Mental Health Commission of Canada

Commission de la santé mentale du Canada

The Diversity Task Group Report:

Issues and Options for Improving Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Groups – A Summary

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About the MHCC

The Mental Health Commission of Canada is a non-profit organization created to focus national attention on mental health issues and to work to improve the health and social outcomes of people living with mental illness. As a catalyst for transformative change, the Commission works with stakeholders to change the attitudes of Canadians toward mental health problems, and to improve services and support. Its goal is to help bring about an integrated mental health system centered on people living with mental illness. To this end, the Commission encourages cooperation and collaboration among governments, mental health service providers, employers, the scientific and research communities, as well as Canadians living with mental illness, their families and caregivers.

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Mental Health Commission of Canada
Commission de la santé mentale du Canada

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Issues and Options for Improving Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Groups – A Summary

Improving services and health and social outcomes for immigrant, refugee, ethno-cultural and racialized groups (IRER) is a common challenge for mental health systems in high-income countries. Increased rates of mental illness, poor access to care and reduced care outcomes, and poor satisfaction with services have been reported in these groups in Canada and internationally.

The Mental Health Commission of Canada's Services Systems Advisory Committee established a Diversity Task Group to consider the issues and options for service improvement for IRER groups in Canada. This summary of the Task Group's report[1] outlines: (a) the facts and issues that policy makers, health planners and service providers across Canada may wish to consider when undertaking strategies to improve mental health services for IRER groups; and (b) the Task Group's plan and 16 recommendations for service improvement for IRER groups.

A goal of the Task Group report was to inform the Commission for its development of a mental health strategy for Canada. In November 2009, the Commission released Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada, in which it set out a vision containing seven broad goals for transforming mental health systems across Canada. Work is now under way to develop a mental health strategy for Canada that will translate the vision and goals of the Commission's Framework into a strategic plan.

Snapshot: Canada's diverse and growing IRER population

- Canada is one of the most diverse countries in the world. Nearly 20% of the Canadian population was born in another country and hundreds of thousands of new immigrants arrive each year.
- Over 200 different languages are spoken in Canada and 20% of Canadians have a non-official language as their mother tongue.
- Until the 1960s, immigration to Canada was mainly from Europe. This now has changed, so that immigration is mainly from South and East Asian countries.
- Every province, territory and region in Canada has an IRER population. In some parts of the country, visible minorities comprise over 40% of the population.
- IRER groups are themselves diverse and composed of different populations with different histories, cultures, social realities and needs.
- Canada's future economic prosperity will depend in part on population growth and, at present, Canada's main driver for population growth is immigration. Because of this, immigrants are an important national resource.

> "Over 200 different languages are spoken in Canada and 20% of Canadians have a non-official language as their mother tongue. Meeting this need is a particular challenge."
>
> - Diversity Task Group Report

[1] Hansson E, Tuck A, Lurie S and McKenzie K, for the Diversity Task Group of the Services Systems Advisory Committee, Mental Health Commission of Canada. (2010). Improving Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Groups: Issues and Options for Service Improvement.

Mental health in IRER groups

The mental health of a person, their family or community depends on their resources and histories and their current social circumstances. The exact recipe for mental health varies from person to person and community to community.

However, there are clear pressures on IRER communities such as migration and racial discrimination, which, though common, cannot be considered normal life stresses. These pressures have impacts on the mental health of individuals and can decrease the rate of mental health and well-being in a community. For some, the experience of being an immigrant, refugee or belonging to an ethno-cultural or racialized group builds resilience. For others, it undermines their mental health.

Studies conducted around the world found increased rates of mental health problems and illnesses in refugee groups, some recent immigrant groups, and in existing racialized and ethno-cultural groups.

For instance, the best analyses worldwide report that migrant groups have over twice the risk of schizophrenia compared to non-migrant groups and the rates of psychological distress, post-traumatic stress disorder and depression are markedly higher among refugees.

Some of the factors driving increased risk of mental health problems and illnesses among these groups include unemployment, financial insecurity, poverty and poor housing. Other factors such as pre-migration stress due to war, torture or rape and the stress of migration play a role, but only impact some.

The literature investigating IRER mental health focuses on three areas:

- Social determinants (i.e. social factors that act as contributing factors to mental health problems and illnesses);
- Rate of mental illness; and
- Barriers to and facilitators of care.

Social determinants

The Public Health Agency of Canada has produced a list of 12 determinants of health that are applicable to all. Eleven of these determinants of health are particularly important to IRER groups:

1. Income and Social Status
2. Social Support Networks
3. Education and Literacy
4. Employment/Working Conditions
5. Social Environments
6. Physical Environments
7. Personal Health Practices and Coping Skills
8. Healthy Child Development
9. Health Services
10. Gender
11. Culture

IRER populations are impacted by a number of social determinants of health, that can lead to a greater prevalence of mental health problems and illnesses, which can be further complicated by unique issues such as migration adjustments and stress, discrimination and language difficulties.

Rate of mental illness

While national studies in Canada report lower rates of mental health problems and illnesses among immigrant groups, numerous local in-depth studies report increased rates of mental health problems and illnesses in specific groups in particular areas. The rates of mental illness differ in IRER groups.

Barriers to care

Barriers to care include stigma, awareness of services, and language difficulties. According to the literature, these delay access to treatment.

Factors that facilitate pathways to care include literacy; trust in services, cultural competence and targeted health promotion.

National responses to these three issues have been rare. There has been some consideration of the needs of new immigrants and refugees, but this has not led to significant service development. Moreover, there has not been a similar consideration of the mental health needs of existing ethno-cultural and racialized groups.

> "There are clear pressures on IRER communities such as migration and racial discrimination, which, though common, cannot be considered normal life stresses. These pressures have impacts on the mental health of individuals and can decrease the rate of mental health and well-being in a community."
>
> - Diversity Task Group Report

Social factors influencing the mental health of IRER populations

Over the course of a person's life, social factors may increase or decrease his or her risk of developing a mental health problem or illness.

Some of these factors increase vulnerability, while others act as factors that precipitate illness. Some prolong illness and still others prevent illness and restore health.

Vulnerability at specific transitions in life, such as during migration, are due to a significant increase in life stresses at a time when the social safety-net may not be as strong.

The social factors affecting IRER groups are summarized below. (More details about each factor are available in the full report.)

Income and social status: There is a strong link between low income levels, income inequality, financial insecurity, poverty and mental health problems and illness. All of these factors are more prevalent in IRER populations and this is true for all age groups.

Social networks: A significant problem for immigrant groups is the fact that social support networks may be broken and lost when people move.

Education and literacy: Though immigrants are more likely to have a degree, they earn less than their Canadian-born peers and are also more likely to live in low-income areas. Thirty percent of immigrant men with a university degree work in an occupation requiring only a high school diploma.

Employment/Working conditions: Unemployment is not only more common for immigrants, but even more so for immigrants who are also racialized. Unemployed people experience higher levels of depression than those who are employed. Among employed IRER populations, a constant fear of becoming unemployed is a specific stressor.

Social and physical environments: People from IRER groups are more likely to live in poverty and to live in areas that are poor. They are also more likely to live in cities and in areas with poor housing stock. Living in cities increases the risk of a number of mental health problems and illnesses.

Healthy child development: Over a third of immigrant children live in poverty in Canada. As a result of this, children are exposed to a significant number of social and environmental risks that can negatively impact their mental health.

Migration: Pre-migratory stress in refugee groups and trauma such as war, torture, rape and natural disasters increase the risk of developing common mental health problems (anxiety and depression) as well as post-traumatic stress disorder. The process of migration and acculturation can be stressful and may increase risk for mental health problems and illness.

Perceived Discrimination: Perceived racial discrimination is a risk factor for mental health problems and illnesses that are more commonly experienced by IRER groups. This complex social problem has its impacts at a number of different levels: from racial abuse or attack, through to more subtle forms, such as stereotypes in the media.

Language: When people develop mental health problems or illnesses, they may need to use the language in which they can communicate to others what they are experiencing. Indeed, this may lead to better outcomes.

Age – Older Adults: There is a higher risk of mental illness in people who migrate after 65 years of age. This group may have problems adapting to a new culture because of language problems and limited access to lessons. More than any other group, seniors have to rely on their children and grandchildren to assist them in daily activities. Unlike younger age groups who are able to socialize at school or work, the elderly are much more isolated in that their families may be their only social contacts.

> "Language and culture play an important role in mental health service delivery. For example, if I go to a service provider who doesn't know my language and is not familiar with my culture, first of all I will not be able to explain my problem to him/her as I want to say it (and) secondly, even if he/she gets me, (he/she) will still not be able to provide me with culturally appropriate treatment, which is very important."
>
> - Focus Group Participant

A Three-pillar Strategy for Service Development

Across Canada, pockets of good practice exist, but there is no province, territory or region whose respondents say their services are meeting the mental health needs of their IRER populations.

The Diversity Task Group takes the position that the challenges faced by IRER populations need a mainstream service response, while also increasing the diversity of services and providers. All services will need to be capable of offering equitable care to Canada's diverse population.

To move towards the vision of improved services for IRER groups, the Task Group recommends a strategy that has three pillars, which are intertwined groups of actions.

The three pillars are outlined below. (More details about each pillar are available in the full report.)

Pillar 1 – Better co-ordination of policy, knowledge and accountability

Policy development needs to occur on at least two fronts:

- To improve mental health and decrease the risk of mental health problems and illness among IRER groups; and
- To improve services for IRER people with mental health problems and illnesses.

There is a need for specific written plans to improve the mental health of IRER groups. These will be more effective if they are coordinated at the various levels of government and across different sectors.

In an evidence-based system, information is the building block of services and is also a way of monitoring success. The lack of data on the needs for mental health services and the use of mental health services by IRER groups undermine the ability to plan care. Therefore, plans will need data streams.

One approach that brings many of these actions together would be to develop population-based, flexible services. Provinces, territories and regions would produce a plan to tailor service development to their demographic imperatives. The plan would focus on policy improvement and public health interventions aimed at health promotion and illness prevention, as well as interventions targeted at service improvement. The exact extent of the plan would depend on the needs of the population and, of course, the resources available.

Pillar 2 – The involvement of communities, families, and people with lived experience

Engaging local IRER population groups in the planning process helps in the development of more appropriate services and also allows for linkage to community-based services, decreasing duplication, and increasing the diversity.

The planning process will also have a community engagement and knowledge exchange function that may build capacity and networks, as well as improve awareness and access to care.

Pillar 3 – More appropriate and improved services

There are five groups of actions required to improve mental health services for IRER groups:

I. **Changed focus**: an increased emphasis on prevention and promotion
II. **Improvement within services**: develop organisational and individual cultural competence
III. **Improved diversity of treatment**: diversity of providers, evaluation of treatment options
IV. **Linguistic competence**: improved communication plans and actions to meet Canada's diverse needs
V. **Linking needs to expertise**: plans to offer support by people and services with expertise to areas with lower IRER populations so they can offer high-quality care

Sixteen Recommendations for Service Improvements

The Diversity Task Group has put forward 16 recommendations for service improvement, which were developed from the literature and consultations. The recommendations are tied to the three pillars of the Task Group's proposed Strategy for Service Development, which is outlined on page 4, and will help move those actions forward. The 16 recommendations are outlined below. (More details about these recommendations are available in the full report.)

Pillar 1 – Better co-ordination of policy, knowledge and accountability	
1	Each province and territory should include strategies and performance measures in their mental health plans to address the needs of IRER groups. These strategies could usefully align with the mental health strategy for Canada that is being developed by the Mental Health Commission by including specific co-ordinated initiatives for mental health promotion, mental illness prevention, and the development of appropriate and responsive services for the IRER populations for which they are responsible.
2	Each province should gather data on the size and the mental health needs of their IRER populations. They should plan their services based on this population data.
3	The mental health strategy of each province should consider a cross-sectoral plan for improving the social determinants of mental health problems and illness for IRER groups.
4	A virtual national centre for research into the mental health and mental health problems and illness in IRER groups should be developed. The Centre could perform a regular one-day mental health census of mental health care service use and a community needs survey sampled by province.
5	Health Canada, Canadian Institutes of Health Research, and the provinces and territories should produce a research and development fund for studies aimed at answering strategic policy and practice questions for IRER groups' mental health and service provision. For instance, there is an urgent need for Canadian research into the identification and evaluation of culturally appropriate systems of care for immigrant children and youth.
Pillar 2 – The involvement of communities, families, and people with lived experience	
6	A central part of each provincial and regional plan to improve the mental health of IRER groups must include the involvement of IRER communities, consumers, and families in planning, decision-making, implementation and evaluation.
Pillar 3 – More appropriate and improved services	
7	Health funders should require that service providers take steps to attract a more diverse workforce and that there is a monitoring of the workforce to assess how it reflects the communities being served.
8	Service provider organizations and provincial ministries should develop strategies to enable good candidates from IRER groups to advance into appropriate leadership positions within their organizations.
9	Each service provider should have an organizational cultural-competence strategy.
10	Cultural competence training should be made available to all who have direct contact with clients and should be provided to existing staff in all service organizations. Training should include interactive, case-based discussions and consultation.
11	Cultural competence training should become a standard part of the training of all professional care staff. This should be insured through standards of accreditation

	of training programs and institutions and licensing professions.
12	Provinces and territories should encourage diversity in the organizations that provide care, the models of care used, and the sites at which care is offered in order to meet the mental health needs of IRER groups.
13	A knowledge-transfer strategy for promising practices in the delivery of care to IRER groups should be developed and implemented so that the most effective models are both known to and can be deployed by providers.
14	A linguistic-competence strategy should be mandatory for local/regional service providers, and funding for this should be provided by their funders.
15	A virtual centre of excellence in the treatment and support of immigrant and IRER groups should be developed. This would include representation from each province, and each provincial health department could join it. This centre would facilitate the access to care for IRER groups by sharing knowledge and expertise. It would also facilitate resolution and discuss any problems with licensure that arise.
16	The Mental Health Commission of Canada could develop a project similar its At Home/Chez Soi national homelessness demonstration project to plan, document, and evaluate promising practice in the development of diversity strategies in at least five communities across the country.

Research Methodology

The recommendations for service improvement outlined in this report are the result of a number of different lines of investigation and consultation by the Diversity Task Group.

An analysis of the data from the 2006 census was used to produce a statistical picture of Canada's IRER groups and a literature review was then performed.

Data from these two sources and the experience of a steering group of experts in multi-cultural health from across Canada were used to help develop a draft paper outlining the issues and potential options for service improvement for IRER groups.

A web-based consultation for the draft paper was undertaken, hard copies of the paper were sent to health planners in the federal government, the provinces, territories, and regions and to the different committees of the Mental Health Commission of Canada.

There were also consultation focus groups in seven centres spanning Canada from Vancouver to Halifax.

Once all the results had been considered, focus groups of people with lived experience were undertaken to ensure that there had not been drift and the recommendations continued to be in line with their aspirations.

Finally, a national consensus meeting was set up in May 2009 to review the findings and recommendations.

Mental Health Commission of Canada's Diversity Task Group

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Full Report

The full Diversity Task Group report – Improving Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Groups: Issues and Options for Service Improvement – is available on the Mental Health Commission of Canada's website at:
http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2010/Issues_Options_FINAL_English%2012Nov09.pdf