

The Access to Mental Health Care in Children: Portuguese Speaking Families Living in a Multicultural Context in Europe

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Abstract

Migrant and ethnic minorities youth find themselves in a situation of greater difficulty in terms of access to mental health care. The main objective of this study was therefore to explore possible barriers to access to professional assistance in mental health from the perspective of immigrant families. The methodology included both a qualitative study in which semi-structured interviews ($N = 170$ people from 62 families) and focus groups with health and education professionals ($N = 31$) were conducted as well as a quantitative survey ($N = 887$ youths, 417 mothers and 310 fathers). This paper presents a case study based on the qualitative phase and selected results of the quantitative phase of the project. The results indicate the involvement of the patient's perspective as one of the most valuable sources of information for improving access to mental health care. Overall, the results suggest several trends for intervention projects in order to improve access to mental health care.

Keywords: Mental health care in children and adolescents; Access to mental health care; Concepts; Primary strategies of action; Family; Migration.

O Acesso aos Cuidados de Sa de Mental Infantil: Fam lias de Express o Portuguesa num Contexto Multicultural na Europa

Resumo

Jovens de minorias  tnicas e migrantes encontram-se numa situa  o de maior dificuldade em termos de acesso aos cuidados de sa de mental. O objectivo principal deste estudo foi, portanto, explorar poss veis barreiras de acesso   assist ncia profissional em sa de mental a partir da perspectiva da pr pria fam lia imigrante. A metodologia do estudo incluiu uma fase qualitativa em que foram conduzidas entrevistas semi-estruturadas ($N=170$ pessoas de 62 fam lias) e grupos focais com profissionais de sa de e educa  o ($N=31$) e em cima disso uma fase quantitativa ($N= 887$ jovens, 417 m es e 310 pais). Neste artigo ser  apresentado um estudo de caso com base na fase qualitativa e resultados seleccionados da fase quantitativa. Os resultados indicam o envolvimento da perspectiva do paciente como uma das fontes mais valiosas de informa  o para a melhoria do acesso   assist ncia em sa de mental. De uma forma geral, os resultados sugerem v rias tend ncias para projectos de interven  o, a fim de melhorar o acesso aos cuidados de sa de mental.

Palavras-chave: Cuidados de sa de mental em crian as e adolescentes; Acesso   cuidados de sa de mental; Conceitos; Estrat gias principais de a o; Fam lia; Migra  es.

Mental health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens. We believe that the primary aim of mental health activity is to enhance people's well-being and functioning by focusing on their strengths and resources, reinforcing resilience and enhancing protective external factors. (World Health Organization [WHO], 2005).

International epidemiological studies have shown that about 20% of young people present psychological stress (Belfer, 2008). This is, however, rarely acknowledged, lacking most of the young of a diagnosis and appropriate treatment (Stephenson, 2000). With specific regard to migrant and ethnic minorities' children and adolescents, there is a higher rate of unmet needs, which means a lower rate of mental health services use (Katakao, Zhang & Wells, 2002).

Within the clinical community is known, that problems or mental disorders in youth not only affect the current quality of life and their social contexts, they are also risk factors for other disorders in the ongoing developmental process and for the persistence of mental disorders in adulthood (Belfer, 2008).

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Despite these facts, systematic research on factors influencing pathways to prevention and treatment in child and adolescent mental health is still very rare (Gunther, Slavenburg et al., 2003; Juszak, Melinkovich & Kaplan, 2003). Very little is known on perception and concepts of child and adolescent mental health, and on individual, family or group specific thresholds to categorize mental distress as illness and subsequently as a need for intervention. One study by Owens et al. (2002) analyzed and described the effect of perception about mental health problems and services on access to mental health in children. The authors conclude that particular attention should be given to the needs of families, and barriers should not only be lowered through efforts on the institutional side but through interventions on population perceptions about child mental health problems and knowledge about services.

The AMHC Study in Switzerland

Between 2004 and 2009 as part of the 52 National Research Program funded by the Swiss National Funds we conducted at the University of Zurich, in Switzerland, the AMHC study (Access to Mental Health Care in Children). Aim of this study was to understand the access to child and adolescent mental health services in a multidimensional approach from the perspective of the child/adolescent and his/her family. Concepts of mental health and illness, concepts of effective help and primary strategies of action in the perspective of young people and their families were the subject of this study. The study based on a mixed qualitative-quantitative methodology and intended to cover the entire Swiss population, including migrants.

Methods

Initially 170 semi-structured interviews were conducted within 62 families on topics such as concepts of health and illness (physical and psychological), primary strategies of help seeking (thresholds of action), knowledge of the health system (including mental health care) and facilitators and barriers to access to child mental health system. To complement these qualitative data, focus groups were conducted with professionals from primary health care and with education professionals/teachers ($N = 31$). The topics covered were the same as the individual interviews differing only in perspective, that is, professionals were asked what they think or know about the concepts young people have. Based on the results of the qualitative study (according to the statements of the interviewed sample) a questionnaire was constructed, which was subsequently passed to a broader study sample ($N = 887$ youths, 417 mothers and 310 fathers).

The study covered the three main linguistic regions of Switzerland: German, French and Italian, including migrants. Special emphasis was given to migrants from Portugal and Brazil (the largest unique language group after the three national mentioned), since, although these two groups have the same linguistic background, there are numerous cultural differences. For example, Brazilian migrants are mostly women that search in Switzerland better life conditions while migrants from Portugal are mostly couples, searching better conditions for the family and willing to return home one day. Simultaneously the attitude of the host country is different toward these two groups: being from Brazil is estimated (“cool”), triggering associations with Capoeira and Samba.

In the AMHC study families with children aged between 12 and 16 years were included. The interviews were conducted with three different groups of families: families of the general population (children without specific psychological stress), families at risk (children with psychological stress, substance abuse, aggressive or expansive behavior, but still not in treatment) and ‘clinical’ families (children already diagnosed with mental illness). This labeling occurred in accordance with their recruitment process: schools, youth associations, children’s homes and hospitals/clinics.

Given the lack of assessment tools available in the literature and considered suitable for the subject under study, encompassing the perspective of children and youth as well as their parents and grandparents, a interview guide was developed in German, tested and validated for the other three project languages French, Italian and Portuguese. The interview was divided into three main parts: one part was more open to questions about concepts, strategies of action and direct experience with the health system. In the second part were presented vignettes of cases questioning strategies for action and knowledge in health. In both parts barriers and thresholds for access to mental health care were evaluated indirectly. The third part focused mainly on the origin of concepts and knowledge about mental health. For migrant participants there were two complementary parts: one relating to language skills and barriers and another to issues such as collective self-efficacy. The children and adult version of the interview differed only in its performance, since parents and grandparents had to respond in a double or triple way respectively to each question, e.g. “What does ‘mental health’ means to you?”, “What do you think is ‘mental health’ for your children?”, “What do you think do your grandchildren consider to be ‘mental health’?”.

In each family were studied whenever possible three generations through individual interviews in their mother tongue. All interviews were transcribed and analyzed in terms of content following the method of

reducing of Mayring (2000) and using the software MAXqda. In order to guarantee the quality of the obtained data, the whole analysis process followed a constructed manual of categorisation used by independent researchers.

Taking into account the limit of pages in this paper, only a part of the study can be presented here (for more details please cf. Gonçalves, 2009) – a case study based on the qualitative phase and some results of the quantitative study part.

Case Study

Case studies are a proper methodology to present complex issues (Merken, 2000; Stake, 2000), in the AMHC study for instance the intergenerational aspects of mental health concepts and strategies of action. The family chosen for this case study was a bi-national family. To assure the anonymity of the family all identity data were modified for presentation.

Family Grasset consists of a bi-national couple, a Brazilian mother 39 years old, a Swiss father 52 years old and four children aged between three months and 15 years old. The family lives in Canton Vaudt and was recruited by an association of immigrants. In the AMHC study participated mother, father and a 15 years old son. The mother was 17 when she met her husband in Switzerland. She is housewife and cares for the children, speaks slowly and seems to be a calm person. The father works in a company and confesses participating little in the education of their children due to lack of time. Roger, the eldest son, is a young responsible guy and cares deeply about the brothers. He was born in Switzerland and feels Swiss.

The interviews took place in the family home during an afternoon. The apartment, situated in a quiet area on the outskirts of the city is big and geared for children. Greetings went well. The mother was with the children in the garden of the building, interacting with other mothers and children. The father got home late afternoon, when mother and son had already been interviewed separately. Both interviews were interrupted several times by the other children. Just the interview with the mother was conducted in Portuguese; the other two were conducted in French. All interviews ran quietly and collaboratively. Here are some answers to issues of the interview.

To the question “*What does ‘mental health’ means to you?*” mother, father and son respond in a different way, but in similar directions (see Table 1).

To answer this question, the mother begins with a negative definition of health using disease as the contrary. Then she refers, however, to psychological well-being (category “psychological state of being”) and the ability to deal with problems (category “coping/self-efficacy”). The father makes a parallel with the physical health and mentions, as the mother, the psychological well-being. The child refers to the absence of symptoms and to psychological problems (categories “psychological symptoms” and “no stress/having no problems”).

The question: “*What does ‘mental illness’ mean for you?*” is considered by all three family members differently (see Table 2).

For the mother mental illness is synonymous of marked distress (category “suffer/pain”), for which the cure is difficult (category “recovery”). According to the father, mental illness refers to stress/life problems. The child refers, as in the previous question, psychological

Table 1
Mental Health Concepts

Mother	“And health, I think, would be also the absence of disease. It would be like a pure health, of course not 100% pure. This is difficult to achieve. I think it is when you have an emotional balance, when you can deal with the problems.”
Father	“It’s like the physical: how you are.”
Child	“There are many people who see things that do not exist. Simply, for example, having no problems.”

Table 2
Concepts of Mental Illness

Mother	“I think the person has already suffered so much and it should be cured, she has been so hurt that the recovery process will take even longer.”
Father	“When something in life does not run as it should. But I do not know this, neither my children.”
Child	“For example, to see people that do not exist, such diseases. Being in psychiatry or so.”

symptoms and this time completes with reference to the mental health care system (category “psychiatric clinic”).

The third question, “*Why do you think that children and young people suffer from mental illness?*” shows the concepts of causes of mental illness (see Table 3) that each member of the family presents.

According to the mother, the psychological problems of children and adolescents are caused by having to deal with stress and problems, combined with heavy pressure from something or someone (categories “coping/self-efficacy” and “stress/having problems”). The father answers in a similar direction, but with the emphasis on society (category “quality of life”) and specifies all the possible causes of stress, such as family, school and fashion. For the child, parents, or rather the absence of, is the main cause of mental illness in children and adolescents.

On the specific question: “*What do you think that helps in case of mental illness?*” mother, father and son answered again differently, again with some similar directions (see Table 4).

For the mother, such assistance is to show care and understanding, the social skills of the person who helps others (categories “social competence” and “social support”). The father does not specify what he means by “outside help”. However, he emphasizes the difficulty of detection of mental illness (category “detection/visibility”). The child, in contrast to his father, refers as an effective help, a treatment and stresses the importance of having the opportunity to express himself about the disease (category “professional help”).

The question of *what do they do when they feel psychologically ill* show which primary strategies of action would be used by the members of the family in such a situation (see Table 5).

From the mother’s response it is understandable that the expression of her problems is more important as a strategy, even if she takes this step in a thought way (category “formal thinking/reasoning”). Father and son mention the daily activities as a strategy, in different directions though (category “functioning/activity”). For

Table 3

Concepts of Causes of Mental Illness

Mother	“I think that’s when they can not withstand more pressure of something or someone, I think that then the body is also affected.”
Father	“All the social pressures of today: the Nike’s tennis, the increased demands in all contexts as family and school. Because young people themselves put pressure on themselves, because they live in a more fast, intense and noisy society. Among those where psychological problems arise, some can handle with this alone in a natural way, others do not.”
Child	“For example because of their parents. I’ve seen a lot about this on television, they take little account of the children and make little together with their children and that has worsened even more.”

Table 4

Concepts of Effective Help

Mother	“A great understanding. I think this attention, the understanding has to be doubled, there is a black hole.”
Father	“Help from outside. Often it is not recognized, very few times. The disease can have very serious effects.”
Child	“A treatment in which a person could talk about mental illness.”

Table 5

Strategies of Action in Case of Mental Illness

Mother	“Our feelings change our way of feeling, of seeing things. Often I’m at a more sensitive stage and easier to hurt myself or be hurt by another person. In these moments I try to put everything in balance in order to see whether is needed to express them or not.”
Father	“Mark presence at work and one can forget the ill feeling.”
Child	“I stay mostly at home.”

the father the strategy is to continue working, for the child is not going to school.

Former experiences with mental health care is described by each parent differently. Noteworthy is the fact that the child answered this question with a “no”, like he had never contact with mental health care, which according to the interviews of his parents is not equivalent to the truth (see Table 6).

The parents present the problem differently, though both mention that they perceive the help seeking behavior of the family as a result of the inability to resolve the problem. The mother mentions an aggression by the child and refers to the development stage. The father sees the problem located in the relation mother-child and explains this way the aggression mentioned.

If one takes into account the responses from both parents (see Table 7), we realize that it took a while to decide which professional to choose. The mother mentions, however, that the suggestion of the paediatrician and the neighbour had a strong influence.

From the description on the mother’s experience with mental health care (see Table 8), one might conclude that the conversations with the therapist were not so comfortable for her, even though she perceived the therapist and his working method as positive. Another aspect mentioned by the mother is the fact that the child did not accept the therapy and was not feeling well. Regarding the father there seem to be a great resistance to therapy. For him, this is related to the costs and the artificiality of the context: now I have to talk about my problem. In the second part of the father

Table 6
Problem Presentation

Mother	“It was during adolescence that I sought help for him. Especially because at that time he had an exaggerated aggressiveness and I was not sure why. I wanted to know the problem’s root.”
Father	“Certain things between mother and him were not right. Not able to be resolved anymore in the family or was too difficult.”

Table 7
Help Seeking Behavior

Mother	“It was done by the pediatrician. For me it was a confirmation, the fact that my neighbor had indicated the same person... a lot of discussions were needed before I arranged the first visit. I think he did not understand it as being necessary.”
Father	“The daily struggle with him is: What am I doing wrong for him to be like that? An outsider can explain and present the situation differently... Hard: the step of seeking help, there are many offers...”

Table 8
Positive (+) and Negative (-) Aspects Related to the Therapy

Mother	(-) “On one hand interesting, on the other also depressing, because as a mother I had recognize what I did wrong; difficult because he was very aggressive.” (+) “But as the therapist was very good, with a kind of therapy also very good, the experience was more positive than negative.” (-) “My son did not accept. I think he was ashamed, not feeling well.”
Father	(-) “I always have difficulties, do not feel right. When I’m with colleagues and this arises in conversation, one can go against the topic, what is more liberating than the obligation of having to go to consultation. I think the money underlying, the therapist can only give advice that also gives others, which is perfectly legitimate. I do not feel comfortable with it, do not like to go, I can not download.” (-) “Only when he goes there alone it can work. If you go with the father or mother it’s useless. For the child: very difficult. He has the feeling he is guilty of something. Does not tell the truth, this is no lie, just happens because of the feeling of guilt and inhibitions.”

narrative he also recognizes the aforementioned statement of guilt. Even when he says: “Only when he goes there alone can work,” emphasizes again that he believes the problem lies on the child and not in the family system.

In the several representations of each family member facilitators and barriers in accessing mental health services can be found, as can it be seen in the discourse concerning the positive and negative aspects of the experience with the mental health problem end system of care (see Table 9).

Table 9
Summary of Possible Barriers and Facilitators

	Mother	Father	Child
Barriers	<ul style="list-style-type: none"> - Health as contrary of illness - Difficulty in curing mental illness - Strategies of action require extensive interior reflection - Perception of the problem in the other (child) 	<ul style="list-style-type: none"> - Parallel mental-physical health - Difficulty of defining mental illness due to lack of experience - Difficulty of detection of mental illness - Strategy of action includes continuation of employment and distraction - Perception of the problem in the other (mother-child relationship) - Defensive attitude towards the therapy/ therapist (costs, artificial context) 	<ul style="list-style-type: none"> - Health as absence of symptoms - Mental illness as a symptom directly connected to mental health care - Isolation at home as a strategy of action - No recollection of past experience with the mental health system - Perception of the problem in others (parents)
Facilitators	<ul style="list-style-type: none"> - Psychological well-being and coping with problems as mental health - Mental illness as severe suffering, cause of stress/problems - Attention, comprehension and expression as help - Family stress - Pediatric and social contacts (therapist choice) - Therapist and Therapeutic Approach 	<ul style="list-style-type: none"> - Psychological well-being as health - Mental illness as result of stress/life pressure - Family stress 	<ul style="list-style-type: none"> - Place for expression during treatment as help

As a conclusion, the case study of family Grasset allowed on the one hand, a better understanding of concepts, action strategies, limits and barriers in access to mental health and the differences in each families' members perspective, and, secondly, gave a basic impression of the everyday experience of a bi-national family constellation.

Selected Results of the Quantitative Study

Regarding the quantitative part of the AMHC study some results about concepts of mental health and perceived barriers in access to mental health care will be presented. The sample will be referred as 'Swiss', 'Portuguese speaking migrants' and 'other migrants' (include migrants from Italy, Germany, Balkan and others).

Concepts of Mental Health

Adolescents. A multivariate analysis of variance on all items showed that the group difference between Swiss and immigrant children is not significant ($p = .498$),

the interaction tends, however, to be significant ($p = .076$ (*)). In terms of a more detailed presentation of the results in this respect, the items with differences between Swiss and children with immigrant background are shown in Figure 1.

Significant differences occurred in three items: item 6 “not to take drugs,” item 14 “to have a sense of what we better not do” and item 13 “to be normal”. Not taking drugs as an indicator of mental health seems more important for Portuguese compared to Swiss youth ($p = .021$ *) and other migrants ($p = .066$ (*)). Other migrants seems to believe more that mental health means “to have a sense of what we better not do” compared to Swiss ($p = .072$ (*)). For Portuguese speaking youth compared to Swiss ($p = .019$ *) mental health means more “to be normal”.

To view the results summarized at an aggregate level, factor analysis with each questionnaire parts were carried out. However, no differences were founded between Swiss and immigrant adolescents.

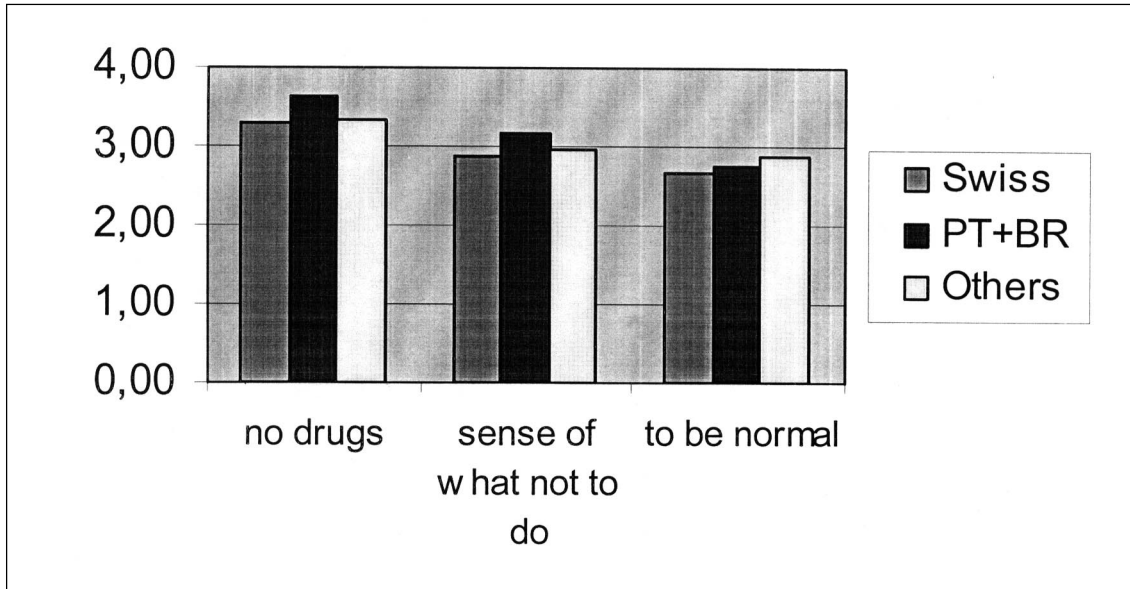


Figure 1. Differences between Swiss, Portuguese speaking migrant and other migrant children in their concepts of mental health.

Parents. The next step of analysis, now based on the perspective of parents participating in the study, revealed no differences between mothers but between fathers from migrant and Swiss families. It was found that the group differences between Swiss, Portuguese speaking migrants and other migrant fathers tends to be significant ($p = .075$). The items, which show differences between Swiss, Portuguese speaking and other migrant fathers will be presented in Figure 2.

Significant mean differences were found among item 6 “not to use drugs,” item 13 “to be normal” and item 14 “to have a sense of what one should better not do”.

Thus, not taking drugs seems to be more important for Portuguese speaking fathers than for other migrant fathers ($p = .019 *$). Portuguese speaking compared to Swiss fathers ($p = .023 *$) and to other migrant fathers ($p = .069 (*)$) indicated rather that mental health means “to be normal”. Portuguese speaking in comparison to Swiss father ($p = .008 **$) and to other migrant fathers ($p = .001 ***$) seem to be more of the opinion that mental health means “to have a sense of what one should better not do”.

The previous analysis was again conducted on factorial level, showing, however, no significant differences.

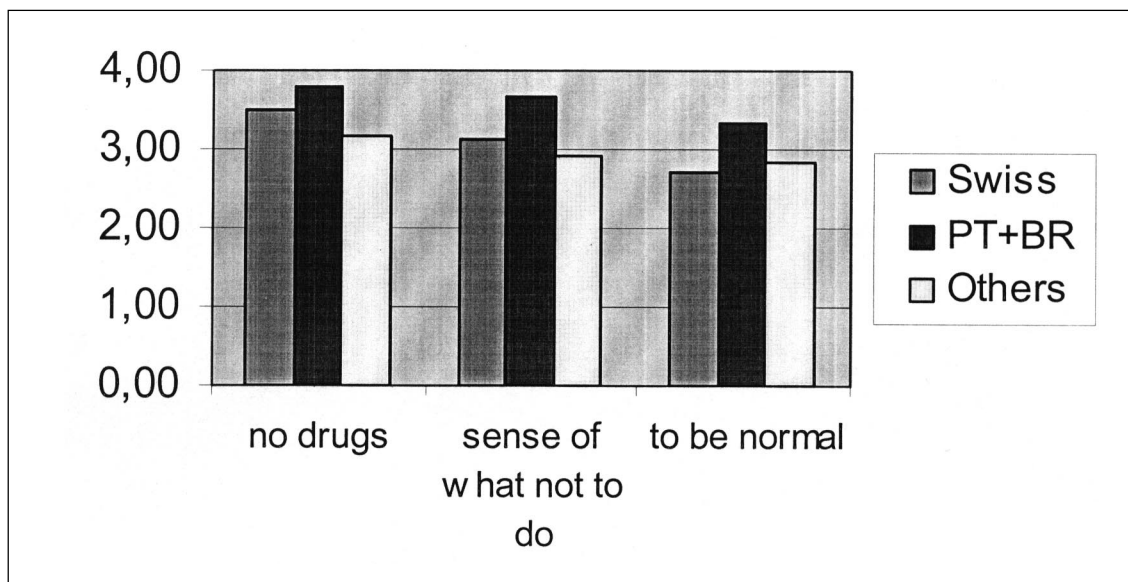


Figure 2. Differences between Swiss, Portuguese speaking migrant and other migrant fathers regarding concepts of mental health.

Perceived Barriers to Mental Health Care

Adolescents. In the following the findings regarding perceived access barriers to services and institutions in the field of mental health care will be described.

The biggest barriers in access to mental health care from the perspective of the adolescents is the fear of stigmatization “He does not want to be laughed by the colleagues” and negative stereotypes “He thinks a psychologist/ psychiatrist is only for the crazy ones”. In second place concerning perceived barriers comes the statement “He considers help not necessary at all”, followed by lack of information on mental health care: “He does not know what the psychologist/psychiatrist will do with him”. The fourth frequently mentioned barrier shows once more the fear of discrimination/marginalization: “He fears that he will end up in a psychiatric hospital or a home” and “He fears that he must then switch to a special class or school of special education”. Then statements follow concerning treatment concepts such as: “He thinks that mental/psychological problems should be better resolved in the family”, “He thinks that one can help himself best when there are mental/emotional problems” or “He thinks that a therapy costs too much money” and “He thinks that psychotherapy takes too long”. Lack of information on mental health care is then addressed again: “He does not know where to get help or who is responsible”. Statements with low significance appear to be: “He thinks that actually the parents are responsible for the problem and they need help” or “He thinks, psychologists/psychiatrists prescribe too many drugs” and “He thinks that this problem is common for his family” The lowest support statements found were related to family values:

“He thinks his parents do not wish he goes to a psychiatrist/psychologist” or pragmatic hurdles “He thinks that the practice of the psychologist / psychiatrist is too far away from home”.

Differences between adolescents of Swiss, Portuguese speaking migrant and other migrant origin were not found in terms of perceived barriers in access to mental health care.

Parents. Looking at the parents’ perspective on access barriers to child and adolescent mental health care and differentiating it between Swiss and migrant parents, gives the following picture. Figure 3 shows that in five of the total 16 items, significant differences between Swiss and migrant mothers are observed. Portuguese speaking mothers compared with Swiss ($p = .000$ ***) and to mothers of other migrant groups ($p = .001$ ***) reported more often the fear of discrimination and marginalization as an access barrier (“He feared that he must then to a special class or school”). Portuguese speaking mothers also emphasized more often compared to Swiss the statement “He fears that he will end up in a psychiatric hospital or a children’s home” ($p = .024$ *). Portuguese speaking migrant mothers compared to mothers of other migrant groups are more of the opinion that “He can only help himself in case of mental/emotional problems” ($p = .072$ (*)). Again, compared to Swiss and mothers of other migrants groups, Portuguese speaking mothers referred more that the cost and duration of therapy represent for them potential access barriers: “He thinks that psychotherapy takes too long” ($p = .049$ */.016 *) and “He thinks, that therapy costs too much money” ($p = .050$ * / .021 *).

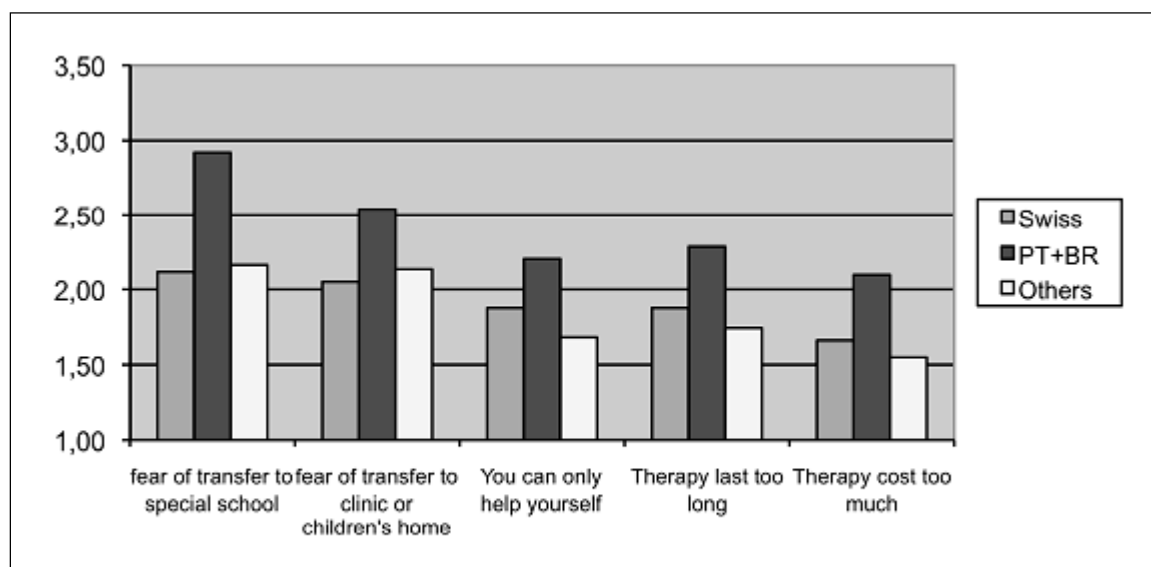


Figure 3. Differences between Swiss, Portuguese speaking migrant and other migrant mothers in terms of perceived access barriers.

Differences found between Swiss, Portuguese speaking and other migrant fathers are presented in Figure 4. Compared to Portuguese speaking migrant father ($p = .097$ *) and to Swiss fathers ($p = .041$ *), migrant fathers from other groups chose more often the item “He thinks his parents do not want that he goes to a psychiatrist/psychologist”. Swiss fathers ($p = .014$ *)

and other migrant fathers ($p = .007$ **) compared to Portuguese speaking fathers confirm rather “Mental/psychological problems should be better resolved in the family”. Other migrant fathers compared to Swiss fathers ($p = .009$ **) are more frequently of the opinion that an access barrier is the lack of information: “He does not know where to get help or who is responsible”.

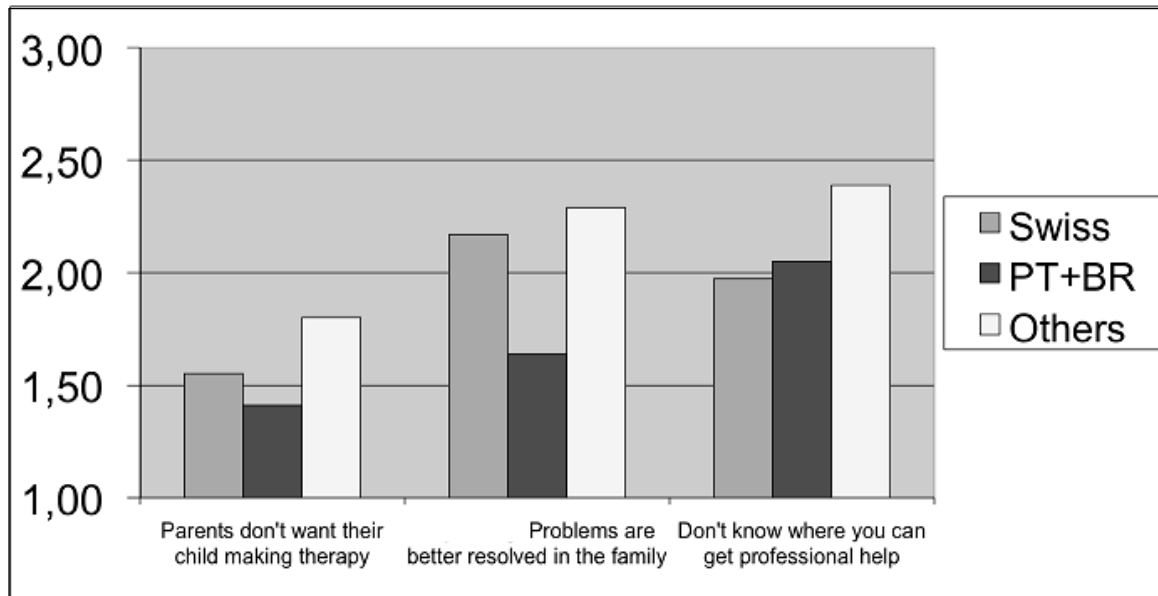


Figure 4. Differences between Swiss, Portuguese speaking and other migrant fathers in terms of perceived access barriers.

Conclusion

The present study sought to contribute to the understanding on mental health concepts and help seeking behaviours of migrant and non-migrant families in Switzerland. Our results showed that there are similarities and differences in concepts of mental health, as well as help seeking strategies among people. Stigma continues to be recognized as a barrier in the access to mental health care (cf. Owens et al., 2002). Noteworthy more significant differences were found among the parents' compared to the adolescents' generation. Thus, the study illustrates the wealth of data gained in client-oriented research and strengthens the valuable role of the migrant population itself as a crucial source of information.

Despite the contribution of this project in understanding the mental health concepts and help seeking behaviours of migrant and non-migrant families in Switzerland, from a multi-informant perspective (cf. Forrest, Riley, Vivier, Gordon, & Starfield, 2004), limitations of the study must be acknowledged. Mainly, the representativeness of the sample despite its size was not assured. It seems important to emphasize that

a better understanding of concepts and requirements relating to migrants and non-migrants child and youth mental health as well as a deeper knowledge of current thresholds for intervention offers and a better cooperation in the triangle of school – family – health care will allow to close the need-service gap step by step. In that sense future studies could explore these concepts and strategies of action in representative samples still considering regional and cultural differences. Thus, extensions of the Swiss AMHC study are being conducted in Portugal and in Brazil in order to compare the data in a cross-cultural perspective.

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