

# Immigrants and Mental Health Services: Increasing Collaboration with Other Service Providers

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## ABSTRACT

**Introduction:** This article examines the potential modifications of care indicated to engage migrant and refugee families in making use of needed mental health services for their children in Canada and the role psychiatrists can play in this process. **Method:** The clinical and consultative role of the members of the Transcultural Child Psychiatry Service at the Montreal Children's Hospital is used as a model. This model has been useful in engaging both migrant families and local front line service providers to work with each other in a collaborative manner. **Results:** Important aspects to be considered in these cases are: Modifications in obtaining access to care; Issues of communication (i.e., the use of interpreters); Addressing cultural differences in understanding and responding to a child's difficulties; recognizing the plasticity of culture; Collaboration with colleagues in hospitals and with professionals in the community. **Conclusions:** New models of care, involving increased collaboration between professionals, need to be devised to facilitate the mental health care of immigrant and refugee children and their families.

**Key words:** immigrant, refugee, children's mental health care, modifications of services, role of child psychiatrists

## RÉSUMÉ

**Introduction:** Cet article analyse les modifications à apporter aux soins pour encourager les familles d'immigrants et de réfugiés à avoir recours aux services de santé mentale pour leurs enfants, et explique le rôle du psychiatre dans cette démarche. **Méthode:** Le rôle consultatif et clinique des membres du Service de pédopsychiatrie transculturelle de l'Hôpital de Montréal pour enfants est le modèle qui a servi à encourager les familles d'immigrants et les services de première ligne à collaborer. **Résultats:** À l'heure actuelle il convient de modifier l'accès aux soins; d'améliorer la communication (ex.: recours à un interprète); de tenir compte des différences culturelles dans la compréhension du problème de l'enfant et dans la réponse apportée; de reconnaître la plasticité de la culture; de collaborer avec les collègues des hôpitaux et les professionnels de la communauté. **Conclusion:** De nouveaux modèles de soins, impliquant une collaboration accrue entre professionnels, doivent être élaborés pour renforcer les soins de santé mentale aux enfants immigrants et réfugiés, et à leurs familles.

**Mots clés:** immigrant, réfugié, soins de santé mentale, modification des services, rôle du pédopsychiatre

## INTRODUCTION

Immigrant children and youth use different pathways to make their initial contact with mental health services. Family doctors, pediatricians, social workers and schoolteachers are the most common sources of referral to mental health services for these populations (Measham et al, 2001). This means that these first line providers have a privileged and essential position in recognizing psychological difficulties, and potentially deciding on needed interventions. Considering the scarcity of mental health resources for children, it is useful to elaborate the role first line service providers and child mental health professionals have in working with migrant families, and outline mental health problems that are best addressed in a collaborative way. This article is based on clinical work done in Montreal, both within a tertiary care hospital and in community settings. We will first review some common aspects of working with migrants in different health service milieus, and then address specific situations where psychiatrists may be asked to collaborate.

## WORKING WITH MIGRANT FAMILIES

### 1. Access to care

There is good evidence that new migrants and refugees do not readily seek consultations on their own (Murphy & al, 2002; Measham & al, 2001) and utilize conventional mental health care services less than majority culture youth. When referred

by others, they are also less likely to attend follow-up sessions after the first appointment (Pepler & Lessa, 1993; Roberts & Cawthorpe, 1995). Beiser (1988) has pointed out how the host country institutions need to adapt their services to reach migrant families. The quality of the initial experience in the health system will be crucial for these families to engage them in a therapeutic process. Furthermore, many of these families have faced organized violence prior to immigration (Rousseau & Drapeau, 2002), and mistrust or social isolation may be a seemingly useful survival strategy. A sensitive discussion of fears and issues of confidentiality in the context of the host country may help them feel more comfortable to use health services.

### 2. Interpreters

Interpreters play a key role in the understanding of a clinical situation within a mental health service (Singh & al., 1999; Jalbert, 1998). This is also true in pediatric or medical settings (Jacobs, 2004). Apart from making communication potentially possible at all, interpreters allow families to express themselves in their mother tongue, which may facilitate the discussion of delicate issues, even when immigrants are fluent in an official language of the host country. The interpreter may then also take the role of a cultural broker and help transmit knowledge about a particular cultural aspect in the clinical encounter (Jalbert, 1998).

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Interpretation may also have a crucial role in preventing misunderstandings that may be at the root of misrepresenting a family, either by not being aware of its struggles, or by being blind to available strengths:

S's parents had come from Pakistan before she was born with major developmental difficulties. The medical team felt the parents were intellectually challenged or suffering from other mental health difficulties because they seemed not to follow medical suggestions. As they had difficulty trusting the family, the team also felt unease about the parent's plan to have an aunt come from Pakistan to help them. With the interpreter it became clear that the family was in fact taking rather good care of the child though feeling fatigued. The team was reassured about the parents' mental state. It was also revealed that the mother was very sad not to be able to properly pray for her daughter as she felt prayers were the most important stimulus for her child's progress. The presence of another woman of the family would permit her to have time to respect her prayer duties. The medical team, reassured by this information, was then pleased to write a letter supporting the aunt's request of a visiting visa to Canada.

It is often important to encourage the use of interpreters in medical settings, especially in places where their benefit has not yet been established. Constraints of time and money and lack of hospital policies to encourage their use have often made this a difficult task, though recent literature has shown interpreter services to be financially viable (Jacobs, 2004). The use of untrained interpreters or of family members may be proper in instances of casual information sharing, but has also been described as disadvantageous and even problematic (Flores & al, 2003). In particular, established family dynamics may be compromised by prescribing a role of authority for children towards more senior members of the family.

In some cases families refuse the presence of an interpreter and the family's reasons for this refusal need to be explored. Sometimes after discussing issues of privacy or of their will to communicate in the country's majority languages, a collaborative effort to find an acceptable interpreter for all parties will be possible.

### **3. Addressing differences**

Initial contacts with the culture of western biomedicine may force newly arrived families to take up the challenge of making sense of their new environment. Contacts with migrant families will also bring clinicians in contact with the different ways migrant parents may understand and respond to a child's difficulties. Thus clinicians and migrants may both experience a sense of "otherness". These differences ought to be recognized to establish a working alliance, although Murphy (1987) also pointed out the challenging aspect of meeting immigrants:

"The immigrants foreignness can be felt unconsciously as a threat that provokes rejection despite a conscious desire to help. This is because attempting to identify with such foreignness often leads to a questioning of one's own most elementary beliefs, and this questioning can create an anxiety-arousing insecurity." (p.84)

Western scientifically based expertise needs to welcome other forms of knowledge brought by immigrant families, often

presented in the form of tradition centered knowledge and techniques. In particular, models of child development vary considerably around the world and are loaded with cultural expectancies, well illustrated by the diversity around feeding a child or family sleeping arrangements.

A recent survey of general practitioners' opinions in London, England, noted that refugees should be helped by members of their own culture (Murphy et al, 2002). Ethnic matching is a complicated issue since meeting a professional from one's own community may bring advantages but will not always meet the expectation of the patient. Proximity between the professional and the community of the patient means shared cultural, social and historical knowledge that may favor a more thorough understanding of the family's situation, and may also mean more comfort for the family when identifying culturally with the professional. However, in some instances families will look for a certain distance from their community either because of discomfort with some aspect of their cultural background or because of the socio-political context of the country of origin (Moro, 1988), and fear of stigmatization. It may also be difficult to ensure confidentiality in small communities, as it may be impossible to maintain anonymity.

## **4. Considering context and plasticity of culture**

Mental health care needs of migrant children and youth require special attention (Rousseau, 1995; Beiser & al., 1995), as their needs are influenced by context and shaped by their culture. Deciphering cultural and contextual influences implies learning about pre-migratory, migratory and post-migratory contextual issues such as past trauma, family separation and reunification during migration, as well as host country institutions' policies towards migrants or financial difficulties (Crockett, 2005). It also implies getting a sense of how much a migrant family is rooted in its culture of origin. Migrant families have been described as being in between cultures because of their migration (Bhabha, 1994). Thus, families should not be denied their cultural specificities nor should they be trapped in a stereotyped cultural representation, as culture needs to be defined contextually (Bibeau, 1997).

Some medical departments have become knowledgeable about the reality of refugees and immigrants in Canada and developed good working relationships with community services for migrants. Other outpatient departments have less knowledge and will need to learn about the many challenges new immigrants and refugees have to face when they first meet Canadians.

## **SPECIFICITIES OF DIFFERENT SETTINGS**

### **1. Collaborating in a medical setting**

The suffering body is often at the forefront of a family's health concerns and may serve as an entryway into the mental health field. Together with our medical colleagues we need to understand how difficulties may be expressed through physical symptoms, and decide which complaints should be dealt with by purely medical disciplines and which may need to be understood through the lens of emotional difficulties where culture plays a role in the presenting symptomatology (Mrazek, 2002). Migrant children and adolescents may be particularly prone to show bodily symptoms when they or members of their family have

been physically harmed by organized violence (Viñar & Viñar, 1989). Torture victims may display symptoms associated with the experience of physical injury. Also, when the body has been a source of suffering, traumatic memories may take the form of physical symptoms. Rousseau (2002) talks about a “psyche and body scar” brought about by traumatic experiences. When a true medical illness follows such an experience, the traumatic and medical issues may be symbolically linked in such a way that neither can be treated without exploring the other. On occasion it may therefore be indicated to propose a joint meeting of medical and psychiatric staff with the family where the issues can be linked by the mere presence of both types of professionals, and the complexity of the symptoms can be discussed together.

M. was kidnapped during his childhood while still in Bangladesh. He was diagnosed with epilepsy not long after. The family came to Canada seeking refugee status to protect M. But they were afraid he could have a seizure if alone on the street thus kept him mostly inside the house. Their fear seemed to be linked to both post-traumatic and medical issues.

A child’s developmental delay is a particular challenge for medical professionals if the child’s family has faced organized violence. In this situation, one has to decide to what extent constitutional or nutritional factors are the cause of the delay, in particular when it led to a stay in a refugee camp where feeding and security were less than optimal (Crockett, 2005). Similar challenges occur when hallucination-like symptoms are present which may be expressed rather frequently in some cultural contexts (Jenkins, 1998; Johns & al, 2002), and may cause unfamiliar practitioners to diagnose a psychotic illness although the symptom may be better understood as depressive, dissociative or even a non-pathological and socially valued expression of distress.

When a child is hospitalized the family is most directly forced to deal with “our” health care system and its associated customs, ranging from expected clothing, eating habits, social rules and care of children, to general ways of communicating. The role and behaviour a hospital expects from parents may feel unnatural, especially for families coming from environments where a collective way of intervening is highly valued (Nikapota, 2002). Hospitalization imposes proximity with the host society and thus a greater experience of otherness.

F. is a four years old girl from China. When she developed a viral encephalopathy, psychiatry was consulted for a delirium state. The medical team was surprised how long the parents would tolerate agitation in their child before asking for PRN medication. More detailed observation revealed that during periods of agitation the parents were actively massaging the feet of their child to stimulate energy points to manage the agitation. They therefore provided a familiar form of therapy as they felt uncomfortable with the prescribed “novel” anti-psychotic treatment.

## **2. Collaborating with social services and community groups**

Case discussion seminars with professionals at the community level have been put in place in Montreal’s social and health community centers. Here first line workers are invited

to participate in exchanging knowledge around clinical cases where issues particular to migrant and ethno-cultural minority families are brought for discussion (Rousseau & al, 2005). The goal of these meetings is to provide a supportive consultation framework for consultees with challenging cases.

We have also started direct and indirect consultations to youth protection services and the above-mentioned centers where both medical and non-medical professionals are present. Consultations often involve discussions about whether a parent or a youth has a psychiatric illness, whether a parent is able to care for a child or on how best to deal with a youngster’s behavioral difficulties. In cases of migrant or refugee families, discussions often help to integrate elements around the dynamic of the family or its socio-cultural background and clarify issues pertaining to the presence or absence of a medical or psychiatric condition.

A 15 year old youth who had a traumatic birth with a long stay in hospital and subsequently had experienced a complex migration route, passing through five countries before coming to Canada, was now in a group home and seen as a delinquent adolescent. The discussion pointed to the need to rule out a frontal lobe syndrome and understand the destabilizing aspect of the complex migration which left the youngster with difficulties behaving socially if not structured by the presence of strong rules.

## **CONCLUSION: SHARING ROLES IN CARING FOR MENTAL HEALTH ISSUES**

Migrant families may face culturally universal mental health challenges where general psychiatric clinics or general practitioners are very effective caregivers. At other times a more specialized treatment will be required when contextual issues specific to migrant and refugee realities and/or cultural issues are at the forefront (Nadeau & Measham, in press). But overall, enhanced collaboration between psychiatry and first line service providers can avoid fragmentation of the care.

It is thus important to devise a model of care and consultations that incorporate a continuous sharing of knowledge, expertise, support and training which in turn allow for an optimal use of diverse levels of care, both first line and specialized. This model would allow the common management of specific clinical situations for first line professionals and mental health specialists and provide a supportive consultation framework between these two professional groups where treatment decision can be jointly reached. Within the model, issues such as access to care, need for interpreters, and experience of “otherness” can be addressed.

As shown in this paper, such a model of care is needed to adequately take up the challenge of welcoming ethnically diverse populations to Canada and provide them an environment where their children can grow up and develop with the best possible opportunities.

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