Meeting Complex Needs Through Community Collaboration: a Case Study

Stephanie M. Robinson¹ · Michelle M. Gallagher¹

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Abstract

This case study focuses on complex trauma in a refugee family. It explores the barriers faced while supporting a family presenting with complex and multifaceted needs. It reviews the roles, processes and participation of practitioners from Service Coordination (case management) and Treatment (therapeutic intervention) perspectives. This case study also examines the gaps in existing services for new immigrant and refugee populations within a community and provides recommendations for closing these gaps.

Keywords Case study · Refugee · Trauma · Child · Adolescent · Mental health

Introduction

Canada is a multi-cultural society. Canadians are a diverse mosaic of different languages, religions and races. According to Statistics Canada (2013), there are over 6 million foreign-born individuals living in Canada, totaling over 20% of the population. While not all foreign-born individuals have come to Canada under refugee status, recently the Government of Canada has welcomed 25,000 immigrants from Syria due to conflict in that country which contributed to a refugee crisis. Further, it is reported that approximately half of all refugees are youth under the age of 18 (Ellis et al. 2008).

The purpose of this case study is to discuss an Integrated Intervention used with a complex refugee family that experienced violence and trauma in their home country before seeking asylum in Canada. This paper will review the ways in which a Children's Mental Health Agency (forthwith known as "the Centre") worked to overcome known barriers to mental health service provision for refugees. It will also discuss clinical dilemmas, identified learnings, successes, and proposed changes to assist future clients who need support from the community.

Intervention

Service Coordination – First Author's Perspective

In January 2015, the first author was assigned to be the Service Coordinator for a unique and challenging case. As a Service Coordinator at the Centre, her role involves assessment, referral and case management until discharge from the Centre. The formalized family meeting (known as the Service Coordination Assessment), encompasses an orientation to the Centre, discussion of the family's concerns and review of the available treatment options. By the end of this biopsychosocial assessment, the Service Coordinator and the family agree to the treatment referrals that seem to fit their needs best. While the service coordinator typically has limited contact with the family after the Service Coordination Assessment is completed, the first author remained heavily involved throughout the course of this family's interaction with the Centre.

Prior to the meeting, the service coordinator reviewed the intake packages which indicated that the family was new to Canada and had experienced horrific trauma in their home country. These traumas involved murder, sexual assault and discrimination. The father had tragically been murdered, leaving a single mother to care for the children whose ages ranged from 6 to 16. The intake packages also described symptoms being experienced by all of the children, including: depressed mood, physical complaints, sleeping and eating difficulties, enuresis, and school issues (including,

✉ Michelle M. Gallagher
Michelle.Gallagher@hdgh.org

¹ Hotel Dieu Grace Healthcare, Windsor, Canada

academic, social and coping difficulties). In addition to the complex trauma and mental health concerns, the family members did not speak English. Some members of the family spoke French, but their first language was Swahili, and therefore, an interpreter would be required.

The first author researched the available services in the community for newcomers. There were several settlement agencies that support new Canadians. She attempted to locate a professional Swahili and English-speaking interpreter for the family meeting, but was unsuccessful, and therefore, planned to use a step-sibling with limited English skills for interpretation purposes. This was less than ideal but no other option was available at the time.

The children and their mother attended the Centre for the initial appointment, but the English-speaking step-sibling was not present. Instead, the family brought their Settlement Worker who spoke Swahili and English. The first author learned that this Settlement Worker had made the family aware of the Centre. The family members presented as confused and scared. The family was brought down to the first author's office where the children huddled together and chose to share seats. The mother's affect was notably flat, as evidenced by her discussion of traumatic events while showing little to no emotion in her voice and expressions.

The Settlement Worker explained that she became aware of the family and their story a few months prior, and realized quickly that they needed mental health support. She explained that her agency provided education to newcomers, but it did not provide mental health support. The Settlement Worker provided further details about the family and helped the mother and children to answer the service coordinator's questions. While explaining some of the tragedy that had occurred in their home country, the mother shared some violent pictures she had taken when her husband was murdered. No one in the family reacted negatively to the pictures being taken out of the mother's purse, appearing desensitized.

Once the family had shared their story and answered the first author's questions, treatment recommendations were made. The service coordinator recommended that the children be referred for trauma-focused Individual and Family Counselling- High Risk. The high risk designation was intended to reduce the length of wait before services. The first author also suggested that another agency that specializes in treatment for survivors of sexual assault be involved. The family explained that they did not have transportation to get to and from the Centre for appointments. They had arrived today with the Settlement Worker, but she was not able to assist with transportation on an ongoing basis. The Settlement Worker also advised that she could not commit to ongoing interpretation for counselling sessions, as she is not a trained interpreter.

The first author recognized that this was a family who desperately needed help. The mother's flat affect and the

family's apparent desensitization were concerns, somewhat predictable given all the family had been through. Despite being in Canada for a few years, they also seemed not well connected in the community and had few supports. The parent shared that she did not have money for food, clothing or transportation. The parent was asked to sign releases of information so that the first author could follow up with other community resources on her behalf. She expressed concern about signing the releases, but once it was explained that they would assist the Centre in helping her, she signed.

After the Service Coordination Assessment, an email was sent to Centre staff explaining that a recently referred family was in desperate need of help with basic needs, including clothing and food. A collection for the family was organized. Over the next few weeks, the first author's office was filled with donations of new and used children's clothing, outerwear, purses, shoes, pull-ups and gift cards. The family appeared appreciative when these items were delivered.

In the following months, there were several meetings with the Centre's management team and the service coordinator to develop an innovative strategy to support this complex family and overcome barriers. The first author had connected with a therapist from a local Sexual Assault Treatment Agency. Given the overwhelming nature of this family's needs and the risk for vicarious traumatization, the Centre's management team arranged for the treatment team (once assigned) and the service coordinator to consult and receive clinical supervision with a well-known trauma expert in the province.

The first author searched the community for a Swahili-speaking social worker, who, if available, could perhaps provide counselling services to the mother while the Centre supported the children. The first author found one Swahili-speaking social worker in the community, who graciously offered to help, but then realized her Swahili Language skills were lacking. The service coordinator contacted a local agency that helped facilitate language services, but they only employed Swahili language aids, not interpreters. They explained that language aids are not professionally trained, and therefore are not recommended to be used for therapeutic treatment. It was discovered that the Centre had access to a Language Line, but it was thought that involving a third person and passing a phone receiver back and forth would also not be conducive for ongoing therapeutic treatment. It seemed that the community had a gap in terms of Swahili language services. Another person from the community came forward to help. She was a secretary at a settlement agency, who spoke English and Swahili. She offered to assist with translation for the family's counselling sessions. Again, this informal interpreter was less than ideal, but there seemed to be no other choices.

In further consultation with the Centre's management team, a preliminary treatment plan was developed in June

2015. It was determined that the youngest child was most appropriate to receive counselling from the Sexual Assault Treatment Agency, and therefore, her file would be closed to the Centre. The other children would receive counselling with Centre staff that had trauma training and/or French-language skills, and that the informal Swahili interpreter would participate in those sessions. One of the French-speaking staff is the second author who will elaborate on the treatment plan and therapeutic intervention below. A plan was developed for the youngest child to be provided counselling sessions at the Centre, even though her sessions would be facilitated by the sexual assault therapist. It was hoped that if the family only had to attend one agency, this would be easier and less confusing for them.

The first author learned of a community agency that supported Francophone families and was able to locate an individual through the agency who could assist with the family's transportation needs. This individual was fluent in French and English. Her role was initially to provide transportation to and from counselling sessions at the Centre. This individual's role later included French language interpretation for some. The first author learned that another community agency was offering a summer lunch program for low income families. Through this program, the treatment team obtained healthy lunches for the family every day that they attended the Centre for sessions throughout the summer.

A case conference occurred in July 2015, involving the mother, Centre staff and all involved community partners. The preliminary treatment plan was discussed, with which all parties were in agreement. The first treatment sessions were booked in the coming weeks on a weekly basis. In discussions with management and the treatment team, it was arranged for the family to use an available group room as their personalized waiting room when they attended the Centre for appointments. This would allow the family to eat their lunches without interruption and would provide a central meeting location while they transitioned to and from the treatment providers' offices. The Sexual Assault Therapist was provided a treatment room at the Centre for her sessions. The treatment team was given the opportunity to continue the phone consultation sessions with the trauma expert on a weekly basis.

Through the course of treatment, the Centre accessed several other community agencies to support this family including financial, housing, medical and legal services. The Centre purchased groceries for this family and delivered the food to their home on several occasions, when they could not afford food. The family was connected with a Swahili-speaking child protection worker, who offered further advocacy and support to the family. As well, the team consulted with the children's schools to ensure that there were no concerns for them in that environment. For the treatment team, knowing that these efforts were being made to meet the family's

basic needs allowed for increased comfort in delving into the mental and emotionally-laden work of exploring and processing their trauma experiences.

Treatment – Second Authors' Perspective

The introduction of any case traditionally stays with the practitioner throughout the length of treatment. The details provided about this case were vague initially, but the impression of the significant trauma experienced by the family was impactful right from this initial introduction. While the Centre deals with some of the most intensive and high-needs children and families within the community, this felt different from the start.

As mentioned, the clinicians slated to be involved with the case were invited to a case conference to be provided further detail about the family's experiences prior to gaining refugee status and immigrating to Canada. The information from other community agencies suggested that while the family was not thriving they were indeed surviving, though in need of mental health supports.

The initial introduction to a member of the family was meeting the family's matriarch. She attended the conference in July 2015, along with members from a variety of community agencies that were already involved. At this meeting the importance of clear introductions given the number of individuals involved was evident. Given the nature of the work that would be done there was an identified need to have clearly defined boundaries and roles for the multiple agencies involved. This conference ended with scheduling several treatment appointments with the children and staff providing examples of what the mother could tell her children regarding the purpose of their attending the Centre. The goal was to decrease feelings of anxiety about their engagement in services.

The family (mother and all children receiving treatment) arrived for their first treatment appointment and appeared excited and apprehensive. All appointments for the children were blocked together given the limited access to interpretation and transportation. Attempts were made to predict and proactively plan for issues such as comfort, hunger and boredom for those who were waiting for their respective therapist and the sole translator. The family had access to snacks and activities such as puzzles, colouring and fidget toys each week.

The Centre was committed to supporting this family and the practitioners who worked with them. For example, decisions regarding some aspects of service provision were left to the individual practitioners. In consideration of language skills and of strengths with the adolescent population, a decision was made to work with a dual-therapist model. As well, per consultation with the trauma expert, each of the children were provided with small gifts geared toward their

interests (a doll for the youngest daughter, stuffed animals for the middle children, and a fuzzy blanket for the oldest child) during initial appointments. These were meant to be items of comfort that could aid in the transition from home to an unfamiliar agency such as the Centre from 1 week to the next. These would be termed transition objects, though they were used intermittently by the children as such.

The initial appointment with the adolescent client evoked a sense of surprise and confusion in comparison to the case presentation on paper. Staff had conducted brief research on the country of origin in an attempt to avoid any significant cultural missteps. However, the adolescent presented in a very Westernized manner in terms of clothing and demeanor. She often used French ‘slang’ that was more common to Canada during conversations. She was, above all else, open and clear about the reasons she believed she was attending the Centre. Therapy sessions were conducted in French (a second language to the co-therapists and client alike) and as such patience was needed as topics were translated that could present complexities in expression even in ones’ native tongue.

While the limited access to interpretation services created a lengthier visit for the family as a whole, this also allowed for observation of the interactions between family members between their appointments. This allowed the team to tailor the approach based on clearly observable behaviours and expressed needs. Specifically, observing the experiences of each family member as an individual within the family system aided in selection of family session activities and general approach by the group. This case continually reaffirmed the idea that each person and family system responds to experiences very differently as a whole and as individuals within the family system, and that any approach must be tailored specifically to their presented needs.

Clinical Approach

Over the course of approximately one year, the treatment team met with the family on a near-weekly basis. The appointments were a mix of individual or family sessions dependent on client and clinician availability. If one child’s therapist was unavailable, the group would often engage in a family session to decrease the expressed and exhibited disappointment of being ‘left out’. The involvement of multiple therapists facilitated this approach and allowed for greater continuity of sessions for the family. Given the myriad of people that had come into and out of this family’s life over the course of their experienced traumas, immigration to Canada and subsequent period of settling, it was seen as important that the family experience as much continuity and consistency as possible with the Centre.

The case as a whole was approached with a trauma-informed lens, specific to the presenting needs of the

client(s). A multi-modal approach was utilized including: attachment-focused, solution-focused, play therapy, narrative therapy and cognitive behavioral therapy. Each child was considered both individually and as part of the family system. This was important as the family experienced several of their traumas together, but their reported responses have varied widely since the initial incident. A key component to the use of multiple therapists was the debriefing period. This occurred on two levels: peer-to-peer and clinical supervision with the trauma expert.

The peer-to-peer debriefing was a significant aid in developing a more rounded understanding of the family’s experiences. This allowed the treatment team to put together a more complete timeline of the family’s initial and subsequent traumas. This form of debriefing also helped in normalizing some of the experiences of each clinician.

The clinical supervision was paramount in expanding the treatment team’s understandings of the family’s experiences and responses. The supervision included a review of each session and discussion regarding possible linkages within the case and plans for next steps. The supervisor also provided multiple opportunities for self-reflection that allowed for clinician growth. The use of effective clinical supervision and support was vital in ensuring that the practitioners themselves did not experience secondary trauma or compassion fatigue given the profound violence of the family’s trauma experience.

Individual sessions emphasized the development of rapport and comfort for a lengthy period of time. As well, the children and family themselves were consulted and their lead was followed in terms of readiness for the initiation of a trauma assessment and subsequent treatment. This progression was particularly challenging and was a point of difficulty for several of the clinicians. It was not unusual for the group to have a consensus that the children were ‘ready’ for trauma-related work but there continued to be considerable concern for parent/caregiver readiness. Ongoing impact of the family’s trauma was being reported by the family’s matriarch.

Despite the Centre’s best efforts to facilitate treatment and minimize the impact of these challenges, the language barrier, cultural difference and other unknown factors may still have contributed to this not being feasible. The clinical team felt that for the children’s progress to continue there was significant need for consistent parent support and readiness. Efforts were made to engage the mother, but challenges relating to her need for tangible items like money, in combination with the previously identified barriers, made these efforts even more difficult. This consequently impeded the trauma-specific work with the younger siblings. With consistent attention to the client’s level of comfort and emotional regulation, discussions regarding the experienced trauma were broached with the adolescent. This was done

because it was determined that parental readiness was not as significant a concern given the adultified role this youth played within the home. As such, a trauma assessment and a narrative were started with the adolescent.

Yet again, translation proved to be complex. Typically this activity with an adolescent would also include delving further into the experience of each symptom in terms of frequency, duration, intensity and triggers. However, due to limitations in session length the language-barriers the activity was simplified slightly. The adolescent/adult list of symptoms was used with the child approach of stickers and simplified questions related to frequency and views regarding perceived size of concern. Once the identification of symptoms was complete, the next step was a rating of severity for the adolescent whereby she was tasked with placing her identified triggers in order. Interestingly, the symptoms which were identified as the most distressing were not necessarily those previously identified as having the greatest level of severity of occurrence.

It is important to note that these symptom identification and rating tasks were done in separate appointments. They were also accompanied with a wrap-up activity geared toward emotion re-regulation. Cues were taken from the adolescent, who was quite open with how she felt, what she thought would be helpful and the impact of the discussions on her mood. Work on the trauma narrative began following the symptom assessment and examination of the client's willingness to engage with the therapists.

When treatment was nearing the 1 year mark there was a case conference to discuss further ways to support the family with community partners present. At this meeting, Centre staff were notified of the mother's expressed intent to terminate her involvement with counselling services for her children. As such, a termination session was planned. Due to the abrupt termination of services the trauma narrative was not completed with the adolescent. Discussion occurred with the eldest child about the availability of services and supports from other agencies (due to aging out) in the future should she wish. The termination session was designed to be a celebration of the work done with the family. Practitioners provided small gifts for the family and each clinician wrote a small note to their client to wish them well.

Discussion and Recommendations

Clinical Dilemmas

Throughout the course of this family's involvement at the Centre, the team encountered various clinical dilemmas, particularly related to the barriers of communication and transportation. From the point of intake, it was difficult to obtain a consistent Swahili interpreter. Members of the team

were able to communicate effectively with the children in French, but it remained quite difficult to communicate with the mother, since her French- and English-language skills were limited. This contributed to the children progressing in treatment while little or no emotional support or treatment was being provided to the mother. This was in direct contradiction to the general practice at the Centre. In this case, meeting the mother's mental health needs was highly challenging.

Another clinical dilemma was the occasional utilization of the oldest child for translation purposes. There was an interesting dynamic, because the oldest child reported not wanting to interpret consistently, but then was also resistant at times to someone outside the family providing translation services when it was available. Using a family member for interpretation is discouraged in the literature. The oldest child was at the Centre to access her own mental health treatment, not to translate for others. Also, via translation she was privy to sensitive adult information.

An additional clinical dilemma related to communication was the practice of signing consents and releases. When involved staff discussed consent forms, releases of information and the risks/benefits of treatment with the mother, someone translated the information in Swahili. The first few times, the mother stated that she understood and signed. As time passed, the mother seemed to grow concerned about the number of forms she was signing. Towards the end of treatment, the mother was quite uncomfortable signing any forms, even if staff went to great lengths to assure her why that information needed to be requested. As a result, once the initial releases expired, staff were no longer able to consult with other involved community agencies.

There were also many sessions that the mother did not attend. If it was a week that the therapists had prepared a family activity, she was unable to participate. Although staff had arranged a consistent transportation provider, the mother was not always at the pick up site. Staff speculated that this could be due to the mother not being actively engaged in her children's treatment (due limited understanding or frustration over perceived lack of progress), or the mother's potential disinterest in participating in family sessions. As a result, staff were put into a situation where they needed to go against the Centre's policy of having the guardian in the Centre at all times in case of emergency. Many sessions occurred with just the children and their driver who became somewhat of a surrogate caregiver throughout the course of treatment.

Successes

This case emphasized the importance of recognizing all the successes that have occurred. First, the ability and willingness of the service coordinator to advocate for the family,

to remain involved for a longer period of time, to meet the family's basic needs and to develop a creative approach that enabled the family to remain engaged for a full year.

Second, the team found that the ongoing flexibility within the Centre was an area of significant contribution to success. This case demonstrated the importance and ability to place emphasis on the needs of the client and to facilitate services around those needs. While this sounds simple, it can be challenging given the pressure on many agencies to decrease wait lists, increase measurable outcomes and decrease length of treatment. Specifically for this case, flexibility included the use of a personalized waiting room, engagement of a specialized therapist from another community agency, facilitation of that therapist's services being provided at the Centre, and the use of a multi-therapist model.

The ability to meet the family's basic needs in session (organization of transportation, provision of snacks/meals) and out of session (donations, provision of groceries, gifts of winter wear) was understandably important. Based on comments from the family, it would seem that the Centre's ability to provide these tangible items played a role in developing the rapport and engagement of the family's matriarch. This was crucial to the children's attendance and participation.

Finally, significant portions of the sense of success for this case can be connected to the regular access to peer and clinical supervision. The risks of compassion fatigue and secondary trauma are well identified within the literature. With this in mind, and given the extensive traumas experienced by this family as a whole and individually, the level of support for the clinicians internally (within the treatment team) and externally (access to a trauma expert and regular access to the management team as needed) was paramount. These supports allowed each practitioner to provide more to the clients: more support, more engagement and more energy.

Proposed Changes: Agency and Community

While success was experienced with this family, the impact of this case has simultaneously demonstrated that there is room for change. In some ways it felt as though the team encountered a gap in available supports and services at each turn. A common commentary from team members emphasized experienced confusion, frustration and disappointment as well as a recognition of how much more challenging this would be for individuals who do not fully understand the systems, the culture, the language or the expectations being placed on them. With this in mind, several areas of change within the Centre and the community have been identified.

Within the Centre, identified needs included the development of a toolkit and system for handling complex new immigrant families. The needs of new refugee and

immigrant families are becoming bigger, and the world is seemingly becoming smaller. There is a responsibility as practitioners, and as an agency as a whole, to be prepared to meet the needs of the families presenting for services. Further, easy access to up-to-date information about language services, settlement agencies, transportation supports and ways to meet families' basic needs for food, shelter and financial support will be imperative. Additionally, as was noticed with this family, the provision of tangible items can be of extreme importance in laying the foundation for trust and therapeutic rapport in preparation for the work related to mental and emotional health. It will be important that these families experience decreased wait times.

As well, further education for staff about working with complex new immigrant and refugee families is important. Ideally this education would occur for any staff member with whom the family could have contact. Education is also crucial in relation to the warning signs and potential impacts of vicarious trauma. As an agency, the Centre is seeing an increase in new immigrant and refugee referrals with tremendous experiences of trauma. Professionals will hear these stories repeatedly. A clinician's ability to support themselves and their colleagues and to be supported by management will, in many cases, influence their ability to truly support their clients.

Within the community, identified needs included increased cohesion between community agencies. As mentioned previously, the difficulty experienced by the practitioners in navigating the settlement, legal, financial and mental health systems serves to clearly identify the multitude of potential barriers for families. Additionally, when the individuals and families that are navigating these systems have experienced a significant trauma (including the overall experience of immigration; L. Kirmayer, personal communication, April 29, 2016) there will be another layer that adds to the complexity of engaging in the system for these families. As such, it will be imperative that community agencies develop methods to ensure consistent, proactive and responsive communication and collaborative work to meet the needs of these families as part of their circle of care. This could also include community-wide engagement with a variety of agencies in a proactive way such as developing a committee that meets regularly to anticipate potential areas of increased need and to be responsive as patterns become apparent. As well, based on the team's experience there would be significant benefit to the inclusion of consultation related to cultural competency prior to a family beginning services and throughout their engagement.

Finally, the team's experiences identified a significant gap in availability of translation and interpretation services. Engaging as a community to identify areas of language need and to invest in the necessary training or recruitment within these areas would be vital. As well, emphasis would need to

be placed on developing methods to ensure that the translators are not experiencing any vicarious symptoms as a result of their roles given the amount of triggering information they would be likely to hear.

Key Points

1. **Basic needs come first.** It is essential for an individual or family to feel their basic needs are met before they will be able to dedicate significant mental and emotional energy to resolving or processing any experiences of trauma or other impacts of their experiences. As such, helping a low income client/family with accessing basic needs may be necessary before clinical intervention can occur.
2. **Language matters.** Finding a well-trained professional interpreter is crucial. While family members/informal interpreters may be the only option, these individuals should only be used in an emergency or as a last resort.
3. **Staff well-being must be considered.** Mitigating compassion fatigue, vicarious traumatization and burnout is critical for workplaces where employees support trauma survivors (immigrants, refugees or other). The ability of a staff to support these clients will inevitably be impacted by their own mental state. The risk for secondary trauma, compassion fatigue and burnout will be high for staff carrying larger case loads comprised of highly traumatized individuals/families. Further, staff who are trained and feel confident in their skillset will be better able to support these populations long-term.
4. **Children do not exist in silos.** A child exists within their environments (home, school, community). As such,

family work is extremely important when supporting traumatized children. The implications of the experienced trauma on members of the family will influence the environment in which the child lives.

5. **This process is about the client, not the practitioner or their policies.** Assessment and treatment with traumatized newcomers can be time consuming and progress may occur very slowly. Innovative interventions must be tailored specifically to clients depending on their needs. While the emphasis is increasingly being placed on outcomes and decreased wait times, it is important that individuals and families be met where they are at instead of rigidly insisting they conform to agency expectations. This will contribute to better outcomes.

Compliance with Ethical Standards

Conflict of Interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

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