing access to traditional and religious treatment. Contrary to Euro-American modalities that center the problem on the psychotic adolescent, these approaches locate the etiology in external causes of significance to others in the family and community. This allowed family and community to gather around and support the adolescent.

Our results suggest that the transcultural intervention allows us to strengthen the alliance with the family, to enlarge the therapeutic space of possibilities, and to reconnect rather than isolate the psychotic person. This is accomplished essentially because of:
1. the exposure and validation of different explanatory models
2. the presentation of the medical model as one knowledge among others
3. the possibility of play between different models, as a function of family and intrapsychic dynamics, in a way that re-establishes a family homeostasis that gives a meaningful place to psychotic experience.

Discussion

The analysis of cases of trauma and psychosis provided evidence of how novel practices can emerge from questioning dominant models. This de-centering allows: (1) re-equilibrating the power relations in therapeutic interventions to give due recognition to the knowledge and experience of families and community; and (2) introducing polyvocality into the therapeutic space. This can enlarge the possibility of reconstructing

the definition and meaning of the problem (traumatic history or first episode of psychosis) and also permit the gradual integration of painful experiences following a rhythm that is partly determined by the family.

The Transcultural Clinic of Hôpital Jean-Talon
(Appendix D)

The Transcultural Clinic (TC) at Hôpital Jean-Talon Hospital 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 and other members of the Department of Psychiatry and received some infrastructure support from the hospital as well as small private donations. Six clinicians attached to the hospital formed the core staff. However, throughout its existence the clinic has relied on volunteers; 3/4 clinicians involved donate their services.

The clinic offers two types of outpatient service: (i) cultural consultations for professionals needing assistance in assessment and treatment planning; and (ii) time-limited treatment offered directly to patients of different cultural backgrounds. The clinic also provides training and community prevention and mental health promotion programs.

The clinic's therapeutic approach is strongly influenced by the French ethnopsychoanalytic approach originated by George Devereux (1970) and further developed by Tobie Nathan (1991) and Rose Marie Moro (Moro & Rousseau, 1998). The service uses two models, one using a small group with 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.

According to Nathan, the rationale for the large group method includes at least four distinctive features (Nathan, 1991; 1994, Streit, 1997):
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 counter-transference
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 intervention strikes many as posing the threat of a power imbalance that would be unsettling to most patients. The only evaluations of this model to date have come directly from Nathan's group and have involved detailed analyses of cases. There has been no account of the experience of patients who receive this intervention. Accordingly, the aim of the present evaluation was to better understand the perspective of patients who received treatment at the Jean-Talon clinic with this extended group psychoanalytic model. The goal was to identify the acceptability and impact of the intervention from the patient's point of view.

Method

The sample comprised the 20 patients who had completed therapy at the clinic between November 1995 and September 2000. Based on earlier pilot work with a sample of 4 families, and interviews with clinicians, a semi-structured interview was devised to inquire about patients' experiences with the therapeutic intervention and its impact.

Findings

Of the 20 families seen by the service, 9 (45%) were traceable and agreed to the follow-up interview. While 5 found the group setting comfortable, 4 reported it made them uneasy. Five patients felt from the outset that the team was responding to their needs, while 4 only gradually came to trust the intervention as it unfolded over time. Most (8/9) of respondents appreciated the interventions and found the following aspects helpful: (i) it allowed them to express their suffering in their own language, (ii) it was useful to hear to proverbs that recalled their countries of origin (cf. Bagilishya, 2000); (iii) 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. Only one patient reported that the necessity to use an interpreter interfered with the creation of a proper rhythm of communication.

This initial evaluation of the impact of the large group ethnopsychoanalytic intervention is limited by the small sample size and the large number of non-respondents. However, it does suggest that the intervention is acceptable for some patients. Most patients did not find the group overly threatening and gradually came to see it as supportive and helpful. Patients' emphasis on the value of making links to their countries of origin, and between various proverbs, models and metaphors proposed by the clinicians and their own cultural experiences, supports some of the claims made for the specific efficacy of this type of therapy.

Despite the large team involved, the intervention remains cost effective because it enhances the therapeutic alliance and supports the active participation of the patient's network in the therapeutic process. In addition, some clinicians are willing to donate time on a voluntary basis to take part in this type of treatment because of the stimulation they receive from encountering multiple perspectives and because the team supports and facilitates their work with complex and challenging cases. The clinic also provides a unique setting for training and research. Future analysis of patients' experiences in therapy may help to assess the claims for the specific efficacy of the intensity and cultural diversity of the large therapy group.

II. Development of Information Resources for Intercultural Work
(Appendix E)

To facilitate cultural consultations, referrals and identification of appropriate clinical and community resources, we developed three database projects: (i) a Community Organisation Resource Database; (ii) an Individual Clinicians, Interpreters, and Culture Brokers Database; (iii) a bibliographic database and library of literature in culture and mental health (963 books, over 3,000 articles). These databases are available in multiple formats: over the Internet, in printed form, and by telephone, fax or e-mail from the CCS.

The Community Organisation Resource Database was based on earlier work by Heather Clarke and collaborators at the Montreal Children's Hospital. We transformed their document into a searchable database format. We developed a questionnaire to update the existing database requesting information about community services being offered including: the cultural populations served, availability of interpreters, and mental health related services. The questionnaire was mailed to 87 organisations in the greater Montreal area and followed up with telephone contact. The updated database is available at the CCS and over the Internet. We also designed a secure software database of clinicians, interpreters, and culture brokers who can participate in cultural consultations. The database is accessible via password in the CCS offices.

The CCS Web Site can be accessed in French or English versions. The site is designed to address specific demands of five user groups: clinicians, consumers, researchers, students, and planners.

The CCS Web Site provides a wide range of information, including: (i) access to the CCS organizational databases; (ii) information on professional training and conferences in intercultural mental health; (iii) bibliographies and references to online texts and technical documents; (iv) patient information handouts, pamphlets and other documents for users in multiple languages; (v) web-based programs providing both real-time and other interactive means of communication such as chatting, bulletin boards, mailing list, for discussion and informal consultation.

Two ongoing projects involve: (i) the development of an international e-mail *listserv* for discussion of issues on cultural psychiatry which currently has 127 members; and (ii) the creation of web-based computer assisted training in cultural psychiatry for graduate study.

III. Intercultural Training of Mental Health Professionals

We established a multidisciplinary group to assess the education needs of different professionals and develop specific training activities in: (i) primary care; (ii) interpreter and culture-broker programs; and (iii) graduate training programs. These groups met regularly to coordinate their activities. Group members were active in intercultural training.

The primary care work group comprised physicians, social workers, and frontline workers who identified cultural training needs in their respective disciplines. They organized workshops to increase the competence of clinicians in the domain of culture and mental health, particularly for refugee services, and to know how to make appropriate use of specialized services.

The interpreter training subgroup included Isabelle Hemlin from the Regional Board of Health and Social Services, who is responsible for the training and deployment of interpreters throughout the health care system. This group made recommendations for improving the training of interpreters in the domain of mental health. It also interfaced with the primary care group to help train practitioners to make appropriate use of interpreters, since there was evidence of under-utilization of interpreters.

The third subgroup was concerned with post-graduate training for psychiatrists and mental health professionals as well as with philosophy and methods of training and education at a more global level. This group organized a conference on Models of Training in Culture and Mental Health to be held May 2001 as an Advanced Study Institute with the McGill Summer Program in Social and Cultural Psychiatry

We initiated monthly seminars at both the JGH and the MCH open to mental health professionals in the community. The MCH series ("Culture & Clinic Rounds") addressed clinical assessment issues including: trauma; family reunification; psychotherapy with South Asian women; and boundary issues in transcultural psychiatry. The JGH series ("Culture & Community Mental Health") focussed on issues in community psychiatry. Topics included: minority origin professionals in health and social services; women, racism and the mental health system; rape as a crime of war; linkage between community organisations and mental health professionals; dilemmas of ethnic match; and the asylum-seeking process.

An integral aspect of this project was to establish dialogue and liaison with existing community resources in culture and mental health. We met with representatives concerned with training from many community organizations including: (i) Réseau d'Intervention auprès des personnes victimes de violence organisée (RIVO); (ii) Table de Concertation des organismes de Montréal au service des réfugiés et immigrantes (TCRI) (iii), Institut Interculturel de Montréal (IIM); (iv) l'Association Canadienne Pour la Santé Mentale; (v) Alliance des Communautés Culturelles pour L'égalité dans la Santé et des Services Sociaux (ACCES); and (vi) Centre Sociale d'aide aux immigrants. We identified

areas of possible exchange including: training mental health professionals in intercultural awareness and skills; information and resource sharing; and the development of a mechanism for providing ongoing clinical consultations for mental health professionals working in an intercultural context. We participated in organizing a conference on the role of religion and spirituality in mental health. A complete list of training activities is provided in Appendix F3.

Review of Programs and Practices (Appendix F1)

The research gathered and evaluated the state of the art in training practices in cross-cultural mental health. The focus was on instructional or learning activities that aimed to increase the effectiveness of mental health practices within and across cultural milieus. Training practices were defined as any explicit theoretical approach, didactic method, or program; we also considered implicit training ideologies or practices in clinical, academic, or community mental health. The mental health professions covered included psychiatry, psychology, counselling and to lesser degrees social work and nursing. Training practices, and models, from university, hospital, and community settings were gathered and compared. The research was conducted at the local, national, and international levels.

Method

The review involved three strategies: (1) a systematic review of available literature on training, course syllabi, and program descriptions using PsychLit, Medline and Internet search engines (Appendix F2); (2) a brief survey questionnaire and subsequent dialogue with international leaders in the field addressing pedagogical philosophy, methods, models, trends and gaps in cross-cultural training in mental health; and (3) on-site visits to local, national and international programs.

Findings

Literature Review: A growing body of theoretical literature in the area of cross-cultural training in mental health in the last ten years; supports the need for renewed effort to define cross-cultural training and clinical practices in mental health. There is general agreement that the notions of race, ethnicity and culture have been conflated and inappropriately applied in clinical settings. There is divergence of opinion on the emphasis of various training models, i.e. anti-racism, cultural awareness, cultural competence, and culture specific vs. culture general approaches.

Training programs and manuals: Although several training manuals have been developed, it is not, clear, whether these programs have been implemented or what they outcomes have been. Many of these are designed as manuals that meant to be used in clinical settings. Most follow a modular formats, and can be presented as sections over six to eighteen hours to address a spectrum of issues related to cultural awareness and

skill development. Interpreter Training Programs: are somewhat more developed and offered as a specific area of study in colleges. There is a lack of research evidence to support the effectiveness of most training programs either in terms of cognitive and attitudinal changes or ultimate impact on clinical skills and practice.

Cross-cultural university curricula have been developed and implemented in clinical domains of study but largely in piece-meal, ad hoc fashion. On a global level, there is little evidence of systematic approaches to cross-cultural training in mental health. The United States, Australia and England are leaders in integrating cross-cultural curricula in clinical university programs but these program cannot be considered standard practice within those countries. Other noteworthy initiatives are listed in the full report (Appendix F1). Within the United States, for example, there is a lack of consensus on how to view the cultural mosaic and consequently the basic goals of cross-cultural care. Managed care is sometimes viewed as an engine which drives a politically correct version of the cultural competence model, which in some circles translates mainly into providing services for the four major under-represented, under-served minority groups defined by census categories. Canada has very little in the way of organized cross-cultural curricula in the clinical health or mental health domains.

The role of the Community is ill-defined in major institutional structures and yet "cultural experts" often work in their own community milieu. As such, parallel training structures and initiatives seem to be in place in a number of instances. Often groups working on intercultural mental health care were unaware of the contributions of other groups locally, nationally and internationally.

Implications of Study for Practice and Policy

The evaluation of the Cultural Consultation Services has implications for access to service, quality of care, and the integration of services, and transferability. It was not possible to assess the impact on health outcomes of the population or the cost-effectiveness of the intervention because of the nature of consultative practice

Access to Services

Our data confirm that there are important gaps in the delivery of mental health care to refugees, immigrants and First Nations peoples.

Our results clearly indicate that the limitations of length of treatment and availability of psychiatry and psychology create problems of access to services for asylum seekers, refugees, immigrants and members of cultural communities. The consultations found that these problems go beyond those experienced by others in the health care system for several reasons:

1. These cases required more time and more resources (interpreters, culture brokers, meeting with extended family, linkage with community organizations) than comparable cases from Canadian-born patients to accomplish basic clinical tasks of diagnostic assessment and treatment planning
2. Given this greater demand, and the technical and logistical complexity of conducting and formulating an adequate assessment, in many cases we saw such a basic assessment had never been attempted even though people had been in the treatment system for many years.
3. The complexity of the cultural formulation and the strategies for working with cultural difference are not widely known by clinicians and, up to now, have not been an adequate part of their training or ongoing education.

The specialized teams in transcultural psychiatry facilitated access to services in several ways:

1. they provided service for under-served populations who usually do not receive
2. for patients already receiving mental health care, they providing links to clinicians, interpreters, culture-brokers and community organizations with knowledge and expertise in working with specific ethnocultural groups;
3. by providing access to specialized consultation that increases the knowledge and skill ("know how") of clinicians in diverse milieus, the service immediately improved the quality of care of patients;
4. by creating a place for clinical training of professionals from different disciplines who can use transcultural perspectives in their subsequent practice milieus the services contribute to the development of new resources.

The development of a specialized resource also brought with it certain problems:

1. the development of a sensitivity to cultural questions leads to an increase in demands, exceeding the capacity of the team;
2. the subsequent tightening of criteria for admission reduced accessibility to the services the team while increasing the bureaucratic quality of the process which harms the alliance with a vulnerable population.

The CCS increasingly recognized the need to offer time-limited treatment interventions and long-term follow-up to meet the needs of referring clinicians and patients to have access to basic care. On the other hand, the Transcultural Clinic at the MCH, which offered comprehensive treatment and longer-term therapy from the start, found that it quickly became backlogged and was unable to respond to its unique populations (including refugee children). As a result, the MCH considered a move toward more consultative services based on supporting care providers in other parts of the hospital and other institutions or community settings. Thus, both services, although starting out with different models converged on a mix of consultation-liaison (mainly diagnostic assessment and treatment planning) and direct treatment provision (including various forms of individual and family therapy and aspects of case management, coordinating care form many providers).

Quality of Care

The Transcultural team allowed the development of innovative interventions, that allow space for plurality of models to understand and respond to mental health problems.

One way in which the teams improved the quality of care was by giving a space and time where the voice of patients and clinicians could be heard to identify their most pressing needs and concerns. This was accomplished by several basic strategies:

1. an ethical stance that granted the primacy and validity of patient's stories; and insisted on the necessity for full and adequate communication as the basis for the clinician's assessment and intervention;

2. an epistemological view insisted on the fluidity and multiplicity of narratives so that, contrary to the juridical view of the refugee review board and other systems, no one narrative was privileged as the "final" truth. This multiplicity was not only present in discourse but reflect in the composition of the teams and their collaborators.

3. a pragmatic approach that emphasized the use of interpreters and culture brokers. Interpreters were integrated into the teams as partners in the assessment and treatment process. While recognizing that they could not provide an unbiased or perfect window onto patients' experience, they were nevertheless absolutely essential to go beyond the imprecision and error found when there were significant linguistic barriers to communication.

Integration with Other Services

The Transcultural teams worked in collaboration with other services and institutions. The MCH team, in particular, developed the concept of institutional mediation for immigrant and refugee children and families in settings of schools, the Department of Youth Protection, and immigration (including the Commission of Immigration for Refugee Status).

Mediation, between the institutions of the host country and families or communities allowed an integration of services that were otherwise extremely particularly fragmented for refugees and migrants. This mediation is based on several principles that have emerged from our practice:

1. the recognition of the vulnerability of families due to barriers of communication, and inequalities power and influence with host country institutions;
2. equally, the recognition of the fragility of institutions, which may be more hidden than that of families, but no less important. This fragility tends to be underestimated due to the image of power given by the legal mandate of the institution. Often intervenors within the institutions were found to live with considerable anxiety and feelings of powerlessness that paralyzed them or leads them to adopt rigid positions.
3. The necessity, therefore, to reinforce the anchoring of the family in their familiar frames of reference, but also to support institutions before beginning the mediation
4. The anchoring that constitutes the first phase of engagement in mediation subsequently allows the two parties to begin to de-center from their conventional frames. This de-centering creates the possibility of meeting around an initial mutual understanding to begin to negotiate new collaborative strategies for problem resolution.

Health Impacts & Cost Effectiveness

Due to the extremely heterogeneous nature of the cases, the relatively brief intervention, and the lack of direct patient contact in many cases, it was not feasible to measure or reasonable to expect direct health impacts on the patients seen by the service. Nor was it possible to define a delimited population that would be affected by the intervention, since the service aimed to address gaps in services for many different types of patient.

However, there were significant changes in service use, diagnosis and treatment in individual cases that will have dramatic impact both on their long term wellbeing and functioning and on the ultimate costs of their care to the health and social service systems.

Some of the cases we saw were clearly costing the system more because of neglect that they would if effective treatment were provided (not to mention the ethical and humanitarian issues) also there is a long-term cost. Problems that may be amenable to a relatively brief intense intervention, like having an interpreter available to make a proper

diagnosis at the start, become complicated and refractory to treatment as errors pileup, relationships of trust deteriorated, and the functioning of the individual deteriorates.

In several cases patients who had not been receiving any effective treatment for their conditions were accurately diagnosed and enrolled in appropriate treatment. In some cases, this involved children who had been incorrectly diagnosed due to a lack of use of interpreters and cultural expertise and who had treated for years with inappropriate medications and other interventions.

The existence of the service raised awareness about of issues related to culture and the use of interpreters throughout the health care system. Among the unanticipated effects of the service was a great increase in interest in training in cultural psychiatry among students in medicine, psychiatry, social work and nursing. It attracted a number of trainees to McGill postgraduate pgorams. The availability of this type of clinical experience may have a major impact on the skills and orientation of future generations of mental health practitioners.

Transferability

Similar services could be developed in other cities based on the needs of the local population. The requirements for transfer of the model include:

1. An explicit and long term commitment on the part of regional health and social service authorities and health care institutions to the ideals of cultural competence in health care and to a meaningful response to improving the quality of services for a culturally diverse population.

2. A willingness to work closely with representatives of ethnocultural communities and community organizations to identify unmet needs and potential resources for the delivery of cultural appropriate mental health care. This requires understanding the internal diversity of cultural communities and provides the opportunity to build up a network of resources that can be deployed in the assessment and management of specific cases. This process can also contribute to reducing psychiatric stigma and educate the community to be more effective consumers of available services. This work must scrupulously respect issues of confidentiality, which are particularly delicate in small ethnocultural communities

3. The process of implementation involves identifying core staff with the requisite skills and obtaining infrastructure support (offices, secretarial support, telecommunications, computers). It is important to locate the service in a place within the health care system that makes it acceptable both to patients and clinicians (preferably a non-psychiatric setting easily accessible to the cultural communities and clinicians who are being served.)

4. An individual or small group of clinicians with expertise in cultural psychiatry including familiarity with the elements of cultural formulation and the techniques of consultation-liaison work, obtained by training at major sites and by systematic efforts to reflect on their own ethnocultural background and clinical experiences with diverse populations.

5. A multidisciplinary, culturally diverse team of professionals open to rethinking standard practices to incorporate the use of interpreters, culture brokers and community consultants to generate cultural formulations

6. The ready availability of a stable pool of professional interpreters (for evaluations and long-term interventions), which allows the clinical team to develop a mutual collaboration. Ideally, these interpreters should have specific training in mental health.

7. The ability to fund professionals and non-professionals with cultural expertise (culture brokers) provided by the Health Transitions grant dramatically increased the capacity of the service to provide appropriate interventions. Other services have had rely on volunteer time and this makes it difficulty to insure availability, a high level of expertise, and benefit from cumulative experience.

8. Given the innovative services and approaches involved, there is a need for a flexible institutional framework that can adapt to the pragmatic aspects of cultural consultation including:
- changes in the flow of patients,
- the need for more time and longer sessions to complete assessments involving many participants as well as interpreters.
- the need to work closely in collaboration with other established institutions
- the need to involve extended families and community organizations in decision making processes.

Obstacles to Implementation

The research identified important obstacles to the implementation of cultural consultation services, and culturally sensitive care more generally.Some of the obstacles to implementation of the program reflected ambivalence in the broader medical sector (including their respective hospitals), which at once welcomed the effort to promote transcultural mental health services but simultaneously found it difficult to understand or appreciate the clinical exigencies or therapeutic models used, which fell outside of the realm of conventional practices and routines.

1. There was pressure to replace the consultation-liaison model with an outpatient treatment team approach to provide additional services that would simply take some of the load off conventional serves. There was also pressure to respond to

emergencies (imminent deportation) or provide quick consultations when time was needed to bring together the requisite expertise.

2. Finding resources (consultants, cultural brokers, interpreters, clinicians) of particular cultural backgrounds was sometimes difficult, especially when the local immigrant community in question was small.

3. One barrier to addressing these structural problems is the prevalent ethnocentrism of health care providers and planners. For example, many hospitals under-utilize existing interpreter resources because practitioners are satisfied with a minimal level of communication with their patients, or find it too difficult logistically to obtain the requisite help.

4. There was also a tendency to reframe social structural and economic problems in cultural terms and so divert attention from larger issues that demand political action. For example, the MCH has been asked to take on increasing numbers of cases from Northern Quebec involving Aboriginal families, at times referred through court orders. Many of the problems of this population result from larger structural issues, the request for "medical" expertise from the team raised systemic issues that exceed clinical knowledge.

5. The Transcultural clinic evoked both fear of change and resistance to calling into question one's professional knowledge and authority. Adopting a consultation-liaison model that emphasized the transfer of skills reduced this. In many cases, it was possible to put cultural notions in the framework of family interventions, which reinforced clinician's existing competence and made the new ideas easier to integrate.

6. Barriers to engaging individual psychiatrists included the fact that some did not identify social, cultural, racial and economic issues as an important dimensions in psychiatry, while others did not view consultation — particularly the more time-consuming and complex consultations promoted by the service — as useful in difficult cases. Concerns voiced by clinicians who had not used the service included the impression that such consultations would increase their workload, were too lengthy, take too long to arrange, and therefore not respond to the need for rapid problem-resolution necessitated by acute psychiatric treatment. Such clinicians would prefer to hand over these cases altogether rather than go through the consultation process.

7. Finally, funding remained a particularly salient problem for these teams. In the Medicare system funding for psychiatrists can be readily arranged but support for other professionals (i.e. psychologist, nurse-practitioner, social worker, etc.) needed for an interdisciplinary team is less available. The most pressing needs are for a fulltime clinical coordinator to provide telephone consultation and triage, and funds to compensate the cultural consultants and culture-brokers drawn from the ethnocultural communities.

Policy Implications

The findings from this project are important because (a) they indicate significant unmet need for mental health services for Aboriginal peoples, immigrants, refugees and asylum seekers and (b) because they suggest some effective means of responding to these needs by developing additional services, providing ongoing training within clinical institutions, and by training and supporting professionals to make systematic use of their linguistic and cultural expertise.

Unmet Need

1. The analysis of cases seen in the cultural consultation services and transcultural clinics indicates that language, cultural background and racism all diminish access to mental health care or undermine the relevance and reception of conventional care. The cases seen in our clinics had inadequate treatment for mental health problems, in some cases despite having being "in the system" for years. In a significant number of cases, the absence of interpreters or culture brokers and the cultural complexity of the cases prevented adequate assessment in conventional mental health care settings.

2. Given the great diversity of immigration to Canada, ethnospecific clinics are not practical for most groups, in most regions. For small communities, specialized clinics are undesirable because they cannot provide the requisite privacy and anonymity for patients, since everyone in the community knows everyone else. The antiracist focus favored in Britain is not appropriate both because of less endemic racism and because it tends to ignore the more positive and pervasive significance of culture and ethnic identity. The Australian approach is most relevant to the Canadian context, but it often stops with simply providing interpreter services and does not incorporate the broader perspectives and tools of cultural psychiatry.

3. While there are grassroots community initiatives that address the mental health needs of immigrants and refugees, there remains a significant lack of co-ordination of resources as well as a lack of a coherent structure to manage the needs of an increasingly diverse population. As well, there are too few clinical consultants available to support primary care and frontline workers in the community.

Model of Service

Our results suggest that there is a need to balance three sources of help for culturally diverse populations: (i) to increase awareness and skills at the level of primary care; (ii) to support community services and improve liaison with professional mental health care; and, (iii) to provide specialized teams with cultural knowledge and language skills essential to work with patients who require a high level of expertise to diagnose and treat their problems.

1. The model we advocate involves the development of specific cultural consultation services which can provide assessment and treatment planning as well as networking with community resources for clinicians in primary care, psychiatry, social services and other mental health disciplines. This service can also contribute directly to the training of interpreters and culture brokers as well as developing links with helping resources within the cultural communities.

2. Given the need for similar resources (clinicians from specific backgrounds, interpreters, culture brokers) for both consultation and treatment, the most useful services will allow a combination of consultation with the availability of intervention and follow-up for complex cases or those requiring specialized resources.

3. There is a need to support community services and improve their liaison with professional mental health care as well as to develop culture brokers who can work closely with clinicians to mediate clinical encounters and identify appropriate resources to assist with the social care of patients. This includes seeking means to remunerate culture brokers for their time and expertise.

4. Health care and social services institutions must make it easier for practitioners to access and use interpreters and culture brokers. This requires supporting the additional time and personnel needed to work interculturally and across languages as well as recognizing (and recruiting) clinicians with diverse backgrounds and linguistic skills.

Training

Cross-cultural training is a necessary component of clinical training for all mental health professionals. However, in most educational and practice settings it remains largely undeveloped. What does exist is mostly informal and poorly defined. In particular, most mental health professionals receive no training on how to work with interpreters and culture brokers and no systematic education in cross-cultural assessment or intervention.

1. There is a need to strengthen training of mental health practitioners in concepts of culture and strategies of intercultural care. This should include recognition of the value of clinician's own linguistic and cultural background knowledge as added skills. Professional training should provide explicit models for integrating tacit cultural knowledge and current best practices in mental health care. Trainees should be given opportunities to reflect on and make use of their own cultural backgrounds and to employ their linguistic skills in working with patients.

2. There is a need to train mental health practitioners to work with interpreters. This should become a standard part of graduate training programs in psychology, psychiatric residencies, and the education of other mental health and social service professionals. In-service training and continuing education programs should be provided for practitioners.

3. Interpreting in the context of mental health care is especially demanding because of the technical need to transmit not only the gist of what someone is saying but its precise form and quality (set against a backdrop of cultural norms) in order for the clinician to assess the patients mental status. Mental health interpreting also involves emotionally intense and challenging situations that may affect all participants. Interpreters need additional training in mental health as well as, supervision and support to work with potentially distressing or traumatizing situations.

4. There is a need to define and train interpreters and other knowledgeable community members or clinicians for an expanded role as culture brokers. This requires addressing specific ethical issues that challenge the narrow role currently assigned to interpreters.

5. Quality assurance and accreditation standards for specific and generic cultural competence must be further developed and applied to both training and service programs.

Networking

Finally, there is a need for a national network in transcultural mental health that can act as a national clearinghouse for models of intervention, clinical resources and training materials. This network could also sponsor interdisciplinary training activities and collaborative research across centers. Through the internet this may be readily extended to an international network to provide an added level of support and exchange of ideas.

Dissemination Activities (Appendix F3)

The primary audiences for the findings from this project are:

- mental health professionals (psychiatrists, psychologists, social workers, nurses) and primary care providers working with a culturally diverse clientele
- health planners and administrators involved in developing and implementing mental health services for cultural diverse populations
- educators of mental health professionals
- organizations and administrators responsible for quality assurance and accreditation of clinical services and institutions
- organizations responsible for setting standards and curricula for professional training and certification

The secondary audience includes community organizations and mental health consumers concerned with identified alternative models of care that can respond to cultural diversity.

The methods to be used to reach these target audiences and their timelines are as follows:

1. To promote awareness of the service, a brochure was prepared and sent to mental health practitioners throughout the region.

2. Members of the CCS team gave presentations to groups of clinicians and administrators at local hospitals, clinics and CLSCs. An ongoing seminar series for professionals takes place every 2-weeks alternating at the JGH and the MCH. Additional workshops and in-service training were provided for health professionals at CLSCs and hospitals (a list of activities is provided in Appendix F3). We will continue these seminars and workshops for local practitioners and institutions

3. We plan meetings with the regional health and social service board and the Jewish General Hospital administration in May 2001 to present the major findings and discuss possibilities for continued funding for the services. We will also arrange meetings with the Quebec Ministry of Health and Social Services.

4. We will present the results of the study at professional meetings including the Canadian Psychiatric Association, American Psychiatric Association, World Psychiatric Association, the Society for the Study of Psychiatry and Culture, and the American Anthropological Association.

5. Over the next year, we will conduct workshops on "Implementing and Assessing Cultural Consultation Services" at professional associations and at CME activities at the Division of Social & Transcultural Psychiatry at McGill. It is our hope that this will lead to parallel projects being conducted at other sites.

6. We have organized a conference on models of training in culture and mental health to take place at McGill in May 2001.

7. The CCS web site disseminates information on our activities over the Internet. We will continue to update our website and e-mail listserv to provide the results of the research and resources useful for the development of consultation services.

8. Over the next 12 months, we plan to publish a series of articles on our work in psychiatric journals (*Canadian Journal of Psychiatry*; *Canadian Medical Association Journal, American Journal of Psychiatry*; *Culture, Medicine and Psychiatry*; *Psychiatric Services*; *Social Science & Medicine*, and *Transcultural Psychiatry*) and prepare an edited volume entitled "*The Practice of Cultural Consultation*," which will summarize the experience of the team in a form accessible to clinicians.

9. In conjunction with the conferences and training activities at the McGill Summer Program in Social & Cultural Psychiatry, we plan meetings with journalists to arrange for coverage of the key findings in newspapers and mass media.

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Appendices

A. Institutional Histories of the Three Services

B. Evaluation of Cultural Consultation Service, Jewish General Hospital
       B1. Quantitative Evaluation of Service
       B2. Process Evaluation

C. Evaluation of Transcultural Psychiatry Service, Montreal Children's Hospital
       C1. Description of the Cases Seen at the MCH
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D. Evaluation of Transcultural Psychiatry Clinic, Hôpital Jean-Talon

4.   Information Resources & Website

F. Training & Dissemination Activities
       F1. A Review of Training Models in Culture and Mental Health
       F2. Annotated Bibliography and Reference Materials
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G. CCS Handbook

Appendix A

Institutional History of Transcultural Psychiatry Services at Jewish General, Montreal Children's and Jean-Talon Hospitals

Patricia Foxen

Three clinical services in Montreal took part in the evaluation project: the Cultural Consultation Service (CCS) of the Sir Mortimer B. Davis—Jewish General Hospital (JGH), the Transcultural Child Psychiatry Service at the Montreal Children's Hospital (MCH) and the Transcultural Clinic at the Hôpital Jean-Talon (JTC). For each of these services, the sections of this report review the origins, organization and intervention models, clinical ideologies or philosophies, links with other health and social services and community organizations, and perceived barriers to implementation and service provision. These capsule histories are based on interviews with the directors of the clinics and a review of available historical material. Since all of the services are relatively new and in evolution, this exercise was intended to identify main trends in the development of the services and provide background for consideration of the potential transfer of these service models to other settings.

Origins

A review of the institutional histories of the three services shows that all three developed in response to demographic changes over the past 10-20 years in Montreal, which has seen a large increase in the cultural diversity of both the general and patient populations in the city. The Côte des Neiges area, where the JGH is situated, is the most ethnically diverse area in the entire greater Montreal metropolitan area with more than half the population being foreign born. The MCH and JTC responded to an increased diversity among the specific populations served (e.g. 50 % of children are allophone (MCH) and 33% of the Jean Talon area are allophone (JTC)). As such, the services are rooted in a broader political imperative to engage and implement the multicultural mandate assigned to the health sector in Canada, and more specifically to meet the specific, and unmet, mental health needs of immigrants, refugees and cultural minorities.

Each clinic was originated by a psychiatrist with extensive previous experience in the area of transcultural psychiatry, and whose particular perspective and experience in the field has shaped the development and orientation of services through time, along with input from other professionals working with each group. All three clinics consider themselves to be fairly young institutions, with the JTC originating in 1992, the MCH in 1995 and the CCS in 1999. While all see the relatively recent and evolving nature of their services as contributing, in part, to present continuing efforts and concerns to strengthen their institutional structures (see below), the CCS in particular points to the "pilot" nature of its project over the past year and a half. In examining the evolution and barriers experienced by the three clinics, I shall note several common elements and processes as

described by their directors. At the same time, I show how the services differ in terms of their institutional roots and guiding philosophies, the populations they serve, their overall mandate, structure and objectives, and the types of interventions and psychiatric and cultural therapeutic models utilized.

The CCS at the Jewish General Hospital was organized under the leadership of Dr. Laurence Kirmayer, a research psychiatrist with training in anthropology and a background in consultation-liaison psychiatry who is also the Director of the McGill division of Social and Transcultural Psychiatry. Dr. Kirmayer's interest in developing this service stemmed in part from his previous involvement in the U.S. National Institute of Mental Health Work Group on Culture and Diagnosis in DSM-IV from 1991-1994 (Mezzich et al, 1999). Appointed to the steering committee of this group near its end, Dr. Kirmayer was enjoined to develop and disseminate the cultural formulation outlined in Appendix I of DSM-IV (American Psychiatric Association, 1994) in psychiatric training and clinical practice. This project was also influenced by Dr. Kirmayer's site review of the Australian National Transcultural Mental Health Network in 1998 (Kirmayer 1998; Kirmayer & Rahimi, 1998; Minas et al., 1993, 1995). More locally, a 1995 epidemiological study by Dr. Kirmayer and colleagues that examined help-seeking patterns among immigrant populations in the Côte-des-Neiges district of Montreal found a high degree of unmet need for mental health services in these populations (Kirmayer, et al, 1996). All of these factors sparked the idea for establishing a cultural consultation service which would enable existing clinicians and institutions in Montreal to better understand, manage and help their immigrant and refugee patient populations.

The transcultural psychiatry division of the MCH is led by Dr. Cecile Rousseau, whose long involvement and contacts with community organizations working with refugees at multiple levels (including, but not restricted to health issues, e.g. RIVO and the TCRI), situates this service within a broad grass-roots network and partnership. Key staff and collaborators with the team thus work within this broader context. In addition, Dr. Rousseau has a history of participation in community research projects examining issues such as racism, access to institutional support, and the social inclusion or exclusion of immigrants and cultural minorities. As a child psychiatrist, Dr. Rousseau perceived 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 are thus its focus on children and families, and its commitment to viewing refugee mental health within a broader political and structural context, integrating issues of socioeconomic realities and broader power dynamics with subjective suffering and mental health.

The Jean Talon Clinic originated under the leadership of Dr. Carlo Sterlin, who has worked in the area of transcultural psychiatry since the 1960s, starting with the McGill team headed by Murphy and Cowell. The origins of this clinic stem from the large numbers of Haitian patients attending the outpatient clinic of HJT who spoke only Creole and whose clinical manifestations fell outside conventional psychiatric frameworks. Despite early perceptions of the clinic as focused solely on the Haitian population, the

clinic has grown into a well-established transcultural psychiatry service working with a broad diversity of immigrant and refugee patients. The clinic's model is based on the French ethnopsychiatric or ethnopsychoanalytic perspective which proposes interventions that re-anchor cultural others in their traditional culture rather than imposing an occidental psychiatric perspective (Streit, 1997; Nathan, 1994).

Intervention Models

The directors of the three clinics indicate that from their inception, and despite the "specialized" nature of services, the goal has been to work within and collaborate with the broader existing psychiatric structure. They do not wish to be seen as segregated services with special privileges or a separate status. This aspect is built into the consultation services of the CCS and the JTC, which emphasize working with and training outside clinicians and care-givers; at the JTC and MCH, it is also part of clinical service models, which have fine-tuned their intake criteria over time and do not take cases that can be seen elsewhere. All three directors note that while the conceptualization of services was initially broad, tentative and open, the services have evolved significantly over time through dynamic processes of change, learning and adaptation to their various milieus, collaborators and patient populations. Given the innovative and non-conventional services and approaches proposed by these projects, an adaptive and flexible institutional framework has been required due to a number of elements including the pragmatic aspects of working with other established institutions, factors such as changing rates of patient referrals, as well as a constant re-evaluation and self-critique of approaches and interventions. In tandem with this dynamic and flexible process, institutional adjustments and maturation have also been geared toward strengthening and solidifying bonds with both the internal hospital sector and outside institutions.

The first phase of the CCS involved both setting up the consultation service and conducting on-going research to evaluate its effectiveness. The main goal of the CCS project has been to address existing gaps in research and service-provision regarding psychiatric care for adult cultural minorities. This out-patient consultation model seeks to use existing structures, acting as consultant and liaison for mental health care providers in order to mainstream cross-cultural mental health care. The CCS developed a roster of organizations (e.g. CLSCs, community refugee organizations) and persons (clinicians, cultural brokers, interpreters) who can be contacted on an as-needed basis for consultations or who to whom they can refer specific cases. In addition, the CCS team includes a number of cross-cultural clinicians who also function as consultants (and, more recently, as therapists on the team).

Consultations organized through the CCS have been conducted with individual clinicians as well as with institutions (e.g. Jewish family services, CLSCs) where case conferences and in-service training workshops on cultural issues have been conducted. The goal of these consultations is to draw out and make explicit both the psychiatric and cultural knowledge expertise of consultants, in order to enable a transfer of skills to clinicians. As such the service operates more as a teaching setting, a medium for transferring expertise

rather as a specialized clinic. Another major goal of the CCS is to help train cultural consultants; to this end, it has prepared a cultural formulation booklet to be used as a teaching tool and guideline for cultural consultants. Trainees in psychiatry, psychology, social work and other disciplines take part in the weekly CCS case conferences. Due to an some caregivers response to the limitations of the consultation model (see *Barriers* section below), the CCS has considered expanding its consultative orientation to include ongoing treatment services.

At the transcultural psychiatry clinic of the MCH, interventions revolve around clinical assessments and on-going therapy for refugee and immigrant children and their families. This model utilizes a team approach toward clinical intervention (see *Philosophy* below). While the team started out very small, it has progressively integrated a number of caregivers who are present at the initial assessment and serve as principal or co-therapists throughout the course of therapy. In addition, the team trains a small number of students and residents from Montreal universities (McGill, Université de Québec à Montréal, Concordia University) as well as other Canadian and European universities.

The MCH team began with a very open mandate and initially received referrals for a wide range of problems. 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 delimited patient population, in order to reduce patient load and increase efficiency. Referrals to the MCH now come primarily from schools, lawyers, a CLSC or another clinician. A priority is 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) are also seen. In addition, the team works closely with the psychiatric emergency ward and sees a number of patients with acute psychoses. Although the relevance of "cultural" aspects in cases of psychosis was initially more difficult for clinicians to appreciate, the team has been able to work well as consultants to the inpatient ward at the MCH to develop interventions with these families.

The evolution of the MCH service from broader grass-roots accessibility to institutional integration within the hospital has also meant changing its practices to adapt to the norms and criteria of the hospital. For example, given the hospital's referral and triaging policies, the transcultural division 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 is 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 JTC intervention model includes both consultation and clinical services. During its first two years, the JTC was devoted only to training and structuring the service and

team-members. Due to the multiplicity of care-givers involved, it was felt that an important initial phase was to create cohesion at the level of proposed interventions and approaches. During this period, team members received training from French ethnopsychiatrists, who conducted a series of workshops. This stage was followed by a process of self-training and peer supervision within the clinic.

The JTC consultation service is designed to accompany outside caregivers in the application of an ethnopsychiatric dimension to clinical cases, through a concrete demonstration of specialized intervention. Different intervention models are used depending on the case and its referral; these may involve several outside caregivers who come with the family, several internal co-therapists, as well as interpreters (see attached). Initially these consultation groups were very large; because they became difficult to manage, smaller intervention groups were created. Currently, group interventions often involve approximately 8-10 care-givers from different institutions (including the JTC).

The JTC team also offers a complementary clinical service, accepting primarily cases that are referred from within the hospital. Within the outpatient psychiatry unit of the hospital (which has a designated geographic sector or catchment area), a separate group composed of psychiatrists, psychologists, nurses, social workers and an art therapist have been given the mandate to help develop the transcultural team; this group refers cases to the transcultural team, who then decides whether to set up a consultation or take on the case. When referrals come from outside the hospital, the team insists that the patient's care-giver participate in a consultation, rather than taking on clinical cases from the outside. In addition to clinical and consulting interventions, the team is also involved in working on primary prevention interventions in schools.

Philosophy

All three directors describe the ideology behind their transcultural services as one that is flexible and based in multiple theoretical frames. Due to the multidisciplinary nature of the caregivers and teams, the somewhat "in-between" institutional and philosophical spaces within which they work, and the relative newness of institutionalized transcultural mental health programs in general, they reject the imposition of, or strict adherence to, one particular theoretical or intervention model. As mentioned, a key component to these services is a constant process of self-criticism and dynamic evaluation. However, different core approaches are evident for the three teams, which incorporate psychiatric and cultural perspectives in different ways and to different degrees.

The CCS positions itself primarily within cognitive-behavioral therapy models, favoring a pragmatic approach toward therapy that gives people the tools to empower themselves. The team works within the framework of the cultural formulation of DSM-IV, seeking to examine the ways in which cultural information interacts with a more standard psychiatric evaluation. At the same time, the senior clinicians on the team espouse a systems and interactional model that emphasizes social factors, gender and the dynamics of racism. The team generally tries to formulate problems in terms of social networks,

looking at how cultural factors are implicit in communities and systems rather than emphasizing an individual-oriented therapy. Overall, while the team works within established psychiatric categorizations, it tends to view the meaning of symptoms as indeterminate, with no single or correct interpretation, focusing rather on the most useful interventions for specific patients. As such, both psychiatric and cultural expertise are seen as separate dimensions that are as useful in their own right, that must be assessed and integrated for comprehensive patient care.

Perhaps because interventions at the JTC and MCH include direct clinical services, their approaches tend to steer further from conventional psychiatric frames. Clinical interventions at the JTC and the MCH are based around a system of team evaluations. Here, initial patient assessments are conducted by a principal therapist but usually with input from the rest of the team; long-term therapy is often conducted with co-therapists, who may include a clinician and cultural broker/interpreter or other participants. In both cases the team represents a multi-disciplinary and multi-cultural group of caregivers. (For example, the MCH team includes psychiatrists, psychologists, art-therapists, students, an anthropologist, with members originating from Canada, Asia, Africa, the Middle East, Latin America and the Caribbean). In both cases, most of the team is usually present for the initial evaluation and often an outside person as well (either a culture broker, translator, and/or social or community worker familiar with the patient). Although the team approach has been criticized for imposing an unequal power dynamic, both the MCH and JTC directors view this approach, on the contrary, as a way of diffusing or shifting the entrenched power relations of individual therapy. This system is designed to provide a multiplicity of cultural and disciplinary representations — unlike more conventional models whereby a single clinician (often of the host culture) is present. Rather than providing an intimidating or unequal relation with the family, it is thus felt that the team's diversity and multiplicity opens space for rich cultural and clinical communication with the patient, and encourages a dynamic exchange among the therapists concerning different perceptions, interactions and interpretations of the patients and their problems, which then become useful in proposing therapeutic interventions.

The MCH model utilizes an eclectic and flexible clinical model that incorporates various theoretical streams. The team uses a hybrid "bricolage" of therapeutic approaches that borrow from European (Tobie Nathan and Rose-Marie Moro), North American (Harvard) and Latin American psychiatric models, in particular the latter's emphasis on the political dimensions of collective and individual suffering. Dr. Rousseau emphasizes that the team does not accept patients based on strict ethnopsychiatric criteria because there is a dynamic interaction between culture and suffering among refugee patients, such that the complexity of their stories, situations and distress cannot be approached by looking at cultural aspects only.

In the MCH model, decisions regarding treatment are based on an assessment of whether or not the team can efficiently intervene (rather than on the urgency or gravity of the case). This decision is rooted in a philosophy of non-aggression — that is, the realization that an imposed intervention at particular times and in particular cases may be, for fragile refugee families, experienced as aggressive and harmful rather than helpful. This decision

corresponds to the team's humanist approach toward working with victims of violence and trauma. From this perspective, a key element of intervention (or non-intervention) is to incorporate non-psychological aspects, such as issues of weakness and power people's interactions, in the clinical work with families. Here, it becomes particularly important to fully respect the process of silence and disclosure according to the family's norms, beliefs and pace rather than to impose the disclosure of suffering as in certain trauma models.

This humanist perspective avoids looking at particular clinical strategies as universally positive or negative; from this view, disclosure, trust and "making sense" are not necessarily positive, and silence, denial, loneliness and absurdity are not always "negative" impediments to mental health. Instead, enabling families to move slowly around trauma, to shift and find an equilibrium between these various aspects of healing, is seen as preferable strategy. The therapist's main role thus becomes not only to help the family to "make sense" of their suffering — by proposing stories, ideas, key words and actions that may help rebuild their worlds — but also to hold the tremendous uncertainty and confusion surrounding their experiences and feelings.

Another key element of this approach is to understand the complex relationship between collective, structural violence and the individual, subjective spaces of violence; for example, the relation between organized violence and domestic violence, which is found in a number of cases, cannot be addressed without seeking to understand, and enable the family to understand, the connections between political and interpersonal aggression and suffering. The team's philosophy is thus to integrate a broad view of suffering — its political and subjective aspects, its uncertainties, confusions and contradictions — in clinical work, and to both empathize with and hold the patient/family through this process.

In addition, rather than looking at "culture" as something that can be clearly delineated in terms of "tradition", "modern", "home culture" and "host culture", the team approaches the cultural aspect of therapy, and of the patient/family, in terms of a play between numerous interacting and dynamic representations. In other words, rather than seeking to either focus on or impose an essential "home culture", on the one hand, or view a rejection of the host culture as an "acculturation" problem, the team looks at the culture as a process of approximation and distancing, in which therapy may create an intimate and playful space where individual and collective representations — those of family members and of the therapists — can circulate and be bridged. Often, therapy sessions (with the child, the parents, or both) are conducted with two therapists, one of whom represents the home culture. While the team tries to assess the particular vulnerability or possible pathology, it also seeks to bring out as well the strengths, capacities and networks that the families have, including the particular combination of social and personal resources and cultural belief systems. The family is helped to develop its own knowledge and resources for coping with distress or illness.

The MCH team tends to approach psychiatric diagnosis as a tool to be used with specific cases in contexts of power (i.e. in interactions with other institutions such as the IRB or schools that require a diagnosis for specific reasons). In such contexts, it makes selective

use of "medicalized" psychiatry. When families or institutions request a more traditional psychiatric response to a problem (e.g. medication for Attention Deficit Disorder or psychosis), and when the team's clinicians view it as appropriate, they combine medication with other types of therapy. Given the attention to issues of social power, medication is viewed, as a means of alleviating suffering rather than "normalizing" social behavior.

Although the clinical ideology of the JTC borrows heavily from French ethnopsychiatric models (i.e.Tobie Nathan) — thus trying to bridge traditional/cultural interpretations with a Western psychoanalytic dimension — they emphasize the fact that, because their main purpose is to try to translate theoretical notions into clinical application, they have remained highly flexible and do not adhere to an imposed model. While they do not disqualify psychiatric knowledge, they are less prone to use conventional diagnostic categories; the psychiatric perspective is seen as one among others that may be useful to clients. Within their clinical model, primary importance is placed rather on presenting a traditional space and cultural concepts that make sense to the patient, using only those definitions of "mental health" that make sense from the client's perspective. The JTC team thus tries to incorporate psychodynamic intervention models with an anthropological approach that draws on the client's cultural interpretation of the problem, thus creating a space for the interaction of discourses. As such, clinical interventions are also geared toward creating an atmosphere that enables the client to incorporate and rework elements from various cultures.

Links with Other Institutions

For all three services, working closely with other institutions, as well as within a larger hospital setting, has meant a process of both continuity and constant change oriented by the different teams' relationships with these outside institutions. The process of developing both personal and institutional relations has been a critical, and complex one for all, and has included a slow process of learning the strengths and weaknesses of other organizations, key actors, and how to work with them. Overall, the inter-institutional aspect of these services has involved constant work to sensitize other institutions to a transcultural approach, one that has, in turn, affected the evolution of the services themselves.

This process of mutual accommodation has taken place in relation to the larger medical institution (hospital) within which the service exists as well as with the outside institutions with whom the transcultural teams interact on a service or mediation basis. Because these other institutions are prone to their own changing dynamics (governed by political and structural decisions), and given the non-traditional aspects of the transcultural services (see Barriers below), this process has not always been smooth. For example, both JTC and CCS mention that because conventional psychiatric care is based on sectorization according to different geographic regions, it has been difficult or for their host institutions to accept the non-sectorized, nature of their services. In addition, when

other institutions undergo administrative or organizational changes, partnerships can become diffused and collaboration becomes more difficult.

Nevertheless, each of the services has built strong ties to a wide range of health care, social service and community institutions and organizations. The CCS has worked with numerous community organizations including CLSCs, SARIMM, the Clinique Santé Accueil, the Herzl Family Practice Center, Jewish Family Services, and the Module du Nord, as well as Aboriginal and Filipino Community organizations.

The community-oriented foundations of the MCH services have developed into important partnerships during the institution building process. The MCH team works in close partnership and alliance with community organizations such as the Equipe Santé Accueil of the Côte-des-Neiges CLSC, SARIMM, TCRI, CSAI. These institutions are seen to provide a trans-institutional network of support and knowledge vital to the clinic's work. In addition, the MCH also works with important partners such as schools, the DYP, and the IRB. With these institutions, the team sees its relationship as often one of mediation — whereby the team acts as mediators between the family and the other institution, or between institutions. This has involved for example reaching out to schools (to open the doors toward a greater cultural sensitivity in understanding diverse family norms and behaviors) and to the IRB (to increase awareness of suffering and distress and counter the perception of refugees as manipulators). Some of these relationships have evolved over time, particularly those with whom the team has had major differences or conflicts in the past such as the IRB and DYP. Rather than seeing these institutions as monolithic and all powerful, the team has forged alliances within them. Over time, it has become clearer that the institutions are, in some ways, fragile and those working within sometimes feel vulnerable, limited and threatened by a lack of comprehension concerning their work with refugee and other cultural different populations. At the same time, the perception of the MCH team on the part of these institutions has also evolved, as evidenced, for example, by the fact that the DYP recently asked the MCH team to meet and discuss a trans-institutional seminar that would enable sharing models and practices.

From its inception, the JTC team has also had a strong relation with outside institutions. Indeed, the director notes that the clinic was initially better known on the outside, and received more external referrals, than it did from within the Jean Talon hospital. Although it continues to receive references from community organizations such as CLSC, Centres Jeunesses, CSAI, SARIMM and others, the JTC has noted tensions with certain other community organizations, possibly due to a perception that they receive more funding. Overall however, inter-institutional collaboration has been positive. The director states that increased collaboration, interest from and alliances with outside institutions has strengthened relations within the hospital sector, which has increased referrals to the clinic.

Barriers to Implementation and Service Provision

Despite the ambiguous politics within Quebec concerning support for multiculturalism and multilingualism, all three of these services are situated within hospitals committed to issues of community, culture and diversity. This positioning within institutions that support, and are conducive to, transcultural work has facilitated their ability to operate within the broader health sector.

Dr. Rousseau notes that the MCH has traditionally been open and sensitive to multicultural issues. The hospital is well organized and staffed in this respect, and provides for the ready availability of interpreters (for evaluations and long-term interventions) as well as maintaining a multicultural clinic from which the team receives many referrals). The fact that the MCH team received an award from the Multiculturalism bureau reinforced this positive institutional profile as well as the team's relationship with the hospital.

Dr. Sterlin states that the JTC hospital's favorable attitude toward the idea of a transcultural clinic is evidenced by the immediate provision infrastructure resources (such as secretaries, photocopiers, space), as well as the fact that the larger institution has been an important source of support both within the hospital as well as within broader field (with Régie Régionale).

Finally, Dr. Kirmayer notes the Montreal Jewish General Hospital's origins which emphasized issues of equity and community in the face of anti-Semitism in the medical sector. The JGH has made responding to diversity (in its staff and patient population) a central theme in its recent long range planning efforts. In addition, the CCS and MCH also note that their location within teaching hospitals has strengthened their relations to the university research environment.

Despite this favorable positioning, all three services face ambivalence in the broader medical sector (including their respective hospitals), which at once welcomes the effort to promote transcultural mental health services but simultaneously finds it difficult to understand or appreciate the clinical exigencies or therapeutic models used, which fall outside of the realm of conventional practices and routines.

This ambivalence affects not only the nature of collaboration with the specialized services, but in evident particularly in the lack of commitment to resources and funding for specialized services. For example, Dr. Rousseau notes the difficulties in the first two years of the service to justify the existence of a transcultural psychiatry division to the hospital. Despite the team's alliances with key staff in other departments, the hospital's formal recognition by the outside sector through the granting of an award received by the transcultural team, and a general appreciation for the team and its strengths, there still seems to be a perceived lack of legitimacy, and the team still remains relatively marginal and precarious within the hospital's institutional structure. Dr. Sterlin, also points to tensions within the JT hospital caused by the team's alternative ideological stance toward mental health, which does not wish to frame itself within a psychiatric mode. For example, he notes that in the past a major conflict was created when the department head refused to name the service "Transcultural Clinic," insisting that it must incorporate

Psychiatry into its name. Dr. Sterlin argued that this would not be conducive to access in the community, where the stigma of psychiatry for immigrants and refugees is felt as particularly negative or simply does not make sense within their culture.

Ideological differences aside, a number of pragmatic problems have also arisen due to the fact that these services, to some extent, do not conform to conventional medical models. Both the MCH and CCS, for example, have been frustrated by the broader institution's requests to speed up services, and the constant questioning regarding why patients or cases cannot be seen immediately. The CCS is trying to cope with this time-lag problem within the hospital by instituting a liaison position who can work with the in-patient unit in identifying systemic problems and issues. An additional difficulty that affects the speed of response by the CCS is finding resources (consultants, cultural brokers, interpreters, clinicians) of particular cultural backgrounds when the local immigrant community in question is small.

Both the CCS and MCH state that another major problem has been the perception by the hospital that all cases that include a "cultural" or linguistic barrier are to be referred to the specialized services. Because it is impossible to satisfy this load, and is not within the objective of the either service, this external perception has created problems. The MCH, for example, has been asked to take on increasing numbers of cases from Northern Quebec involving Aboriginal families, at times referred through court orders. Because the team feels that many of the problems of this population are highly specific and result from large structural issues, the request for "medical" expertise from the team has been frustrating.

In the case of the consultation services provided by the CCS and the JTC, both have run into similar barriers. As Dr. Sterlin notes, initial problems with consulting clinicians revolved around fears that a specialized clinic would increase work load, and that a different intervention model would mean a questioning of the usual clinical practice. The transcultural clinic evoked both the fear of change and the threat of calling into question professional knowledge and authority. For its part, the CCS has encountered a fair amount of institutional resistance and hurdles on the part of the hospital as well as individual clinicians toward whom the consultation service is targeted — as reflected in relatively small number of referrals received. Barriers in engaging individual psychiatrists have included the fact that some do not identify social, cultural, racial and economic issues as an important dimensions in psychiatry, while others do not view consultation — particularly the more time-consuming and complex consultations promoted by the service — as useful in difficult cases. Many feel that such consultations increase the work load, are too lengthy, take too long to set up, and therefore do not respond to the need for rapid problem-resolution necessitated by acute psychiatric treatment. They would prefer to hand over these cases altogether rather than go through the consultation process and have to continue with difficult management issues. This problem has led the CCS team to re-evaluate its focus on consultation and to consider providing direct clinical services.

Finally, funding remains a particularly salient problem for these teams. Although the CCS has been well funded for the first phase of its project by the Health Transitions Fund of Santé Canada, with the end of this grant there is no definite commitment on the part of the Hospital, Regional Health Council or other agencies to maintain funding of the service. The JGH has committed 40% of the time of a psychiatrist to the service but funding for other professionals (i.e. psychologist, nurse-practitioner, social worker, secretary) needed for an interdisciplinary team is not available. The most pressing need remains for a fulltime clinical coordinator to provide telephone consultation and triage, as well as for funds to compensate the cultural consultants and culture-brokers drawn from the ethnocultural communities.

For the MCH and JTC teams, funding has been highly precarious. While two-and-a-half positions on the team (including Dr. Rousseau's) are paid through the hospital, other team members rely on funding from small projects, research grants and fund-raising for particular projects (e.g. the school prevention project). The JTC receives a minimal amount of funding through grants from private organizations, amounting to $15,000 over two years; in addition the hospital pays for half a salary and a small amount for training. Given that both teams function through the input and work of numerous persons of various professional backgrounds, there is a need for basic clinical and non-medical staff with special skills and expertise (psychologists, social workers) crucial to the running of the services, but an inability to procure stable funding for such positions or to compensate non-professional culture brokers. To date, much of the work provided by collaborators has been non-remunerated.

Appendix

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Appendix B1

**Evaluation of the Cultural Consultation Service
of the Jewish General Hospital**

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The Cultural Consultation Service (CCS) at the Sir Mortimer B. Davis—Jewish General Hospital was designed and implemented expressly for the current research project. The function of the CCS was to provide specific cultural information, links to community resources or formal cultural psychiatric or psychological assessment and recommendations for treatment. This report presents the systematic evaluation of the service. The CCS was located adjacent to the Culture and Mental Health Research Unit, which served, as the coordinating center for the overall research project.

This report provides a quantitative analysis of the implementation and effectiveness of the CCS. A qualitative analysis of cases and the consultation process itself is presented in a second accompanying report. The structure and function of the service are described in the Handbook in Appendix G.

Methods

The CCS began operation in mid 1999, The initial development involved the recruitment of staff(two research coordinators/assistants, a clinical coordinator, two post-doctoral fellows, and an information officer) and the development of links with clinicians and culture brokers who acted as core consultants for the service.

A series of cases were discussed in depth at the inception of the project with a large number of consultants present. This served to train the staff and to help the team to cohere as a work group. Weekly clinical meetings were organized for case presentations and formal cultural consultations and were attended by core staff as well as trainees. These meetings were tape-recorded and transcribed for later process evaluation.

Case Accrual and Consultation Procedure

A brochure announcing the service was prepared and distributed to the mailing lists of the Quebec Corporation of Psychologists and the Quebec Psychiatric Association. Promotional literature describing the service 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."

Appendix

Initial inquiries about the CCS as well as intake and triage of all cases was dealt with by the CCS clinical coordinator (a clinical psychologist), or by the medical director (a psychiatrist). The goal of the initial intake was both to document the nature of the request and to assess whether it qualified as an appropriate referral to the service.

 A standard procedure was followed to collect information and triage all cases (see *CCS Handbook*, Appendix G):

1. The consultee (individual or organization requesting the consultation) was identified and basic information collected on the referring clinician: their position, institution, profession and contact information.

2. The actual reason for the consultation request was asked in an open-ended way, with additional questions to clarify and complete information regarding the circumstances of the patient and referral.

3. The primary case manager or practitioner following the patient in treatment was determined as a way of knowing to whom the recommendations should be directed and to ensure that the CCS would be able to function strictly in a consultative role.

4. Consultees were then asked to specify the *cultural* reasons for which they were seeking consultation. Consultees were read a list of options (see Intake form, Appendix G) from which they could choose. It was emphasized that they should choose as many categories that applied to their request.

5. Consultees were asked what their expectations were with respect to how our service could assist them. Again, consultees were read a list of options (see Intake form) from which they could choose. If they chose the option requesting that we take over treatment of the patient, it was then clarified what our role could be and how we might assist from a consultation perspective only.

6. If the referral request seemed appropriate, the clinical coordinator would clarify whether the patient was aware that this request was being made and whether the consultee felt that the patient understood what a cultural consultation would involve. This question was particularly important to address cases where the patient was likely to be seen directly. When needed, the coordinator discussed the need to reassure the patient about confidentiality. Finally, a description of the consultation process was provided, as well as an indication of the length of time needed to arrange the consultation.

7. In cases where the request for a consultation was not appropriate, clarification of our possible role was described, the consultee was redirected to other resources, or brief interventions and recommendations were made at the time of intake.

Cultural consultations took one of two forms:

3. A direct assessment of patient by a cultural consultant and or culture broker preferably with the participation of the referring person. A complete assessment usually involved 1 to 3 meetings with patient, a brief written report, transmitting initial recommendations, followed by a clinical presentation to the team for discussion, and a longer cultural formulation report.

4. The second major form of consultation occurred strictly between the referring person and the cultural consultant, without the patient being seen directly. Typically, the consultee presented the case and their concerns during a clinical meeting in which the CCS team members and the invited consultant discussed the case and make conceptual and intervention- related suggestions.

A Handbook was prepared for consultants working with the CCS team which outlined basic procedures and provided guidelines for the cultural formulation and other resource materials. A copy is provided in Appendix G.

Evaluation of Services

One of the main goals of the project was to evaluate the effectiveness of the cultural consultation service. This goal was met in two ways: (1) obtaining feedback from consultees about their level of satisfaction with the cultural consultation as well as their suggestions for how the consultation could have been improved and (2) evaluating whether recommendations provided by the consultation were implemented.

A literature review was conducted in the general domains of patient satisfaction with mental health and medical services, utilization concordance and consultation as an intervention in order to find appropriate measures. Existing measures referred to in the literature did not adequately meet the needs of the project. As a result, we developed new questionnaires (Appended to this report).

Quantitative evaluation.

The quantitative evaluation of the service assessed the outcome of consultations in terms of (i) consultee satisfaction, and (ii) recommendation concordance. Although our original plan was to evaluate patient outcomes as well, this proved impossible for two main reasons: the great heterogeneity of cases; and the intrusiveness of the consultation process.

Four instruments were used for the quantitative evaluation:
- an intake form and consultation progress tracking database;
- consultation recommendation form;
- consultee satisfaction form;
- recommendation concordance form.

Consultee's Satisfaction with the Consultation

In the literature reviewed, satisfaction with a consultation was typically assessed using open-ended questions which covered three main domains: (1) satisfaction with feedback and support provided; (2) likelihood of making future referrals to the service; and (3) impact of the consultation on the consultees knowledge base (e.g. increased psychiatric knowledge, clinical confidence, diagnostic/treatment confidence)(Carr, Faehrmann, Lewin, Walton, & Reid, 1997; Brown & Weston, 1992). The "Client Satisfaction Questionnaire" (Attkinsson, 1989) (CSQ) was used as a general guide in developing our own measure, although we significantly modified the questions to meet our specific needs and objectives. Consistent with the general domains assessed in the medical consultation literature, our consultee satisfaction questionnaire assessed consultee level of satisfaction with the feedback and support provided, the likelihood of making future referrals, the extent to which the consultation increased their knowledge base as well as their input about what aspects of the consult they found helpful or difficult as well suggestions for the improvement of our services (questionnaires are appended to this Appendix).

Although it was hoped that the satisfaction questionnaire could be administered at a standard period of time following the consultation, it proved difficult to standardize the time because the length of the consultation process was not fixed and feedback often was provided to consultees over the course of several meetings. We decided that consultee satisfaction would be obtained 2-3 weeks after the brief report (which included the immediate treatment plan and recommendations) was provided to the consultee.

Recommendation Concordance: Follow-Up Questionnaire

Another common way in which the outcome of a consultation has been measured in the literature is through recommendation concordance, i.e. whether or not medical staff followed through with recommendations made as a result of the consultation process. Researchers typically assess whether there was concordance, partial concordance or non-concordance with the recommendations (Huyse, Strain, & Hammer, 1990; Huyse, Strain, Hengeveld, Hammer & Zwaan, 1988; Salvador-Carulla, 1999). Concordance is determined by first categorizing the nature of the recommendations such as whether they involved psychosocial management, psychosocial diagnostic treatment (i.e. obtain additional information from the primary care physician or family), discharge management, biological diagnostic action (i.e., lab tests, medical consultation), medication, or aftercare (Huyse, Lyons & Strain, 1992; Huyse. Lyons & Strain, 1993). Additional variables measured to assess consultation outcome included: (1) the amount of time involved for a consultation (in hours); (2) utilization reductions in medical inpatient or outpatient department; (3) length and number of visits with each patient; (4) number and types of contacts with others performed as part of consultation; and (5) frequency of referrals to consultant (Levenson, Hamer, & Rossiter, 1992; Cole, Fenton, Engelsmann, & Mansouri, 1991; Knapp, & Harris, 1997).

Appendix

For the purpose of the present study, recommendation concordance was measured by a brief follow-up interview with consultees after the cultural consultation report with specific recommendations was sent. Consultees were asked to rate the clarity and feasibility of the recommendations on 4-point Likert scales (from "not all" to "completely"), and to indicate which recommendations they had carried out. For recommendations not implemented, consultees were asked to describe the obstacles that prevented implementation and to suggest what would have facilitated the implementation of that recommendation. Additional questions asked about the possible influence of the cultural consultation on the patient's utilization of various heath and social services.

Summary of Data Collection Procedure

1. Patient was referred to the CCS. Basic information was collected from the referring person at the time of triage. After the initial meeting/consultation with the patient, the CCS Consultant asked the patient the intake questions.

2. Immediately following the consultation, clinical recommendations were written and sent to the consultee.

3. Consultee satisfaction was obtained by the Clinical Coordinator approximately 2-3 weeks following the end of the consultation.

4. *Three months following the end of the consultation, the Clinical Coordinator recontacted the consultee to complete the recommendation follow-up questionnaire.*

Qualitative Evaluation

The qualitative component of the evaluation used a semi-structured protocol for summarizing case conferences, as well as interviewing consultees and consultants who attended the case conferences, to document: (i) the type of intercultural problems referred to the CCS; (ii) types of persons and institutions who utilize the CCS; (iii) types of cultural formulations and their influence on interventions; (iv) types of clinical and community recommendations proposed; (v) barriers to service implementation (e.g., legal and ethical barriers for refugees) and how they are overcome; and (vi) intrinsic and extrinsic factors that facilitate or hinder the implementation of the CCS recommendations.

Results

Here we present the preliminary results from the quantitative evaluation of the service. The results of the qualitative evaluation are presented in a separate report that follows this one (Appendix B2).

Description of Consultation Requests

A total of 102 consultation request were received by the service from December 1999 to November 2000. Of these, 69 (68%) were for individuals, 29 (28%) for couples or families, and 4 (4%) involved requests for consultation from organizations concerning dilemmas they faced in working with specific ethnocultural communities or groups (e.g. refugees from Kosovo).

The sources of requests by institution and profession of the referring clinician are summarized in Tables 1 and 2. Almost two-thirds of consultations came from hospitals (primarily the JGH where the service was situated) including the ER, emergency psychiatry, inpatient and outpatient wards. Of these, half came from psychiatric settings and half from other medical clinics or services. The next most frequent sources of consultation requests were CLSCs (comprehensive community clinics) and community organizations.

The three most frequent types of professionals requesting consults were social workers, psychiatrists and nurses. Nurses came from both psychiatry and primary care (CLSC) settings. Almost half of all requests were from mental health practitioners (psychiatrist, psychologist or psychoeducator) (n=47); a further 20 cases came from trainees in psychiatry and psychology (residents and interns). About 1/4 of requests for consultation came from social service providers (social workers, community workers, or lawyers, n=22). About 10% came from primary care providers (family physician, family medicine resident, or pediatrician, n=11).

During the early stages of the project, we did not insist that the consultee (primary clinician or case manager) be present during the cultural consultation. However, it quickly became evident that having the consultee present greatly facilitated the consultation and its goals. First, having the consultee present allowed for the transfer of knowledge about the patient to occur directly. It provided a means for the consultee to learn about possible lines of inquiry and issues to explore, particularly concerning the potential effects of migration. This approach was consistent with the goal of enhancing the cultural knowledge and skills of the consultee, rather than acting as "experts" whose methods and knowledge remain mysterious or opaque. Having the consultee present also allowed for an immediate reframing of the problem by the consultee as well as a better understanding what was guiding patient behavior. Finally, the presence of the consultee improved continuity of care because it fostered the clinician's interest in the patient and kept the consultee at the center of the patient's future care.

Table 1. Institutional Sources of Consultation Requests (n=102)

	n	%
Hospital	60	58.8
ER, ER Psychiatry	9	8.8
Inpatient (Medical & Psychiatric)	11	10.8
Outpatient Psychiatry	19	18.6
Other outpatient clinics	20	19.6
CLSC	23	22.4
Community Organizations	11	10.8
Private Practitioner	2	2.0
Schools	3	2.9
Other*	3	2.9

* Law firm, family member

Table 2. Profession of Clinicians Requesting Consultation (N= 102)

	n	%
Social Worker	18	17.6
Psychiatrist	17	16.6
Psychiatry Resident	12	11.8
Nurse*	16	15.7
Psychologist	10	9.8
Psychology Intern	6	5.9
Family Physician or GP	8	7.8
Family Medicine Resident	2	2.0
Medical specialist	1	.98
Pediatrician	1	.98
Community Worker	2	2.0
Psychoeducator	2	2.0
Lawyer	2	2.0
Other	5	4.9

* Nurses came from both psychiatry and primary care settings

Appendix

For a subsample of 33 consecutive cases, consultees were asked how they came to know about the service. The most frequent response was from a third party who knew about the service (n=16, 48%), followed by knowing a member of the CCS team (n=9, 27%), reading the CCS brochure (n=6, 18%), working at Jewish General Hospital (n=2, 6%), past use of the service (n=2, 6%), and miscellaneous other sources (n=4, 12%). Thus, for 27 cases (81%) word of mouth was the most important way that consultees learned of the service.

Of the 102 cases, sociodemographic information was available for 118 individuals (69 individuals and 49/58 partners in couples). These 118 individuals came from 42 different countries; the most frequent countries of origin were India (n=15, 12.7%) and Pakistan (n=10, 8.5%) and Canada (n=6, 5.1%).

Of 85 cases for whom the mother tongue was known, 70 (82%) had a mother tongue that was neither English nor French, but one of 28 other languages. The four most frequent non-English and non-French mother tongues were Punjabi (n=17), and Arabic (n=12).

Of 71 cases for which languages spoken was directly assessed, 64 had some English or French. However, this was not always sufficient to allow adequate diagnosis and treatment and consultation was often sought due to the effects of language barriers.

Of the 98 individual or couple cases, 49 (50%) needed an interpreter involved at some stage. Interpreters needed covered 19 languages: 8 Asian languages, 6 European, 3 Middle Eastern, 1 African, and 1 Aboriginal. The three most frequently needed languages were Punjabi (6 cases), Spanish (4 cases), and Turkish (4 cases).

The sociodemographic characteristics of the individual and couple consultation requests are summarized in Tables 3 and 4. For individual cases the mean age was 36.6 years (SD=15.4), range 11 to 84; almost 2/3 were female and less than half were married. The level of formal education was relatively low with almost half having only elementary school education. Fully 2/3 were unemployed. In terms of immigration status, the largest group of referrals were refugees or refugee claimants (many of the latter were referred from the regional refugee medical clinic (the Clinique Santé Accueil) located in the CLSC Côtes-des-Neiges adjacent to the JGH.

For the 29 cases involving couples or families the mean age of the husband was 41.1 years (SD=8.2, range 31 to 55) and for the wife 36.3 years (SD=8.8, range 21 to 47).

Information on religious affiliation or background was available for 78 cases. The most frequent was Moslem (n=31), followed by Christian (23). Sikh (9), Jewish (7), Hindu, (4) and Buddhist (4).

Table 3. Sociodemographic Characteristics of Cases Involving Individuals (N=68)*

	n	%
Gender (Female)	40	59
Marital Status (n=62)		
Married	26	42
Separated/Divorced	9	15
Widowed	2	3
Never Married	25	40
Education Level (n=43)		
Elementary School	19	44
High School	4	9
College	9	21
University	11	26
Employment Status (n=52)		
Employed	10	19
Unemployed	34	65
Student	7	13
Homemaker	1	2
Immigration Status (n=49)		
Citizen	13	27
Landed immigrant	12	24
Refugee/Refugee Claimant	20	41
Aboriginal	3	6
Student visa	1	2

* Sociodemographic information is incomplete because in many cases the patient was never met but only discussed with the referring clinician. The number of cases for which information is available is given after each variable name and the percentages for each category calculated with this denominator.

Table 4. Sociodemographic Characteristics of Cases Involving Couples or Families (N=29)*

	Husband	Wife
Education Level (n=10 husbands, 12 wives)		
Elementary School	1	3
High School	3	3
College	5	5
University	1	1
Employment Status (n=15 husbands, 12 wives)		
Employed	10	4
Unemployed	5	4
Homemaker	0	4
Immigration Status (n=15 husbands, 20 wives)		
Citizen	3	4
Landed immigrant	6	8
Refugee/Refugee Claimant	3	7
Diplomatic status	1	1
Not in Canada	2	0

* Sociodemographic information is incomplete because in many cases the patient was never met but only discussed with the referring clinician. The number of cases for which information is available is given after each variable name and the percentages for each category calculated with this denominator.

Table 5 summarizes the main initial reasons for consultation. The most common request was help in clarifying a diagnosis, obtaining psychological assessment, or interpreting the cultural meaning of symptoms and behaviours. Almost as often, there was a request for advice on appropriate treatment. In about 25% of cases there was a request for information or help linking to an appropriate professional or community resource (e.g. refugee aid organization, cultural community organization).

Although 50% of cases (51/102) had one main reason for consultation, more than a third (35/102) had two reasons, 16 gave three reasons and 3 (3%) had four reasons for seeking the consultation. The most common reasons were for diagnostic assessment, treatment planning, or a combination of the two.

Table 5. Initial Reasons for Consultation (n = 102)

	n	%
Diagnostic Assessment	59	57.8
Treatment Planning	46	45.1
Information or Link to Resources	26	25.4
Need for Interpreter or Culture-broker	18	17.6
Cultural Community or Group Issues	4	3.9
Other*	4	3.9

* *Other* includes: forensic issues; ethical questions; and query about potential usefulness of cultural consultation.

CCS Resources, Responses and Interventions

Of 102 initial contacts, about half were handled with only telephone contact which involved directing the clinician to other resources (e.g. community clinics, organizations, professionals, or the emergency room), arranging for an interpreter, or provided generic advice on intervention strategies (Table 6). In 17 cases, the triage decision was that there was no need for a consultation. Of the 52 cases for which a consultation was recommended, 70% involved seeing the patient and in 21% the patient was not seen; in the remaining 6 cases, the consult was incomplete or the patient lost to follow-up.

Table 6. Types of Triage Responses and Interventions (n=102)

	n	%
Consultation recommended (n=52)		
Patient seen directly	36	35.3
Patient not seen	11	10.8
Partial or incomplete consultation	5	4.9
Telephone consultation at triage (n=50)		
Consultee directed to other resources	12	11.8
Arranged for an interpreter	7	6.9
Provided advice on intervention	11	10.8
No consultation needed	17	16.7
Patients lost to follow-up	3	4.9

A total of 72 consultants were available to the CCS in its database and three specialized transcultural teams (at the Montreal Children's Hospital, Jewish General Hospital and Hôpital Jean Talon). Not all of these consultants were used in the present case series. Table 7 summarizes the professional backgrounds of the consultants in the CCS bank and also lists the frequency with which consultants from a particular background were actually used.

Table 7. Types of Professionals Available in Bank and Used by CSS

	Available in Bank	Used (N=52)	
		n	%
Psychologist	21	50	96
Psychiatrist	18	41	75
Social Worker	14	17	31
Multidisciplinary Team	3	9	16
Interpreter	7	9	16
Anthropologist	5	4	7
Other Culture Brokers*	7	4	7

* students, community members

When selecting an appropriate consultant for a cultural consultation, the ideal selection was conceptualized as being a mental health professional who possessed the needed cultural knowledge and who spoke the patient's language. Often, however, these criteria were not possible to meet. As a result, several individuals or consultants would be asked to act as a team, combining their knowledge or expertise for the consultation. For examples, lay culture brokers were sometimes teamed with a mental health practitioner for a cultural consult. Many culture brokers were, in fact, professionals in their home countries who had been unable to receive licensure in Canada. However, it was only through the process of acting as a consultant for the service that a clear appreciation and assessment of their knowledge and areas of expertise could be achieved.

Table 8 displays the specific types of consultation resources needed for the 102 cases referred to the CCS. In all cases some form of matching of the clinician or consultants background was desirable and this was achieved (very roughly) in 80% of cases. Specific clinical skills were needed in 34 cases and again this was possible in almost 80% of cases. The most difficult matches involved finding a psychiatrist, which was not possible in about 1/3 of cases (in part this may have reflected the use of psychologists on the team), and finding a non-clinical consultant (an interpreter or culture-broker) for certain small ethnocultural groups. In 49 cases, there was a need for an interpreter; often however this was fulfilled by using a multilingual clinician. In 4 cases the need was only for an interpreter.

In all, there were 241 specific resources identified as needed in response to the 102 cases for an average of 2.36 needs per case. When they could be found in one person (e.g. a Tamil speaking child psychologist) then a single consultant sufficed. More commonly, 2 to 3 consultants were required to provide the requisite linguistic, cultural and medico-psychological expertise to assess a case and plan treatment.

Table 8. Types of Consultation Resources Requested & Actually Used

	Requested		Fulfilled Requests	
	n	% All Cases	n	% of Requested
Cultural Consultant	**69**	**68**	**60**	**87**
Clinician	60	59	55	92
Non-clinician	9	9	5	56
Matching	**100**	**98**	**80**	**80**
Ethnocultural group	54	53	43	80
Language	34	33	29	85
Religion	9	9	6	67
Other	3	3	2	67
Specific skills or expertise	**34**	**34**	**27**	**79**
Psychiatrist	9	9	6	67
Child psychiatrist	7	7	5	71
Family therapist	5	5	4	80
Trauma	4	4	4	100
Refugees	3	3	3	100
Somatization	2	2	2	100
Other*	4	4	3	75
Interpreter Only	**4**	**4**	**3**	**75**

* Specific expertise with disability, substance abuse, sexual identity, CBT

Table 9 summarizes the types of recommendations made in the cultural consultation for the 52 cases where a consultation was provided. The most common type of recommendations were to re-assess or change the treatment (2/3 cases) or institute a new or additional treatment (1/2 cases). Treatments recommended include medication, cognitive behavioral and supportive psychotherapy, family therapy, and social system interventions. In 1/5 of cases, referral to a new professional was recommended to provide needed treatment or follow-up.

The consultation resulted in a modification or change of diagnosis in 23% of cases. Most often this was a qualification of the existing diagnosis. In several cases, the consultation indicated that a patient had been wrongly diagnosed. This occurred when, due to lack of familiarity with the patients language or culture, dissociative symptoms were misdiagnosed as psychosis, and affective disorders were misdiagnosed as personality disorders. The presence of severe trauma related to organized violence (e.g. torture) was sometimes minimized or over-looked by clinicians unfamiliar with conditions in the patient's country of origin.

Finally, family systems problems were often attributed to personality difficulties or other psychiatric conditions by clinicians unfamiliar with the culture-specific dynamics and politics of family life (e.g. the structure of patriarchal families) or with the impact of migration on extended family systems and vulnerable individuals. More detail on the salient aspects of the cultural formulation is provided in the companion report on the process evaluation of the CCS.

Table 9. Recommendations of Consultation (n=52)

	n	%
Reassess or Change Diagnosis	12	23.1
Reassess or Change Treatment	36	69.2
Refer to New Professional	11	21.2
Advise Additional Treatment	25	48.1
Advise Interpreter/Culture-broker*	3	5.8
Ethnic Match		
Clinician	3	5.8
Service	5	9.6
Treatment	1	1.9
Referral to Community Resource	7	13.5

* These recommendations involved the use of an interpreter or culture broker alone where there was no need for a clinician.

Satisfaction

A Consultee Satisfaction Survey was completed by 29 clinicians who received consultations by the CCS service. Fully 86% (25/29) reported that the service had met most or all of their needs; 21/29 = 72% found the service helped them to effectively with their clients quite a bit or a great deal, and only 1/29 = 3% found it did not help at all. All clinicians would recommend the service to a colleague and 100% would come back to the service.

Clinicians also responded to an open-ended question asking what they found useful about the cultural consultation. The most frequent benefit was increased knowledge regarding either the social, cultural or religious aspects of the cases or specifically psychiatric and psychological aspects. About half of consultees found that the consultation had improved the patient's treatment and almost 1/3 found that it had improved their communication, empathy and understanding of the patient or strengthened the therapeutic alliance.

Table 10. Aspects of Clinical Case the CCS Consultation Helped (N=29)

	Cases Relevant	Cases Where Consultation Helped	
	n	n	%
Diagnosis	25	18	72
Treatment	29	28	97
Compliance	19	13	68
Migration Issues	15	10	67
Cultural	29	25	86
Psychiatric	27	23	85
Trauma	16	11	69
Racism	16	11	69
Identify Resources	22	17	77

Table 11. What Consultees Found Useful about the Consultation (N=29)

	n	%
Increased Knowledge	18	62
of social, cultural or religious aspects	12	
of psychiatric or psychological aspects	6	
Improved Treatment	14	48
Improved communication, empathy, understanding, or therapeutic alliance	9	31
Increased Confidence in Diagnosis or Treatment	4	14
Useful to have ethnic match of consultant and patient	4	14
Increased Skill	3	10
Helpful to alliance with family	3	10

In response to an open-ended question about what they found useful about the consultation, consultees' most frequent responses were that the consultation increased their knowledge particularly about the social, cultural and contextual aspects of the case as well as psychiatric and psychological aspects. Almost half of the respondents felt the consultation had affected their treatment of the case by providing new therapeutic strategies (8 cases) or confirming their ongoing treatment approach (4 cases). About 1/3 felt the consultation had improved their relationship with the patient in terms of better communication, increased empathy and understanding or a stronger therapeutic alliance. Three consultees also noted that the consultation had helped improve their collaboration with the patient's family. Four respondents noted that it increased their own confidence in the diagnosis or treatment plan. Four consultants felt that having a consultant from the same background as the patient was particularly helpful. Only three consultees reported that the consultation had improved their own skills for conducting assessments themselves or identifying appropriate resources.

Among the other aspects of the service that some consultees found useful were the thoroughness of the team's evaluation, the multidisciplinary nature of the team, and practical assistance with writing official letters (i.e. to the Refugee Review Board).

Table 12. Difficulties or dissatisfactions with cultural consultation (N=29)

	n	%
Wanted treatment or more follow-up	4	14
Resources suggested were not appropriate	4	14
Concerns about competence of culture broker	3	10
More focus on psychiatric issues rather than social context	3	10
Concerned that they would lose client due to consult	1	4
Need more concrete strategies	1	4
Quicker response	1	4
Concern that cultural elements were missed	1	4

The most common concerns with the need for more treatment or follow-up from the team and with the difficulty in locating appropriate treatment resources for clients with specific language or ethnocultural needs. A few consultees expressed concerns about competence of culture broker assigned to their case. In one case, they expected someone with greater psychiatric expertise; in another, they felt that culture broker/consultant was not well prepared as he had not read documentation provided to familiarize himself with the client beforehand. In a third case, the consultee felt there was insufficient collaboration with the consultant and he did not agree with consultant's intervention. Three consultees felt that there was insufficient input on the psychiatric level in their case due to the emphasis on contextual factors; e.g. there was a greater emphasis on the patient's experience of victimization and other issues were not dealt with. One consultee expressed

dissatisfaction with the discussion during the CCS clinical meeting because he would have liked the presentation to be more interactive and less focused on reading a report. Another consultee would have liked more concrete clinical intervention strategies to deal with the issues raised by the consultation. They felt there was a need to translate the cultural formulation into clinical interventions.

There were only a few suggestions from consultees on how the service could be improved. The most frequent suggestion (n=4) was that the service should be better advertised and promoted so that detailed information was readily available. Two consultees felt the service should provide more training opportunities, as well as written materials and references; one felt that a resource bank with short recent histories on the countries of origin of their clients would be helpful. Two consultees thought that providing short to mid-treatment for cases would make the service more useful. Two suggested changing the format of the consultation. One felt that performing such long and in-depth evaluations creating unrealistic expectations for subsequent treatment on the part of patients. A second respondent suggested that setting up formal meetings with the consultant before and after they met with the patient would help them to obtain more feedback and useful information. One consultee pointed to the need to further train and improve the skill levels of culture brokers and to carefully screen the pool of culture brokers to insure their competence.

Recommendation Follow-up

A total of 21 respondents provided detailed information on which of the cases recommendations they had follow-up. Of 21 respondents, 19 found the consultees recommendations mostly or completely clear, 16 found them mostly or completely feasible to carry out.

For each recommendation that had not been carried out, respondents were asked to describe why they were not implemented (Table 13). There were three main reasons specific recommendations were not carried out: (i) patient noncompliance (13 cases), (ii) lack of or inefficiency of resources (5 cases) and (iii) lack of staff follow-through (4 cases). In 7 cases the situation had spontaneously improved so that certain recommendations were no longer deemed necessary or appropriate.

Table 13. Reasons Why CCS Recommendations were Not Implemented

	Recommendations	Cases (N=21)	
	n	n	%
Patient Non-compliance	13	8	38
Due to poverty	3	3	14
Recommendations too complex	3	3	14
Symptoms too severe	1	1	5

Situation Spontaneously Improved	7	5	25
Lack of Staff Follow-Through	4	4	20
Lack/Inefficiency of Resources	5	5	25
Unknown	2	1	5

Respondents were also asked what could have made the recommendations work. The reasons offered were: (i) better transition from CCS to community follow-up (n=6); (ii) improved availability of resources (n=6); (iii) better assessment of patient (n=3); and (iv) greater professionalism on the part of the staff (n=1).

It was not possible to track the health care utilization of patients seen by the CCS directly. To obtain a crude estimate of the potential impact of the CCS intervention on patient's use of clinical services, the referring clinicians were also asked to the best of their knowledge, whether the CCS consultation had affected their patient's use of specific health services. Table 14 summarizes the results. Perhaps reflecting the source of information, the greatest impact was on the services provided by the referring clinician, followed by other primary care settings, mental health and emergency room use.

Table 14. Impact of Consultation on Services

	Information Available	Cases Where Consultation Affected Use of Services	
	n	n	%
Your own services	19	13	68
Primary Care	18	8	44
Mental Health	18	6	33
ER	15	3	20
Other	20	5	25

In response to an open-ended question about the reasons why the CCS influenced patients' use of services, clinicians offered the following explanations: the CCS consult (i) facilitated contact with medical and mental health professionals (n=10); (ii) improved the therapeutic alliance (n=7); (iii) improved patient's compliance (n=6); (iv) facilitated access to community resources; and (v) other (n=10).

Discussion

Over the 12 month period of formal data collection, the CCS service received 102 requests for consultation. These came from the whole range of health and social service professionals based at hospitals and community clinics (CLSCs). The majority of consultation requests concerned individuals but almost 1/3 involved couples. Four cases involved requests from organizations to discuss issues related to their work with a whole ethnocultural group or community.

Most clinicians requesting consultations had heard about the service through word of mouth, and the rate of referrals gradually increased over the course of the project as consultees who had found the service useful spoke of it to others or asked for help with a new case. Presentations to clinical services by CCS team members also increased awareness of the service and its usefulness.

The cases represented an enormous diversity of countries of origin, languages, ethnocultural groups and religions. This demanded a wide range of consultants, interpreters and culture brokers. It precluded developing ethnospecific services. Indeed, we were aware of some ethnocultural communities that did not make a significant number of referrals simply because they were aware that we did not have consultants who spoke the appropriate language available; contrariwise, certain ethnocultural communities are probably over-represented in our sample because it became known that our team had multilingual clinicians from that groupreadily available. This was a sort of de facto ethnospecificity to our service.

The most common reasons for consultation were requests for help with clarifying a diagnosis or the meaning of specific symptoms or behaviours (58%), treatment planning (45%), and request for information or a link to organizations and resources related to a specific ethnocultural group or issue (e.g. refugee status (25%). Half of all cases had multiple reasons for requesting consultation giving some indication of the complexity and inter-relatedness of issues.

About half of all requests to the CCS could be resolved with telephone contact and informal exchange of information or linking to specific resources. In about 1/5 cases the clinical coordinator felt that there was no need for a cultural consultation. Some of these cases represented inappropriate referrals in which basic medical and social services had not yet been arranged or employed, others involved an effort to refer a difficult case that had no indication of a cultural component in the hope of obtaining additional services. Of the 52 cases where a consultation was recommended, in 21% the consultation occurred entirely through discussion with the referring clinician and the patient was not seen.

The specific resources needed for consultation involved interpreters for about half of all consultations. Some form of matching of the consultants' background (language, ethnicity or religion) with that of the patient was needed in 2/3 of cases, and some specific clinical skills (psychiatric expertise, family therapy training, experience working with trauma, refugees, somatization) was needed in 1/3 cases.
Building on the existing network developed by the MCH, the CCS established a bank of 75 consultants (see Appendix E), 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 and they evinced. Consultants integrated directly into the team (as staff at the JGH, postdoctoral fellows or trainees) were used most frequently. In general, it was necessary to use 2 to 3 consultants to address the specific cultural and mental health issues raised by a case.

It was possible to find appropriate resources to conduct the consultation in most cases. However, ethnic matching was very approximate and it was particularly difficult to find psychiatrists and child psychiatrists with skills needed to work with specific patients. As well, for smaller ethnocultural communities or more recent immigrant groups, 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 impossible to maintain.

According to consultees, the CCS consultation had its greatest impact on treatment and on the cultural and psychiatric aspects of the case. What clinicians found most useful about the consultation was that it increased their knowledge of social, cultural or religious aspects of the cases, or of the psychiatrist or psychological aspects. Almost as frequent was an effect on improved communication, empathy or understanding of the case.

Benefits of the Cultural Consultation Model

Most clinicians (86%) reported they were satisfied with the consultation and that it had helped in the management of their patients. All who had used the service said they would use it again and would recommend that their colleagues use it.

Cultural consultation often facilitated the therapeutic alliance between the referring person and the patient. Although consultation is intrusive, the act of the consultee seeking a cultural consultation may demonstrate to the patient an interest in better understanding the patient within their own cultural framework which can have the effect of facilitating treatment and increasing empathy on the part of the referring person.

Even where patients were not seen, the advice and re-interpretation 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.

Challenges, Obstacles and Limitations to Cultural Consultations

A number of important challenges and potential obstacles were faced in the process of conducting cultural consultations:
5. When responding to a request for a cultural consultation, it was necessary that the patient's permission to be seen by a cultural consultant was secured. While some clients welcomed the opportunity to be seen by a clinician or culture broker from a

similar cultural background or with relevant cultural knowledge, other clients expressed reservation or worry that being seen by someone from their own community might compromise the privacy of their problems. Some cultural communities are very small and certain mental health or family problems highly stigmatized so that their concerns may be realistic. Reassuring patients about rules of confidentiality may be necessary but not sufficient.

6. The same concerns about confidentiality applied to the use of interpreters during the consult. Given that the CCS strictly used interpreters from the regional bank of interpreters maintained by the Régie Régionale, the rules of confidentiality were clearly in place. Patients needed to be reassured about what this would mean.

7. Similarly, sometimes clients who were seeking asylum expressed concern about how information gathered during a cultural consultation might affect their application for refugee status. Again, clarification of the CCS's role to these patients was essential.

8. We often needed to clarify repeatedly with consultees that we functioned strictly as a consultation service and not a treatment service. We had several experiences with consultations in which, once the process began, the consultee became inaccessible or discontinued treatment with the patient, presumably on the assumption that the CCS would become responsible for the patient's subsequent care.

9. The cultural consultation service was sometimes asked to respond to emergencies or crises (e.g. crises related to the imminent deportation of a patient). The CCS did not have sufficient resources and staff to respond quickly to these requests; nor was it designed to provide emergency care.

10. During the process of developing a cultural consultation service, an appreciation for the difficult position that a cultural consultant can be placed in was developed. The role of the cultural consultant is often to act as a bridge between the patient and the referring person. They are also often expected to balance the demands of developing an alliance with the patient based on cultural understanding while still negotiating the rules, norms and standards of traditional psychiatric or psychological care. The demands of these two positions do not always coincide and can sometimes be in complete opposition to one another. As a result, the skill level of the consultant and their relative comfort in negotiating this position is important in any consultation.

11. The CCS was very active in promoting the use of professional interpreters in hospital and other mental health settings. The recommendation to use an interpreter was frequently made as part of a consultation but also as a phone intervention even when a consultation was not pursued. Despite the increased use of professional interpreters in the hospitals, resistance to their use was still common, particularly in the case of hospitals that tended to rely on staff members to act as interpreters. Despite the intervention of the CCS, the JGH continued to under-utilize the interpreter pool and the most of the funds assigned by the Régie Régionale to the hospital for this purpose went unused.

Appendix

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Appendix B2

**Évaluation de Processus du Service de Consultation Culturelle (SCC)
de l'Hôpital Général Juif—Sir Mortimer B. Davis**

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Introduction

Deux constats relatifs avec la question des communautés culturelles et des services de santé mentale sont bien documentés:

• les communautés culturelles sous-utilisent les services de santé mentale;
• les producteurs des services existants ont de la difficulté à faire face aux demandes qu'ils reçoivent parce qu'ils ne sont pas outillés adéquatement.

Ces problèmes se retrouvent aussi bien en psychiatrie qui s'occupe de troubles sévères de santé mentale que dans le domaine psychosocial (CLSC, médecins généralistes, services sociaux, centres jeunesses, écoles, organismes communautaires) responsable du champ de la santé mentale. Ces besoins particuliers ont donné naissance, dans la région de Montréal, à différentes cliniques et projets pilotes qui s'inspirent de courants internationaux de l'ethnopsychiatrie. Basé sur diverses expériences montréalaises, le projet du Service de Consultation Culturelle (SCC) tel que financé par le FASS vise à développer et à évaluer des services de consultation spécialisés en santé mentale dans trois centres hospitaliers différents soit l'Hôpital Général Juif, l'Hôpital de Montréal pour Enfants et l'Hôpital Jean-Talon. Deux types de service de consultation culturelle ont été offerts dans ces cliniques externes. Le premier est un service clinique offert directement aux patients et à leurs familles via les cliniques externes de psychiatrie. L'autre type de service en est un de consultation culturelle offert aux intervenants en santé et services sociaux qui éprouvent des difficultés avec un cas précis. Ce deuxième type de service ne s'adresse pas directement aux patients bien que ceux-ci en définitive soient ceux qui en bénéficieront. Le SCC offert à l'Hôpital Général Juif est totalement nouveau au sein de l'institution et correspond exclusivement au deuxième type de service mentionné, c'est-à-dire à un service offert uniquement aux intervenants. La finalité du service est de soutenir et orienter les professionnels dans leur travail clinique où la différence culturelle pourrait être en cause. Dans le présent document, comme au SCC , on considère qu'un cas peut

être une personne adulte ou enfant, une famille ou encore une communauté spécifique. Étant donné l'aspect novateur du SCC à l'Hôpital Général Juif, l'objectif général de la recherche évaluative vise à documenter : 1) le processus de mise en œuvre du SCC à l'Hôpital Général Juif et; 2) les types de consultations culturelles produites. Ce nouveau service a émergé du milieu clinique et les cliniciens responsables de l'implanter ont exprimés le besoin d'être guidés durant sa mise en œuvre afin de maximiser la capacité du service à répondre aux besoins des utilisateurs. L'équipe de consultants culturels tout comme l'évaluatrice, issus d'univers disciplinaires différents[1], n'avaient pas accès directement aux patients qui, pour bien des cas, étaient très malades. Seul le consultant culturel mandaté pour chaque cas a généralement rencontré le patient dans le cadre d'une entrevue visant à évaluer les aspects culturels impliqués dans le problème d'intervention. Pour des raisons d'ordre éthique, clinique et administrative et en vue de maximiser la participation des producteurs du nouveau service à son évaluation, il a été décidé de réaliser une évaluation de type participative. La participation active des consultants/clinciens et de la coordonnatrice à l'évaluation du SCC avait, entre autres finalités, de permettre aux changements de procédures envisagées par l'évaluation d'être appliquées le plus rapidement possible.

Le présent rapport comprend trois chapitres. Le premier décrit les problèmes culturels relatifs aux demande de consultation et de quelles façon ces problèmes se sont transformés durant le processus de consultation. Le deuxième chapitre présente une typologie des formulations culturelles produites par les consultants du service. Le dernier chapitre discute des changements apportés au SCC suite à l'évaluation de processus ainsi que les barrières et succès de la mise en œuvre du service. Enfin en conclusion nous abordera les limites de ces résultats et les questions de validité. On y discutera aussi des incidences des résultats sur les questions de formation professionnelle, d'accessibilité des services et enfin de politiques de santé.

Objectifs de l'évaluation

Le but de la recherche évaluative sont d'identifier : 1) une typologie des problèmes clinique interculturel relatifs aux demandes de consultation soumises au SCC; 2) une typologie des formulations culturelles produites par le Service de Consultation Culturelle 3) identifier l'existence de barrières à la mise en œuvre du service; 4) identifier les facteurs ayant facilité la mise en œuvre des composantes du service; 5) identifier les composantes du services qui ont été changées suite à l'évaluation.

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[1] psychologue, psychiatres, anthropologue, professionnel de santé publique, travailleur social, médecin de famille, infirmière, résidents de psychiatrie, interne de psychologie, directeurs de psychiatrie interne, étudiants du 2ième et 3ième cycle en anthropologie.

Méthodologie

Devis

Le type de devis envisagé pour l'évaluation de processus du *SCC* de l'hôpital Général Juif est du *type étude de cas multiples avec niveau d'analyse imbriqués*. Il faut distinguer l'existence de quatre types possibles de devis de type *étude de cas* en recherche-évaluative de type qualitative.

- cas unique;
- cas unique avec niveaux d'analyse imbriqués;
- cas multiples avec un seul niveau d'analyse;
- cas multiples avec niveau d'analyse imbriqués (Yin ,1984).

Le devis de type étude de cas est une stratégie par laquelle le chercheur décide de travailler sur une unité d'analyse ou sur un très petit nombre d'entre elles. L'observation se fait à l'intérieur du cas ou des quelques cas. La puissance explicative découle de la profondeur de l'analyse du cas et non du grand nombre d'unités d'analyse étudiées.» (Contandriopoulos, 1990: 37). Ces devis se distinguent alors par le nombre de cas où d'unité d'analyse retenus et le nombre de niveau d'analyse considérés. Le nombre de cas étudiés dans le cadre de ce projet correspond à l'ensemble des consultation complètes que le SCC a produit durant les deux années du projet, i.e. un total de n=52. Il s'agit alors de cas multiples.

Les différents niveaux d'analyse correspondent aux perspectives et explications de : 1) l'équipe de consultants participant à la réunion clinique, i.e. ceux qui offrent le service de consultation tels que représentée par une professionnelle présente aux sessions d'évaluation; 2) de la coordonnatrice clinique du SCC et 3) du chercheur responsable de l'évaluation. On a procédé par triangulation des perspectives pour maximiser la validité des résultats qualitatives. On pourrait argumenter avec raison que la perspective du client, i.e. ici le professionnel qui demande une consultation au SCC est importante et devrait contribuer à cette triangulation de perspectives. Cet aspect de l'évaluation a été prise en compte à l'aide du *Satisfaction Questionnaire* dont les résultats sont discutés dans le rapport principal présenté au FASS. L'objectif de produire une analyse de processus n'est pas uniquement pour documenter et évaluer la pertinence et la mise en oeuvre du service. En l'absence de devis expérimental randomisé pour évaluer les effets du service, l'évaluation de processus avec un devis de type *étude de cas* permet dès lors d'affirmer avec une forte validité interne et externe que la variable indépendante (service consultation culturelle SCC) est effectivement implanté et responsable des effets observés (variable dépendante : changement clinique). Le changement clinique documenté ici est à la fois interne et externe au service. Le changement interne fait référence aux changements de procédure encourus durant la mise en œuvre du service. Alors que le changement externe se réfère aux changements cliniques encourus chez le professionnel ayant demandé une consultation. C'est-à-dire aux changements apparus dans sa façon de percevoir son problème clinique, de le comprendre et aux changements de stratégies cliniques qu'il adoptera suite à la consultation. Le degré d'implantation des

recommandations cliniques produites par le SCC, i.e le changement souhaité (variable dépendante) dans cette perspective, sont importantes à documenter pour confirmer la présomption de faisabilité et d'impact des recommandations cliniques produite par le SCC. La degré d'implantation et de faisabilité des recommandations cliniques produites par le SCC a été mesuré à l'aide du *Recommendation Follow-up Questionnaire* dont les résultats sont également présentés dans le rapport principal. Étant donné le petit nombre de cas, (n=52) et l'absence de devis expérimental randomisé, cette analyse de processus confère un excellente validité interne et externe nécessaire à l'évaluation général du projet permettant en somme d'affirmer avec évidence que le changement clinique observé (variable dépendante) chez les cliniciens qui ont utilisé le service est causé par l'implantation du SCC (variable indépendante).

Procédure

Les étapes de l'évaluation-participative sont les suivantes :

1. *Observation-participante lors de la consultation culturelle de groupe* : participation à la session de consultation de groupe et observation -participante par les trois participantes à l'évaluation. De notes ont été prises par les participantes lorsque possible durant cette réunion clinique.

2. Évaluation-participative en post consultation : retour sur les événements et les échanges qui ont eu lieu durant la consultation de groupe et réponses par consensus aux questions du questionnaire. En cas de non convergence entre les parties quant aux réponses produites, il y a eu négociation entre les participantes pour en arriver à un consensus pour chacune des réponses. La session évaluative n'était considérée terminée pour chuaqe cas que lorsqu'il y avait consensus au sujet de toutes les réponses produites. Cette stratégie visait à produire des résultats par triangulation dans le but de maximiser la validité des résultats qualitatifs et minimiser les biais personnels voir même disciplinaires. Les réponses étaient généralement entrées immédiatement dans la base de données informatiques.

3. Présentation des décisions de changement de procédure. Après avoir négocié et rempli le questionnaire d'évaluation en groupe il est fréquemment arrivé, surtout au début du projet, de décider de changer certaines procédures du SCC. Les décisions quant aux changements de procédure à apporter au service étaient généralement présentées à la consultation de groupe de la semaine suivante. Dans certains cas, il a fallu négocier avec les autres membres consultants la pertinence d'apporter tel ou tel changement et les façons de les implanter.

4. Implantation des changements de procédure. Seuls les changements acceptés par tous les consultants étaient implantés à court ou à moyen terme.

Mesures

Appendix

Il y avait quatre types de mesures :

1. *Observation-participante :* La première étant l'observation lors de la discussion de cas par les trois participantes à l'évaluation. L'évaluatrice et la coordonnatrice clinique ont toutes les deux pris des notes dans leur propre journal de bord auxquels elles se référaient au besoin lors des sessions d'évaluation post-consultation.

2. *Questionnaire qualitatif :* le questionnaire était très structuré et composé de peu de question (voir les questions dans le prochain article). L'objectif des questions était de stimuler et diriger une discussion et une réflexion de groupe relatifs à ce que les participant-consultants ont observé durant la consultation. Le but ultime était que le produit de ces discussions aide à répondre aux objectifs d'évaluation. Les trois participants ont initialement conceptualisé les questions, les ont transformées et en ont ajouté d'autres au fur et à mesure qu'il semblait pertinent de le faire. Répondre en groupe au questionnaire a impliqué beaucoup de réflexion, de discussion et de négociation entre les trois participant(e)s et reposait largement sur la capacité des participantes à dialoguer, écouter et négocier un point de vue interdisciplinaire[2] au sujet du phénomène social observé, i.e. le processus de consultation. Le temps moyen pour négocier et répondre en groupe aux questions du questionnaire pour un seul cas était de 3 heures au début du projet et de une heure pour les 10 derniers cas du projet.

3. *Dossier de la consultation culturelle du patient.* En cas de doute les participantes se sont quelques fois référées aux documents écrits dans le dossier du patient relatant : a) les raisons explicites à la source d'une demande de consultation,; b) les notes de la coordonnatrice clinique relatant les événements depuis l'étape du triage jusqu'à la fin de la consultation; c) le document complet de la formulation culturelle du cas et les recommandations cliniques, d) le document d'une page résumant les recommandations cliniques.

4. *Toutes les conférences de cas ont été enregistrées* et le verbatim a été transcrit sur traitement de texte. Ce matériel était disponible aux participants de l'évaluation pour vérifier des informations pour des situations de non consensus, entre les participants à l'évaluation .

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[2] La coordonnatrice clinique était psychologue, la ou le représentant des consultants était psychologue ou psychiatre selon la disponibilité de chacun, et le chercheur non clinicien responsable de l'évaluation était anthropologue et professionnel en santé publique.

Questionnaire qualitatif

Les questions du questionnaire devaient être répondues en groupe par les trois participants. Elles étaient :

5. En regard des raisons initiales ayant justifiées la demande de consultation est-ce que le processus même de consultation a permis d'identifier d'autres problèmes liés au cas? Si oui les quels?
6. Est-ce que le processus de consultation a révélé l'existence de raisons de consultation qui étaient implicites? Si oui, les quelles?
7. Une formulation culturelle a t-elle été présentée pour ce cas? Si oui, quels en étaient les thèmes principaux?
8. Sur la base des observations du processus de consultation culturelle pour ce cas précis, y a t-il lieu d'améliorer le processus du SCC ? Si oui, de quelle façon?
9. Est-ce que la consultation a permis d'identifier des besoins de formation? Si oui les quels?
10. Observations et commentaires généraux.

Codage et analyse. À la fin du projet chacune des réponses a été codée en attribuant un à plusieurs thèmes par réponse. Nous avons ensuite regroupé les thèmes par catégorie. Pour la plus part des questions ce processus de codage a été discuté et négocié entre l'évaluatrice, la coordonnatrice et le directeur du projet. Ensuite nous avons calculé les fréquences pour chacun des thèmes et catégories. Nous avons ensuite procédé à l'analyse. La réflexion sous jacente à l'analyse a requis un retour constant depuis les fréquences représentant l'importance de chacun des thèmes et catégories et le contenu des réponses sous forme de textes écrits.

Échantillon. La présente évaluation porte sur la totalité des cas (n=52) pour lesquels il y a eu une consultation complète. Une consultation culturelle complète correspond aux cas pour lesquels une demande de consultation a été retenue après l'étape du triage et pour laquelle un consultant culturel attitré a produit une formulation culturelle et des recommandations cliniques spécifiques.

Résultats

1. L'évolution de la perception des problèmes d'intervention durant le processus de consultation

Quand on se réfère à une consultation culturelle ceci implique qu'un intervenant a contacté le SCC, via la coordonnatrice clinique, parce qu'il ou elle éprouve des difficultés d'ordre clinique avec un cas précis. La coordonnatrice aide alors le requérant à préciser son problème d'intervention et juge si oui ou non le contexte interculturel est lié au problème. Après discussion si la coordonnatrice juge que la dimension culturelle n'est pas liée au problème d'intervention elle l'informe et le réfère à la ou aux ressource(s) appropriée(s). Si elle juge que le problème d'intervention est lié au contexte interculturel

elle organise une consultation en attitrant un consultant culturel au cas; généralement un intervenant qui connaît bien la culture du cas. Le consultant culturel assigné par le SCC réalise dès lors une entrevue auprès du cas ou de son représentant (patient, représentant d'une famille ou représentant d'une petite communauté) portant sur les aspects culturels lié au problème clinique. Pour ce faire, les consultants ont utilisé l'outil *Formulation Culturelle du DSM-IV* qui a été transformé par notre équipe pour le rendre plus facile à utiliser en contexte clinique. Cette entrevue sur les aspects culturels se fait généralement en présence du requérant. La totalité des requérants ont été invités à observer l'entrevue culturelle, afin de faciliter et accélérer le transfert des connaissances culturelles. Le consultant est ensuite invité à présenter un rapport sur les aspects culturels du cas au groupe de consultants cliniques du SCC qui ont pour mission de l'appuyer, discuter et proposer des explications socioculturelles au problème d'intervention. La dernière étape de cette réunion clinique de groupe vise alors à proposer, le jour même, des stratégies d'intervention au requérant pour l'aider à résoudre son/ses problème(s) d'intervention. Cette réunion de groupe se fait généralement en présence du requérant et du consultant culturel assigné au cas. Le requérant quittait généralement cette réunion clinique avec des recommandations écrites en mains résumées sur une page. Le tout étant suivi, quelques semaines plus tard, par une formulation culturelle complète contenue dans un rapport écrit accompagné des recommandations détaillées. Ce rapport se trouvait dès lors intégré au dossier du patient et accessible pour tout autre soignant ultérieurement assigné au cas.

Bien que la coordonnatrice clinique aidait les requérants d'une consultation à identifier et à formuler les raisons qui les amenaient à demander une consultation culturelle, les participants à l'évaluation ont observé qu'il pouvait arriver que des problèmes additionnels au problème d'intervention initial soient identifiés en cours de consultation. Voir même il est arrivé que des requérants aient dissimulé certaines raisons qui les avaient amené à demander une consultation culturelle au SCC. Dès lors, il nous est apparu important de documenter ces phénomènes et d'analyser leur raison d'être et leurs implications.

Les catégories présentées au tableau 1 ne sont pas mutuellement exclusives. Les problèmes d'intervention explicites qui ont motivé une demande de consultation sont très diversifiés. Néanmoins le bloc le plus important exprimées par les professionnels au moment du triage, est lié à des difficultés cliniques, plus précisément à des difficultés à établir un diagnostic, à sélectionner un traitement approprié (incluant ici la médication) et à résoudre des problèmes d'observance thérapeutique. La fréquence totale pour ces types de problèmes est de 95/168 , ce qui représente la cause d'un peu plus de la moitié (56%) des problèmes identifiés au moment du triage. L'autre catégorie de problème la plus importante est liée à des problèmes d'interaction (37/168) représentant ainsi 22% des problèmes liés à la culture. Les problèmes d'interaction interculturelle identifiés étaient relatives, soit entre l'intervenant et le patient, entre le requérant et la famille du patient ou entre requérant et l'interprète. Enfin la troisième catégorie en importance des problèmes pour lesquels il y avait une demande de consultation avait trait à des problèmes systémiques relatifs à procédures, pratiques ou problèmes institutionnels relatifs à différents systèmes (santé, social, éducation, légal, immigration) impliqués dans le problème du cas.

Appendix

Tableau 1: Raisons de consultation explicites, implicites, et nouveaux problèmes pour lesquels il y a eu une consultation culturelle complète (n=52).

	Explicites		Implicites		Nouveaux	
	n	%	n	%	n	%
Systémique	12	23	7	13	10	19
Patient	0	0	0	0	2	4
Requérant	18	35	1	2	0	0
Communication	37	71	2	4	4	8
Interprétation	6	12	0	0	4	8
Diagnostic	26	50	0	0	5	10
Traitement	48	92	0	0	0	0
Observance	21	40	0	0	0	0

Le tableau 2 nous informe du nombre de cas (19/52) pour lesquels le processus de consultation a permis d'identifier l'existence de un ou des problèmes additionnels liés au problème clinique initialement exprimé et identifié par le requérant. Pour un peu plus de la moitié des cas 33/52 (63%) aucun nouveau problème associé à la raison initiale de consultation n'a été identifié durant le processus de consultation. Ceci signifie que dès l'étape du triage le professionnel (le requérant) ayant demandé une consultation au SCC a été en mesure, avec l'aide de la coordonnatrice clinique, d'identifier et d'exprimer clairement les raisons pour lesquelles il désirait obtenir une consultation culturelle. Pour les 19 (47%) autres demandes de consultation il s'est avéré que l'on a découvert l'existence de un, deux ou même trois nouveaux problèmes qui n'avaient pas été identifiés au moment du triage, i.e. ni par le requérant, ni par la coordonnatrice clinique.

Tableau 2. Fréquences des cas pour lesquels un ou des nouveaux problèmes ont été identifiés durant le processus de consultation

Nombre de nouveaux problèmes	Nombre de cas
0	33
1	7
2	6
3	3
4	3

Ces résultats semblent indiquer qu'il est possible, avec l'aide d'une coordonnatrice, d'identifier le ou les problème(s) d'intervention interculturels (63%) dès le moment du

triage. Cependant d'autres problèmes cliniques interculturels sont trop complexes et multidimensionnels pour être identifiés et articulés comme tels au moment du triage et ce même si l'intervenant est guidé par une coordonnatrice. En réalité, certains problèmes d'intervention liés au contexte interculturel requièrent une consultation culturelle complète avant même que l'on soit en mesure d'identifier l'ensemble des problèmes et des dimensions impliqués dans la problématique initialement identifié.

Le tableau 1 décrit les nouveaux problèmes, classés par catégorie (non mutuellement exclusives), qui ont émergés en cours de consultation, c'est-à-dire après que l'étape de triage soit complétée. La catégorie de problèmes la plus fréquente était vraisemblablement liée à la distribution des services, la continuité des soins et aux pratiques institutionnelles appartenant à différents systèmes de la société. Les systèmes impliqués sont le système de santé , les services sociaux, les institutions d'éducation, et enfin le système légal et les processus administratifs gouvernementaux liés à l'immigration. Ces problèmes systémiques étaient suivis, en importance, par les problèmes liés au besoin d'obtenir un diagnostic supplémentaire, à des problèmes relatifs à l'utilisation ou à l'absence d'interprètes et à la communication interculturelle.

La catégorie de problème lié au besoin d'un diagnostic supplémentaire se réfère à des cas où les membres du services se sont rendus à l'évidence, en cours de consultation, que le patient avait besoin d'une évaluation médicale spécialisée supplémentaire pour éliminer la possibilité d'existence d'un autre problème de santé ou une déficience spécifique. Par exemple, il est arrivé que l'on se rende compte qu'il était essentiel qu'un neuropsychologue évalue un patient pour estimer son QI afin d'exclure la possibilité d'une déficience ou d'un handicap intellectuel. Dans un cas, on a demandé une évaluation psychiatrique spécialisée afin d'éliminer la possibilité d'un trouble précis et rare avant de commencer la consultation culturelle.

Tableau 3 : Distribution du nombre de problèmes implicites par cas

Nombre de problème(s) implicite(s)	Nombre de cas
Aucun problème implicite	37
1 problème implicite	11
2 problèmes implicites	4
Nombre de cas pour lesquels il y avait un ou des problème (s) implicite(s)	15/52 (28%)

Dès les premiers mois d'implantation du service, les consultants/cliniciens qui participaient aux réunions de consultation et aux sessions d'évaluation se sont rendus à l'évidence de l'existence d'un phénomène précis qu'il a été décidé de documenter de façon systématique. Bien que les raisons de consultation présentées par les requérants étaient réelles il demeurait que certains requérants n'ont pas dévoilé l'autre raison ou l'autre problème important qui les amenaient à demander une consultation culturelle au SCC. Dès lors on s'est demandé pour chacun des cas présentés si il existait un problème implicite lié au problème d'intervention initialement identifié au triage. Dès le début du

service quelques cas ont contribué à créer cette impression qui par la suite s'est vu confirmée par des cas ultérieurs. Le tableau 3 présente la distribution de ces problèmes implicites. En définitive, on a estimé que 15 des 52 demandes de consultation complètes (28%) étaient également motivées par des problèmes implicites assez importants pour que l'équipe de consultant considère, par consensus, que des gains secondaires ou qu'un agenda caché motivaient la demande de consultation au SCC. Pourquoi dès lors des professionnels cacheraient–ils une des raisons qui les amènent à utiliser un service de consultation culturelle? Quand on examine de plus près la nature même des raisons implicites identifiées le phénomène trouve tout son sens.

La coordonnatrice expliquait à tous les requérant, au moment du triage, que le SCC n'acceptait que les cas pour lesquels il y avait une composante clairement culturelle potentiellement liée au problème d'intervention et que le SCC ne prenait pas en charge le traitement de ces patients en post-consultation. Bien que les problèmes liés au requérant (10/15) aient été les plus fréquents, les problèmes liés au système social se retrouvent tout juste derrière (8/15). Le total des problèmes implicites est supérieur à 15 parce qu'il est arrivé dans plusieurs cas qu'un requérant avait plus d'un problème implicite lié à sa requête de service. La catégorie *problème implicite lié au requérant* se réfèrent à des situations ou le professionnel se questionne quant à ses propres compétences professionnelles ou encore manifeste un manque de confiance en ses capacités de traiter son patient. Pour ces types de problèmes, les consultants du SCC sont intervenu auprès du requérant pour le rassurer et lui confirmer ses compétences thérapeutiques et sa capacité de prendre en charge son patient. D'autres situations implicites avaient trait à des requérants qui demandaient une consultation au SCC parce qu'ils questionnaient la compétence d'un autre professionnel impliqués avec le cas. LA consultation au SCC contribuerait alors à changer le thérapeute du patient. Ces situations sont naturellement difficiles à dévoiler à un tiers parti, en l'occurrence le SCC, car elle remet en cause les compétences professionnelles, i.e. de soi même ou encore d'un autre professionnel. D'autres problèmes implicites correspondaient à des situations où le professionnel était face à un cas clinique qui par sa nature remettait en cause ses présomptions, stéréotypes ou préjugés culturels. Ces types de problèmes ont tous rapport à des questions de respect pour soi-même, pour ses collègues ou encore envers le patient. Il est dès lors attendu que ces raisons de consultation ne soient pas faciles à dévoilées et ne soient pas révélées durant le processus de consultation.

L'autre catégorie de *problèmes implicites* est différente et relève, comme pour les *nouveaux problèmes*, à des problèmes systémiques. À la différence des *nouveaux problèmes* de type systémiques les *problèmes implicites* de type systémique sont tous uniquement liés au système de santé (8 problèmes système de santé/8 problèmes systémiques). Un seul des cas noté avait à la fois un problème implicite lié au système de santé et un problème implicite lié au système de l'immigration. Gardons ici à l'esprit que les intervenants qui ont fait une demande de consultation au SCC, pour un cas précis, connaissent généralement bien le système de santé et savaient comment y naviguer. Si on regarde de plus près les raisons implicites qui auraient motivé ces intervenants à demander une consultation on peut diriger notre réflexion dans une direction intéressante. En effet tous ces cas de problèmes implicites systémiques (8/15) étaient relatifs à des

situations où le requérant souhait, via une consultation au SCC, résoudre le problème d'accessibilité aux services de santé mentale de son patient. Ces problèmes d'accessibilité étaient liés à des situations où leurs patients étaient susceptibles, à court terme, de perdre leur accès aux soins de santé mentale. En effet, ils avaient tous atteint leur quota soit de temps d'hospitalisation alloué en psychiatrie, soit de nombre de session de thérapie pré-accordées. Tous ces requérants (8/8) souhaitaient que la clinique de psychiatrie externe de l'Hôpital général juif, à laquelle le SCC était attaché, prenne en charge le traitement de leur patient ou la coordination de ses soins.

L'ensemble de ces résultats (raison explicites, nouveau problèmes, implicites) indiquent clairement que les quotas limitant la durée des soins psychiatriques et psychologiques externes et internes créent un problème d'accessibilité aux services de santé mentale pour plusieurs patients issus des communautés culturelles. Les patients issus de communauté culturelles ne sont pas plus malades que les Canadiens d'origine. Mais il semble qu'une proportion importante des cas vu au CCS et voir même ceux éliminés au triage se trouvaient dans une situation où ils allaient perdrent incessamment leurs accès aux soins parce qu'ils avaient atteints leur quotas. Pourquoi donc, ces professionnels de la santé mentale avaient-ils besoin de plus de temps pour traiter leur patient d'origine culturelle différente. Les résultats qualitatifs de l'évaluation de processus du SCC nous permet de proposer l'explication suivante au problème d'accessibilité des services relevé:

> L'interface entre culture et problème de santé mentale complexifie la tâche clinique du professionnel de la santé mentale requérant ainsi plus de temps pour comprendre le contexte culturel et systémique des problèmes d'une proportion importante de patient, diagnostiquer son problème de santé mentale et trouver les stratégies de traitement culturellement adéquates. La complexité des formulations culturelles et l'ensemble des recommandations cliniques produites et documentées par le SCC , font foi de la complexité de ces tâches. Pas étonnant dès lors que les traitements aux patients culturellement différents puissent, dans plusieurs cas, exiger plus de temps que pour un patient d'origine canadienne.

Les principales raisons explicites, implicites et des nouveaux problèmes présentées par les requérants au moment du triage confirment l'existence et la nature de ces difficultés cliniques (Tableau 1). L'importance des changements cliniques suggérés (changement de diagnostique, de médication, de traitement, de stratégies d'intervention) après une consultation complète (voir rapport principal) témoignent également de la complexité de la tâche clinique que incombe un travail clinique interculturel.

2. Les changements de procédures au SCC relatives à l'évaluation de processus et les barrières à la mise en œuvre du service

Changements apportés

Sans l'avoir prévu ainsi, mais largement due à la participation de la coordonnatrice clinique du service, cette évaluation s'est être avérée du type recherche-action. En effet,

la vaste majorité des décisions prises lors des réunions d'évaluation visaient des changements de procédure dans le service. Ces changement souhaités étaient dès lors implantés à l'intérieur d'une durée moyenne d'une à deux semaines.

Certains besoins de formation pour les membres du SCC ont été identifiés durant les sessions d'évaluation post-consultation. Lorsque les besoins de formation concernaient les membre du CCS, des mesures pour y remédier étaient généralement prises à l'intérieure de quelques semaines. Par exemple, nous avons décidé d'inviter des représentants d'un organisme communautaire spécialisé pour nous former sur les aspects légaux relatif à la situation des réfugiés en attentes de statut et des rôles et implications d'une évaluation psychiatrique classique et d'uns d'évaluation du SCC dans le processus administratif du CISR[3]. Plusieurs demandes au début du service étaient en lien avec la santé mentale de réfugiés victime de violence organisée. Nous avons dès lors organisé des séminaires de formation et des projection de film sur ce sujet. Plusieurs des sujets discutés lors des séminaires de formation mensuels du SCC étaient sélectionnés sur la base des besoins de formation identifiés lors des sessions d'évaluation post-consultation. (Voir la liste de séminaires mensuels *Culture & Mental Health Seminars* dans le rapport principal).

Les procédures du SCC qui ont été changées l'ont généralement été de une à deux semaines suivants la discussion évaluative post-consultation clinique. Les changement de procédure apportés au service ont ainsi largement précédé l'analyse des résultats et la rédaction du rapport de recherche-évaluative. Cette stratégie volontaire a clairement donnée priorité à l'action et a contribué, selon l'évaluatrice principale, à motiver la participation des cliniciens et de la coordonnatrice clinique aux sessions d'évaluation post-consultation. Voyant les fruits de leur efforts actualisés, généralement la semaine suivant la réunion d'évaluation, est semble t-il une bonne source de motivation pour participer à des réunions évaluatives longues et exigeantes. L'ensemble des décisions relatives aux procédures qui ont découlées de ces réunions évaluatives ont été réunies dans le document *CCS Handbook* qui a par la suite été distribué à tous les différents acteurs impliqués régulièrement ou de façon *ad hoc* dans le service *(voir annexe du rapport principal)*. Entre autre le *CCS Handbook* décrit les rôles et responsabilités respectives de tous les acteurs impliqués (interprètes et consultants culturels ad hoc, membres du groupe de consultants, coordonnatrice clinique, directeur(trice) de la consultation de groupe, requérant) et les procédures à respecter pour les acteurs (éthique, recherche, temps requis etc) impliqués dans le service. Des corrections et des changements ont été apportés au *CCS Handbook* à différents moments du projet selon le besoin.

Il n'y pas eu de consensus à l'effet de deux point différents discutés aux réunions évaluatives. Le premier point concerne la dimension éthique liée à la présence d'étudiants et de stagiaires non cliniciens lors de la présentation de cas. Ceci a fait l'objet de discussion lors des réunions évaluatives et avec le groupe de consultants/cliniciens. Finalement les membres résistants à la présence des étudiants ont accepté que les

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[3] CISR : Commission de l'immigration et du Statut des Réfugiés.

étudiants assistent aux réunions cliniques pour des raisons heuristiques. Les étudiants venant des disciplines cliniques ont continuer à participer aux réunions cliniques sur une base relativement régulière. Les étudiants des sciences sociales et non cliniciens sont graduellement venus de moins en moins; probablement parce qu'ils avaient été informé de la controverse éthique au sujet de leur présence. Mais on ne peut être assuré de cette interprétation. L'autre problème était vécu principalement par l'évaluatrice qui a demandé que les noms de patients ne soient pas mentionnés lors des discussion de cas pour protéger leur anonymat, leur vie privée et celle de leur famille. Les cliniciens ont accepté cette requête mais elle pas été adoptée en pratique probablement parce qu'elle différait trop de leur habitude clinique antérieure.

Barrières et succès de l'implantation du service

La mise en œuvre complète du service a dû faire face à différentes barrières. Peu de demande de consultation ont été faites au début du projet; probablement parce que le projet n'était pas connu dans le réseau de la santé. L'implantation du service a également été ralentie parce que les demande de services, au début du projet, n'étaient pas approprié, i.e. qu'elles n'avaient pas de véritables composantes culturelles. Les habiletés cliniques de la coordonnatrice ont été essentielles à cette étape, i.e. le triage , pour aider les requérants à se rendre compte que leur problème clinique n'était pas relié au contexte interculturel impliqué. Certains intervenants qui faisaient face à des difficultés cliniques avec un patient culturellement différent tendaient, à priori, à croire que leur problème clinique était de nature interculturelle alors que dans bien des cas l'entrevue au triage a révélé que la dimension culturelle n'était pas impliquée dans le problème. D'autres cliniciens non formés à la pratique interculturelle et/ou sans expérience clinique interculturelle ont fait une demande au SCC parce qu'ils considéraient à priori qu'un intervenant homo-ethnique serait plus approprié pour traiter leur patient. Nous avons également observé que le réflexe de demander une consultation a pris du temps à imprégner la pratique des professionnelles du réseau de la santé qui connaissaient l'existence du service SCC mais qui ne pensaient pas nécessairement à l'utiliser dans leur pratique quotidienne. On peut expliquer ce phénomène en partie parce que le service était connu depuis peu mais aussi parce les consultants, le directeur et la coordonnatrice clinique ont du expérimenté le processus de consultation sur une période de quelques mois avant d'être en mesure de négocier et définir la mission et les mandats spécifiques du service dans son contexte institutionnel et systémique. Plusieurs demandes de consultation culturelles au début du projet qui n'étaient pas appropriées ont néanmoins contribué à accélérer le processus de clarification de la mission du SCC.

Une autre barrière a l'implantation du service était la difficulté à trouver des consultants culturels pour certaines communautés culturelles spécifiques, plus précisément les communautés les plus récemment arrivées et celles qui sont moins importantes d'un point de vue démographique. Par exemple, la communauté de réfugiés Kosovars pour laquelle quelques demandes de consultations ont été faites dès le début du projet a posé problème car il n'existait tout simplement pas de consultant culturel dans la région métropolitaine pour cette communauté. Nous avons dès lors dû reposer nos demandes d'informations

auprès d' interprètes d'origine Kosovar. Nous nous sommes rendus compte que n'étant pas intervenant et appartenant eux même à la communauté qui faisait l'objet de consultation, les interprètes ont été, bien malgré nous, mis en position à la fois de consultants culturels et de quasi-cas. Cette situation a naturellement posé des difficultés et des embûches importantes au moment de la consultation. En fait ce problème vécu en cours de consultation, bien que révélé tard dans le processus, s'est avéré lié au problème d'intervention pour le quel il y avait eu demande de consultation au SCC. Ce genre de situation a fait l'objet de nombreuses réunions et discussions évaluatives et des mesures ont été prises pour prévenir l'apparition de ce genre de problème.

Néanmoins le problème a permis de mettre à jour l'importance de former tous les interprètes professionnels à l'intervention en santé mentale et communautaire. L'absence actuelle de ce type de formation peut rapidement engendrer des situations problématiques qui limitent nécessairement l'accès aux services de santé mentale et sociaux de certaines communautés culturelles.

Le fait de ne pas avoir de manuel de procédure pour le service au début du projet a également contribué a ralentir la mise en œuvre complète du service. Les cliniciens devaient néanmoins expérimenter le service et l'observer de façon critique pour être en mesure de définir ce que l'on devait y inscrire. Dès que le manuel fut complété et utilisé par les différents acteurs impliqués dans le service, le problème s'est résolu. Le principal obstacle à l'implantation, de l'avis de la coordonnatrice clinique, fut très certainement les pressions à la fois internes (Intervenants à Hôpital Général Juif) et externes (les requérants des autres institutions) pour que le service de consultation culturelle offre des traitements psychiatriques et psychologiques. L'importance et l'existence de ce problème a été confirmé par la documentation des problèmes implicites de type systémiques documentés lors des sessions d'évaluation (voir Tableau 1).

Le SCC est un nouveau service qui a émergé depuis le milieu clinique ce qui a très certainement facilité son implantation et son acceptation par les intervenants impliqués, i.e. ceux qui produisent le service et voir même ceux qui l'utilisent. Les résistances à la mise en œuvre d'un nouveau service ne sont pas inhabituelles dans le réseau de la santé, très souvent parce que le service clinique ou le programme est planifié d'en haut, i.e. par des non cliniciens ou par une instance administrative. L'expérience d'implantation de ce projet illustre la pertinence et l'utilité de planifier des services ou des programmes depuis le milieu des cliniciens ou encore en collaboration étroite avec les cliniciens. Cette démarche peu prendre plus de temps, certes, qu'une planification de service plus classiquement administrative mais son acceptation par le milieu clinique et par voie de conséquence ses chances d'implantation sont dès lors largement bonifiées.

Les autres éléments qui ont facilité l'implantation et la mise en œuvre de ce service est très certainement la philosophie de collégialité et de partage de pouvoir qui a entouré les négociations quant aux décisions de changement de procédures entre la coordonnatrice clinique, les membres cliniciens du SCC, le chercheur évaluateur et le directeur du projet. La coordonnatrice clinique avait droit a beaucoup de flexibilité pour organiser et implanter le service selon son jugement, son expérience et son expertise à la fois clinique

et interculturelle. Cette approche couplé à sa compétence clinique et interculturelle a très certainement facilité la mise en œuvre du service et a joué un rôle pivot quant à la capacité du service à s'adapter rapidement aux exigences du milieu.

3. Formulation culturelle comme système de sens étique des problèmes cliniques

Les formulations culturelles produites pour chacun des cas étaient conceptualisées par les consultants attitrés à chaque cas en tenant compte des critères proposés dans l'annexe du manuel de psychiatrie DSM-IV appelée *Formulation Culturelle*. Les membres du SCC ont transformé et simplifié cet outil afin de faciliter son utilisation dans un contexte clinique. Une formulation culturelle a dès lors été produite par chaque consultant ayant interviewé un cas. Or ces formulations, parce que leur conceptualisation vise à mettre à jour le contexte culturel impliqué dans le problème d'intervention, étaient généralement contenues dans un texte de plusieurs pages suivi à la fin par des recommandations cliniques précises. Il a dès lors été impossible de présenter dans le présent document l'ensemble de ces *formulations culturelles* sans perdre la richesse de leur contenu. C'est pourquoi nous avons décidé simplement de documenter la fréquence des thèmes dominants des *formulations culturelles* et de commenter les plus importants. Ce faisant on a pu identifier les thèmes récurrents qui deviennent incontournables dans le contexte de toute formation interculturelle de professionnels en santé mentale. Les trois participants à l'évaluation devaient, par triangulation, convenir des thèmes qui avaient dominé la *formulation culturelle* du cas discuté.

Au tableau 4 on voit que le système de parenté, les traumatismes liés à la guerre, les problèmes cliniques interculturels et les questions d'identité sont les thèmes dominants les plus fréquemment utilisés par les consultants pour expliquer les problèmes d'intervention qui ont fait l'objet d'une consultation culturelle. En ce qui a trait au système de parenté les questions liées au pouvoir et au soutien familial notamment chez les familles étendue et patriarcales a été une explication au centre de nombre de consultation. L'impact de l'isolement social sur la santé mentale et le rétablissement lorsque le patient vient d'un pays où la famille étendue constitue la norme a fréquemment été présenté comme explication des risques et difficultés de réhabilitation vécus par divers patients. Des explications culturelles et historique ont fréquemment été proposées pour éclairer et guider les intervenants quant aux question des traumas liés à la guerre ou à la violence organisée. Les problèmes adjoints aux expérience de persécution politique et ethnique ont été utile notamment pour identifier si le récit de divers patients était cohérents d'une part et plausible de l'autre. Cet aspect était essentiel pour déterminer si à la fois les diagnostics et les interventions proposées étaient pertinentes.

Tableau 4 : Distribution des thèmes dominants des formulations culturelles présentées par le SCC.

Thèmes	Fréquences
Système de parenté	25
Traumas liés à la guerre	17
Clinique	15
Identité	12
Comportements/ valeurs	8
Perception/biomédecine	7
Religion/surnaturel	6
Communication/relation	5
Émique/maladie	2
Migration	2
Total	99

Les problématiques liées à d'identité ont également constitué des explications pivot parmi *plusieurs formulations culturelles*; depuis l'identité professionnelle et culturelle du patient, des liens à comprendre en situation d'acculturation, des questions de l'identité biculturelle et des incidences communicationnelles dans le contexte clinique relatives aux identités ethniques, nationales et religieuses. Plusieurs valeurs centrales diffusées dans le monde non occidentale telle que l'honneur et les statuts social des femmes et l'importance culturelle des mariages arrangés ont été proposés à maintes reprises pour expliquer des problèmes sociaux et guider les stratégies d'intervention. Enfin un autre thème important a été la perception du patient et de sa famille quant au pouvoir et au stigma associé aux intervenants, à la clinique psychiatrie et à la maladie psychiatrique. Les perceptions religieuses et surnaturelles de patients ont été expliquées notamment en lien avec les questions de fatalisme versus *l'empowerment* du patient en réadaptation. Les interventions du monde surnaturel et de l'utilité et la signification des guérisseurs traditionnels ont également été discuté en lien avec l'observance aux posologie. Les perceptions *émiques* des maladies mentales et chroniques et leur implication notamment dans les problèmes d'observance et de stigma social ont fait l'objet de différentes explications. Enfin la dimension et les implications des problèmes d'adaptation à la société d'accueil occidentale et de ses incidences pour des personnes vulnérables a constitué un thème récurrent des formulations culturelles.

Assister à la présentation de ces formulations culturelles liées aux récits de cas fut un privilège en soi par ce qu'il constituait une porte d'entrée dans un univers exceptionnellement riche en expérience humaine, sociale et interculturel impossible à rencontrer ou à observer de façon aussi intensive dans la vie de tous les jours. Les étudiants des métiers tant cliniques que ceux issus des sciences sociales pourraient inévitablement bénéficier de façon exceptionnelle de tel type d'activités.

Conclusion

Incidences des résultats pour la formation professionnels

Étant donné les changements démographiques qui amènent notre société à se complexifier et à multiplier sa diversité culturelle , la formation des intervenants sur les aspects interculturels impliqués dans les problèmes de santé mentale et le travail clinique sont des actions incontournables pour assurer à la fois la compétence des professionnels notamment à ce qui a trait à leur capacité de poser un diagnostic adéquat et de proposer un traitement qui répond d'une adéquation culturelle. Assurer une meilleure formation des intervenants et des étudiants amenés à faire du travail clinique assura, sans conteste, une meilleure accessibilité aux services de santé mentale pour les communautés culturelles. Les thèmes les plus fréquemment utilisés dans les formulations culturelles présentées dans ce rapport et la complexité des formulations culturelles produites dans le cadre de ce projet témoignent de la complexité des dimensions culturelles impliquées dans les problèmes d'intervention que de l'inadéquation d'un modèle de formation plus traditionnel pour résoudre les problèmes cliniques interculturels. En réalité la majorité des thèmes sont davantage de type transculturel que relatif à une ethnie spécifique, rendant ainsi possible la formation des professionnels aux aspects interculturels sans pour autant être obligé de connaître toutes les cultures des diasporas présentes au Canada. La formation des interprètes professionnels pour leur donner les outils nécessaires à travailler en contexte clinique et communautaire également est incontournable et essentiel pour contribuera à prévenir des problèmes cliniques et améliorer du coup l'accessibilité des santé mentale aux communautés culturelles.

Incidences pour les politiques de santé

La documentation des catégories de problèmes (explicites, nouveaux ou implicites) d'intervention vécus par les professionnels confirment l'existence d'un problème d'accessibilité des services qui ne se limite pas aux questions d'adéquation culturelle des interventions et des services. Les résultats indiquent clairement que le modèle des soins de courte durée, que ce soit en clinique externe ou interne, ne répond pas aux besoins de bien des patients issus des communautés culturelles et immigrantes. Disloqués de leur réseau de soutien traditionnel et fragilisés par l'isolement social qui accompagne leur situation de réimplantation dans une nouvelle société occidentale les rends bien sûr plus vulnérables aux difficultés de réhabilitation et d'adaptation. Les résultats indiquent clairement que la sectorisation des services de santé mentale a un effet néfaste sur l'accessibilité des services de santé mentale pour les immigrants, les réfugiés et les patients de communautés culturelles. L'évaluation du service montre que la création d'un service régional tel que le SCC pourrait pallier à cette lacune et aurait la capacité, avec peu de ressources supplémentaires, contribuer significativement à résoudre ce problème d'accessibilité à l'échelle provinciale. Les politiques de santé mentale au Québec et dans les autres provinces canadiennes doivent énoncer l'objectif d'améliorer l'accessibilité des services de santé mentale pour ces communautés afin que des fonds publiques soient dirigés vers la création permanente de ce type de ressource afin de combler ce besoin important dans notre système de santé. Les recherches futures sur le sujet doivent être prioritaires et inclurent une participation active des étudiants et des stagiaires en milieu clinique afin de permettre le transfert immédiat des nouvelles connaissances produites.

Appendix

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The Montreal Children's Hospital's Transcultural Child Psychiatry Clinic:
A Unique Clientele and Diversity of Clinical Interventions

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Introduction

The Transcultural Child Psychiatry Clinic at the Montreal Children's Hospital has a particular history that has contributed to its uniqueness. The clinic's present approach has been shaped through the process of its development, from the moment of its conception to its birth, and then through its ongoing redefinition as a result of the multiple encounters between patients and professionals that have occurred. This has resulted in a particular method of service provision for a unique clientele of immigrant and refugee children and adolescents.

Objectives

The goal of this paper is to describe the Transcultural Child Psychiatry Clinic's development, method of functioning, and clientele. A specific objective is to describe aspects of the clinic's method of functioning which are considered by its personnel to be necessary to meet its mandate: that of providing effective psychiatric services for a transcultural child psychiatry population. Specificities of the clinic's clientele in relation to their sociodemographic profile and their cultural and historical experiences will be described. Parallel to this, both clinical and philosophical aspects of the clinic's method of providing services will be detailed. A particular goal of this paper will be to examine the efficacy of the clinic's method of service provision for its clientele.

Method

The clinic's development and refinement of service provision for its clientele will be described. This will be based on an examination of all 239 cases referred to it from its inception in July 1996 until December 2000. Variables describing the clinic's clientele which will be examined include the age and gender of the referred patient and their country of origin, the reasons for referral as described by the referring source, and the referring source. Events experienced by the clinic's clientele considered to be specific to their premigratory and postmigratory histories will be documented. Variables describing the clinic's method of functioning will also be described. These include the nature and methods of treatment following referral. Finally, outcome, as judged by the clinic's therapists, will be examined. A quantitative analysis of the clinic's service provision will

be performed. Representative examples will be provided in order to illustrate the clinic's philosophical and clinical approaches.

Results

1. The Installation of the Transcultural Child Psychiatry Clinic at the Montreal Children's Hospital: the Development of a Service and Clientele

Like many Canadian cities, Montreal has a sizeable and growing community of children and adolescents who are migrants. In parallel, the city also has a well-defined and established network of health care and social services, including mental health care services, for its child and adolescent population.

The Montreal Children's Hospital is one of two pediatric tertiary care hospitals in Montreal that provide services to the city and its surrounding regions. An estimated one-third of the patients seen by the hospital speak French at home, one-third speak English, and the remaining third use other languages in their homes. In addition, the more than 2,000 hospital staff members come from over 45 ethnic groups and speak more than 50 languages and dialects.

The Department of Psychiatry at the Montreal Children's Hospital has a mandate to provide out-patient psychiatric services to English-speaking youth living in particular geographic regions, called "sectors" in the city of Montreal. In addition, the Department also provides emergency, inpatient and outpatient psychiatric services to Montreal Children's Hospital patients. The establishment of a Transcultural Child Psychiatry Clinic in the Department thus invited a creative tension as professionals attempted to define the mandate of this clinic, as well as its method of functioning.

Both administrative and economic barriers and facilitators contributed to practical aspects of the clinic's development. These facilitators and barriers were in turn linked to the capacity of the Montreal Children's Hospital and its Department of Psychiatry as institutions to welcome this new service and its clientele.

Some facilitators, particularly the hospital's culturally diverse staff and clientele and its Multiculturalism Programme, were already present, and these helped in the introduction of psychiatric services for a culturally diverse clientele. The hospital had established a Multiculturalism Programme in 1986. Among other initiatives, this programme had developed services aimed at staff education and development, community liaison, the collection of resource material, and the organization and training of a bank of linguistic and cultural interpreters readily accessible to hospital staff (Clarke H, 1993).

The idea of a Transcultural Child Psychiatry Clinic within the Department of Psychiatry needed time to find a place and to gain support. This support has been provided amply in terms of the allowance of the team to exist within the Hospital and Department. At the

same time, the service remains at the margins. In today's climate of budgetary compressions, it has not been possible to obtain funding for a new service, and economic barriers have presented a challenge to the clinic's functioning and development. Part of the clinic's continued existence has been due to the dedication of people who both formally and informally have leant support to the team. The team functions both as a formal institution, and also relies on social economy (fundraising).

2. Origins of the Requests for the Clinic's Services

An analysis of referral sources reveals that the clinic is responding to a diversity of requests from both within and outside the hospital (Table I). These requests originate largely from health, mental health and social service professionals working in the Montreal region, although some requests for services also originate in other areas of the province. These requests for referral represent a challenge to the existing provision of services along linguistic (French or English) and regional (address of patient) boundaries.

Table I: Sources of Referral of Patients to the Transcultural Child Psychiatry Clinic (July 1996 – December 2000)

Referral Source	Percent of Referrals
School or Community Social Worker or Psychologist	26.8
MCH Multicultural Health Clinic	21.3
Hospital Psychiatrist or Psychologist	15.5
Community Health & Social Services for Immigrants & Refugees	9.6
Family Physician or Pediatrician	8.7
Unknown	8.4
Family	5.4
Immigration Services or Lawyer	2.5
Other	1.7

The clientele were less likely to be self-referred, with only 5.4% self-referring, than to be referred by a helping professional already involved with the family (86.2%). The source of referral for 8.4% of the patients was unknown. Referrals were received from multiple sources. The largest source of referrals to the clinic from the community and the largest source of referrals to the clinic as a whole at 26.8% originated from social workers and psychologists working in schools and in the city's primary health care clinics. Another large source of referrals from the community at 9.6% were from health and social service providers within the community who have developed a particular expertise in providing services for newcomers. Immigration services and immigration lawyers in the community referred to a much lesser extent, at 1.7%.

The largest source of requests from within the hospital came from the hospital's Multicultural Health Clinic, with 21.3% of referrals originating from this clinic. This medical clinic has been established in order to respond to the needs of newly arrived children and adolescents in Montreal, defined by a length of stay in Montreal of less than two years.

Another important source of requests at 15.5% came from hospital mental health professionals, chiefly from child psychiatrists working on medical wards and in the emergency psychiatric service at the Montreal Children's Hospital, and also to a lesser extent from child psychiatrists working at other hospitals. Referrals from pediatricians and family physicians, at 8.7%, were largely derived from the community, with some originating from within the hospital.

3. From Referral to First Appointment and Beyond

As a response to the clinic's largely non self-referred patient base, a number of changes to the procedure of accessing services to the Transcultural Clinic have occurred. A related philosophical underpinning to this referral negotiation has been recognition of the power imbalance between the referral source and the patient and their family. As such, a request for services was elicited from the families themselves, in addition to their referral source. When patients were referred from hospital wards, efforts were made to meet these patients during their admission in order to negotiate follow-up. When patients were referred from outpatient departments of the hospital or from the wider community, the referral source was asked to request the family to call the team's secretary either themselves or through a hospital interpreter in order to begin the referral. This resulting contact initiated a complex process of negotiation between referral source, the referred patient's family or their elected representative, and the Transcultural Clinic.

An analysis of the rates of retention from the initial referral to the first appointment and beyond provides some information about this referral process. The largest rate of dropout in the clinic's services occurred prior to the patient and their family's first appointment. Of the 239 referrals, 37, or 15%, did not attend a first appointment as a result of not calling for an appointment after a consultation or referral from a referral source was received, or by canceling or not attending the first appointment. Once the family attended the first appointment, 74% remained in treatment until its completion or currently remain in treatment. Of those offered treatment who left treatment prior to its completion, 13% did not follow-up with treatment after it was offered, while 7% dropped out of treatment later in its course. Finally, 6% of patients left treatment involuntarily as a result of a refusal of their requests for asylum in Canada.

In summary, the largest source of dropout occurred at the initiation of the referral. Given that the overwhelming numbers of patients were not self-referred, this dropout likely represents a negotiation between patient and referring source as to the definition of the problem at hand and the appropriateness of the Transcultural Child Psychiatry Clinic as a means of addressing this problem. This dropout continued to a lesser extent after the first

appointment, where a further negotiation of fit likely occurred. Following this, retention in treatment was good, although treatment was uniquely and involuntarily interrupted for a minority of the clinic's patients by external sources: the refusal of their request for asylum in Canada.

4. The Clinic's Clientele

Who then, has been referred to the Transcultural Child Psychiatry Clinic? Over the past four years, 239 children and adolescents have been referred to the clinic. These youth have come from over 70 countries. Table II describes these countries by the top five ranks by percentage of referrals to the clinic.

Table II: Top Five Countries of Origin of Referrals to the Transcultural Child Psychiatry Clinic from July 1996 to December 2000

Rank	Percent	Country Of Origin
1	7.1	Algeria
		Zaire
2	6.7	Bangladesh
		Russia
3	3.8	Cree Nation, Canada
		Somalia
4	3.3	Pakistan
		Rwanda
5	2.9	Chile
		India
		Mexico
		Sri Lanka

Three points are noteworthy. First, the vast majority of patients who were referred to the service are recent newcomers to Quebec. Second, the vast majority of youth referred came from countries who have recently or are presently experiencing armed conflict. Third, the countries of origin of referred patients were diverse, with some sharing a closer proximity and others a more distant one to the heritages and values of the French and Anglo Saxon cultures in Quebec, upon which its health and social services (including psychiatric services) have been built.

The population of youth seen by the Clinic who are members of Quebec's Cree community differed in some ways to children referred from other countries. In contrast to the other youth seen by the clinic, this community's presence in Canada, like other

aboriginal communities, predates the colonization of Canada by European peoples. In common with the other countries of referral, the Cree community shares a position of being a member of a non-dominant culture in Quebec and has experienced and continues to experience cultural upheaval as a result of the power imbalance between the community and Quebec and Canada's dominant cultures.

A number of events occurred frequently in the histories of the clinic's clientele. First, over half of the clinic's population experienced family separation (56.1%) largely as a result of the family's experience of armed conflict and/or as a result of their migration process. Similarly, over half of the clinic, at 52.7%, experienced organized violence. Lastly, 6.7% of the clinic's population experienced a refusal of their request for asylum. These numbers are all likely to be underestimates, as information was generally lacking for the 15% of patients who were referred to the clinic who did not proceed to a first appointment.

Children from all age groups were referred to the clinic. The mean age of referred children was 10 years. In terms of the distribution of referrals by age group, an equal number of children aged 5 to 9 and 10 to 14 were referred, at 32.2% each, while 22.2% of referrals were for adolescents and 13.4% for children aged 4 and under. In terms of the gender of referred patients, just under two-thirds were males.

5. Reasons for Referral

A description of problems for which children were referred to the clinic was wide ranging. While some problems described by referring sources were similar to problems shared by children and youth referred for psychiatric services in general, some appeared specific to the clinic's clientele (Table III).

The three greatest numbers of referrals for boys were for externalizing and internalizing symptoms (29.8%), followed by internalizing symptoms (25.1%) and then externalizing symptoms (15.9%). Internalizing symptoms made up almost half of referrals for girls (48.9%) followed by internalizing and externalizing symptoms at 15.9% and then externalizing symptoms and psychosis, each at 6.8%. The variety of internalizing and externalizing symptoms were diverse. Questions for referral were formulated in terms of concerns about Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder and learning problems, as well as depression, suicidality and poor social adjustment manifested either by withdrawal or aggressive behaviour. A particular specificity of referral requests were concerns related to the evaluation of developmental delays and of medical symptoms, as well as referrals for the evaluation and treatment of psychotic symptoms and other symptoms with the concomitant use of traditional treatment modalities. Lastly, referrals from primary care providers were specific to this clinic's patient population, and concerned the patient or their family's experience of catastrophic events including genocide, whether or not the children were symptomatic.

Table III: Description of Problem Type (%) By Gender

Problem Type	Males	Females
Internalizing	25.1	48.9
Externalizing	15.9	6.8
Internalizing and Externalizing	29.8	15.9
Developmental Delay	9.3	5.7
Psychosis	2	8
History of Personal or Family Trauma Without Associated Symptoms	6.6	6.8
Attachment Problem	0.67	3.4
Medical Symptoms	5.2	2.3
Unknown	4.6	2.3
Other	0.67	0

6. The Therapeutic Encounter: Treatment Modalities and Outcome

While the above table describes the formulation of the patient's difficulties as presented by the referring source, a reformulation and questioning of the referred patient's experience occurs at the time of evaluation (Rousseau 1998; Measham 1998). This reformulation is a result of the therapeutic encounter between the treating team and the family, and is related in part to the specificity of the clinic's philosophical approach and method of functioning.

The Transcultural Child Psychiatry Clinic at the Montreal Children's Hospital has based its practice on a number of principles, including the process of decentering, the recognition of multiplicity, and the acknowledgement of the role of power relationships in the therapeutic encounter (Rousseau, 1998). The clinical result has been a reformulation of the therapeutic setting, both physically and symbolically, in a manner which invites a complementarity of knowledge systems in order to elicit a multiplicity of viewpoints concerning how a problem is perceived, understood, and responded to. Examples of these viewpoints include but are not limited to the individual, collective, professional, religious, traditional and socio-political. This is in keeping with George Devereux's conception of the principles of work with people from other cultures, where different views, in sequence, shed different rays of light and offer ways of treatment that are not mutually exclusive, but instead complementary (Devereux, 1985).

The treating team, which is multicultural and multidisciplinary, generally meets as a group with the patient and his family, as well as with an interpreter, who helps to

negotiate the space between family and team, both as cultural broker and translator. From this a number of treatment modalities are proposed.

The result is that treatment modalities were in some ways particular to this treatment setting. The treatments proposed were often multiple, with over a third of clientele being offered two or more treatment modalities. In addition, these modalities differed in some ways from classical psychiatric practice. Aspects of treatment considered more particular to the team were the proposals of treatment in both the symbolic and real space, a reformulation of the representation of the individual and collective space in treatment, and alterations in the process of treatment. While considered particular to the clinic's work, these modifications of treatment are not unique to the clinic, as they are to some extent shared by child psychiatry in general.

First, treatments were proposed in both the symbolic and the real space. This results from the treatment team's questioning of the principle of therapeutic neutrality. As the previous description of the clinic's clientele has demonstrated, the majority of the clinic's patients are in a position of power imbalance as members of non-dominant cultural groups in Quebec. Part of the referred children's path to well being was considered to involve their and their families possibility of securing a space of physical and psychological safety in order for the children to continue with their development. As such, one aspect of the team's treatment was to provide their services as mediators between the family and dominant society institutions. Treatment modalities proposed included the securing of daycare space for refugee applicant children who otherwise did not have access to this service, the provision of letters for asylum seeking hearings which described a child's experience of war trauma, and the negotiation of conceptions of what was in a child's best interests and who was considered the legitimate parental authority for children who were receiving services from host country authorities mandated to protect children considered to be at risk for abuse or neglect.

A second particularity of proposed treatments was a reformulation of psychiatric treatment modalities in terms of the representation of the individual and collective in the therapeutic process. Thus, dyadic psychotherapy was sometimes reconfigured as triadic therapy, where an interpreter or another team member was present and represented part of the negotiation of the therapeutic space between the values and traditions of the host country and the country of origin. In addition, recourse was made to collective in additional to individual means of understanding and addressing a particular person's difficulties.

Thirdly, the process of treatment was sometimes also altered. In particular, the therapeutic efficacy of the disclosure of horrific events was questioned. A balance between disclosure and nondisclosure as well as a recognition of the particular and sometimes differing needs for disclosure of different family members resulted in a redefinition of the therapeutic space. This led, for example, to multiple concurrent individual and subgroups of therapies for different family members (such as siblings or parents) as the team attempted to provide a containing and securing environment for the family as they negotiated their difficulties. It also led to incorporation of therapies that

differ in their emphasis on verbal activity, such as art therapy (Lacroix, 1998, Heusch, 1998). Finally, the role of traditional therapies was also invited into the therapeutic space.

Outcome at last patient contact as judged by therapists was rated as good, moderate, poor or unknown for patients who were seen at least once by the team, whether or not they had completed treatment. In general, outcome was rated as either good (40%) or moderate (24%). For 30% of the patients, outcome was judged as unknown and consisted largely of patients seen once in consultation or who did not follow-up, so that information to determine outcome was not available. Finally, outcome was judged as poor for 10% of the patients. In general, cases with poor outcome shared in common a burden of catastrophic stressors, with the additional component of a worsening of symptoms in the context of severe difficulties for the family and host country institutions in establishing a climate of trust and a shared vision of the child's best interests. In a number of these cases the team failed in their attempts to act as mediators between the family, their values and their culture of origin and the values of host country institutions.

A review of the cases referred to the clinic revealed that few treatments ended in a formal disengagement from therapy with a concomitant administrative "closure" of a file. In general, treatment and outcome were considered to be an ongoing and interlocking process, with the child's symptoms being strongly influenced by the resolution of ongoing stressors including the reunification of families and the accordance of asylum. The imposition of further stressors, including the rejection of requests for asylum, led to a new reworking of treatment as families attempted to cope with this event. Parallel to the process of treatment was the child and their family's reformation of social ties during the resettlement process. As such, while patients no longer actively received treatment when their problems resolved, they were assured continued access to services should future needs arise. This also occurred for children who reached the age of majority while in treatment, who traditionally would have been considered ineligible for treatment at a children's hospital. As a result of their ongoing tenuous circumstances, efforts were made to remain available to these families in consultation to the adult service providers to whom they were referred.

Discussion

A review of the past four years of experience of the Montreal Children's Hospital's Transcultural Child Psychiatry Service reveals a specificity related to the clinic's clientele and to its methods of functioning and treatment. The clinic, by allowing a place for difference, has necessarily challenged the existing premises of mental health care practice (Rousseau, 1998). As such, the inscription of the clinic into the mainstream of mental health and social service institutions has introduced a tension within these institutions, as it has provoked a questioning of how services are presently organized, to whom and how services should be offered, and who are best seen to act as service providers to youth who are members of Montreal's non dominant cultural communities.

Appendix

It is at this point that the team's presence provokes a paradox. While the Transcultural Child Psychiatry Clinic is situated within a tertiary care hospital and allowed to function beyond administrative and theoretical boundaries because of its superspecialization, the team's presence, philosophy and manner of function provokes a requestioning of this superspecialziation. Thus, part of the team's function has been its recognition of mainstream society's lack of knowledge of and of its failure to acknowledge and represent the knowledge, traditions and values of non dominant cultural communities within its institutions, whether formally or informally.

The clinic's position within a mainstream institution is proposed to be one that has the potential to be transformative. First, by its presence it hopes to provoke a transformation of institutions and methods of practice so that they better reflect present cultural and social realities. Secondly, by questioning hierarchies of knowledge and the construction of knowledge, the team hopes to question mainstream society's present medicalization of suffering, which has confined suffering within the categories of disease and disorder and which has resulted in an overemphasis of individual aspects of suffering with a neglect of its collective aspects. (Kleinman, Das & Lock, 1997).

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