UNDERSTANDING LANGUAGE BARRIERS TO MENTAL HEALTH SERVICES OF NON-ANGLOPHONE AND NON-FRANCOPHONE PATIENTS FROM THE PERSPECTIVE OF PSYCHIATRISTS, ADMINISTRATORS, AND PATIENTS

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Abstract

Canadian patients face barriers in access to mental health care if they do not speak Canada's official languages: English or French. Canada does not have a law supporting professional interpreters, and many practitioners and hospitals must rely on informal interpreters despite the proven risks for patients and healthcare providers. We conducted a qualitative evaluation to understand better the language barrier to mental health access from patients, mental health clinicians, and healthcare administrators.

Methods: Data collection consisted of 21 in-depth interviews with 11 patients and 10 psychiatrists and high-ranking officials. We asked them about their views regarding language interpreters' role in psychiatric care and the factors that may limit access to language services for patients and their proposed solutions to these issues. Data were analyzed using a content-analytic approach.

Results: The study found that non-English, non-French speakers who received professional language assistance felt that the provision of this linguistic service re-humanized them. Also, the provision of linguistic services made patients feel that they received appropriate and effective care. Despite patients' and psychiatrists' perceptions that professional interpreters provided trustworthy services, mistrust could happen in some cases. We also found that the lack of a proper provincial language policy about non-Francophones/non-Anglophones and a lack of

language standards in healthcare settings were significant issues associated with mental health services barriers.

Conclusions: Lack of law in Canada to support patients' right to access language assistance services were prominent. Also, hospitals' lack of care standards for non-Francophone/non-Anglophone patients can be barriers to accessing mental health services. More robust policies and appropriate funding of non-Francophone/non-Anglophone translation services are recommended for increasing access to mental health services.

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Part 1- Background

Introduction

In Canada, in the past few decades, increased immigration and refugees' acceptance has increased language diversity in clinical settings (Chavez, Bouchard-Coulombe, & Lepage, 2010). This intensification of language diversity brings new challenges to clinical settings, including the accuracy of psychiatric assessments and the quality of treatments (Brisset et al., 2014). The Mental Health Commission of Canada has emphasized addressing language diversity in clinical and healthcare settings to improve mental health services (Chodos, Mulvale, Bartram, & Lapierre, 2009).

Background

The 2011 National Household Survey of Canada reported that Canada's population includes 20.6%, foreign-born immigrants. Canada has a higher population of foreign-born immigrants than many other developed countries who receive immigrants and refugees (Statistics Canada, 2011). Canada has long welcomed refugees; most recently, from January 2015 to December 2017, almost 94,000 refugees resettled in Canada. 51,000 of these recent refugees were of Syrian origin (Citizenship and Immigration Canada, 2018), and 6,341 have settled in Quebec (*Tableau synthèse Objectifs du Québec et ombre de réfugiés syriens parrainés ou pris en charge par l ' État arrivés au Québec en 2015 et en 2016 Réfugiés parrainés n charge par l ' État n Total n Réfugiés arrivés Réfugiés arrivés Réfugiés arrivés Réfugiés*, 2016).

Cultural and language diversity is increasing, in particular in Canada's larger cities and metropolitan areas. Canadian policies about immigration and its welcoming refugees over the past few years are related to recent language diversity increases (Canada, n.d.; Government of

Canada, n.d.). Based on the 1951 Refugee Convention, eligibility criteria designate who may be considered a refugee. Individuals who fear being prosecuted due to religion, race, nationality, political standpoint, and who fled from their country of origin due to the mentioned fear can be considered refugees. Although there is not a certain consensus about the definition of "migrants," the most common version based on The International Federation of Red Cross policy is "a person who leaves his place of residence in order to go to another place or country." It can be within the borders of a country or across the international borders for seeking a better or safer life. This can happen voluntarily or forcefully, and most of the time, limitations, personal choices, and willingness to live abroad contribute to an immigrant (Redcross-Canada, 2019).

Traditionally based on policies, Canada's government receives refugees from across the world (Government of Canada, n.d.). Inside Canada, Amnistie Internationale, Amnesty International Canada, and the Canadian Council for Refugees make Canada more welcoming through national and public awareness campaigns (Canadian-Council-for-Refugees, n.d.). Refugees who arrive in Canada receive a wide range of services designed to ease resettlement and integration. These services include financial support for the first 12 months, including temporary housing and housing support for a year. Refugees also are assisted in acquiring their new identity cards, medical insurance, and bank accounts. They also receive help in finding schools for themselves and their children, as well as finding employment. Language classes in local languages are also offered to Canadian immigrants (Canada-Immigration, n.d.). Immigrants receive some of these social and job services; however, they are not provided with either financial or housing support from the government. Many local community groups are privately funded and government-funded, which support both groups (Government-of-Canada, n.d.-a).

Canada has two official languages, English and French. All government forms and communications are offered in both languages, and new immigrants and refugees are persuaded to learn these languages. Government-funded classes are available full-time and part-time (Government-of-Canada, n.d.-b). However, in Quebec province, only French courses are government-funded. They are provided free of charge for immigrants for the first five years from the time of their arrival (Ministry-of-Immigration-Diversity-and-Inclusion, n.d.) Learning a new language like French for 11 months can make immigrants and refugees familiar with the language but not yet fluent.

In 2016, Quebec province had 7,965,450 total population, from which 1,091,305 were immigrants, approximately one out of 8 people, and there was a mild trend in the increase of the number of immigrants from 2001 until 2016 (Statistics-Canada, n.d.-a). In Canada, in 2016, there were 7.5 million immigrants; therefore, the immigration rate to Quebec province is slightly less than Canada's whole (Statistics -Canada, n.d.). From January 2015 until May 2016, 40,615 refugees were resettled in Canada, of whom 25,035 were Syrians. 5,295 of those Syrian refugees were settled in Quebec province (Statistics-Canada, n.d.-b).

Immigrants face many stressors during immigration and resettlement, including integrating into new houses or communities, new cultural norms, learning a new language, and finding a new job. These stressors can put immigrants at higher risk for mental health issues (Chadwick & Collins, 2015). Moreover, mental health issues are accompanied by stigma in some cultures and backgrounds. Stigma may be present in their own country, but moving to the new place may exacerbate it and avoid seeking mental health services. On the other hand, due to cultural and language barriers and immigration and settlement stressors, proper diagnosis and

treatment in primary care for their mental health problems is more difficult (Kirmayer et al., 2010).

Moreover, many people in the general population cannot recognize the signs of depression and other mental health issues—even those who had previously experienced depression themselves. This is important because it helps people understand that a "non-refugee" even has trouble understanding who needs help for depression. A person with language barriers or new to the culture may have even more difficulty (Goldney RD, Fisher LJ, 2001).

All of the factors mentioned, especially the language barrier, may lower access to health services. For example, in a study in British Columbia on Chinese immigrants between 1992 and 2001, the rate of health care visits of Chinese female immigrants was 59% of their control nonimmigrant group. Compare this to mental health visits for female and male patients and find that only 20% and 10% respectively sought treatment compared to the dramatically lower control group (A. Chen & Kazanjian, 2005). In several other studies, it has been shown that levels of healthcare system use, especially mental health, is lower in more recent immigrants in Canada compared to other Canadian, which is due to multiple factors such as language barriers, religion, culture, and facing discrimination (A. W. Chen, Kazanjian, Wong, & Goldner, 2010; Whitley, Kirmayer, & Groleau, 2006). For instance, in one study, it was shown that immigrants from Philippines and Vietnam use mental health services in Montreal much less (one-third) than those residents who were born in Canada (Kirmayer et al., 2007a).

Another phenomenon named the "healthy immigrant effect," which means when immigrants arrive in the host country, they have a better health status than the same age-gender of natives (Gee, Kobayashi, & Prus, 2007; Waddan & Béland, 2008). This is mostly because immigrants go through medical tests as part of the screening process before coming to Canada.

Other studies are showing that the level of health of immigrants drops in the first four years of their living in Canada, and many factors, including language skills and experiencing discrimination, contribute to this health decline in addition to other stressors they faced (Fuller-Thomson, Noack, & George, 2011).

Based on research done by Farah Islam on immigrants to Canada, it was shown that the risk of developing mood disorders, including depression, is higher on those who have immigrated in childhood rather than adult immigrants (F. Islam, 2015). Another study comparing South Asian immigrants with South Asians born in Canada showed that immigrants had higher chances of anxiety disorders and stressful life and generally lower perceived mental health status (Farah Islam, Khanlou, & Tamim, 2014). Another study linked the age of immigration to later mood and anxiety disorder and substance use disorders. It was shown that immigrants arriving in Canada before the age of 6 are more at risk of developing those problems later than other ages of immigration to Canada (Patterson, Kyu, & Georgiades, 2013). Based on a study by Murray and Lopez in 1997, depression may become the second-leading cause of time lost to death or disability worldwide by 2020 and is expected to rank first in disease burden in economically developed countries and third in developing countries. Therefore, depression causes lots of burdens and causes governments' financial costs (Murray & Lopez, 1998). Lifetime depression rate in Canadians is 11.2 percent and we know that depression affects almost anything in life, including job, family and social function, and physical health as well which increases the burden of disease (Knoll & MacLennan, 2017.) Parenthood is affected by stress and emotional problems, and consequently, it may affect raising healthy children (Browne et al., 2017). In one government published a study in 2012, almost 30% of immigrants face emotional problems and 16% of them experience distress and high levels of stress in a few years after arriving Canada

that they could not experience before (Robert, 2012), which potentially lowers their quality of life and affects their raising children.

Moreover, the Liberal government decided to increase the number of refugees accepted who, due to pre-migration stressors, are at risk for anxiety issues and require mental health services. This happens after the previous conservative government made those number limited and also made lots of budget cut on providing health services for refugees, and right now there is a shortage of mental health services and staff after this surge of refugees (Leotaud, 2015). Some of these limitations still exist. For example, refugees can only use 10 sessions of free psychotherapy during their course of treatment and after that, they should pay out of pocket (LEE, 2015).

There are many cultural variations in feeling and experiencing illness and patients' corresponding behaviors. This might include the ways they express it through language, and language have a key role. It has been shown that these cultural variations and language expressions influence the accuracy of diagnosis, and consequently, the proper treatment for mental health issues is also dependent on that. (Mezzich J, Kleinman A, Fabrega H, Jr., Parron D, 1996). Doctors tend to treat patients based on what patients report with a degree of suspicion. (Hyden, 1997). Most often, doctors have other tools like imaging or laboratory tests to overcome the potential doubt; however, in psychiatry, those tools are limited, and doctors rely only on words and patients' narrative of their illness. Therefore, language and how patients communicate and express their illness or stories are very important in mental health issues. Without language as a human tool for communication, doctors can be substituted by machines or robots. However, the relationship between doctor-patient and the trust built between them is a key element of treatment. This therapeutic relationship can be considered the art and the heart of medicine (Ha

et al., 2010). Patients should not fight for creating a trustful clinical relationship with their doctor, and with less effort, their voice should be heard (Carpenter-Song, 2011).

Patterns of help-seeking in different patients are affected by linguistic differences and cultural models. This also can affect the response to specific treatments or medical recommendations (Rogler & Cortes, 1993). For example, some people may only believe in traditional healings due to their culture and do not seek western medical help. Some may only seek medical help from the healthcare professionals that they speak their mother tongue, making their options for medical help limited. This can lead to a situation where people from some ethnocultural backgrounds do not seek mental health care. This can be due to different reasons. First, they may not conceptualize their problems as appropriate for medical or psychiatric attention because, for example, they may think that this mental issue is part of their religion or has happened to them as a compensation for the bad things they have done. Another reason may be patients' fear of social stigma (Fabrega, 1991; Goldney, Fisher, & Wilson, 2001; Kirmayer et al., 2007b; Mojtabai & Olfson, 2006; Stuart et al., 2014). Fear of stigma happens because being seen at a psychiatrist clinic can lead to a label of madness within their community, and they are scared to be called crazy or mad due to seeking mental health care. Due to the above reasons, people might not get the care they need.

Even when patients receive medical treatment, immigrants, refugees, and patients from ethnocultural and linguistic minority groups may receive incorrect diagnoses (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003). Different racial and ethnic backgrounds may lead to disparities in access to health care. Many studies have shown that ethnicity, race, and language can even be important factors in the quality of care, which they have called it "Unequal

Treatment" (Good, James, Good, & Becker, 2005; Mary-Jo, Seth, Ken, & Lawrence, 2011; Smedley BD, Stith AY, Nelson AR, 2003).

Other possibilities are inappropriate or inadequate care from clinicians unfamiliar with their language, cultural background, and social situation (Rockville, 2001; Wilson, Chen, Grumbach, Wang, & Fernandez, 2005). When a patient who is not proficient in the language that doctors speak presents to the clinic, there are barriers to effective communication, including the language barrier, cultural barriers, and health literacy, leading to a lower quality of care (Schyve, 2007).

Curricula of most medical schools in Canada and the United States cover topics relevant to cultural sensitivity (S. S. Willen, Bullon, & Good, 2010) and differences, especially in the mental health field, including the influence of race and socioeconomic status, the relationship of patient-doctor (Pena Dolhun E, Munoz C, 2003; Weissman JS, Betancourt J, Campbell EG, 2005). While courses provide information about some of the ethnocultural communities they serve, few give adequate attention to issues of healthcare access or complex language barriers in healthcare (Hobgood C, Sawning S, 2006; Park ER, Betancourt JR, Kim MK, Maina AW, Blumenthal D, 2005). Moreover, there may often be no specific training in working with interpreters or culture brokers for medical students or residents (Karliner LS, Perez-Stable EJ, 2004). Recently, in the US, since it is a law that patients must have access to an interpreter, usually in some hospitals, physicians are given instructions on how to work with interpreters, although not in official courses during their education.

Cultural brokerage, based on Mosby's Medical Dictionary, is defined as "the deliberate use of culturally competent strategies to bridge or mediate between the patient's culture and the biomedical health care system" (*Mosby's Medical Dictionary,* 2009). In another definition,

"cultural brokering is the act of bridging, linking or mediating between groups or persons of different cultural backgrounds to reduce conflict or produce change" (Jezewski, 1990). We should have in mind that sometimes the roles are mixed like the interpreter plays the role of cultural broker and vice versa. This is also addressed in interpreters' roles as "Mixing and Matching of Models" (Willen in Mary-Jo, Seth, Ken, & Lawrence, 2011).

All interpreters in Quebec should be a member of the Ordre des Traducteurs, Terminologies et Interprètes Agréés du Québec (OTTIAQ), which ensures that members behaving professional and competent in interpretation and use of technical words ("Mission and History - OTTIAQ - Ordre des traducteurs, terminologues et interprètes agréés du Québec," n.d.). To be a member of OTTIAQ, they need to have training and pass exams. In healthcare settings, when a patient is not fluent in English or French, they can ask the health authority or doctors to provide the interpreter service for them. If they accept, the costs are covered ("Quebec – Interpreter Services – MMHRC," n.d.).

Professional attitudes and practical constraints were associated with a lack of using medical interpreters for low English-French proficiency patients. As a result, interpreters are widely under-utilized in health care in Québec and Canada, as elsewhere (Flores, 2005; Karliner, Jacobs, Chen, & Mutha, 2007.). It was shown in another study that there are few factors which affect health care professional decisions for using interpreters. Limitation of time, alliances of care, treatment goals, and organizational-level considerations were named key factors (Hsieh & Ph, 2015). This happens, although mental health care professionals know that professional interpreters' utilization leads to better medical care. It increases the quality of clinical care for patients who are not fluent in English or French (Karliner et al., 2007). In another study, it was shown that performing the mental evaluation in a non-primary language of the patient is

associated with distorted or insufficient assessment. They also compared trained interpreters with untrained ones. They showed that ad hoc interpreters might have errors that compromise the accuracy of diagnosis and leads to a deficient evaluation of patient thoughts.(Bauer & Alegria, 2010).

Serious errors have been documented in clinical care due to the failure to use interpreters (Kirmayer LJ, Rousseau C, Rosenberg E, 2001). For example, in a study in Germany, a German-origin psychiatric trainee and a Turkish-origin psychiatric trainee and clinician interviewed German and Turkish patients with the paranoid-hallucinatory syndrome at the time of admission. There was disagreement in psychosis diagnosis in 19% of Turkish-origin patients and only 4% of German-origin patients (Haasen, Yagdiran, Mass, & Krausz, 2000). This shows that patients are at risk for misdiagnosis in psychiatry if they cannot communicate in patients' original language. To avoid error, language interpreters' use is a necessary medical practice approach that is neglected these days.

The report of the Standing Senate Committee on Social Affairs, Science and Technology recognized that an effective mental health care system that is consumer-oriented and focused on recovery must tailor services to meet the needs of individual clients in a culturally appropriate manner (Kirby, 2005). In the "Framework for a Mental Health Strategy for Canada" produced by the Mental Health Commission of Canada, Goal 3 focuses on issues of cultural diversity: "The mental health system responds to the diverse needs of all people in Canada" (Mental Health Commission, 2009). In the Framework, it is advised that attention to age, gender, migration status, cultural and linguistic backgrounds is required to achieve adequate medical care for diverse populations. It has emphasized promoting patient-centeredness as a crucial factor for high-quality healthcare. Thus, there is a great need to evaluate service and clinical interventions

to determine if appropriate and effective mental health care is provided to linguistically diverse populations. To date, however, there is a lack of research considering the mental health of French and English populations in Canada, let alone the mental health care received by Allophone patients in hospital settings. To address some of these issues, the present study will evaluate the access to mental health care provided to linguistic minorities, including immigrants and refugees, who do not speak English or French fluently through qualitative interviews at a university teaching hospital in a metropolitan city in Quebec.

Like an ECG for the heart examination, words are the tools used in psychiatric assessment; therefore, I use the expression "PQRST of mental health" for emphasizing the importance of language in mental health, which due to the new set and background of colonization, is neglected in many countries who have multi-ethnic population. Emphasizing on providing services, including health services and education in only English and French, is a kind of devaluation and language genocide for other languages spoken by immigrants and refugees, which was systematically performed during the colonization era by educating kids in schools and changing the formal language of colonized countries to English or French.

This study is "placed-based research," and people who have come from many different places living here are obliged to put aside their language and be used to the new ones, which certainly takes away many aspects of their lifestyle and compromises mental health access and services.

The significance of the Research

Between 2006 and 2011, the number of Canadians who had a mother tongue rather than official languages (French and English) increased to 20.6 percent. This was reported in Quebec province to be 12.1 percent; however, in Montreal, the biggest city in Quebec province, it was 32.5 percent. And at the same time, there was a decreasing trend in the population of people who only spoke French in Montreal (62.4% in 2001 to 56.5% in 2011) (Statistics Canada, 2012). This trend can be seen in patients, and at least one-third of psychiatric patients are expected to have a mother tongue rather than English or French who are rarely offered translators during their medical visits. No official report or research shows how many percentages of such patients receive language assistance services like an interpreter but based on the experts' sayings. It's very low.

On the other hand, as observed by experts and researchers and reported by the media, there is an increasing number of refugee applicants coming illegally to Montreal. They are called "irregular border crossers." They cross the Canada-United States line (The Immigration and Refugee Board of Canada (IRB), 2019). This is mostly happening from Canada's southern borders due to Trump's statements and policies about immigrants in the USA and his comments about black people. Moreover, anti-Muslim, anti-refugee, anti-DACA and anti-everything measures of the Trump administration have enforced the immigration of vulnerable people to Canada (Canadian Council for Refugees, 2017). Unfortunately, some of them risk their lives to come to Canada, while crossing borders via the forest, especially in the winter, they are at risk of many dangers, including frostbites of fingers and organs and possibly their life (Grabish, 2017; Kassam, 2017; Mallory Simon, 2017). And as we know, this category of people staying in Montreal has not considered censusing Canada statistics. At the same time, they do not have

legal status. However, they can be added to those populations who have a mother tongue rather than official languages and need healthcare services and potentially a language assistance service for interpretation.

In this study, we will investigate the thoughts of patients, psychiatrists, and hospital administrators about the need for language assistance services in psychiatry settings, and we will search for solutions to improve access to language assistance services in their treatment period. We will present study results and potential recommendations in academic journals and meetings and teaching seminars. They will also be presented to psychiatrists, hospital administrators, clinical teams, and mental health policy makers at the provincial level.

Results will be used to shape the background for future research and policy change. Moreover, since the effects of language barriers on the quality of psychiatric and mental health services are presented to hospital and community leaders, policy changes affecting clinical practice will more likely be implemented in meaningful ways. This will be especially critical in medical departments that provide treatment for illnesses and injuries requiring an immediate attention, such as emergency departments, where adequate urgent care may be compromised due to lack of available language interpreters. Our study's potential findings will highlight proposed solutions by various stakeholders to address the lack of language interpreters in the mental health care of cultural and linguistic communities. Also, this study will: 1) Foster institutional awareness and efforts to make the provision of language interpreters an integral part of clinical care; and 2) Lay the groundwork for future research, specifically, a randomized controlled trial comparing psychiatric diagnosis and treatment with and without the use of language interpreters. It will also lead to a study comparing how interpreters are utilized in different treatment settings, such as outpatient clinics versus emergency and inpatient departments. These findings will

highlight the needs of culturally and linguistically diverse communities and enable health services to adapt their priorities accordingly.

None of the available research has yet studied the issue qualitatively, including the population who use mental health services and those who provide at the same time. Some researchers have just interviewed health professionals, and others have done quantitative research. One study used a self-reported survey to investigate quantitively the linguistic needs, and they examined primary care mental health professionals including family physicians, nurses, social workers, and psychologists and found that approximately 20% of patients were allophones and in need of linguistic assistance services but available resources are limited (Brisset et al., 2014). They did not consider the patient's perspectives and did not do a qualitative study on health care professionals, which I have done in my research. In another study in Alberta, they conducted qualitative research on mental health care providers' perspectives for immigrants and refugees. They found the barriers, including the language and cultural barrier and stigma on receiving mental health services (Salami, Salma, & Hegadoren, 2019). In this study also, they did not consider the patient's thoughts on how the language barrier affects their access to mental health services, and it covered a broader spectrum of all barriers. My qualitative research covers both perspectives of patients and mental healthcare providers and administrators, and it was in a metropolitan city in the province of Quebec.

This research's main objective is to explore how patients speaking native languages other than English and French (coming from other countries to Canada, including refugees and immigrants) access treatment for mental health problems to identify catalysts for language barriers to care. For this purpose, I will interview immigrants and refugees, mental health authorities and psychiatrists, community leaders, experts in a primary health care clinic, Centre

Local de Services Communautaires (CLSC), and policymakers to review data on access and receiving mental health services. It will be a qualitative study to suggest policy recommendations to facilitate better access to mental health care facilities for culturally and linguistically diverse populations in Montreal and Quebec.

Patients' perspective involved in the research is very important to understand their encounter and experiences with the mental health care system. Besides, we get different perspectives: patients, clinicians, and administrators, and study recommendations will be based on their different perspectives and the details of their experience. The Quebec health care system will benefit from the results of my study. It will have material to base policy decisions to strengthen processes already in place that benefit immigrants and refugees' better access to the health care system.

Part-2: Understanding Language Barriers to Mental Health Services of Non-Anglophone and Non-Francophone Patients from the Perspective of Psychiatrists, Administrators, and Patients

Introduction

Studies indicate that health and especially mental health access for Canadian patients who do not speak Canada's official languages are more challenging than other Canadians. Immigrants and refugees who do not speak official languages have been shown to have reduced access to health care, and mental health care in particular (Ohtani, Suzuki, Takeuchi, & Uchida, 2015). Canada welcomes many immigrants and refugees who do not speak either of the official languages, and many refugees settle in Quebec province, which is more francophone (Statistics-Canada, 2018; Statistics Canada, 2011). Many studies address language minorities' ideas and challenges to healthcare access, which may happen in any setting. For example, in some English-speaking provinces in Canada, Francophone patients are considered a minority. Studies show that the language barrier of these Francophone patients is similar to that of Canadian refugees who do not speak English or French, which affects their access to healthcare and the quality of care, such as misdiagnosis or delayed treatment (de Moissac & Bowen, 2018).

Since there are no specific rules established that patients have rights to professional interpreters in Canada, healthcare professionals continue to rely on their staff, laypersons, and Google translates. However, higher risks, including misdiagnosis, are associated with such practices (de Moissac & Bowen, 2018). Even for professional interpreters in the US, there are no standardized processes or guidelines for interacting with patients and conveying the meaning of their words (S. Willen, 2011). In medicine, especially psychiatry, since words are a technology

for mental health assessment, communication is a vital component of the provision of good quality mental health care (Jackson, 1998).

In recent years, there has been increasing attention to language barrier studies in mental healthcare, including patient safety and quality of care. In contrast, studies about the effect of the language barrier on the patients themselves are limited. While people believe that language barriers only affect patients, there is a growing body of evidence that documents that language barriers can affect physicians and hospitals (Domino, McGovern, Chang, Carlozzi, & Yang, 2013). Not many studies have been carried out looking at doctors and administrators of hospitals and health policymakers' experiences and attitudes in dealing with a dense diversity of languages in clinical settings. Thus, we seek to build a deeper understanding of the effects of language barriers on patients and their care-providers, such as their psychiatrists and the institutions where they seek care. Therefore, we conducted a qualitative study to assess how language barriers and lack of interpreters affect non-Anglophone/non-Francophone patients' mental health access, from the patients' perspective and the healthcare professionals' lens.

Methods Section

Study design

We conducted a qualitative study involving individual in-depth semi-structured interviews with patients, doctors and case managers and administrators, and health policymakers from different ethnic backgrounds to assess the language barrier for mental health access in the study setting. We interviewed 11 patients and 10 psychiatrists-administrators.

Patients

We used a purposeful sampling strategy to identify patients from Middle-Eastern and North African countries from a roster of current patients in outpatient psychiatry clinic at the study setting provided to us by the hospital. From that list, we then selected 12 patients to interview. We consented to all participants, one declined to participate, so we interviewed 11.

Physicians and case managers and Administrators and Policy Makers

We approached psychiatrists and case managers about participation in the study. We interviewed select hospital administrators and policymakers in healthcare regarding the language barrier in psychiatric care and what factors may limit access to mental health services for patients. We also interviewed key administrators based on the organizational chart to get their views on the caregiving process. A total of ten case managers, physicians, or administrators completed interviews; an additional two agreed to participate in the study. Due to time conflicts, they were not able to participate at this point for this project.

Setting

The out-patient stable patients were recruited from an academic medical center's psychiatric department in a metropolitan city in the Quebec province of Canada. This hospital is located in a part of the city with most ethnic and national diversity. The standard of care in this hospital is English and French. Physicians and administrators who participated in the project were major medical centers in a metropolitan city in Quebec. Administrators and policymakers who participated work in the metropolitan health policy sector of Quebec province. We interviewed patients in a private room assigned for this purpose, and the doctors and admins/policymakers were interviewed in their private offices. All interviews were conducted between July 2018 and December 2018.

Participants, sampling, recruitment

A. Study population

Patients

We included psychiatric out-patient stable patients who speak Arabic or Farsi, with North Africa or Middle East descent on a roster, whose mother tongue was neither French nor English. We excluded patients whose mother language was French or English or lived in Canada for more than 10 years or were fluent in one of the languages. Patients who were admitted to inpatient hospital-based care were also excluded from the study.

Physicians and Case Managers

We included psychiatrists or case managers affiliated with a major medical center caring for at least one patient whose first language is neither English nor French and agreed to be enrolled in

the study. We excluded those who did not consent or did not have non-Anglophone non-francophone patients at all.

Administrators

We were particularly interested in gathering administrators' opinions and experiences directly involved in mental health care in the Province. We included those who, based on their organizational chart, had a managerial position.

B. Recruitment

Patients

Twelve patients were selected from the sampling list, and these patients were invited via email to participate in the study.

Physicians and Case Managers

Case managers and doctors were chosen based on caring for any patients who met the study's inclusion criteria for patients. An invitation by email was sent to case managers/doctors.

Administrators and Policy Makers

An email invitation was sent to the administrators and policymakers using the publicly available contact information.

C. Consent

All interviewees were given a copy of the consent form, and oral consent was taken.

Key procedures and measure

Data collection

All questions of participants were answered, and consent was obtained before starting the interview. Arabic and Farsi consent forms were provided to the patient-participants. Some patients could understand French or English; however, a translator was present throughout the consent process. Participants were offered a copy of the consent information. No names were recorded; all information was de-identified.

Measure:

We obtained basic demographic data from participants, including gender, age, immigrant status, years of having left their home country, duration of their stay in Canada, and their mother tongue. The researcher performed semi-structured interviews and used an interview guide. We had separate guides for each population. Interviews were conducted with patients in Arabic or Farsi with a translator and in English with other participants. Participants were interviewed once for one hour, with each interview audio recorded with their permission.

Topics discussed in interviews included:

1. Views regarding the role of language interpreters in psychiatric care
2. Views regarding what factors may limit access to language services for patients
3. Proposed solutions to factors that limit access to language services for patients

Analysis

Our qualitative data analysis consisted of an inductive, content-focused approach with category construction, comparison, and interpretation, used to analyze the interview data. First, the audio recorded interviews were transcribed, translated into English, and reviewed in detail. All data were loaded into the Dedoose software. After a careful review of the full set of interviews, open coding was conducted for each group of interviews. Separate open coding was conducted for patients, doctors, and administrators. Open coding included category labels, definitions, and illustrative quotes with specific examples from each code's transcripts. Separate codebooks were created for patients and doctors/admin groups. Again, we performed another comprehensive systematic review of data. Some new codes were created. Then similar codes were grouped into broader categories to characterize participants' experiences. We used an iterative approach for category development. We labeled each category and elaborated and illustrated them with excerpts from the data. Then, we examined categories interpretively and grouped them, linking ideas to form a broader concept. Categories are presented according to patients experiences and then according to health care workers opinions in 6 and 8 categories accordingly

Ethical Considerations

We obtained IRB approval from Harvard medical school and the local medical institution site. We received a waiver from written consent due to anonymity and confidentiality of cases, and also the study had minimal risk to participants, and just oral consent was taken. If a patient agreed to participate but went into an acute phase of the disease, the patient was withdrawn from participation. The hospital where the research was conducted had expert

medical/emergency team and referral protocols set in place if this could happen. In the case of stress-related issues, the patient has referred again to his doctor or emergency department. The study team ensured that all recruited patients are stable at the time of consent by confirming their status at the recruitment time and were not at risk for immediate danger.

Result Section

Study sample

We had two different groups of subjects. The first group, a total of 11 patients, were patients who had the experience of using mental health services at the hospital. The second group was professionals, psychiatrists, and high-ranking administrators at the hospital who were in charge of mental health services. These participants worked in and across different psychiatric specialty sites, including psychiatric inpatient services, emergency services, and outpatient psychiatric clinics. Some also worked in a subspecialty clinic, for example, the "FEP: first Episode of Psychosis," which serves patients who are referred for the first episode of psychosis for treatment, or on the "CCS: Cultural Consultation Service," which is a unique service for providing in-depth psychiatric evaluation based on the cultural background of patients with the use of a cultural broker and, generally, a team.

The average age for patients was 38.3 years and 45.6 years for providers. Sixty percent of psychiatrists-administrators who were interviewed were male, and this number was 23.3% for patients. On average, our patient population lived 1.2 years, while providers were in Canada for an average of more than 41 years. Patients' mother-tongue was mostly Arabic or Persian, with some bilinguals of Turkish, Kurdish, Dari, and Urdu. Doctors and administrators mother-tongue were mostly bilingual (French-English) with some other languages, including German, Italian, Greek, Persian, and Urdu.

Table 1: Demographic characteristic of interviewee population

Column1	Male No(%)	Female No(%)	Immigrants No(%)	mean age years	if immigrant, duration of leaving their home country, mean(y)	duration of stay in Canada
admin/doctor	**6 (60)**	**4(40)**	**3(30)**		**45.6**	**25.3**	**41.3**
Patients	**3(23.3)**	**8(72.7)**	**11(100)**		**38.3**	**3.1**	**1.2**

Table 2: Mother-tongue of interviewee population

mother tongue	
Professionals	Patients
English, French	Urdu, Persian
English, Italian	Arabic
English	Arabic
French	Persian
German, English	Arabic
French	Arabic
French, English	Dari, Persian
English, Urdu	Arabic
French, English, Greek	Persian, Turkish
English, Persian	Kurdish, Arabic
	Turkish, Persian

The results are presented in two parts. The first section presents analyses of patient interviews in six categories; the second section features interviews from providers and administrators in eight categories.

Patients Results

1- Complicated access to mental health services

1a- Long process of visiting a psychiatrist

Patients in our study indicated that they often experienced long delays between the time they began their search for a mental healthcare professional and the time they were able to obtain an appointment. This is because of many factors. First, Patients explained that they were often

unaware of the mental health resources available within their communities, and, if it was, how to access them, which is on the patient side. The referral system from the family physician to psychiatrists involves significant delays, or sometimes patients do not have a family doctor. In some other cases, mental health services at the hospitals are only accepting patients from their sector, which is on the administrative side.

> *Finally, my husband took me to the doctor. She said I am depressed and referred me to this hospital, but visiting a doctor here took almost five months, and my situation became worse, I wanted to commit suicide, but my husband understood and stopped me. (patient female-32Y)*

> *I was feeling low, did not have the energy to do anything, my mother told me possibly I am depressed, but we did not know where to go. It took a long time that one of my mother's friends advised going to a walk-in clinic since we did not have a family physician, and the doctor there gave me a referral letter to see a psychiatrist. When I asked her where to find him, she said, "you can go to any hospital," and I went to one hospital and they told they do not accept me since I am not for their sector and again, we were in the first place that we did not know where to go. (patient female-36Y)*

1b- Complicated way of getting an appointment for a psychiatrist

The paperwork and process of getting an appointment for a psychiatrist are sometimes very complicated. First, patients need a referral letter for a psychiatrist from a general practitioner or a family physician. Since many people do not have a family physician, they wait to get one and then ask their family doctor for a referral. And this may cause an initial delay.

Then, the next delay is the complicated process of getting referrals. For example, written letters must be scanned and faxed, which is often an unfamiliar and awkward process for patients and families. The final delay occurs at the level of the hospital. Patients explain that once the paperwork is completed, they sometimes have to wait months to be seen by a psychiatrist. Hospitals often tell the patient that they will call them near their appointment, and it can be a few months, and the patient does not know when to estimate a psychiatrist can see approximately him. Sometimes, this waiting time is a few months. The process is vague and unclear for the patients. When patients call again for a follow-up, the hospital operators repeat one answer: "You are on the waitlist and need to wait until we call you."

> *He referred us to a psychiatrist. My husband went to the hospital to make an appointment, but they told us we do not accept papers, you should scan the letter and send a fax to us, which was so awkward while he was there. They asked for a fax or email! And then my husband's friend helped him send a fax to the appointment center of the hospital. After two months, they called us and gave an appointment for a month later, which was almost 3-4 months from the time we got the referral letter. The whole process was ridiculous and playing with papers. (patient female-33Y)*

1c- Unavailability of professional interpreters at the clinics and use of family members for this purpose

Generally, interpreters are not available at the time of the visit to the clinics or hospitals. Therefore, doctors need to use other staff or family members for translation, especially when they do not expect some languages. This is often practiced in psychiatry settings, although there are disadvantages of using a family member or a layperson as a translator.

When we visited the doctor on the appointment day, they told me that they do not have a Persian translator at the clinic, and the doctor asked me if I want my husband to translate for me, and I said yes because there was no other choice. (patient female-46Y)

The first time we went to the psychiatrist's clinic was hard because she did not know we are blind or cannot speak French, and was not ready. My sister can speak English but not fluently and could convey some messages. However, generally, it was a really hard situation. (patient female-38Y)

1d- Being dependent on family members in getting health services

Most of the time, as our patients indicated, they are dependent on their families for seeking medical care. This can be due to their dependency on translation. Generally, they need to go with their family members to receive the services because of their physical incapability, illiteracy, or familiarity with the new environment. In some cases, due to language issues, patients cannot find the proper address or location of clinics and doctors and cannot read the signs and need their family members to guide them. Our patients have described it as below:

Everywhere I go. First, they speak French, then when I do not understand, they start speaking English if they are kind, but I know just a little English, and my husband should be with me to translate, I cannot do anything independently. (patient female-33Y)

I was born with eye issues and could not go to school and learn how to read and write. I did not have much chance to learn English or other languages. My brother and sister are semi-blind, but they see things and can speak English, so I need to go out there with one

or two of them to help me find the way and translate what I say. And I trust them more, so even going to a doctor, they may ask if I need an interpreter at the CLSC, I still need to go with my brother or sister or both, and I trust them more in translation cause they understand English better than me. (patient female-38Y)

2-Lack of official language fluency shapes overall well-being

2a- Being isolated

Lack of motivation to see friends or being involved with the community, possibly due to the stigma of mental illness or possibly because of a lack of language skills, can be a risk factor for isolation and worsening mental problems.

As you know, all those stressors made me depressed, and I was always at home and did not want to go out, was ashamed to meet my friends or other people from my community. (patient female-35Y)

I was not good in either French or English and did not have much motivation to go out or participate in the events, even my children were ashamed that their father could not speak English or French fluently or with an accent and did not want to go out with me. I preferred to stay at home, and I guess it made my depression worse. (patient male 38Y)

2b- Conflating a lack of French (or English) with a lack of education

Although many immigrants and refugees are well-educated in their own countries, they are treated as if they are uneducated when they come to Canada and cannot speak French or English.

They look at me in a weird way that I am illiterate, but I was a teacher in my country, and it is not fair. I feel this more with those people who speak French. They look at me in a way like I have captured their land. I feel it is a kind of racism coming out of their eyes and their languages. (patient female-37Y)

2c- Feeling incapable

Patients feel they are incapable of speaking the hospitals' formal languages and possibly cannot manage their things, which may increase their stress level. Lack of language skills may put patients at risk for mistakes or shameful situations, as described by our patients.

I do not speak French at all, but I understand English and can speak a little, which was not good enough to talk, and I was feeling much more stressed while someone was talking with me in French and little stressed in English, but both of them were giving me a bad feeling of incapability. (patient male-44Y)

When I was at the hospital, the secretary asked me to fill a form. I really could not understand some parts but was shy to ask her or other patients waiting there. It took me a long time filling the form by using google translate, and in the end, still, one part was filled by mistake that the secretary laughed at me, I was ashamed, and my face went red, had a weakness in my feet when she laughed at me. (patient female-32Y)

2d- Feeling dehumanized.

Whenever healthcare team could not communicate well with the patients, patients believed that they have not behaved as a human, but they had a feeling that they are being treated as an object like a machine or a car that a mechanic wants to fix it. This feeling of dehumanization can

make everything else worse, including the treatment outcome. Patients expect to be treated by the healthcare team as a human. When healthcare professionals cannot communicate with patients due to language issues, it is so disappointing and embarrassing for them.

> *It was awful, I could not connect well; I was thinking about why I have left my country at that moment, cause doctors are super caring in my country, but here if you do not speak their language their do not care a lot and think you are just a paper or a machine, not a human, it was a miserable experience going to emergency department here, and I hope not to go there again (patient female-37Y)*

> *I was in the ER and to seek a psychiatrist, and first, an emergency doctor visited me, he did not understand me, and I did not understand him, then he started examining my body while I had a mental problem and I thought he is like a mechanic for cars that treats patients as metals without any spirit, in that situation, I could not trust the treatments that the doctor wanted to give me even if I could understand them" (patient female-32Y)*

2e- Mistreatment by staff associated with language

As patients described, the lack of proper communication and language skills creates feelings of racism or anger in patients and possibly staff while the patient cannot speak French. This is because those staffs are not prepared to face someone who does not speak French or have no proper resources like interpretation for short communications as a nurse or cleaner wants to communicate with the patient.

> *She asked me in French to wait outside, I did not understand initially, but she shouted at me and showed the way to the outside room. I then noticed I should leave that room; I*

was tired and frustrated and more upset about why this French-speaking staff is short-tempered and angry. It is not my fault that I am sick, or I do not know their language. They were looking at me as an outsider/enemy or, I do not know, someone who has occupied their land! It is not fair. I have legal status in Canada and living legally here. (patient male 38Y)

While the doctors and nurses or receptionists were talking in French, I could not understand anything. I was having a weird sense that I am a stranger or they are talking on my behind especially one of the nurses whom I was thinking she is mean to me, so I thought she is intentionally speaking in French, not English with the doctor that I don't understand at all. She can say whatever she wants to the doctor. (patient female-32Y)

3-Positive outcomes with interpreters

3a- More trust in the treating team

Patients indicate that they can create more trust in their treatment team when speaking their language in the clinic. Speaking in their mother tongue gives them a sense of security and trust like they are safe and helps them trust the treating team better. As patients described, having a better feeling and trust makes them give more needed details and information to the treatment team necessary for their care process.

It was not bad, but you have better feelings of trust toward that person and can communicate faster and better when you speak the same language. (patient female-35Y)

When I was able to describe things in my mother tongue and translate it to the doctor, It gave me a good feeling that I am home. I was able to tell as much as details I wanted to the doctors, this caused me to trust him and whatever treatment he is going to give me since I ensured now he knows all the things about me. (patient female-33Y)

3b- Expressing feelings and emotions is easier in patients' mother-tongue to doctors.

Patients expressed that they can easily reveal their feelings without thinking of using what kind of words in another language, which helps both the doctors and the patients. When patients speak in their mother tongue, they do not need to think about grammar, sentence structure, and choosing the proper word or equivalent to what they have in mind, as they would have to do when speaking in a foreign language. This will overall make the process of connection and assessment easier.

Communication in my mother tongue would be easier, especially for mental issues, describing sadness. You feel it is too hard in other languages; you always need to think not to make grammar mistakes and choose the right words. In contrast, in your mother tongue, you do not need to think consciously about using words, and you easily express your deepest feelings to the doctor. (patient male-32Y)

I needed this, I mean talking to my doctor via a translator, I could easily tell him what is in my heart and head without too much thinking. (patient female-36Y)

3c- It is not just the language. Cultural issues also exist in understanding the patient.

Language and culture are woven together. Different cultural backgrounds may express things differently, and it needs more elaboration to the treating team if they do not understand that culture. Sometimes an interpreter from the same region or country of the patient can help clarify those things or confirm the facts the patient is referring to. This means a lot for their care. The patients see this as an added benefit. This can shape a better quality of care, especially in mental health.

> *And sometimes, doctors do not understand what I say because I come from a different culture, so when I express something in my language and the translator translates that to English or French, it might be a vague thing. The doctor asked me several times to explain more about some of the topics. I guess the interpreter talked with a doctor a few minutes about that. (patient female-46Y)*

> *A doctor was perfect when I was talking about our traditions or Jinns and ghosts, but the others were thinking I am mad. However, that doctor thought this is part of our culture and helped to understand me and my issues; the interpreter from our region confirmed that to the doctor that some houses may have Jinns, doctors didn't know about Jinns. They were thinking I'm talking about ghosts instead. (patient female-36Y)*

4-Feeling humanized

4a- Translation services humanize the patients

Patients will feel respected and important when a translator is available. It gives them a feeling that they are treated like a real human instead of treated as just an object which needs

treatment. This is very important in terms of establishing a relationship between doctors and patients.

> *It was like I am an important person. I felt someone cares for me for who I am, and they care about me as a human who has issues, and language is not a problem if you cannot speak their language. Also, I could talk about my concerns and emotions first because of explaining them in my language, and then because my husband or none of my family members were there. (patient, male-47Y)*

> *It was awesome to talk with the doctor like a real man, the other times, I was not feeling to be treated as a human, but when the translator was there and could translate whatever I was telling, I felt that they consider me a human, not a patient or a subject. (patient male 44Y)*

5-Effect of the third person in doctor-patient visits

5a- Not revealing important things in front of someone they know

Patients mentioned that possibly they might not be willing to reveal all things to the doctor. Simultaneously, a family member or a translator they know (possibly from their community) is being used as an interpreter. This is because they do not want to raise more concerns for their family members and avoid spreading words about their illness in their community.

> *But I did not want my father to be concerned more about my health situation, and there was something that I wanted to discuss with the doctor about my sexual life, which I was not convenient in front of him, and I just did not explore them. (patient female-46Y)*

I think sometimes it can change things cause, as I said before, I did not want to mention a few things in front of my husband as a translator, or even there was a translator whom I know from before, if she was translating, she could tell everything to other women in the community but what if those things could change my treatment plans? (patient female-36Y)

5b- Gender match for the interpreter is important

As patients indicated, they feel more convenient when the interpreter is from the same gender. Due to cultural backgrounds, they cannot talk in front of someone from the opposite gender, especially about some sensitive cultural issues. This can be very important in revealing things instead of blocking the flow of giving proper information to their treating team.

I am happier and more convenient with a female interpreter, and even a female doctor cause culturally. We do not feel relaxed in front of men and cannot talk a lot. (patient female-33Y)

5c- Translation adds time to the clinical interaction

Some of the interviewed patients mentioned that they feel translation is boring and time-consuming in consultations. When they tell something should be translated, and in this way, everything is said twice (in different languages), and a consultation that could be 30 minutes takes one hour.

It was easier to talk with a doctor in my language, but someone needs to translate when you do not know their language. The doctor then asks questions and needs to translate that too, so it is time-consuming and boring. (patient female-37Y)

I had an interpreter a few times, and those meetings are so long that I felt tired after each. It is like everything is said twice and repeated; communication is not direct; however, it is better than not understanding what the doctor is telling. (patient female-32Y)

6-Mistrusting interpreters

6a- Lingering concerns about the accuracy and completeness of the translation

Patients describe their different experiences of translation. Some are great and humanizing. Others are not so good. Sometimes, patients cannot trust what is being translated by interpreters since they think they are making things shorter or, in some cases, patients feel translators are not translating exactly what has been said. This may affect how the patient feels about details and translation.

Well, I could not speak English or French, my father was partly translating, and we had an interpreter. Talking with the interpreter was different from talking directly to a doctor. It is like you talk with someone else, and then she tells the doctor what is happening. You do not know always know what she is saying. Sometimes, my father, who knew English were adding or correcting the interpreter, like she was not translating enough, but anyways was better than not talking with a doctor at all. (patient female-46Y)

6b- Cultural/political mistrust

On the other hand, sometimes, due to patients' cultural or political background, they reject an interpreter from their own country or region or certain religions. This might be because of civil wars and cultural or religious clashes from back home. Pre-migration baggage and problems may still be with patients due to having their community in the new country. This can be a possible reason why some patients do not like to have an interpreter from their community.

> *I was telling the doctor about my background history that we are from Ismaili Shi'a Muslims and were a minority there and at risk for our lives daily due to other groups were harassing us, and were living in different houses and just going out hiddenly in the nights, but seems she (the translator) just made it one sentence when told to the doctor and did not explain the whole situation which was important for us why we are here now. Then my brother entered the discussion and told some sentences in English directly to the doctor. (patient female-38Y)*

> *I was told that they bring an interpreter to my psychiatrist's visit, and I asked who they are. They said someone from Kurdistan, Syria, and I did not like to see any other Syrian there who can know my mental issues, especially Kurds. (patient male 44Y)*

> *When I went to see the doctor, he said we are a team and also introduced me to the interpreter. He was a guy with a beard and looked to be the religious type we always saw in the government or intelligence agencies. Then I told him I would not come to the meeting, and the doctor asked why and I said I cannot talk in front of this guy and then we had to reschedule the meeting with another interpreter. (patient male 38Y)*

Psychiatrists-Administrators Results:

1- "Setting-dependency of access to interpreters."

Using an interpreter for mental health issues is setting dependent, and interpreters' availability depends on the type of health care setting where the care is delivered. If it is an emergency room or inpatient wards, access to formal interpreters is difficult or rarely happens.

> *For inpatient and emergency room services, it is a very different story. There, almost impossible to get an interpreter, a professional interpreter…I try not to use family members. I try not to use informal interpreters of any kind. Sometimes in the emergency department, I need to. (nurse-admin male,50Y)*

However, at the outpatient clinics and specialized services, including "FEP: first Episode of Psychosis" and "CCS: Cultural consultation service," interpreters are often used if patients or their family members do not speak French or English.

> *If we saw him at FEP, but he was too old for that, anyway, for someone like him in FEP, we would call an interpreter, at least if we could not do for the first interview, we will do that for the second interview. For CCS, we would be much more diligent in tracking down the languages and getting the interpreter needed. So, it is a bit quiet setting dependent. (psychiatrist male, 44Y)*

On the other hand, in emergency rooms, it is not very easy to have professional interpreters. As for requesting an interpreter, they need to call the interpreters' bank, which is the formal authority and works only on weekdays. They may not be able to provide interpreters at any time or even the same day. For example, if a patient comes in the Friday afternoon, the patient should be kept until Monday morning, that the staff calls the bank, and send an interpreter for the next soonest date. This prolonged process may lead to other patent stressors, including

frustration and disappointment from the system due to the sub-optimal situation in the emergency rooms. Doctors and administrators have illustrated this concept that getting an interpreter in the emergency department is difficult.

> *I tried to organize one at the emerge, I called the bank of interpreters, we got an interpreter, we told him, we needed to have an interpreter, this is now a Friday afternoon, we needed an interpreter for the Monday morning, so I called and tried to arrange, but imagine that patient just remains at the ER whole weekend without doing so much for him, I do not know what happened, I should have followed, but did not. So that is difficult as it is to find an interpreter. We did not even have a process in place to confirm if the interpreter could come on Monday. I had just to leave a note for the nurse because the bank closes Friday afternoon around 4. We saw the patient around 3, something like that, so we got through, but that is all we could do. Then we kept the man over the weekend, so we were trying to have a good interview with an interpreter who could understand his language on Monday morning, so that was just one example of problems at the Emerg*. (psychiatrist male, 53Y)

> *In the ER, you cannot get a professional interpreter, because from the time you call the "Bank" till they send you an interpreter may take a few days, especially if it is in night shifts or weekends that they bank closed. Therefore, I, most of the time, use a layperson, possibly a hospital staff who knows the patient's mother tongue. Suppose we want to wait only for the professional interpreter. In that case, it prolongs the process and increases exhaustion for patients unless they get an interpreter. There is a sub-optimal situation in the ER; there should be a way to organize this better. (psychiatrist, female, 52Y)*

2- Adherence to a formal code of ethics distinguishes formal and informal interpretation

Doctors and admins described that they had used both formal interpreters (who have been trained and called from the bank of interpreters) and informal ones, including family members or other hospital staff. They were willing to use formal interpreters whenever possible due to the following reasons: a code of ethics.

> *Interpreters have codes of ethics; at least they know they are supposed to keep confidential and not talk about it with other people about these consultations. Just general house stuff, I do not know what happens after. I do not know even where they go after*. (psychiatrist male, 44Y)

As our healthcare professionals described, formal interpreters have a better knowledge of languages and can use technical words that they may know to help the assessment. This is illustrated below:

> *They are trained, maybe in mental health, maybe not in mental health, but they know how to use proper words and technical words*. (policy maker, male, 40Y)

Confidentiality is the most important thing in mental health issues, which is ensured by having a professional interpreter since they sign special forms before consultations.

> *The good thing about interpreters is that they sign confidentiality forms and the payment forms, so confidentiality is ensured, which is very important in our field. (high-ranking admin, female 51Y)*

Furthermore, professional interpreters have more experience in doing translations and have done several before. This gives them the ability to control situations and choose proper words and speed of translation.

> *Professional interpreted had conducted several cases, and they know how to manage the pace and tone of translation, everyone. (psychiatrist, female, 40Y)*

On the other hand, they may get less valid data from family members. This is because either the family members may be themselves part of the problem and cause the stress of predisposing factors for that mental health issue or change the data, so they want to induce their message to the psychiatrist.

> *True, and this is an issue that sometimes we use translators. As healthcare professionals, we always ask ourselves how reliable the families are and how much we can count on them, but sometimes they are the only source we have. Is the family saying what the patient is saying? We cannot recognize if the family member is twisting what the patient is saying, the only person who knows, even the patient would not know that, because he is not communicating directly to us. (psychiatrist, female, 46Y)*

Some other informal interpreters may also not choose the proper words or translate completely, possibly because they are raised in Canada and lost some mother tongue skills. In that case, some date or most are not understood by doctors nor patients or their family members.

> *I remember who he was now. It was a man from South Asia, I think he was from India, and we were trying to use this informal interpreter. His Urdu was not good, so he was using many English words when he was translating. When he was translating what we said, we could hear lots of English phrases. And things and the other members of the family were puzzled, they could not really understand him, and he could not understand*

them well either, and the patient himself was not telling much, because we had a tricky situation (psychiatrist, male, 52Y)

3- Suggested solutions

There were some solutions raised to solve the problems. They suggested using telephone interpreters whenever formal interpreters are not feasible or accessible. Some of them also emphasized having a multi-ethnic team that helps provide better care. They also suggested accepting professionals and students from different backgrounds in mental health. This is described as below:

In the outpatient and emergent settings, if we cannot find any other person, we may use family members. I have a suggestion for telephone translation for emerg. (psychiatrist male, 44Y)

I never had a problem because I work with a team from different backgrounds. We have Chinese and Greek and Arabic nurses in our ward. Most of the time of psychiatric residents is multicultural too and speaks several languages, so I strongly recommend program directors be open to recruiting nurses, staff, or residents from different cultures and backgrou. These ads are essential for having a successful multi-cultural team. (Psychiatrist-Admin, male, 44Y)

4- Trust or mistrust about formal interpreters

Interviewed mental health professionals indicate that trust is very important in the clinic settings, and they trust formal interpreters more than informal interpreters, such as family or

community. They explain that formal interpreters can offer confidentiality, and they had technical training, which means a more accurate translation.

> *Normally, we like to have formal interpreters since they are neutral versus a family member. They sign the confidentiality forms; therefore, we get a valid date while it is technical and confidential. (psychiatrist, female, 40Y)*

Psychiatrists mentioned patients also trust formal interpreters due to the healthcare system's confidentiality measures, and that patients feel more confident and feel they are taken care of by the healthcare system. The connection will also be better and warmer when in the clinic patient finds someone they can talk with in their own language, which leads to a positive feeling in hospitals/clinics' stressful environment. So basically, the trust will be from both sides to the professional interpreters.

> *Many patients do trust interpreters since they trust the system. Due to the code of ethics, interpreters feel they are taken seriously, care about them and their issue and accept translation by a formal interpreter; they can also connect better with someone who speaks their mother tongue and helps them more. (high-ranking admin, female 51Y)*

On the other hand, there might be a mistrust of formal interpreters from the patients' side. If these patients come with previous cultural baggage or from violent countries or a history of civil war and division amongst nations, they may not trust these interpreters. They may feel they are under surveillance or may find the person from the other opposition groups or consider the possibility that their secrets are sent to their government.

> *If the person from minority groups is open to an interpreter from his community, we use, and if not, that may happen a lot, we may use other sources. For example, Tamils and*

those involved in civil wars are suspicious of translators from their own country. (psychiatrist, female, 40Y)

Many other problems arise, and some people come, and most people accept interpreters, like 80%. However, maybe one-fifth of people do not want the interpreter there, some people come for a consultation, and they see the interpreter there and are very concerned. We do not know why they are concerned. One man came, Russian, he saw the interpreter, who was a man with a big beard, longish hair, and silver teeth, like a guy in James Bond movies, was he in Jazz, he freaked out the patient, he wanted him to leave immediately and did not want to do anything with that guy, he was very concerned about Russian government surveillance because he had back in Russia some information, long story, yeah he kicked him out, the man could speak English poorly, and we could not elaborate a lot, for some reasons some people have negative reactions. (psychiatrist male, 53Y)

In some other cases, patients may feel their mental health problems, which are other community members might know a taboo issue in their community, and they hesitate. They reject a translator from the same ethnicity or community.

Even if you work with interpreters, minority groups may be a problem. Because sometimes people come from small communities, everyone knows another. Words get around. (high-ranking admin, male. 41Y)

5- An over-focus on Franco-Anglo language policies eclipse the needs of linguistic minorities

Some doctors/admins believed that there are many debates overdominance (versus equality) of French or English in Quebec, and due to this, other languages are neglected or missed at all. People speaking those languages are not seen. These psychiatrists feel the dominance of one social group or one language-speaking group will lead to losing opportunities to help patients from different backgrounds. These opportunities can be providing better health services, including mental health services and many other social and cultural opportunities.

> *In Quebec, there is so much focus on the French-English problem that other languages are neglected. I think that debate takes all the oxygen. There is not much energy or interest and money left over for Spanish, Arabic, big languages in this city, and no services, so I think that is a shame, that is what I think, I think for the reason of English-French tension, they will not do a very cultural competitive thing. (psychiatrist male, 44Y)*

Due to the set policies that many services are available only in the French language and some in French and English only, mental health professionals believe that people talking in other languages are excluded from many mental and social services, including advanced psychological testing, psychotherapy, job training and more. For example, suppose a patient needs specific psycho-neurological testing in another language rather than French or English. In that case, they do not know where to refer the patient or even if it is available. Interviewed doctors and administrators have illustrated this concept:

> *Because in many cases, if they do not speak English or French, they are excluded from the study or whatever, not very helpful. (high-ranking admin, female 51Y)*

Oh, much time, if they do not speak English or French, there are very limited things that we can offer, some places you can go with the interpreter, but anything you do with psychotherapy, more complicated psychological testing, job training, all these kinds of things are very difficult to find. (high-ranking admin, male. 41Y)

6- The problem of accuracy

Clinicians mentioned that an informal interpreter's interpretation could be under the question of validity and accuracy and other challenging issues. Some doctors/admins who participated in this study mentioned that they feel interpretation from the formal interpreters. They can have its accuracy challenges, for example, if they simplify the questions and messages not to convey the whole concept.

It is really hard to understand what is happening when there is a translation, and I need to trust the interpreter, accurate sense of what is going on. However, sometimes, I am not sure what is happening, and the sense of things being translated is different. For example, I say, " now that you have told us about your parents, then we move to the current situation," and he just translated, "What is going on now?" He did not convey the message and transition from topics. They cut off many complicated things, I'm worried about that, and a very blunt kind of information and questions is my concern. (psychiatrist, female, 40Y)

Moreover, physicians recognize that sometimes a concept or an exact word in the French or English language does not have a local equivalent (possibly echoing what some interpreters have told them), and they are not sure how interpreters translate that word and what would be the reaction of patients to what has been translated. Therefore, physicians are concerned about how

clear their messages are for the patient when there is no one-to-one translation, and they believe that this disconnect could affect the validity of the data they get.

> *I also worried about languages; there are no words for something, so I do not know, and interpreters say no word for anxiety. They struggle to find something and say something, and I do not know how the patient responds to that word. If the interpreters are confused, the patients must be very confused, so I try to say different words. Are you worried? Are you anxious? (psychiatrist male, 44Y)*

7- Being humanized and valued, better access to mental health

Based on clinicians' access to mental health services may be affected if patients are not speaking one of the two main languages, fluently or do not have someone to help them. For better access to mental health services, therefore, interpretation seems to be very important.

> *I cannot say hesitant to seek mental health services, but they may have internal conflicts for seeking such help. And for a second thought, yes, I think it might happen due to language barrier taking the proper care, which could be an issue. But if they have their loved ones around that can help, it can accelerate things. (nurse-admin male,50Y)*

> *Sometimes patients are hesitant to see a doctor who speaks other languages. This may cause less accessibility in psychiatric services, too, in which words are the tools for assessing the patient, and language is very important. (psychiatrist, female, 46Y)*

As clinicians mentioned, some patients are thankful for giving them this opportunity to have a formal interpreter and let them be heard. This makes them feel valued and makes them

able to talk in their own languages and may have a better thought process in their language. Therefore, interpretation is helping patients feel like they are valued.

> *Many of the patients express gratitude for the chance to talk for the first time, and they can be heard. (policy maker, male, 40Y)*

> *I am going back to the benefits of translation, because maybe, the interpreter may have a good relationship with the patient. Maybe they can better process their thoughts in their mother tongue, but in English, they can say, "it is ok" and those kinds of simple things, which could be beneficial for some patients. (psychiatrist, female, 40Y)*

Generally, having interpretation services and signs in the healthcare settings in diverse yet common foreign languages of local immigrant and refugee populations gives patients the feeling that they exist and humanize them. There are many immigrants and refugees, some who speak French and or English and languages of their lands of origin, who are legally living in this region. Many new immigrants and refugees might not yet be able to read or speak English or French; therefore, in a healthcare setting, having signs and information in foreign languages of large refugee populations might be respectful and shows that they are seen and valued.

> *It might be really helpful if they read something in their language. It gives them positive energy, "wow, I exist."* (psychiatrist, male, 44Y)

> *Or signs in the hospitals in the third and fourth and fifth languages that we should have, and why not? It is ridiculous, big French font and small English underneath, all focuses are on that, but there are tons of Spanish speaking people coming here. Some of them*

cannot read French and English very well, or at all, so if they see a Spanish sign, it would be exciting for them, and they feel at home and respected. (psychiatrist male, 53Y)

8- Language standards in healthcare settings

Based on interviewed doctors/admins in many healthcare settings, there is not a language policy or standard (rules and regulations for how to carry out an interpretation in health care settings) that indicate expectations and rights related to translation services in the health care setting and how to provide services to patients who do not speak French or English, and it is arbitrary how and when to use an interpreter and when to ask help from informal interpreters.

I know some places around here, some clinics no longer provide interpreters at all! They make the patients come with an interpreter, maybe a family/friend. Most patients cannot afford to have interpreters with themselves. (Admin, male, 44Y)

We do not have a language policy at this hospital, or if we have, I have never heard of it. It is arbitrary and based on the need, they may use a family member of hospital staff or call the agency for a translator, and I do not know even at Saint Mary's if we had a policy like that. (nurse-admin male,50Y)

On the other hand, there is no measure for fluency and patients' language level based on that one. Doctors decide which patient needs an interpreter, and it is different from doctor to doctor. Since there is no formal policy for interpretation, it is left up to individual doctors' discretion. It can be seen in the following example mentioned by some doctors/admins:

For outpatient cultural consultation, normally, we have an interpreter. Sometimes during the interview, we understand we need an interpreter cause we ask the referring clinicians

if we need an interpreter. However, sometimes, they have overestimated the patients ability, so those who say speaks fluent French or English, and they come here. We see they cannot, it is hard for them to follow the discussion or it is hard for them to express their emotions or feelings, so in those cases, we try to come back with an interpreter for the second interview if they are open to, that is what we do. (psychiatrist male, 54Y)

Discussion

This study examined the experiences of patients, psychiatrists, administrators, and health policymakers about language barriers in mental health services for multi-ethnic patients in a metropolitan city of Quebec province. The study found that a lack of language assistance services gives dehumanization to patients while receiving such services. On the other hand, the availability of professional language assistance re-humanizes non-English, non-French language speakers seeking mental health services in Quebec. Providing mental health services by using professional interpretation makes the patients feel they have been treated as human beings and that they are being cared for while lack of such services increases the hassle and communicates to patients that they are just an object. The concept of including all stakeholders including patients, psychiatrists, administrators, and health policymakers in the study was the strength of our study design and the fact that all groups of patients brought up the concept of humanization, and psychiatrists and administrators which are the bridging point of all group results were conclusive.

This concept of humanization or giving the patients a human character was less paid attention to language barrier research; however, it was strongly mentioned in other qualified health care studies. As mentioned by (Clark, 1983), the treatment process without language by a physician is similar to a veterinary doctor who treats an animal. Not seeing the patient as a human being and just having a “Reductionist Approach” by doctors by reducing patients to the interactions of their parts, or simpler or more fundamental things not as a human being can be reflected in mental health settings when their patient cannot speak English and French, and interpretation is not available. Moreover, there has been a value framework for qualitative research about healthcare's humanization (Todres, Galvin, & Holloway, 2009), which is

progressively being used. In fact, as Elizabeth Carpenter-Song chronicles, humanization can be even reached by infusing the relationship physician/patient with a degree of uncertainty: refusing to answer the question “Who are you?” in unequivocal and univocal terms, the clinical pair acknowledges the possibility of endless discovery of the other, an uninterrupted process of recognition that renders the relationship fertile and meaningful (Carpenter-Song, 2011).

Trust and mistrust were other important issues raised about interpretation. While both groups of patients and psychiatrists had greater trust in professional interpreters than family members or a layperson or hospital staff (Good, Willen, Hannah, Vickery, and Park. 2011), there were certain cases when mistrust could arise. Doctors sometimes could not be convinced that their message was precisely conveyed to the patient, possibly due to being shortened or summarized by the interpreter or taking over the conversations by them and intervening in the treatment process. Patients also happened not to trust them because of themselves and the interpreters' appearance, cultural or political background. Some had a sense that the interpreters are changing their words. This has been noted in other studies, such as one on mothers’ sense of mistrust in professional interpretation. (Steinberg, Valenzuela-Araujo, Zickafoose, Kieffer, & Decamp, 2016)

Unlike the United States, which has rules that patients have the right to interpreter services (by phone if not in person), there is no clear rule or right of access to such services in Canada. Furthermore, given the battle in Quebec over language prominence of French over English sometimes leads to neglecting patients who neither official language. And even hospitals and academic settings that are more open-minded lack a standard of care for those non-francophone-non-Anglophone patients against Canadian values. The latter may be a consequence of public policies about language that do not provide a budget or hold the importance of such

healthcare services. Although negative impacts of lack of interpretation in terms of access to health, patient safety, and patient satisfaction have been shown in several studies, including a review article of 136 studies by Schweiz et al. in 2016 still the use of interpretation services has not yet become a right for patients in Canada. It has not even become a priority for many hospitals to make it a standard of care.

We recognize that our study has limitations. First, like qualitative research, we cannot generalize the results. However, the results are a way that can inform future studies about language barriers or policies about supporting language assistance services for such patients or officially recognizing the diversity of languages. Second, we could not label many details noted in the interviews. However, we selected the most important ones, and descriptions and elaborations are not definite, but they are suggestions that further use the information provided. Finally, the selection of the patients and doctors and administrators may be another limitation. However, we tried our best to randomly choose the patients from the list of patients (as defined in the methods section) who fulfilled the inclusion criteria and doctors who had such patients and administrators or policymakers who had an important position based on the chart time of interview.

This study emphasizes patients' humanization via adding interpretation services while providing treatments and showing that it is aligned with Canadian values. Hopefully, they can integrate such services into policies and budget forecasts that make hospitals integrate such services as an affirmed standard of care. In the future, researchers may also want to explore further how the feeling of being humanized can affect treatments in terms of compliance and success.

References

Bauer, A. M., & Alegria, M. (2010). Impact of patient language proficiency and interpreter service use on the quality of psychiatric care: a systematic review. *Psychiatric Services (Washington, D.C.)*, *61*(8), 765–773. http://doi.org/10.1176/ps.2010.61.8.765

Brisset, C., Leanza, Y., Rosenberg, E., Vissandjée, B., Kirmayer, L. J., Muckle, G., … Laforce, H. (2014). Language Barriers in Mental Health Care: A Survey of Primary Care Practitioners. *Journal of Immigrant and Minority Health*, *16*(6), 1238–1246. http://doi.org/10.1007/s10903-013-9971-9

Browne, D. T., Kumar, A., Puente-Duran, S., Georgiades, K., Leckie, G., & Jenkins, J. (2017). Emotional problems among recent immigrants and parenting status: Findings from a national longitudinal study of immigrants in Canada. *PloS One*, *12*(4), e0175023–e0175023. http://doi.org/10.1371/journal.pone.0175023

Canada-Immigration. (n.d.). Government-Assisted Refugee Resettlement in Canada,gar_eng.pdf.

Canada, G. of. (n.d.). Immigration, Refugees and Citizenship Canada Departmental Plan 2018–2019 - Canada.

Canadian-Council-for-Refugees. (n.d.). Refugees Welcome Here _ Canadian Council for Refugees.

Canadian Council for Refugees. (2017). Refugees entering from US and Safe Third Country_ FAQ _ Canadian Council for Refugees. Retrieved from https://ccrweb.ca/en/refugees-entering-us-and-safe-third-country-faq

Carpenter-Song, E. (2011). Recognition in Clinical Relationships. In *Shattering Culture: American Medicine Responds to Cultural Diversity* (pp. 168–183).

Chadwick, K. A., & Collins, P. A. (2015). Examining the relationship between social support

availability, urban center size, and self-perceived mental health of recent immigrants to Canada: a mixed-methods analysis. *Social Science & Medicine (1982)*, *128*, 220–230. http://doi.org/10.1016/j.socscimed.2015.01.036

Chavez, B., Bouchard-Coulombe, C., & Lepage, J. (2010). *Portrait of Official-Language Minorities in Canada : Francophones in Alberta*.

Chen, A., & Kazanjian, A. (2005). Rate of mental health service utilization by Chinese immigrants in British Columbia. *Canadian Journal of Public Health/Revue …*, *65*(February), 49–51. Retrieved from http://www.jstor.org/stable/41995901

Chen, A. W., Kazanjian, A., Wong, H., & Goldner, E. M. (2010). Mental health service use by Chinese immigrants with severe and persistent mental illness. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *55*(1), 35–42. http://doi.org/10.1177/070674371005500106

Chodos, H., Mulvale, G., Bartram, M., & Lapierre, L. (2009). *Toward recovery and well-being: A framework for a mental health strategy for Canada*. Retrieved from http://www.mentalhealthcommission.ca/English/system/files/private/FNIM_Toward_Recovery_and_Well_Being_ENG_0.pdf

Citizenship and Immigration Canada. (2018). 2018 Annual Report To Parliament on Immigration. Retrieved from http://www.cic.gc.ca/English/resources/publications/annual-report-2015/index.asp

de Moissac, D., & Bowen, S. (2018). Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada. *Journal of Patient Experience*, 237437351876900. http://doi.org/10.1177/2374373518769008

Domino, J., McGovern, C., Chang, K. W. C., Carlozzi, N. E., & Yang, L. J. S. (2013). Lack of

physician-patient communication as a key factor associated with malpractice litigation in neonatal brachial plexus palsy. *Journal of Neurosurgery: Pediatrics*, *13*(2), 238–242. http://doi.org/10.3171/2013.11.peds13268

Fabrega, H. J. (1991). Psychiatric stigma in non-Western societies. *Comprehensive Psychiatry*, *32*(6), 534–551.

Flores, G. (2005). The Impact of Medical Interpreter Services on the Quality of Health Care : A Systematic Review. *Medical Care Research Review*, *62*(3), 255–299. http://doi.org/10.1177/1077558705275416

Fuller-Thomson, E., Noack, A. M., & George, U. (2011). Health decline among recent immigrants to Canada: findings from a nationally-representative longitudinal survey. *Canadian Journal of Public Health = Revue Canadienne de Sante Publique*, *102*(4), 273–280.

Gee, E. M. T., Kobayashi, K. M., & Prus, S. G. (2007). Examining the Healthy Immigrant Effect in Mid- To Later Life: Findings from the Canadian Community Health Survey. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, *23*(5), S55–S63. http://doi.org/10.1353/cja.2005.0032

Goldney, R. D., Fisher, L. J., & Wilson, D. H. (2001). Mental health literacy: an impediment to the optimum treatment of major depression in the community. *Journal of Affective Disorders*, *64*(2–3), 277–284.

Goldney RD, Fisher LJ, W. D. (2001). Mental health literacy: an impediment to the optimum treatment of major depression in the community. *Journal of Affective Disorders*, *64*, 277–84.

Good, M.-J. D., James, C., Good, B. J., & Becker, A. E. (2005). The culture of medicine and

racial, ethnic, and class disparities in healthcare. *The Blackwell Companion to Social InequalitiesThe Blackwell Companion to Social Inequalities*, 396.

Government-of-Canada. (n.d.-a). Find free newcomer services near you.

Government-of-Canada. (n.d.-b). Improving your English and French - Canada.

Government of Canada. (n.d.). Policies, ministerial instructions, and agreements - Canada.

Grabish, A. (2017). Frostbitten refugee will lose fingers, toe after 7-hour trek to cross U. *CBC News*.

Ha, J. F., Hons, M., Anat, D. S., Longnecker, N., Charles, S., & Hospital, G. (2010). Doctor-Patient Communication : A Review. *The Ochsner Journal*, *10*(1), 38–43.

Haasen, C., Yagdiran, O., Mass, R., & Krausz, M. (2000). Potential for misdiagnosis among Turkish migrants with psychotic disorders: a clinical controlled study in Germany. *Acta Psychiatrica Scandinavica*, *101*(2), 125–129.

Hobgood C, Sawning S, B. J. (2006). Savage K. Teaching culturally appropriate care: a review of educational models and methods. *Acad Emerg Med*, *13*, 1288–95.

Hsieh, E., & Ph, D. (2015). Not Just " Getting by " : Factors Influencing Providers ' Choice of Interpreters. *J Gen Intern Med*, *30*(1), 75–82. http://doi.org/10.1007/s11606-014-3066-8

Hyden, L. (1997). Illness and narrative, *19*(1), 48–69.

Islam, F. (2015). Immigrating to canada during early childhood associated with increased risk for mood disorders. *Community Mental Health Journal*, *51*(6), 723–732.

Islam, F., Khanlou, N., & Tamim, H. (2014). South Asian populations in Canada : migration and mental health, *14*(1), 1–13. http://doi.org/10.1186/1471-244X-14-154

Jackson, C. (1998). *Medical interpretation: an essential service for non-English speaking immigrants. In S. Loue (Ed.), Handbook of Immigrant Health*. *New York: Plenum.*

Jezewski, M. A. (1990). Culture Brokering in Migrant Farmworker Health Care. *Western Journal of Nursing Research*, *12*(4), 497–513. http://doi.org/10.1177/019394599001200406

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research*, *42*(2), 727–754. http://doi.org/10.1111/j.1475-6773.2006.00629.x

Karliner LS, Perez-Stable EJ, G. G. (2004). The importance of training in the use of interpreters for outpatient practice. *Journal of General Internal Medicine*, *19*, 175–83.

Kassam, A. (2017). Refugees crossing into Canada from US on foot despite freezing temperatures. *The Guardian*. Retrieved from https://www.theguardian.com/world/2017/feb/07/us-refugees-canada-border-trump-travel-ban

Kirby, M. (2005). Mental health reform for Canada in the 21st century: getting there from here. 2005;31. *Canadian Public Policy*, *31*, 5–12.

Kirmayer, L. J., Groleau, D., Guzder, J., Blake, C., & Jarvis, E. (2003). Cultural consultation: a model of mental health service for multicultural societies. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *48*(3), 145–153. http://doi.org/10.1177/070674370304800302

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., … Pottie, K. (2010). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal*, *183*(12), 1–9. http://doi.org/10.1503/cmaj.090292

Kirmayer, L. J., Weinfeld, M., Burgos, G., du Fort, G. G., Lasry, J.-C., & Young, A. (2007a).

Use of health care service for psychological distress by immigrants in an urban multicutural milieu. *The Canadian Journal of Psychiatry*, *52*(2), 295–304. http://doi.org/10.1177/070674370705200504

Kirmayer, L. J., Weinfeld, M., Burgos, G., du Fort, G. G., Lasry, J.-C., & Young, A. (2007b). Use of health care services for psychological distress by immigrants in an urban multicultural milieu. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *52*(5), 295–304. http://doi.org/10.1177/070674370705200504

Kirmayer LJ, Rousseau C, Rosenberg E, et al. (2001). *Development and Evaluation of a Cultural Consultation Service in Mental Health Development and Evaluation of a Cultural Consultation Service In Mental Health, Report No.: 11.* Montreal.

Knoll, A. D., & MacLennan, R. N. (2017). Prevalence and correlates of depression in Canada: Findings from the Canadian Community Health Survey. *Canadian Psychology/Psychologie Canadienne*, *58*(2), 116–123. http://doi.org/10.1037/cap0000103

LEE, J. (2015). Canada unprepared for refugees' mental health issues, experts say. *VANCOUVER SUN*. Retrieved from http://www.vancouversun.com/health/canada+unprepared+refugees+mental+health+issues+experts/11541374/story.html

Leotaud, V. R. (2015). *Is Canada addressing the long-term mental health of immigrants_ _ National Observer*.

Mallory Simon, S. S. (2017). Somali refugees risk life and limb to escape to Canada - CNN. *CNN*.

Mary-Jo, G., Seth, H., Ken, V., & Lawrence, P. (2011). *Shattering Culture: American Medicine Responds to Cultural Diversity*. Russell Sage Foundatio.

Mental Health Commission. (2009). *Mental Health Commission of Canada. Toward Recovery and Well-being: A Framework for Mental Health Strategy for Canada.* Ottawa.

Mezzich J, Kleinman A, Fabrega H, Jr., Parron D, eds. (1996). *Culture and Psychiatric Diagnosis.* Washington: American Psychiatric Press.

Ministry-of-Immigration-Diversity-and-Inclusion. (n.d.). Immigration, Diversité et Inclusion Québec - French courses for non-francophones.

Mission and History - OTTIAQ - Ordre des traducteurs, terminologues et interprètes agréés du Québec. (n.d.).

Mojtabai, R., & Olfson, M. (2006). Treatment seeking for depression in Canada and the United States. *Psychiatric Services (Washington, D.C.)*, *57*(5), 631–639. http://doi.org/10.1176/ps.2006.57.5.631

Mosby's Medical Dictionary,. (2009) (8th editio).

Murray, J. L., & Lopez, A. L. (1998). Alternative projections of mortality and disability by cause 1998-2020: Global Burden of Disease Study. *The Lancet*, *349*(9064), 9064.

Ohtani, A., Suzuki, T., Takeuchi, H., & Uchida, H. (2015). Language Barriers and Access to Psychiatric Care: A Systematic Review. *Psychiatric Services*, *66*(8), 798–805. http://doi.org/10.1176/appi.ps.201400351

Park ER, Betancourt JR, Kim MK, Maina AW, Blumenthal D, W. J. (2005). Mixed messages: residents' experiences learning cross-cultural care. *Acad Med*, *80*, 874–80.

Patterson, B., Kyu, H. H., & Georgiades, K. (2013). Age at immigration to Canada and the occurrence of mood, anxiety, and substance use disorders. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *58*(4), 210–217. http://doi.org/10.1177/070674371305800406

Pena Dolhun E, Munoz C, G. K. (2003). Cross-cultural education in U.S. medical schools: development of an assessment tool. *Acad Med*, *78*, 615–22.

Quebec – Interpreter Services – MMHRC. (n.d.).

Redcross-Canada. (2019). What is the difference between a refugee and a migrant_ - Canadian Red Cross. Retrieved from https://www.redcross.ca/how-we-help/current-emergency-responses/syria-crisis-and-refugee-crisis/what-is-the-difference-between-a-refugee-and-a-migrant

Robert, A. (2012). *Mental health and well-being of recent immigrants in Canada : Evidence from the Longitudinal Survey of Immigrants to Canada*.

Rockville, M. (2001). *Surgeon General. Mental Health: Culture, Race, and Ethnicity.* Department of Health and Human Services;

Rogler, L. H., & Cortes, D. E. (1993). Help-seeking pathways: a unifying concept in mental health care. *The American Journal of Psychiatry*, *150*(4), 554–561. http://doi.org/10.1176/ajp.150.4.554

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, *28*(1), 152–161. http://doi.org/10.1111/inm.12512

Schyve, P. M. (2007). Language Differences as a Barrier to Quality and Safety in Health Care : The Joint Commission Perspective, 2–3. http://doi.org/10.1007/s11606-007-0365-3

Smedley BD, Stith AY, Nelson AR. (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. *Washington (DC): National Academies Press (US)*. http://doi.org/10.17226/12875

Statistics-Canada. (n.d.-a). Focus on Geography Series, 2016 Census - Province of Quebec.

Statistics-Canada. (n.d.-b). Results from the 2016 Census_ Syrian refugees who resettled in Canada in 2015 and 2016.

Statistics-Canada. (2018). Linguistic Characteristics of Canadians. Retrieved from https://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-314-x/98-314-x2011001-eng.cfm

Statistics Canada. (2011). Immigration and Ethnocultural Diversity in Canada. Retrieved from http://www5.statcan.gc.ca/access_acces/alternative_alternatif.action?t=99-010-XWE2011001&l=eng&loc=http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.pdf&teng=Immigration and Ethnocultural Diversity in Canada

Statistics Canada. (2012). *Linguistic characteristics of Canadians: language, 2011 census of population.*

Statitics-Canada. (n.d.). Immigrant population in Canada, 2016 Census of Population.

Stuart, H., Patten, S. B., Koller, M., Candidate, M. A., Modgill, G., & Liinamaa, T. (2014). Stigma in Canada : Results From a Rapid Response Survey, *59*(October).

Tableau synthèse Objectifs du Québec et nombre de réfugiés syriens parrainés ou pris en charge par l ' État arrivés au Québec en 2015 et en 2016 Réfugiés parrainés n charge par l ' État n Total n Réfugiés arrivés Réfugiés arrivés Réfugiés arrivés Réfugiés. (2016). Retrieved from https://www.immigration-quebec.gouv.qc.ca/en/informations/reception-syrian-refugees/index.html

The Immigration and Refugee Board of Canada (IRB). (2019). Irregular border crosser statistics - Immigration and Refugee Board of Canada.

Waddan, A., & Béland, D. (2008). a Program for Research on Social and Economic Dimensions of an Aging Population. *SEDAP Research Paper*, (232). Retrieved from

http://socserv.mcmaster.ca/sedap

Weissman JS, Betancourt J, Campbell EG, et al. (2005). Resident physicians' preparedness to provide cross-cultural care. *Jama*, *294*, 1058–67.

Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: a qualitative study from Montreal. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *51*(4), 205–209. http://doi.org/10.1177/070674370605100401

Willen, S. (2011). Pas de Trois: Medical Interpreters, Clinical Dilemmas, and the Patient-Provider- Interpreter Triad. In V. DelVecchio-Good, Mary-Jo, Willen, Sarah S. , Hannah, Seth Donal & L. T. Ken, Park (Eds.), *Shattering Culture* (pp. 70–93). New York: Russell Sage Foundatio.

Willen, S. S., Bullon, A., & Good, M.-J. D. (2010). Opening up a huge can of worms: reflections on a "cultural sensitivity" course for psychiatry residents. *Harvard Review of Psychiatry*, *18*(4), 247–253. http://doi.org/10.3109/10673229.2010.493748

Wilson, E., Chen, A. H. M., Grumbach, K., Wang, F., & Fernandez, A. (2005). Effects of limited English proficiency and physician language on health care comprehension. *Journal of General Internal Medicine*, *20*(9), 800–806. http://doi.org/10.1111/j.1525-1497.2005.0174.x