Mental health, system barriers, and implicit bias in the treatment of refugees and newcomers

An interview with Dr Javeed Sukhera

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ABSTRACT

For psychiatrist Dr. Javeed Sukhera, quality mental health care for newcomer and refugee youth is extremely important. In particular, he advocates for trauma-informed care and awareness of implicit bias in medicine. Though frustrated with the currently inadequate funding of mental health treatment in Canada, Dr. Sukhera suggests that health professionals can take steps to provide care that serves the unique needs of refugee and newcomer populations. Fundamentally, he believes that this simply involves recognition of one's own humanity and the common human experiences shared by refugees, newcomers, and healthcare providers alike.

INTRODUCTION

Dr. Sukhera is an Assistant Professor of Paediatrics and Psychiatry at Schulich School of Medicine & Dentistry and the senior designate physician lead for Child & Adolescent Psychiatry at London Health Sciences Centre in London, Ontario. While originally from Toronto, Dr. Sukhera's interests in global health led him to complete his medical degree in Israel at the Medical School for International Health at Ben Gurion University. Drawn to the resilience of pediatric patients and the complexities of their mental health care, Dr. Sukhera subsequently completed his residency and subspecialty training in child and adolescent psychiatry in Rochester, New York. In addition to his current clinical practice, Dr. Sukhera sits on the London Police Services Board, is President-Elect of the Ontario Psychiatric Association, and recently received his PhD in Health Professions Education from Maastricht University in the Netherlands. We sat down with Dr. Sukhera to discuss his interests and experiences in refugee and newcomer care, trauma-informed practice, and implicit bias in medicine.

What unique challenges do you see in caring for the mental health of children and adolescents who come to Canada as refugees?

Refugees are often coming from experiences of trauma, and that continues here, as the process of resettlement itself can be traumatizing. That is a particular issue in the sense that without understanding of and training in trauma, well-intentioned Canadians who want to be supportive may actually re-traumatize these patients. Additionally, there are culturally-related nuances to how mental health issues present, how they are viewed, and how

people view themselves. For example, a child that comes to London and is a visible minority in their school and speaks accented English will feel very different, and that significantly shapes how they feel about themselves. Newcomers, or even their children, may experience mental health in very different ways than those who have had several generations of their family live in Canada.

What strategies have you developed to deal with these issues?

As a physician, the strategies mainly speak to creating space clinically where the complexities of newcomer and refugee care can be responded to. For example, an assessment with an interpreter will take longer; I need to make sure that I am set up structurally to have that necessary time. Similarly, when members of a family are unable to make an appointment, I do not want to penalize them. As an education researcher, strategies mainly relate to awareness and training of healthcare professionals. If we help people who work in the system to better understand not only who refugees and newcomers are, but also who they themselves are, it sets up a system that is much more compassionate.

What do you see as the most significant barrier in our healthcare system to providing optimal mental healthcare to this population?

The most significant barrier is simply that we do not adequately fund mental health in our system for anyone. When someone has a mental illness, they do not receive the treatments that we know work, such as psychotherapy. It is the same as if we did not offer insulin to someone with diabetes or puffers to someone with asthma. When you have a baseline system with that problem, and then you superimpose these highly complex refugee and newcomer populations with linguistic, cultural, social, and economic issues, you have a serious issue. Patients who have experienced trauma do not receive evidence-based intervention during a critically vulnerable time. Instead, they end up on a waiting list. It is just the opposite of best practice. Furthermore, the system is designed to create lots of smaller barriers because it has been underresourced for so long. For instance, if you have an access process that requires filling out multiple forms and going through an intake exercise, and someone does not speak English, how will they get access? Often, they will just fall through the cracks.

How do different cultural views of mental health and treatment of mental illness affect how you provide care to refugee or newcomer patients?

For one, it is important to push back against the narrative that certain groups have certain opinions on mental illness. Someone who is South Asian may have grown up in a culture that resisted mental health care, but someone who is Eastern European may have had the same experience. Ultimately, I find that a lot of the issues in refugee and newcomer patients relate to trust. With patients and families that have experienced trauma, I need to work harder at building trust and creating relationships. For instance, you can imagine that an individual who has been forced to take medication may be apprehensive to the idea that their child could benefit from a medication for ADHD. As such, I recognize that it will require more than just a single conversation. I strive to provide recommendations in a way that gives patients and families time, space, and respect to make their own decisions. It is okay with me whether it ends up taking one month, or six months, or never happens. My job is to be there to support.

A large focus of your research is implicit bias in healthcare. What have you learned about how it shapes the care of refugees and newcomers?

Implicit bias shapes everything. With refugees and newcomers in particular, it can shape care in both negative and positive ways. It is easy to recognize the impact of negative bias. For instance, we may think, “Okay, a newcomer is coming in and cannot speak English. We may be biased that they will take too much time, and their care will be too complicated.” However, if a newcomer is coming in, and we are overly focused on being helpful, that sort of positive bias can be just as harmful. By immediately positioning ourselves as the helper and them as the helped, we may denigrate their natural strength and resilience, and that mentality can be very patronizing and traumatic for them. Accordingly, thinking about bias in both ways is really important.

What are effective ways to overcome implicit bias in healthcare? Is it even something to overcome or more just to become aware of?

The first thing to recognize is that we are never going to be perfect, nor should we be. Biases should not and cannot be eliminated; they are simply the way that our brains work. Once you accept that, it is really about creating a culture of feedback. We can never truly know our biases ourselves; we need to talk to other people and reflect on how biases either interfere with or help the achievement of goals. Accordingly, my current research is actually starting to explore bias within teams, as opposed to just individuals.

How do you deal on a personal level with the traumatic stories and difficult life circumstances that you hear about from your patients?

I wish that I could say that I have it mastered, but I don't; it is a work in progress. Being able to talk about situations with other people really helps, especially peers and colleagues that know what you are experiencing and can help you relate to it. I also work hard

to disconnect and be present in my personal life. When I feel drained from challenges of my work life, I refuel and recharge through time with my family. A big part of providing optimal clinical care is looking after oneself. In mental health care particularly, we are often surrounded by so much suffering that we put ourselves on the backburner. However, the truth is that without adequate self-care, we cannot be the most compassionate version of ourselves to take care of other people.

What are the most rewarding parts of your work with refugees and newcomers?

I get a lot of inspiration from the resilience of people that I work with. When you care for someone who has experienced extreme trauma and then see them doing well, you end up drawing strength from that. Additionally, I think it is very rewarding to feel trusted. When a patient who has struggled with shame from experiences that were out of their control begins to realize that it is not their fault, and you are a part of that realization, there are really no words.

What is your advice to medical students as they encounter patients with this background in clerkship, residency, and beyond?

The biggest thing is simply to remember your own humanity. There is no caricature or manual or perfect way to deal with things. Treat patients as fellow human beings, break down all the different labels that you may have, and create healing spaces. During training sessions, I am often asked about tools for these encounters; but you yourself ARE the tool. Your intrinsic humanity is what is going to help you through.

CONCLUSION

As Canada continues to welcome refugees and newcomers, learning how to effectively care for this unique population will only become more relevant. Dr. Sukhera serves as an outstanding example of how this may be accomplished through advocacy, awareness, and humility.