

a day in the life of Hadia Baassiri with case study...



Hadia Baassiri
Cultural Clinical
Consultant
Department of
Psychological
Medicine

The Children's
Hospital at
Westmead

Hadia Baassiri has been the Cultural Clinical Consultant at the Department of Psychological Medicine at Children's Hospital at Westmead for 6 years. This position has been a partnership project position with the Centre of Transcultural Mental Health. This article is based on a presentation by Hadia, David Dossetor and Lesley Whatson at the TheMHS Conference (The Mental Health Services) in Sydney in September 2010 describing her role working with families with a child with intellectual disability. Visit www.themhs.org

The developmental psychiatry clinic is a cross agency multidisciplinary conjoint

clinic which runs in partnership between the Developmental Psychiatry team at the Children's Hospital at Westmead, the Statewide Behaviour Intervention Service of ADHC and more recently the Principal Psychologist of DET. This clinic consists of a child psychiatrist/s, clinical psychologist/s, OT, Speech therapist, pharmacist, Principle Psychologist (DET), Special educator, paediatric registrar and Cultural clinical consultant. The clinic consults to the referring paediatrician, the involved Disability team, representatives from the school and other involved services as well as to the child and family. Cases referred to this clinic have complex behaviour, developmental and mental health problems in their context. During the last five years, 45% of cases were from culturally and linguistically diverse backgrounds (CALDB). This over representation of CALDB in this tertiary clinic suggests that as a group they may have greater difficulty accessing services for their children with intellectual disability and mental health problems. This view was also expressed by school counsellors in the CHW School-link needs analysis.

Review of these cases suggest that the problems encountered by CALDB are sometimes directly related to cultural diversity issues such as: language barriers, cultural perspective about intellectual disability or mental health, lack of advocacy within schools and other services and lack of knowledge of existing services. Parenting style is not specific to any culture, but cultural differences often

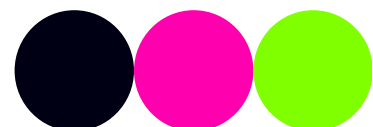
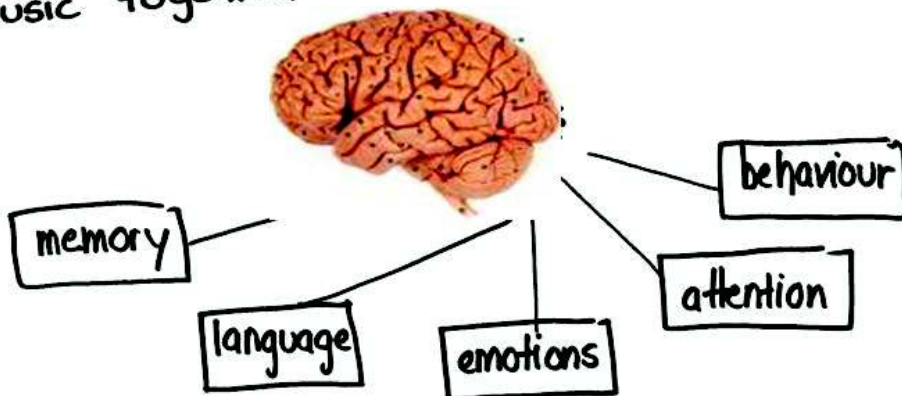
lead to greater inflexibility in understanding the influence of parenting style on childhood development and behaviour such as autocratic/harsh parenting or excessively permissive/enmeshed, indulgent parenting. A regular problem is unrealistic expectations, for example parents wanting children to achieve in maths/reading when they lack basic independence and self care skills as might be expected from a child of a developmental age of 2-3 years old. Sometimes there is a failure to implement strategies recommended or problems with limit setting. Sometimes there is excessive expectation that medication will cure problems. Other factors can add to the burden on families managing their children with intellectual disability and challenging clinicians' expertise. For example, the roles and expectations within the family system in some cultures, cultural experiences of those families prior and after settlement need to be understood to reach CALDB families and help them to understand, implement and comply with treatment. Sometimes this can contribute to relationship stress or mental health problems in other family members.

My role as a cultural clinical consultant is to provide cultural consultancy and reflective clinical practice around culturally based issues prior and during the assessment and intervention process. This includes culturally appropriate assessment, formulation, referral to culturally appropriate services if necessary, educating clinicians about the influence of culture, language and ethnic heritage on symptom presentation and the impact of immigration and adjustment as well as cultural beliefs about illness and treatment. Sometimes my role becomes one of mediating between a clinician and a family over different conceptual frameworks for understanding a clinical predicament, and helping find common ground to progress the treatment of the child or young person.

Case example

A 15 year old boy was referred to the clinic due to problems with outbursts of anger and aggression and other antisocial behaviours that had brought him to the attention of the police. He attended a special class in a mainstream school. He had a mild to moderate level of intellectual disability, history of speech and language impairment, short term memory deficits,

Front part of the brain is like a conductor in an orchestra. It controls and coordinates all the other parts of the brain, like the conductor tells the strings, woodwinds and other parts of the orchestra how to play music together.



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ADHD and a frontal lobe syndrome. His early history included health complications around his birth, and a history of possible head injuries in early childhood. He was only one of a large family to experience significant learning and behavioural difficulties. The family social history was complex, with repeated experience of war related violence in Afghanistan. The family came to Australia as refugees.

Assessment and intervention

The first intervention occurred prior to the initial appointment with the family, while preparing for the assessment. An interpreter was arranged (Dari language). I consulted the treating team regarding the social and political circumstances of the family in Afghanistan. The family experience as refugees pre and post migration experiences were likely to include: loss & grief, trauma, being cut off from families and other sources of social support and settlement issues; experience of health services in the country of origin where many people during wars do not have any access to health services. Political issues affect people differently even within the same culture. This family came from a minority group in Afghanistan (Hazaras). Given the psychosocial circumstances of this family and that literacy problems are common within many CALDB communities, I recommended that verbal information would be more beneficial than written. The traditional family structure in Afghanistan would have respect of the hierarchy and the influence of the extended family.

Assessment confirmed that the family did not have any access to medical services in Afghanistan. All children were born at home. The family had witnessed a lot of violence, trauma and torture. The patient's father was on a disability pension, the older sons look after the siblings, including the patient. Mother was a full time housewife who tried to give the patient anything he asked for and cov-

ered for him when he was in trouble to keep the peace at home and to avoid her in-laws blaming her for his behaviour. The grandparents had a big role in parenting and treatment decisions. Cultural factors that impacted upon this family's engagement and follow through with the service. Importantly language barriers, particularly in the context of literacy difficulties, are likely to limit understanding information and awareness of existing services and resources.

There were issues with the use of an interpreter. In the initial assessment, despite the presence of a Dari interpreter, the family persisted with using his younger sister to interpret for them. The family had concerns about confidentiality with mental health and disability issues within this community. Accordingly I recommended a Dari speaking interpreter from Iranian background. Stigma and embarrassment also contributed to the family reluctance to use an interpreter and they were embarrassed to discuss the son's criminal activities. It was explained to the family through their daughter that our job was to treat their son's mental problems and not to talk about his criminal activities. This helped the family become more comfortable and engaged.

Their understanding and beliefs about disability needed consideration. For example, the family was very focussed on medication, with limited understanding of the nature of their son's problems, and presuming and hoping for a medical cure. They also focused on his problems of memory deficits rather than broader intellectual disability (ID). The family refused the option of a special school and could not understand why their son was not achieving like his siblings. They had difficulty accepting and understanding the diagnosis of intellectual disability in the context of a normal physical appearance and the value of special education.

The team had difficulty explaining their son's conditions, especially medical terminology such as: executive functioning. It was important to avoid jargon and to use clear descriptions in ordinary language to improve the communication with the family. I suggested the use of analogy and visual supports as a strategy to address some of the communication difficulties. Since the father had an interest in music, the concept of an orchestra conductor was a useful analogy for explaining the concept of executive functioning in the brain. This format made the complex concept accessible for the family. Such psycho educational approaches helped their access to services: translated information and visual support strategies, educating all family members about the child's disability, including the extended family, educating family members on services available and encouraging them to use them. We emphasised the rights of family members to request an interpreter and a cultural consultant for clarification and involvement in the treatment plan.

Over a number of sessions, these approaches contributed to a successful engagement with everyone in the family. Respect of the family beliefs, understanding and culture enabled their empowerment and self determination. Interventions reduced jargon and made information more accessible for the family. These approaches contributed to improved outcome. The Multicultural Disability Advocacy Service was involved to advocate for the family and a bilingual Dari speaking clinician from the Transcultural Mental Health Centre was used during a school visit. Such additional culturally appropriate services continued to help the family with their further journey through the specialist service systems for young people with intellectual disability and mental health problems. ●

Interesting Reading
**My Name is Jack-
Australian Story about
Ian Rogerson and his wife Nicole**

<http://www.abc.net.au/austory/content/2007/s2652214.htm>