MODULE 7

• MENTAL HEALTH ISSUES

CONTENTS

MENTAL HEALTH ISSUES

OBJECTIVES OF THIS MODULE

The activities in this module are designed to:

1. Increase participants' awareness of cross-cultural differences in the definition of mental health.

2. Improve participants' ability to detect behavioural signs that a client is in need of in-depth counselling, and increase their sensitivity to cross-cultural factors that may interfere with this assessment.

3. Increase participants' understanding of the factors affecting the mental health of immigrants.

4. Improve participants' ability to distinguish between clients' settlement problems and serious mental health issues, and to explore the overlap.

5. Expand participants' knowledge of the mental health delivery system in the local area, including referral routes for clients.

6. Increase participants' awareness of systemic barriers which may impede the effective delivery of mental health services to immigrants.

ACTIVITY 7.1

DEFINING MENTAL HEALTH

PURPOSE OF THE ACTMVITY

In this activity participants explore cultural differences in perceptions of mental health.

TIME REQUIRED: 1/2 hour.

SUPPLIES NEEDED: Flipchart and marker.

SUGGESTED PROCESS:

1. The trainer leads the group in a brainstorming session about the term "mental health". Participants call out short words and phrases which the trainer records on flipchart.
2. Participants are asked to share with the group what this term implies in their cultures. The group discusses how cross-cultural differences in perceptions of mental health affects the delivery of service to their clients.

RELATED READINGS AND RESOURCES

"The Chinese perception of mental illness in the Canadian mosaic" by Ruth N. F. Lee, in Canada's Mental Health, December 1986.

"The mental health problems of the Vietnamese in Calgary: major aspects and implications for service", by Tung Ngoc Pham, in Canada's Mental Health, December, 1986.

"Ethnocultural issues: the delivery of mental health services" by Bach-Tuyet Dang, in Montage, Clarke Institute of Psychiatry, Vol. 10, No. 1, December 1984.

- All three of these articles deal with perceptions of mental health amongst Chinese and Vietnamese people and serve as a useful contrast to traditional Western assumptions on the subject.

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* This activity was developed by Vanita Sabharwal

RESPONSES FROM CSISW PARTICIPANTS TO ACTIVITY 7.1

The following words and phrases came from participants in the brainstorming session on the meaning of the term "mental health" :

- psychological problems
- adjustment problems
- change
- social problems
- illness
- psychiatry
- broken
- mental disorder
- helpless
- psychological balance
- state of mind
- combination of problems
- sanity
- personality
- functional
- misunderstood

The trainer in this activity responded to the ideas generated by participants with his view of mental health, which is provided below:

- mental health is a continuum of development
- people are always developing along this continuum throughout their lives; as their environment, their genetic makeup etc changes, their position on the continuum changes
- all of us are somewhere along this interesting line
- we as counsellors need to assess where the person is on the continuum of development; we cannot judge where the person is until we know who the person is, their history, the circumstances affecting them - otherwise we may label the clients incorrectly
- depending where you are on the continuum - your family may be able to help, a priest could help, or you might need professional help

notes by Perry Romberg

ACTIVITY 7.2

RECOGNIZING SIGNS OF MENTAL HEALTH PROBLEMS

PURPOSE OF THE ACTIVITY

In this activity, participants begin to look at clients who have emotional and psychological needs that may go beyond the settlement counsellor's skills or mandate. They consider behavioural signs that a client is in trouble, and discuss the difficulties of assessing behaviour across cultures.

TIME REQUIRED: **1 hour.**

SUPPLIES NEEDED: **Flipchart and markers.**

SUGGESTED PROCESS:

1. In groups of three to five, participants list the behavioural signs (what they see the client do or hear the client say) that indicate that the client is in trouble - and has mental health needs that go beyond their skills and mandate as settlement counsellors. Each group records their response on flipchart paper.

2. A reporter from each group posts and explains the group's results.

3. Participants consider whether any of the behaviours listed by the groups could be considered normal in certain cultures, and not indicative of a serious problem.

4. The trainer debriefs the activity.

RESPONSES FROM CSISW PARTICIPANTS TO ACTIVITY 7.2

Participants identified the following behaviours as signs that a client has a serious mental health problem.

See:

- staring intently without speaking
- avoiding eye contact
- wild gaze
- eyes open wide - fixed
- strange body position
- pulling back, withdrawing, crossing arms over chest
- smiling without relevance to the conversation
- wearing inappropriate clothing for the season - eg heavy clothes in summer
- wearing strange uncoordinated clothing
- beating table, stamping feet
- hitting walls, throwing things
- opening and closing doors for no reason
- sudden, uncontrolled outbreaks of emotion for prolonged period
- masturbating

Hear:

- slurred speech
- whispering without reason
- talking to themselves
- abrupt changes in speech - e.g. suddenly stop speaking
- raising their voice
- incoherent speech
- numerous contradictions
- saying they want to kill themselves
- saying someone wants to kill them or is following them
- saying they cannot keep a job, or personal relationships
- repeating their problem continually
- loss of memory
- saying they are afraid to go places unaccompanied

After generating this list, participants discussed the fact that many of these items, such as the first nine items in the first list above, are behaviours that are acceptable in some cultures and therefore could reflect culturally biased assumptions on the part of the counsellor who assumes that they are signs of mental health problems.

ACTIVITY 7.3

IMMIGRANTS AND MENTAL HEALTH

PURPOSE OF THE ACTIVITY

In this activity, participants discuss the factors that impact on the mental health of immigrants, and groups of immigrants that may be particularly at risk. A reading activity supports the discussion.

TIME REQUIRED: 1 hour.

SUPPLIES NEEDED:

Handout 7.3: Reading: After the Door has been Opened: Mental Health Issues Affecting Immigrants and Refugees in Canada
Handout 7.3.1: Immigrants And Mental Health: Questions For Discussion;
Flipchart and markers.

SUGGESTED PROCESS:

1. Participants break into groups of four to five people and discuss the questions on Handout 7.3.1. Each group records their ideas on flipchart paper.

2. A reporter from each group posts the results and gives highlights from the group's discussion.

3. The trainer highlights the main themes and issues.

4. The group is given the reading summarized above to read for the follow-up session.

5. At the next session, the trainer asks the group for general feedback on the reading, and then invites participants to comment on how what they have read relates to the responses from the small group discussion at the beginning of this activity. (Flipcharts can be posted again for comparison, if desired.)

AFTER THE DOOR HAS BEEN OPENED: MENTAL HEALTH ISSUES AFFECTING IMMIGRANTS AND REFUGEES IN CANADA

After the Door has been Opened: Mental Health Issues Affecting Immigrants and Refugees in Canada, Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, Health and Welfare Canada, 1988, Part IV - Special Needs.

SUMMARY OF THE READING:

Part IV of this resource, which is based on findings from submissions and public hearings across the country, documents the special needs of four groups of immigrants:

Chapter 9	Children and Youth
Chapter 10	Women
Chapter 11	Seniors
Chapter 12	Victims of Catastrophic Stress [includes natural disasters, warfare, torture]

These groups were selected for a special focus because 1) they are at higher risk of developing mental health difficulties due to their pre-migration experiences and their resettlement situation and 2) because they lack socio-political power, and therefore are less likely to have their needs addressed. For each group, sources of stress are described and existing public policies and programs to meet the needs of each group are evaluated.

RELATED READINGS AND RESOURCES

1. After the Door has been Opened (details above)

- Participants should be encouraged to read as much of this report as possible, as it is a comprehensive overview, based on extensive input from various community groups in Canada, of the issues related to immigrant mental health and steps that need to be taken to better meet their needs. There is also a companion volume, titled "Review of the Literature on Migrant Mental Health", which is a review and summary of over 1000 publications and unpublished reports.

2. "A model of psychological adaptation to migration and resettlement" by Karen J. Aroian, Nursing Research, January/February 1990, Vol. 39, No. 1, 5 - 9.

- This article reports on a study of 25 Polish immigrants living in the United States for periods of time ranging from four months to 39 years. The findings of the study indicate that psychological adaptation for immigrants is a dual task involving 1) resolving grief over losses and disruption connected with leaving their country and 2) mastering resettlement conditions associated with novelty, occupation, language and subordination.

IMMIGRANTS AND MENTAL HEALTH: QUESTIONS FOR DISCUSSION

INSTRUCTIONS:

In your small group respond to the following questions:

1. What are the key factors that have an impact on the mental health of immigrants?

2. What groups of immigrants do you feel are particularly at risk? Why?

3. What conditions in society would enhance the positive mental health of immigrants and help prevent serious mental health problems?

ACTIVITY 7.4

CASE STUDIES

PURPOSE OF THE ACTIVITY

Part of the task of settlement counsellors in helping clients with mental health problems is to assess how much they can do for the client within their skills and mandate, and whether in certain cases they should refer the person elsewhere for more in-depth counselling (if appropriate services are available). This activity gives participants practice in distinguishing between clients' settlement problems and serious mental health problems; they also discuss the best routes for referral.

TIME REQUIRED: 1 1/2 hours.

SUPPLIES NEEDED: Handout 7.4: Case Studies A To D;
Handout 7.4.1: Case Studies: Questions For Discussion

SUGGESTED PROCESS:

1. Participants divide into groups of four to five people. Each group is given a different case from Handout 7.4 and the questions for discussion in Handout 7.4.1. (Alternatively, the trainer may choose to select one or two cases for all groups to work on.)

2. The large group reconvenes, and a reporter from each group summarizes the group's assessment and plan of action for the case.

3. The large group is given the opportunity to comment on the reports.

4. As a wrap-up for this session, participants are asked to comment on how these cases would be viewed and handled in their cultures.

CASE STUDIES

CASE STUDY A

In June 1987, a young man came to Toronto from Thailand. He was placed at a hotel in downtown Toronto. He did not know anything about the town. He could not speak English. There was nobody who could speak his language at the hotel. He was so lonely and disappointed. About two months later he suffered from mental health sickness.

One day a policeman escorted him to my office and left him there. The policeman told me that the man was lost. The policeman could not communicate with him, but he found his landed immigrant papers, which is why he knew that the man was Laotian. Therefore he escorted him to my office.

After the policeman left my office, I tried to question the man. He did not answer me. He only smiled and looked at me strangely. In the end, he told me that he was hungry; he had no food or money. He lost all of his documents. One thing that he kept saying and asking me was to send him back to Laos.

I tried to comfort him and encourage him to think about his future. A few minutes later, he started to say many things that did not make any sense.

I called my co-counsellor to come over and listen to what he was saying. Nobody understood him. Then he started to laugh and walk in and out of my office. I did not know what to do with him...

by a CSISW participant

CASE STUDY B

Mrs. S. came to Toronto four years ago. All of her 5 children and her husband were killed in Cambodia during the terrible time of the Pol Pot regime. She is about 54 years old.

One day she called me and asked if I could escort her to an eye clinic which is on Dundas Street. I asked her about the date and the time that she was supposed to see the doctor. She gave me the date and I promised I would escort her to that clinic.

From that point on, she started to tell me about her relatives who were living here in Toronto but she couldn't rely on. She complained that people were changing. They looked down on

her. They treated her differently. She said sometimes her niece had tried to burn letters that were sent to her. She said she wouldn't have come to this country if she had known things would turn out that way. She wanted to go back to Cambodia. She cried.

And then she asked me if I could get her some medicine to correct her stomach upset. She said her family doctor was not good because the medicine he prescribed did not do her illness any good. She complained strongly about her loss of appetite. She couldn't eat meat. And then she returned to her eye problem. She said sometimes her vision was completely blurred and then it turned to red/yellow and at certain times she couldn't see a thing.

The day of the appointment came. I called her at home and one of her relatives said that she had been gone since 8:00 that morning. I then rushed to the clinic. It was about 1:30 pm. Her appointment with the doctor was scheduled at 2:00 pm. There I was told by the nurse that the woman had been there since 10:00 that morning. She said Mrs. S. wouldn't talk to anybody, but just sat in the waiting room...

by a CSISW participant

CASE STUDY C

The client was a 26-year-old male from Ethiopia, who had been in Canada for about eight months. He had initially arrived in Montreal and about three months later had come to Toronto. He was somewhat timid and quiet at the start of his counselling but later became less reserved.

He had been referred by his English as a Second Language instructor. He had written a letter to this teacher outlining his dissatisfaction with his own inability to learn English. He stated that if he was unable to learn English, he would end his life.

While speaking to the client, I learned that he had set a time limit for himself to learn English fluently and had been unable to meet that limit. Also, he had a family in Ethiopia whom he felt he should continue to support. This meant that he was working seven days a week and studying English four evenings per week.

His most serious concern was that he had started talking to himself out loud. He had been unaware of this until one of his roommates had pointed it out to him. He was upset as it was something he could not control.

While I realized that my client had difficulty speaking due to a stuttering problem, I was unsure about what caused him to, at times unknowingly, speak aloud.

by a CSISW participant

CASE STUDY D

Ayesha came to Canada two years ago as a refugee, accompanied by her two children, ages 2 and 4 years. She was accepted as a refugee based on gender persecution. Her husband was severely abusive to her in her country of origin and when she went to the police station to report she was raped by the police.

She has panic attacks and these have become more frequent. She hardly eats now and the smell of food repels her. She fears to go out alone and will no longer take the subway.

Recently, Ayesha walked into a medical clinic for help. At this time she asked the doctor for a letter so she could get daycare for her children. After she described her condition, the doctor alerted Children's Aid Society, and the children are now in a foster home.

Ayesha is frightened. She does not want to lose her children, but she also feels helpless to care for them at present.

by Tamem McCallum

CASE STUDIES: QUESTIONS FOR DISCUSSION

INSTRUCTIONS:

Discuss the following four questions for the case you have been given.

1. What do you see as the mental health issues in this case? What are the settlement issues? To what degree do they overlap?

2. What could you do <u>within</u> your mandate and skills as a settlement counsellor for this person? (There may be more than one response in your group.)

3. For the part of this person's problem that falls outside your skills or mandate <u>to whom</u> and <u>how</u> would you make a referral?

4. What follow-up strategies would you use in this case?

ACTIVITY 7.5

MENTAL HEALTH SERVICES: SYSTEMIC BARRIERS*

PURPOSE OF THE ACTIVITY

In this activity, participants review the system of delivery of mental health services in their area, and then discuss systemic barriers which impede the effect delivery of these services to immigrants. They share strategies that they have developed to help overcome these barriers.

TIME REQUIRED: 1 1/2 hours.

SUPPLIES NEEDED: Handout 7.5: Sample Mental Health Services*; Handout 7.5.1: Systemic Barriers: Questions For Discussion

SUGGESTED PROCESS:

1. Handout 7.5, which is a partial listing of mental health services in the Toronto area, is distributed and discussed. The trainer provides clarification if necessary, to make sure everyone is aware of the nature of the services available.

2. Participants divide into groups of four to five people and discuss the questions on Handout 7.5.1 related to barriers to service for immigrants.

3. A reporter from each group summarizes what was discussed.

4. The trainer reviews key themes and issues in this discussion.

* This handout was prepared for use with counsellors in the Toronto area. Trainers working in other areas will likely want to modify this chart or prepare their own to reflect the local realities.

RELATED READINGS AND RESOURCES

After the Door has been Opened: Mental Health Issues Affecting Immigrants and Refugees in Canada, Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, Health and Welfare Canada, 1988.

- Part III of this report addresses concerns about mental health care, staffing and training and suggests ways in which treatment can be made more sensitive to the needs of immigrants and refugees.

"The politics of counselling" by Derald W. Sue, in Counselling the Culturally Different, New York, John Wiley & Sons, 1981.

- In this chapter, Sue disputes the assumption that the principles and practice of counselling are morally, ethically and politically neutral, and shows this thinking has resulted in the perpetuation of the view that minorities are inherently pathological and of racist practices in counselling.

"Culturally selective perceptions in child welfare decisions", by Reginald T. Dumont, in Social Work Perspectives, Winter/Hiver 1988, Vol. 56, No. 4.

- In this article, the results of a field study in Alberta, Canada showed that non-native social counsellors unwittingly projected their own cultural biases when observing and making decisions about native children and their families.

MENTAL HEALTH SERVICES IN THE TORONTO AREA*

Among the diverse ethnoracial communities of Canada, including Metro Toronto, two factors have been identified repeatedly as elevating vulnerability to mental health problems. These include the experience of belonging to a racial minority and the experience of migration. While the experience of moving from one country and culture to settle in another is stressful, migration itself does not threaten mental health. *After the Door Has Been Opened* (Canadian Task Force, 1998) identifies a number of contingencies which elevate risk. These include negative public attitudes; failure to find suitable employment; inability to speak English or French; separation from family and friends; traumatic experience or prolonged stress prior to migration; and adolescent or senior age at the time of migration. Women from traditional cultures are also more likely to experience difficulties.

The existing mental health system does not serve all members of our pluralistic society equitably. The key requirements of a mental health system that can respond more effectively to the needs of our richly diverse ethnoracial population are:

1. It must integrate culturally and racially sensitive care and equity of access into all components of the system.
2. There needs to be a continuum of services based on a plurality of needs in the community. Mainstream organizations (both mental health and general community) and ethnoracial community agencies have equally important roles to play in the continuum.
3. Racism is a major contributor to mental health problems, as well as a barrier to accessing and benefiting from mental health services and supports. Initiatives to eliminate racism must be given the highest priority.
4. Access to mental health care in their first language.
5. Increase the pool of available mental health professionals from ethnoracial communities.

Currently, **Across Boundaries** (**Phone:** (416) 787- 3007) is the only ethnoracial mental heath centre in Toronto. However, many of the other settlement agencies general and family counselling. For clients in crisis, **Gerstein Centre** offers a 24-hour crisis service (**Phone:** (**416**) **929-5200**) for people who have been involved in the mental health system and going through a hard time.

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* Adapted from *" Improving Mental Health Supports for Diverse Ethnoracial Communities in Metro Toronto: Background Paper".* 1992. Toronto: Metro Toronto District Health Council, Mental Health Program Services.

SYSTEMIC BARRIERS: QUESTIONS FOR DISCUSSION

INSTRUCTIONS:

Discuss the following questions in your group.

1. In your experience, what systemic barriers are faced by immigrants who need to access the system of mental health services in your area?

2. Have you, in linking your clients to the agencies and individuals delivering mental health services, found any strategies that help overcome these barriers?

3. What changes in the system of delivering mental health services would you advocate?