Understanding the issues, best practice and options for service development to meet the needs of ethno-cultural groups, immigrants, refugees, and racialized groups

Report by the Mental Health Commission of Canada Task Group on Diversity, 2009

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Executive Summary

The Mental Health Commission of Canada Service System Advisory Committee has produced recommendations for improving the mental health of Canadians from ethno-cultural, racialized, immigrant and refugee groups[i]. We are now circulating them nationally for consultation. This report is posted on the websites of the Mental Health Commission of Canada and the Centre for Addiction and Mental Health for e-consultation (please go to http://www.camh.net/Public_policy/Public_policy_papers/consultation_mhcc_feb09.html). There will also be regional consultations across the country between February and April 2009.

The aim of the consultations is to make sure we have got the issues right and to get feedback from stakeholders on the proposed recommendations. The consultation results will be reviewed at a national meeting in May 2009 and after this a final report will be written for the Mental Health Commission of Canada.

Our report offers an analysis of the data from the national censuses to build a picture of the diversity of groups in Canada. It presents a model describing how individual vulnerabilities and the social determinants of health lead to a pathway from mental health through various stages of distress to service use. It reviews Canadian literature concerning mental health and mental illness in ethno-cultural, racialized, immigrant and refugee groups and federal documents that have considered these issues before offering recommendations for the improvement of service and systems.

The vision of is one where these issues are seen as mainstream, where the extensive diversity that exists within these groups is recognised, and where services move from a position of consultation to a position where they are working alongside communities and community groups to produce action. It is a rights-based vision grounded in the principle of equity and social justice. It should be viewed as part of a strategy leading to a point where culturally competent and culturally safe services are understood as the norm and a fundamental building block of an equitable health system.

The vision is built on the goals of the National Mental Health Strategy that is being developed by the Mental Health Commission of Canada.

[i] The aim of these terms is to include all groups who are marginalized by their culture, ethnicity, race, ethnic identity, history of migration to Canada or immigration status.

The plan for moving towards the vision has four pillars: better co-ordination; information; community engagement, and the development of more appropriate culturally safe services.

Systems will need to be more focussed on health promotion, more reflective of their communities in staffing and in diversity of treatment. They will require linguistic competency strategies and, in areas where ethno-cultural, racialized, immigrant or refugee populations are sparse, there will need to be links to other areas where there is the required expertise to ensure that cost-effective equitable care can be offered.

We now need your input. We specifically would like feedback on our recommendations and to know if there are places in Canada where such initiatives have been tried. But we also would like you to tell us about existing services and areas of good or promising practice in immigrant and ethno-racial mental health care.

Understanding the issues, best practice and options for service development to meet the needs of ethno-cultural groups, immigrants, refugees, and racialized groups

Introduction

Canada is the only G8 country that does not have a mental health strategy. The Mental Health Commission was set up to correct this situation. As part of that process we want to find out how we can improve the mental health and treatment of mental illness for our diverse population.

The mental health strategy for Canada will be developed in two phases. The first phase is the development of a framework document, which establishes high-level goals for WHAT a transformed mental health system should look like. The second phase will develop measurable objectives for HOW to achieve these high-level goals in each sector (e.g. healthcare, justice, education, workplaces and so on) and across different population groups.

The Mental Health Commission of Canada's Service System Advisory Committee has produced recommendations for HOW we can improve the mental health of Canadians from ethno-cultural, racialized, immigrant and refugee groups. They are built on published research, reports from national committees, the views of a team of service providers from across Canada and an environmental scan of targeted services.

We now need your input. We need to know if we have got the issues right. We would like feedback on the recommendations and to know if there are places in Canada where such initiatives have been tried. We also would like you to tell us about existing services and areas of good practice for Canada's diverse population.

Guiding principles

Canada's Mental Health Strategy will be based on the principle that everyone can benefit from improved mental health and well-being, while also acknowledging that many people living with mental illness will need special services and supports to help them recover and achieve greater well-being.

The Commission is firmly convinced that a focus on recovery - based on the principles of hope, empowerment and responsibility - needs to occupy a central place in the transformation of the mental health system in Canada. The objective will be to ensure that people living with mental health problems and illnesses are treated with the same dignity and respect as their fellow citizens and have the opportunity to lead full and meaningful lives in the community, free from discrimination.

However, in order to have a comprehensive mental health strategy, we will also need to look at ways of keeping people from becoming mentally ill in the first

place and at how to improve the mental health status of the whole population. The challenges in this regard are many, but the potential benefits are enormous. The evidence strongly suggests that mental health promotion and illness prevention can both enhance overall mental health and well-being of the population and also contribute to reducing the individual, social and economic burden of mental health problems and illnesses.

To accomplish these objectives, it will be important to act in many different settings and to address the needs of Canadians across their lifespan. In particular, we will need to:

- improve access to recovery-oriented services and supports for people living with mental health problems and illnesses and their families;
- improve early recognition and diagnosis, as well as our ability to intervene in a timely manner as problems emerge – before they become entrenched – especially amongst children and youth;
- expand initiatives that are targeted at people and communities with high risk factors for mental health problems and illnesses;
- expand activities directed at improving the mental health of the whole population, such as the promotion of mental health literacy.

It is clear that a comprehensive approach must address the needs of all sectors of the population, whatever their current mental health status.

The National Strategy Framework Document proposes 8 goals:

1. The hope of recovery is available to all;
2. Action is taken to promote mental health and well-being and to prevent mental health problems and illnesses;
3. The mental health system is culturally-safe, and responds to the diverse needs of Canadians;
4. The importance of families in promoting recovery and well-being is recognized and their needs are supported;
5. People of all ages have equitable access to a system of appropriate and effective programs, services and supports that are seamlessly integrated around their needs;
6. Actions are based on appropriate evidence, outcomes are measured and research is advanced;
7. Discrimination against people living with mental health problems and illnesses is eliminated, and stigma is not tolerated;
8. A broadly-based social movement keeps mental health issues out of the shadows – forever.

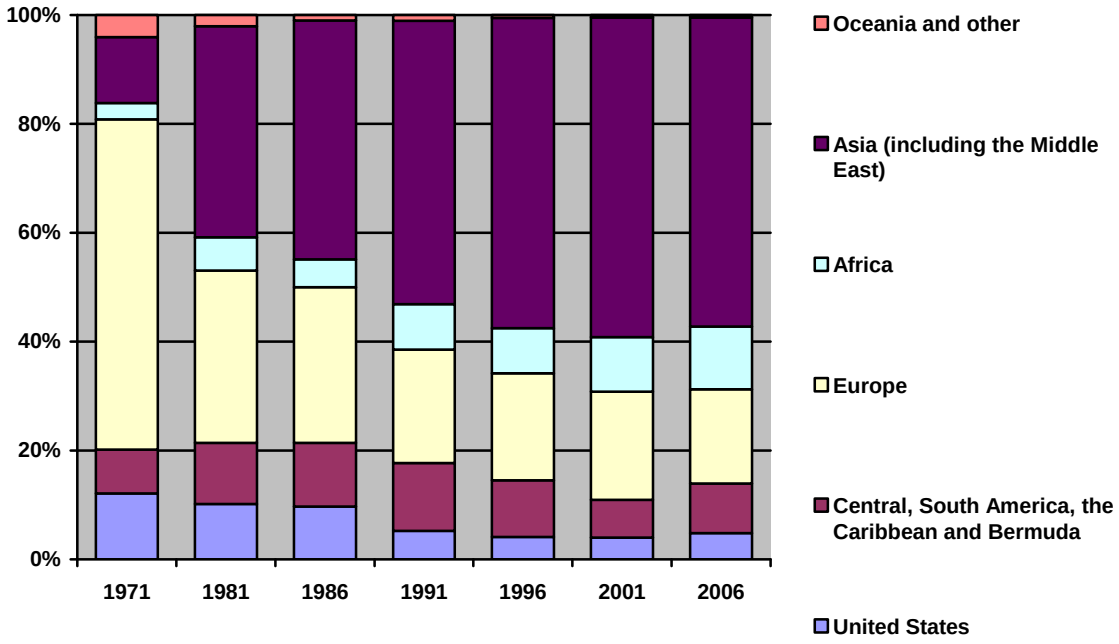
Outlining the challenge of improving mental health services for ethno-racial groups

Demographics

Canada is one of the most diverse countries in the world. Nearly 20% of the population was born in another country and hundreds of thousands of new immigrants arrive each year. Canada's future economic prosperity will depend in part on population growth. Canada's main driver for population growth is immigration. Because of this, immigrants are an important national resource.

Until the 1960's, immigration to Canada was mainly from Europe. This has changed so that now immigration is mainly from South and East Asian countries. As Canada grows it is becoming more diverse because ethno-cultural, racialized, immigrant and refugee groups are encouraged by law to keep their identities and heritage. Diversity, due to newcomers, makes the headlines but the majority of people who identify themselves as belonging to minority groups are Canadians. Some have been in Canada for centuries; however, 80% of people living in Toronto are 1st or 2nd generation immigrants[1].

Region of birth of recent immigrants to Canada, 1971 to 2006



In the rest of this document we use the term ethno-racial to describe ethno-cultural, racialized, immigrant and refugee groups. No one term will adequately reflect these groups. Ethno-racial has been used because it reflects the term ethno-cultural (which includes all cultural minority groups including white groups who feel marginalised) and because it reflects the term racialization (which is an

emerging term that identifies groups who experience systematic discrimination and exclusion based on skin color).

Canada's ethno-racial groups are diverse and composed of different populations with different histories, cultures, social realities and needs. There are some common experiences such as issues of status in society and difficulties with access and use of services but there is substantial and significant diversity. This diversity within groups includes different national heritages and cultures as well as social location due to gender role, sexual identity and physical ability. The challenges for refugees are different from the challenges for new immigrants and these in some measure are different from those faced by ethno-cultural and racialized groups. We have tried to reflect this in the text when there is available research evidence. We understand that for every statement where a group is considered as a collective there will be particular groups and individuals within any group to which the statement does not apply.

Canada's ethno-racial populations mainly live in or around major cities but there are significant rural populations. Every province and territory in Canada has an ethno-racial population. They are different sizes, are growing at different rates, and come predominantly from different places. In some areas the population is small but for others it is up to a quarter of all the people who live there.

Different areas in Canada have different demographics. Some regions like Nova Scotia have a small immigrant population but many are growing at rapid rate. Others like Montreal, Toronto and Vancouver have large ethno-racial populations and large immigrant populations that used to settle in the urban core but are now increasingly settling in suburban areas. Alberta has seen a significant rise in immigration as workers follow jobs.

These different stories offer a challenge for any mental health strategy. It needs to be flexible enough to be useful to areas with stable populations as well as ones where populations are growing rapidly. Any strategy has to meet the challenge of more populous areas as well as areas where ethno-racial groups are a small proportion of residents.

Causes of mental illness in ethno-racial and immigrant groups

Mental Health:
The World Health Organization describes mental health as a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community. While other countries such as the UK and US have published extensively on the health and mental health of ethno-racial and immigrant groups, research in Canada has been fairly limited, but is now increasing.

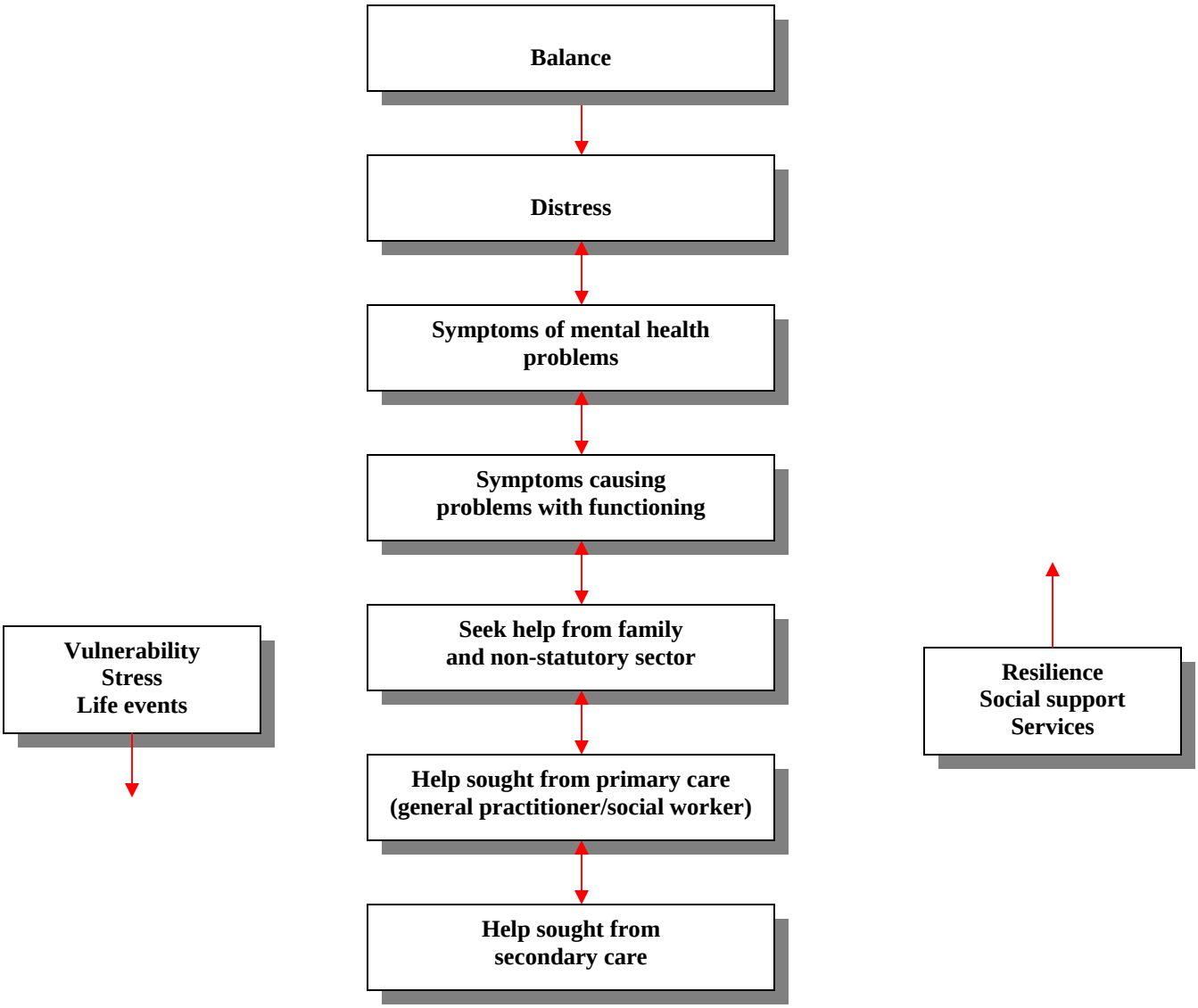
Mental health problems and mental Illness:
Mental health problems and illnesses are clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering or difficulty in functioning in society. There are many different mental health

problems and illnesses ranging from depression through to schizophrenia. They may have different causes and treatments which makes discussing them as one group problematic at times, but they also have some similarities in their impact on individuals, their families and society.

Studies conducted around the world point to 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 than non-migrant groups and the rates of psychological distress, post-traumatic stress disorder and depression are markedly raised in refugees[2]. Some of the factors driving increased risk of illness are common to these groups such as unemployment, financial insecurity, poverty and poor housing. Others, like pre-migration stress due to war, torture and rape and the stress of migration, will only impact on some.

Developing mental health problems

Developing mental health problems and mental illness and getting help for those problems is a dynamic process**.**



Pathway from mental health to mental health care and the impact of social forces

We spend most of our lives in balance – or mental health – but we may move towards developing mental health problems and seeking help because of things that happen to us in our lives. When we encounter problems we may be able to shrug them off or we may temporarily move from balance to distress and then down a pathway that can end with a mental health problem.

Of course most people move from distress back to balance. This is due to their internal resilience or the help they receive - say through the support of their communities and families or through the societal safety-net of social services,

family practitioners and mental health professionals. They all aim to restore us to psychological balance.

When our vulnerability, the events in our life, and stress are greater than our capacity to deal with them we move down the pathway. As we summon up our resources we move back up towards balance. In this way, the pathway to mental health problems can be seen as an interaction between forces that promote mental illness and forces that promote mental health. Of course if the stress is severe or the life event is great then we may not proceed through the pathway and may move directly from balance to a mental health problem.

This model is useful when considering not only how people develop problems but also what we can do about them.

There are many different types of vulnerabilities, life events and social stresses. Differences in the rates of mental illness and the risk of mental illness between ethno-racial groups are due to the balance of stresses and resources that each group has available to them. Scientists have demonstrated that some of our vulnerability is genetic and due to our biology. But there is no evidence that genetic or biological factors account for differences in the rate of mental health problems between ethnic groups. The causes of such differences are found in the social world.

Social determinants of mental health

Social causes of mental illness are called social determinants. This is because they are not direct causes of mental health problems. Mental illness is almost never caused by a single factor as it is a balance between factors that move you up or down the pathway. Social determinants can change a person's vulnerability to mental illness. The social determinants linked to developing mental health problems may also act at other interpersonal or social levels for instance by undermining resiliency and coping networks. Similarly, social determinants that act towards positive health and mental health promotion act at a number of levels in a positive way. Social determinants can also work over a life course to increase or decrease someone's risk of developing a mental illness. Some increase vulnerability 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 at migration, are more due to a significant increase in life stresses at a time when the social safety net may not be as strong.

The Public Health Agency of Canada has produced a list of 12 social determinants of health that are applicable to all[3]; seven of these are particularly pertinent to immigrant and ethno-racial groups:

1. Income and social status
2. Social support networks
3. Education and literacy, i.e. health literacy
4. Employment/Working conditions
5. Social environments
6. Physical environments

7. Healthy child development

Income and social status

There is a strong link between income, income inequality, financial insecurity, poverty and mental illness. All of these factors are more prevalent in ethno-racial populations[4]. This is true for all age groups. On average, it takes 10 - 15 years for an immigrant to become economically integrated but even then most groups still lag behind. Canada's ethno-racial populations are more likely to be in the lower social classes and have lower status jobs. A change in social status, particularly going from a higher status in the home country to a lower status in the host country, can also have a negative affect on mental health.

Social networks

A significant source of problems for immigrant groups is the fact that social support networks are broken and lost when people move. It takes considerable energy and time to reconstitute these networks and though there is a history of immigrant groups organizing to provide support, often this support is limited compared to the extensive networks that have been left behind.

Education and literacy

Education is generally beneficial to mental health. The proportion of ethno-racial groups with a degree is higher than the Canadian average. Between 2001 and 2006 half the people who migrated to Canada had university degrees. This would be expected to decrease the rates of mental health problems in ethno-racial groups. But studies worldwide have shown that, at least for refugee populations, those with higher qualifications do less well. The reasons for this may be that they are not able to work at the same level as they previously had and this loss of status has a detrimental impact on health. According to Statistics Canada reports, immigrants fare less well at work than people born in Canada despite their qualifications. 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

For recent immigrants in Canada in 2001, unemployment was consistently at least triple the rate for Canadian-born. Unemployment is not only more common for immigrants, but for ethno-racial immigrants. In 2001, the rate for immigrant men was 29% if they were part of an ethno-racial group and 16% if not. For women, the rates were 45% and 25% respectively. These rates can vary depending on whether people from ethno-racial groups are Canadian-born where the figures narrow. Unemployed people experience higher levels of depression than those who are employed. Employment provides not only an income, but also a sense of purpose and personal growth[5]. However, some underemployed refugees noted that they take some relief in looking to their children's bright

future as a way of coping[6]. Among employed ethno-racial populations a constant fear of becoming unemployed is a specific stressor[7].

Social environments and physical environments

People from ethno-racial 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 illnesses though the processes through which this happens are not clear. It may in part be due to the physical environment including pollution but also the harsh social environment, levels of crime and the diminished sense of community that characterizes some cities.

Healthy child development

Healthy child development depends on time, community resources and money. 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. Refugee children face even greater issues and are more likely to be malnourished, have a disease or physical injury, and to have been a victim of abuse. If a child is separated from their parents during the process of migration, they face an increased risk of a mental health problem.

In addition to the standard determinants of health, there are specific factors that are important in the mental health of ethno-racial groups.

Migration

Migration is a particular stressor for immigrant groups. The reasons for migration, the process of migration and the reception of the host population are all important factors. Pre-migratory stress in refugee groups and trauma such as war, torture, rape and natural disasters increase the risk of developing common mental disorders (anxiety and depression) as well as post-traumatic stress disorder. The process of migration and acculturation can be potent risk factors for a number of mental disorders.

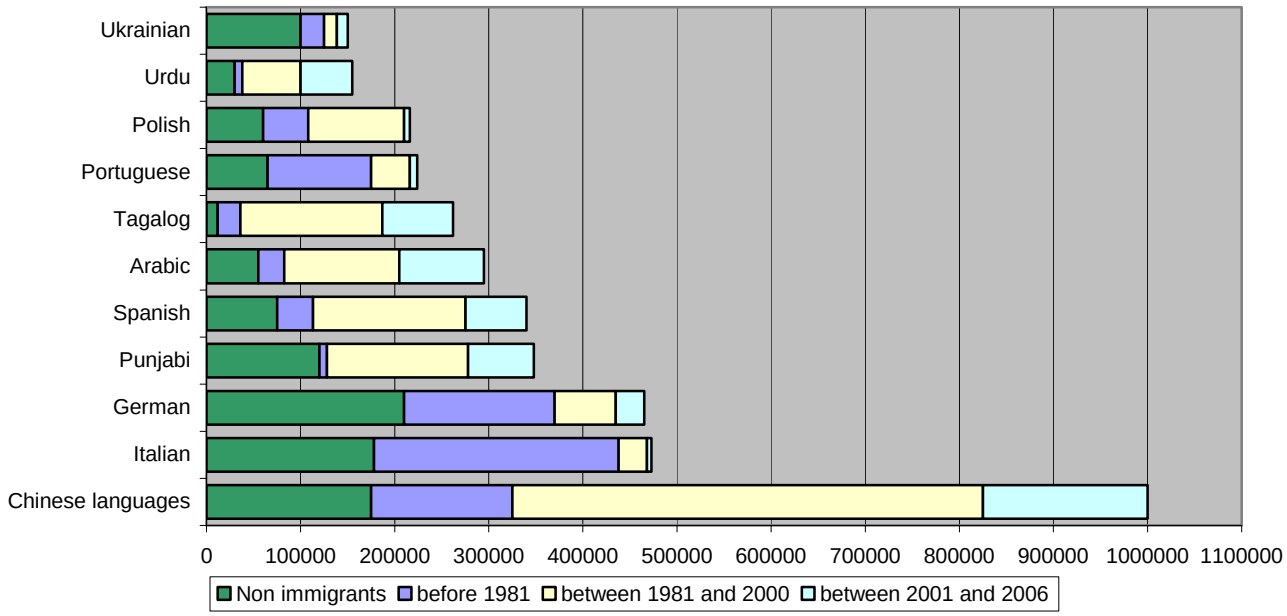
Discrimination

Racial discrimination is a risk factor for mental illness that is more commonly experienced by ethno-racial groups. This is a complex social problem that 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. The economic disadvantage linked to discrimination at work is significant as is discrimination in the receipt of services. Some argue that in Canada there is a colour to poverty. Discrimination impacts on mental health through direct effects on individual's psychology and physiology as well as through its links to other social determinants of health.

Language

The vast majority of Canadians speak English or French but 20% have a different mother tongue (currently there are over 200 spoken here). When people develop mental health problems they may need to speak in the language in which they can communicate best; indeed this may lead to better outcomes. The most common mother tongues apart from the official languages are Mandarin, Cantonese and South Asian languages (Urdu, Hindi and Punjabi). Less than half the people who speak these languages use English or French regularly at home.

Non-official mother tongues by immigrant status and period of immigration, Canada, 2006



Note: 'Chinese languages' includes Mandarin, Cantonese, Hakka, Taiwanese, Chaochow (Teochow), Fukien and Shanghainese, as well as a residual category (Chinese languages not otherwise specified).

Social determinants and mental health problems in ethno-racial groups

All of these social determinants of health are risk factors for the development of mental health problems and mental illness. On the flip side they can also be seen as possible targets for mental health promotion.

Higher rates of mental health problems and mental illness are predictable in populations who are exposed to environments rich in the above social determinants. Many ethno-racial groups have high levels of exposure to such environments and are therefore at increased risk of mental health problems. Furthermore within ethno-cultural groups there are some who are further marginalised for instance by being lesbian, bisexual, gay, transsexual or transgender. The needs of groups at such intersections have not been prominent enough in the literature.

The World Health Organization argues that if there is a difference in rates of mental illness or exposure to risk factors between groups this offers a target for prevention.

Canadian research into the mental health and mental health problems in ethno-racial groups

There have been over 50 Canadian studies in the last 20 years that have investigated mental health or mental health problems in ethno-racial groups. Eight of these studies were national. Half of them are from Ontario, ten from British Columbia, five from Quebec and the others from Alberta and Nova-Scotia. Studies using national samples tend to compare immigrants to non-immigrants. Smaller local studies have offered more in-depth information about particular ethno-racial groups.

It is not possible to discuss all of the research findings in this report so we have produced a synthesis of what the research tells us and have illustrated this with specific scientific papers. In general the studies focus on the social determinants of mental health problems in immigrant and ethno-racial groups, the rates of mental illness and barriers to and facilitators of care.

Evaluating the findings of the research is complicated by inaccurate population counts and demographic differences between groups. In addition, diverse ethno-racial groups are often lumped together as one population or they are separated by major geographic region (e.g. Asian, African, etc.). This blanket approach to research and understanding may not be fine grained enough for the development of equitable services at a local level. Clearly there are major cultural differences within areas such as Asia or Africa. Most research uses quantitative methods when qualitative methods may have provided a better exploration of the issues[8].

Ethno-racial groups often play the participant role in research rather than as evaluators or research designers.

Social determinants

Studies have reported a number of factors associated with improved mental health of immigrant and ethno-racial groups. A study of Ethiopian immigrants and refugees found strong ethnic identity decreased the risk of depression. This was echoed by a study of the beneficial effect on depression in 12 ethno-racial groups of a positive sense of ethnic identity, self-concept, self-esteem and social belonging[9]. Employment improved the mental health of South East Asian refugees in one study and increasing family income for the persistently poor decreased the rate of behavioural problems in immigrant children[10]. Social networks were beneficial in decreasing isolation of South Asian women[11] and in South East Asian groups marriage improved mental health.

Many more factors that have a negative impact on mental health have been reported. These include migration and settlement issues in Cambodian women refugees[12] and Latin American men[13], migration stress in immigrant mothers, and remembering pre-migration stresses in South Asian women. Many of the

studies documented associations between poverty, financial insecurity, unemployment and underemployment and poorer mental health in a number of groups including immigrants in general, immigrant children, immigrant mothers[14], people from Afghanistan, Chinese women, Black African women, Latin American men and South Asian refugees. Neighbourhood disadvantage was associated with poorer mental health in immigrant children and youth, weak community involvement in ethno-racial groups[15], and a lack of social support and isolation were considered important in South Asian immigrant women[16] and Latin American men. Language problems were identified as a social determinant for most groups including Black African women[17] and Latin American men. Childcare was also an issue for women. One study reported discrimination as an important risk factor for the mental health of Korean immigrants[18]. In Asian immigrants, the risk of depression increased the longer they were in Canada[19].

Rates of mental illness

Despite these social determinants, the rates of mental health problems in immigrant and ethno-racial groups are not consistently reported as elevated in Canada.

The Canadian Community Health Survey (CCHS) offers one of the few national studies of mental illness in recent immigrants to Canada[20]. It reported what is known as the healthy immigrant effect. In this study, immigrants to Canada had lower rates of anxiety and depression than Canadian-born residents. However, the CCHS also reported that rates of anxiety and depression increase the longer people have been in the country. Worryingly, in other countries the rates of mental illness in the second generation have been higher than those in the first generation. Studies have similarly found that immigrants have lower rates of suicide. Again this needs to be considered with caution as the trajectory for suicide in ethno-racial groups depends on societal and cultural factors that change over time.

Local studies do not concur with this national view. For instance, a study of adolescents in Quebec found high rates of psychopathology in refugee youth and a study of Toronto University students found that mild depression was more likely in South Asian and South European students than students of East European and Anglo-Celtic backgrounds[21]. In Quebec, immigrant women belonging to minority groups were found to display higher depressive symptoms than women born in Canada or women from larger ethno-racial groups and a study of the Ethiopian origin population in Toronto reported a rate of depression of 28% and a rate of anxiety disorders of 37%[22]. Suicide rates were also five to six times higher than the Canadian population.

It may be that the lack of clear findings at a national level reflect the heterogeneity of rates of mental illness in different groups. If some ethno-racial groups have high rates of mental illness and others do not then when all the groups are put together the different effects cancel each other out. More fine-grained analysis at a national level may be needed.

Barriers to and facilitators of care

It could be argued that the need for services may be a more pertinent issue than simple rates. Groups exposed to life events and social stress, low incomes, fractured support networks and poor societal safety-nets may be more likely to move down the pathway from the development of symptoms to needing to use mental health services. This constellation is more likely to be present in ethno-racial groups.

However, most people in need of mental health care do not get it. Research studies raise concerns about access to mental health services for immigrant and ethno-racial groups and the care that is received.

Immigrants are less likely than their Canadian counterparts to use a mental health service in primary care or speciality settings[23]. A study by Whitley et al found that some of the barriers to seeking treatment include a perception of doctor's over-willingness to prescribe medication, perceived lack of time and interaction between the patient and the doctor, and a stronger belief in traditional therapies[24]. Those who are more educated tend to be more likely to seek services for their mental health (both in the ethno-racial populations and the non-ethno-racial populations).

The research findings are consistent with Whitley et al's view.

Language was often cited as a barrier to care in the Canadian literature as well as cultural insensitivity of services and the lack of service providers with the same ethnic identity[25, 26, 5].

Studies reported that mainstream mental health care was considered inconsistent with the values, expectations, and patterns of help-seeking of immigrant and ethno-racial groups. For instance, they documented the views of incompatibility between services and Black women, South Asian women, immigrant seniors in general, Tamil and Asian seniors and West Indian immigrants[27, 5, 25, 24].

Language is an important barrier to care[29]. This is true for mental health promotion, mental illness prevention and treatment services. It is true for the spoken word as well as non-verbal communication. Generally speaking, the longer someone is in Canada and is able to learn one of the languages, the more likely they are to use health services[35]. Though interpreter services are mandated in the court system, they are not in the health system. Where translation and interpretation services are available, clinicians are rarely taught how to use them.

Even if language services were fully available there would still be a question as to whether the same quality of treatment can be delivered through an interpreter. Some would argue that services in the same language as the person who is attending them are the only way of offering equitable care.

Another issue in access to services is awareness[28]. There are reports that some from ethno-racial groups are either not aware of the services that are available to

them, or do not understand how the health care system works[28]. If people do not know where to get help, they may wait until their symptoms are more severe before they receive care. Some have reported that in the absence of information about services, they find out how Canadian systems work through friends and family[23]. They are less likely to ask about mental health systems because of possible stigma and this leads to people either not getting treatment or a delay in getting treatment[27]. A lack of knowledge about where to get care was reported as an impediment by Afghani[28] and Asian Canadians[29] and poor information about available services by Chinese immigrants[26].

Socio-economic barriers differentially affect immigrant and ethno-racial groups in Canada. Though these groups are more likely to be poor, they are less likely to access benefits[27]. Poor income decreases access to and utilization of health care services. Several provinces impose a three-month delay after arrival into Canada to receive health insurance. Certain categories of temporary workers, foreign students, visitors, and undocumented migrants are excluded from provincial health coverage[30]. Services are often only available during the week and this may act as a barrier for someone who is employed. Transportation costs can also impact service use[27]. A lack of funds can prevent people from purchasing necessary medications. This means that people may not be able to afford any or all of their medications which will further prevent treatment.

Studies of both Asian Canadians and Black women cited racial discrimination as a barrier to care[29]. Institutionalized discrimination has been a way of considering structural barriers to accessing mental health care by immigrant and ethno-racial groups. The argument has not been that practitioners directly and actively discriminate against particular groups but that the system of care works to offer poorer access and treatment to these groups. One size fits all services ignore the differential needs, presentation of problems and desires of groups and could lead to poorer outcomes. Studies have documented differences in presentation of problems in immigrant and ethno-racial groups in populations from immigrant children[31], East Asian university students[32] and Asian Canadians. Some have indicated how therapies can be modified to make them more effective, such as problem focused therapy[33] being more effective for some problems in Korean immigrant groups and emotion-based coping[34] for some South Asian groups. However, these studies are rare.

Stigma of mental illness and of mental health services is a significant barrier to care.

The first line of help-seeking is the existing community, lay healers and religious groups. Religion and spirituality are important sources of support and help in the management of stress and mental health problems. It would not be surprising if alternative therapies and treatments from home countries were common in ethno-racial groups. One study for instance reported this in South Asian and Tamil groups[35]. The next line of treatment is the family practitioner followed by possible referral to secondary care such as psychiatrists. There is little information on family physicians and mental health in immigrant and ethno-racial groups but there is some evidence that they find it difficult to locate culturally appropriate services to refer to when they consider the need[5].

There is some literature reporting factors that facilitate people from immigrant and ethno-racial groups in Canada getting care. For instance, in the Tamil population, this includes length of stay in Canada, trust in the system, knowledge and education and cultural competency[35]. In South East Asian university students acculturation and co-operation between service providers has been reported as helpful and in the Somali community ethno-specific health promotion and diversity of services including alternative approaches have been cited[36].

The federal response –
After the Door Has Been Opened
Out of the Shadows at Last

The mental health of immigrant populations has been of interest for many years. A national task force was established in the mid-1980s to investigate this topic and reported their findings in 1988 (A*fter the Door Has Been Opened)*[37]. A thorough literature review was conducted as well as presentations and written submissions from respondents across Canada. The Task Force concluded that, while moving from one country and culture to another inevitably entails stress, it does not necessarily threaten mental health. The mental health of immigrants and refugees becomes a concern primarily when additional risk factors combine with the stress of migration. One of the main things this report describes is that immigrants and refugees do not have a voice in the mental health care system either from a consumer's point of view, or as service providers.

The Task Force noted three important principles:

1. The mental health issues affecting immigrants and refugees include both issues of cause and issues of cure. To meet the mental health needs of Canada's migrants, risk-inducing factors must be mitigated and remedial services made universally accessible.

2. The steps required to prevent and treat emotional distress in immigrants involve the persons with whom migrants come into contact as much as they do the migrants themselves. Sensitizing Canadian-born persons – immigration officers, settlement workers, teachers, neighbours and mental health personnel - to the ways in which culture can affect encounters between themselves and newcomers to this country can help eliminate major sources of distress for migrants and facilitate effective mental health care.

3. The Task Force recommendations reflect the fact that no single governmental body or level of government is or can be responsible for the mental health of Canada's immigrants and refugees. For newcomers to adapt to and integrate with Canadian society, their strengths, needs and perspectives must be taken into account by decision-making bodies at each level of government, by planners and by service providers.

They then offered 27 recommendations for Citizenship and Immigration Canada, Health Canada, and other federal bodies to improve mental health for immigrant groups.

For the purposes of this project the research team attempted to investigate how much progress had been made on these recommendations. So far in the twenty years since the report was published, only 6 of the recommendations have been implemented in full.

Citizenship and Immigration Canada's direct role in the provision of mental health services is through the Interim Federal Health Program[38]. This offers health services to recent migrants, current refugee claimants, refugees, detainees in immigration detention centres and failed refugee claimants still in Canada who are unable to pay for their health care services. It covers essential and emergency medical services, including mental health services such as consultations with a physician, hospitalization and essential medication.

Citizenship and Immigration Canada attempts to ease the stress of integrating into Canadian society through several programs:

- The Immigrant Settlement and Adaptation Program funds service provider organizations to provide counselling and non-therapeutic services to newcomers, including referrals to services for educational, legal, social and health needs as well as employment and housing.
- The Host Program funds the recruitment, training, matching and coordination of volunteers who can help newcomers to deal with educational and health issues and to learn about and access available services in their community.
- The Resettlement Assistance Program provides income support and a range of immediate services. For the regular stream of government-assisted refugees, the department provides up to 12 months of income support; for those with special needs, this can be extended to 24 months. The amounts are guided by provincial social assistance rates.

Citizenship and Immigration Canada is also involved in other partnership arrangements at different levels. For example, it supports the Canadian Centre for Victims of Torture and the Metropolis project, a national/international forum for research and policy on migration. In addition, the Federal/Provincial/Territorial Working Group on Settlement and Integration discusses issues of a multilateral nature. Interdepartmentally, there are joint initiatives with the Public Health Agency of Canada on migration health challenges, as well as with Industry Canada, Human Resources and Skills Development Canada and Health Canada on informational projects to facilitate integration. Citizenship and Immigration Canada is also responsible for various linguistic programs including the Language Instruction for Newcomers to Canada Program that provides basic language instruction to adult immigrants to help them integrate successfully.

Although Health Canada was named in the recommendations, they explained to this research team that they have difficulty enforcing or contributing to them because they are a federal body that does not actively deal with service delivery. Provincial health departments are responsible for services for immigrant and ethno-racial populations.

The Senate report, *Out of the Shadows at Last* took evidence on mental health services for refugee and immigrants some 17 years after *After the Door has been*

Opened. It underlined the fact that after admission to Canada, the expectation is that the delivery of programs and services related to mental health that fall into the public health care sphere will be a responsibility of the provinces and territories.

The report called for Canada's commitment to provide safe refuge to include assurances that individuals have access to health services to help them with any mental health issues they face. It identified a role for an external body to provide oversight and assessment of how well the federal government is meeting its commitments to immigrants and refugees. It recommended that:

> "the federal government establish an entity for immigrants and refugees, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee; That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of immigrants and refugees; That this entity provide an annual report to Parliament."

It also supported the greater involvement of immigrant and refugee communities as partners in research, program development and service delivery. The report argued that there is a need for more Canadian research into the identification and evaluation of culturally appropriate systems of care for immigrant populations, particularly in relation to vulnerable populations such as children, women and seniors.

Language was considered a key tool to facilitate successful integration and positive mental health among immigrants and refugees. Their view was that all immigrants and refugees should have equal access to official language education and that federal government has an obligation to provide and pay for linguistically and culturally appropriate services; it must not offload them onto the provinces.

It recommended that Citizenship and Immigration Canada provide an annual inventory to Parliament on its programs and services relevant to mental health, including clients served, expenditures allocated and spent, and outcomes achieved, starting in 2008. It also recommended that Citizenship and Immigration Canada increase funding for and access to language training by diverse groups through increased training allowances, appropriate scheduling of instructional hours, and the location of classes in places that facilitate access.

Both reports focussed on the needs of refugees and new immigrants. The need of existing immigrant groups and ethno-racial populations has not been the focus of scrutiny at this level so far.

The response of provinces and territories

Mainstream mental health services are available to all but there are clear challenges for service provision in a multi-cultural context. It has been difficult to gauge the response of provinces and territories to the mental health and mental illness needs of their ethno-racial populations. We contacted all provinces to find

out about specific mental health services or initiatives targeted at ethno-racial groups. This gives an indication of the services they are aware of but does not reflect the full range of programs available in a given jurisdiction or the impact of services in other parts of health or in other sectors that may have an impact on mental health. This exercise indicated that there may be large information as well as service gaps.

British Columbia listed 7 ethno-racial -specific services. They also have mental health fact sheets translated into 9 languages.

Alberta also has some services available including the New Canadians' Health Centre, Calgary Immigrants Women's Association, and the Shared Mental Health Care program.

Saskatchewan noted that they have a relatively small immigrant population and therefore, do not offer any specific services. They do have a service called the Open Door Society which provides support to immigrant families.

Manitoba listed 9 services that provide specific services to immigrant groups. This includes Health Links which is a phone service that offers health information in more than 100 languages. There were no services listed that were directly for ethno-racial populations.

Connex Ontario lists 17 mental health services for immigrant and ethno-racial groups in Ontario; most being in the Toronto area. There are services specifically for people of colour, people from Cambodia, China, Korea, and Vietnam. There are also services for the Tamil population, those from South East Asia, the Black community, and women from Afghanistan. Some services have been developed for people who speak specific languages including Portuguese, Italian and Spanish. All of the services offer a part of the care pathway, whether outpatient or inpatient; none are a comprehensive stand-alone service.

The province of Quebec noted four services which focus on newcomers including PRAIDA, the South Asian Women's Centre and has a medical interpreter service for the greater Montreal region.

Nova Scotia listed two services: one for newcomers and the other for African Canadians. Nova Scotia also has a Community Health Interpretive Service whereby translation services are offered for the health and mental health community.

Newfoundland, New Brunswick, P.E.I. and the Northern Territories did not list any services targeted at ethno-racial or immigrant groups.

There are likely to be more services and initiatives available than we could identify in various communities.

A comprehensive directory of services and service approaches in Canada would be useful. If you know of directories of services for immigrants, refugees and

racialized communities, please let us know by emailing Emily_Hansson@camh.net

Towards improving mental health for immigrant and ethno-racial groups in Canada

The Mental Health Commission of Canada has proposed eight goals of a transformed mental health system. The Commission recognises that most of the goals will require a strategy that is inclusive.

Goal three
Much of the focus for immigrant and ethno-racial groups will be on goal three:

The mental health system is culturally safe and responds to the diverse needs of Canadians
In a transformed mental health system, programs, services and supports are culturally safe, and respond to the diverse needs of Canadians, including those arising from migration, ethno-racial background, age, language, gender, sexual orientation, or geographic location.

In a **Transformed Mental Health System:**

- Service providers recognize the cultural values, as well as the historical and political contexts, of those with whom they are working in order to develop trusting partnerships.
- Providers practice in a way that takes into account the social, political, linguistic and spiritual realities of the people they work with and recognize and address issues of power and discrimination.
- Whatever a person's cultural identity or background, these are seen as a potential source of resilience, meaning and value.
- Training in cultural safety begins early for all mental health care providers so an awareness and response to diversity becomes commonplace.
- Accreditation bodies and professional organizations adopt standards that require the implementation of culturally-safe practices.
- Socioeconomic disparities are addressed in order to minimize differences in mental health outcomes and promote mental health and well-being.

Goals 1, 2, 4, 5, 6, 7, 8

The remaining goals will require action specifically for ethno-racial groups.

For instance, the hope of recovery will need to be available to all and will require specific action for immigrant and ethno-racial groups.

Immigrant and ethno-racial groups are at higher risk of exposure to social determinants of mental health problems. In the US and in Canada, research has reported the effectiveness of targeted prevention and promotion strategies for ethnic groups[39, 36].

Families of some ethno-racial and immigrant groups claim that cultural models of illness and recovery are based on their involvement and that current Canadian laws make their collective approach to well-being and treatment difficult to pursue in the mainstream. Those groups may welcome the emphasis on family as long as their perspective is included. As ethno-racial and immigrant families are less well represented they may fear their voice will not be heard unless they are helped to organise.

Integration of services and seamlessness of care will be particularly important for ethno-racial groups. There is a push for diversity in approaches to mental health care models and providers but this will mean that efforts will need to be doubled to ensure that services still knit together properly.

Evidence-based practice is important but research into mental health in ethno-racial and immigrant groups has not kept pace with the mainstream. *Out of the Shadows at Last* identified the need for better evidence on approaches to the management of mental illness in immigrant groups. There remains a dearth of high quality research. If service development was only based on evidence, the gap between mainstream and ethnic groups could grow.

Discrimination against people with mental illness is ubiquitous but varies in its intensity and form in different cultural groups. Because of this, anti-stigma messages may need to be tailored if they are to be equally effective.

The broadly-based social movement will be inclusive but balancing the voices in such a movement requires active management to ensure minority issues are heard.

A strategy for improvement

Moving forward on all of these fronts will be difficult. In order for a National Strategy to promote equitable services for ethno-racial groups there needs to be action at a number of levels. Similarly, improving mental health and improving the outcome of mental illness requires action across a number of sectors.

One model would be to develop population-based, flexible services that will be engaged enough to understand and meet the needs of Canada's diverse and ever changing population. This would require structural changes in the governance of services as well as changes in the way services are conceived.

The vision is one where these issues are seen as mainstream, where the extensive diversity that exists within these groups is recognised, and where services move from a position of consultation to a position where they are working alongside communities and community groups to produce action. It is a rights-based vision grounded in the principle of equity and social justice. It should be viewed as part of a strategy leading to a point where culturally and

racially competent and safe services are understood as the norm and a fundamental building block of an equitable health system.

We suggest that there will be four pillars to service improvement for ethno-racial groups:

1. Co-ordination
2. Information
3. Community engagement
4. Better and more appropriate services

Co-ordination

It is difficult to move forward with any vision without a strategy. There needs to be a strategy or plan for the parts of health that have federal responsibility and the parts that are under provincial jurisdiction. Each of these plans needs to be co-ordinated so that they move in the same direction. Service providers should also have a strategy for health equity. Some provinces such as Ontario are currently in the process of developing new mental health strategies. What is lacking in current provincial strategies are ways of improving services to meet the needs of ethno-racial groups. Plans should aim to better integrate different service providers and sectors if care is to be seamless. It should co-ordinate mental health services and services in other sectors linked to health. All this will be aided by the inclusion of ethno-racial service providers and service users at the decision making table.

> Recommendation 1: target goals 2, 3, 5. Each province and territory should include strategies and performance measures in their mental health plans to address the needs of immigrant and ethno-racial groups. Like the National Strategy these plans will need to include specific co-ordinated initiatives for mental health promotion, mental illness prevention and the development of appropriate and responsive services for the ethno-racial populations for which they are responsible.
>
> Recommendation 2: target goals 3, 5. Citizenship and Immigration Canada should provide an annual inventory to Parliament on its programs and services relevant to mental health, including clients served, expenditures allocated and spent, and outcomes achieved. This could usefully include services and institutions addressing diversity and disparity issues.

Information

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 for immigrant and ethno-racial groups undermines the ability to offer equitable care. Quantitative data is important but qualitative data will be needed so that experiences that cannot be captured by numerical data can inform service delivery. Ethno-racial groups will

need to be involved in all aspects of research including design, analysis, and presentation.

Unfortunately data by itself does not change services. These data will need to be used intelligently if they are to make a difference. In addition to routine data collection including ethno-racial status, there will be a need for research into improved treatment approaches for immigrant and ethno-racial groups.

In an information age we need to consider knowledge transfer. Not only do services need to be better informed about communities but communities need to be better informed as to what services are available.

> Recommendation 3: target goals 3, 5, 6. Develop a virtual national centre for research into the mental health and mental illness in ethno-racial groups. 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.
>
> Recommendation 4: target goals 3, 5, 6. Self-disclosed ethnicity data – similar to census categories – should be included on health cards or at point of service use so that use and outcome can be monitored by ethno-racial group, gender and age.
>
> Recommendation 5: target goals 3, 5, 6. Each province should gather data on the size and the mental health needs of their immigrant and ethno-racial populations. They should plan their services based on this population data.
>
> Recommendation 6: target goals 3, 6. 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 ethno-racial groups' mental health and service provision.

Community engagement

Mental health services and immigrant and ethno-racial groups may have different models of mental health, mental illness and ideas about what the structure of services should be. If planners engage with communities, this facilitates two-way knowledge exchange and makes it more likely that developments will meet the needs of the communities. Diversifying models of care through the encouragement of local ethno-specific solutions to challenges could be crucial; the aim would be to harness the expertise of communities, increase community efficacy as well as to improve the local safety net. Producing networks of community leaders who are involved in the development of mental health services also acts as a conduit for knowledge exchange about community needs, services that are available and problems with accessing services.

> Recommendation 7: target goals 3, 8. A central part of each provincial or regional plan for improving the mental health of ethno-racial groups

should be a community engagement strategy and network to strengthen the voice of ethno-racial service users and providers.

Better and more appropriate services

Action to produce better and more appropriate mental health services for immigrant and ethno-racial groups can be considered in six groups:

1. Changed focus
2. Improvement within services
3. Improved diversity of treatment
4. Linguistic competence
5. Needs linked to expertise
6. Legislation

Changed Focus

The clear implications of a movement towards prevention and promotion and the recovery model, is that the social determinants of health will need to be given more prominence in health planning. In addition to the known social determinants linked to structural inequalities and poverty, there will need to be specific targeted strategies for ethno-racial groups on the impact of migration, racial discrimination and language barriers. However the work on social determinants should not be solely at the individual level. Geographical or community-based approaches will also be required.

> Recommendation 8: target goals 2, 3. The mental health strategy of each province should include a cross-sectoral plan for improving the social determinants of mental illness for ethno-racial groups.

Improvement within services

Improving services to meet the needs of ethno-racial groups may be easier if there is a diverse workforce that represents the population it serves. For progress to be made, the workforce needs to be representative at all levels including the leadership of both purchasers of care and providers of care.

> Recommendation 9: target goals 3, 5. Ministries should require that providers take steps to attract a more diverse workforce and that there is ethnic monitoring of hiring. This should be considered a performance measure.
>
> Recommendation 10: target goal 3. Service provider organizations and provincial ministries should develop strategies to promote good candidates from ethno-racial groups into appropriate leadership positions within their organizations.

Improving the diversity of staff and developing leadership may help service transformation but there will need to be organisational strategies for cultural

competence and health equity. This will lead to improved understanding of the community and an environment where more appropriate services can flourish. Organizational cultural competence [34] and the development of culturally safe and equitable services will be reflected in such things as the working environment, the policies of the organization including race relations policies, and attention to the minimization of structural barriers to care through the development of an active network of community partners[40].

> Recommendation 11: target goal 3, 5. Each service provider should have an organizational health equity and cultural competence / cultural safety strategy.

In addition to organizational cultural competence and working towards cultural safety, there is a need for direct care staff and others who come in contact with the population to be more culturally capable.

> Recommendation 12: target goals 3, 5. Cultural competence / cultural safety training should be made available to all direct care staff and should be provided to existing staff.

> Recommendation 13: target goals 3, 5. Cultural competence / cultural safety 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 professionals.

Improved diversity of treatments provider and institutions

The issue of the need for more diversity in mental health service provision has been a clear theme of the research[36]. The models of care of different cultural groups need to be recognised, understood and respected by the health care sector. There is a need recognized in *Out of the Shadows at Last* for a better understanding of strategies that work in ethno-racial mental health and a dissemination of that knowledge. Across Canada, same language services and ethno-racial service providers exist in pockets. In addition, some have expressed the wish for services to be where people want them such as one stop shops and mall based mental health services as well as services for children in guidance offices at school.

> Recommendation14: target goal 3. Provinces 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 ethno-racial and immigrant groups.

> Recommendation 15: target goal 3, 5. Best practices in the delivery of care to ethno-racial groups should be shared and disseminated so that the most effective models are known to and can be deployed by providers.

Linguistic competence

Language is a barrier to equitable care. A comprehensive linguistic competence strategy would include language supports at a number of levels including a plain language strategy for those who speak English (or French) and interpretation, translation and cultural interpretation services for those who speak other languages. Signage, documentation and information leaflets should be translated to meet the needs of the population. There would need to training for practitioners on how to work with interpreters, interpreters themselves would need training in mental health and accreditation, and bilingual practitioners will need to be supported. In some instances ancillary services such as tele-interpreting may be of use.

> Recommendation 16: target goals 3, 5. A linguistic competence strategy should be mandatory for service providers in diverse locales and money for this should be provided on a separate budget line by their funders.

Linking needs to expertise

Different provinces and areas have different percentages of ethno-racial groups leading some to believe that the development of specific services is neither possible nor strategically important. This runs counter to the arguments of rights and equity. The challenge is how to offer high quality services in areas where there are few people from ethno-racial groups. One strategy would be for more populous regions or areas with expertise to partner with areas consisting of low concentrations of ethno-racial groups. Centres of excellence could offer satellite services or clinics and ethno-racial and immigrant groups could also be offered an option of same language services via telemedicine.

There is a possibility of developing existing e-health resources and techniques, including online treatment and education, to make them more accessible to ethno-racial and immigrant groups.

The central aim in all of this is to link people with the right information and expertise, and to link organizations with the expertise to those who may find it difficult to offer services because their populations are too small for quality services to be developed and sustained.

> Recommendation 17: target goals 3, 5. A virtual centre of excellence in the treatment of immigrant and ethno-racial groups should be developed. This would include representations from each province and each provincial health department could subscribe to it. This centre would facilitate the access to care for ethno-racial groups by sharing knowledge and expertise. It would also facilitate and discuss any problems with licensure that arise.

Legislation

A challenge for cross provincial knowledge and skills sharing is licensing. If provinces wish to receive the expertise of others in this regard, they would need

to consider a relaxation of their licensing rules to allow experts in cross cultural mental health to advise across jurisdictions.

> Recommendation 18: target goals 3, 5. Provincial ministries should consider the need for licensure changes to allow consultation across provincial jurisdictions to facilitate the better treatment of immigrant and ethno-racial groups in areas where knowledge and skills are not available.

A complaint of many ethno-racial communities is that collective ways of treating mental health and particularly family involvement are made difficult by the privacy laws, or at least their interpretation by mental health professionals. Families believe that their relatives get worse care because families are unable to take the responsibility that they wish to.

> Recommendation 19: target goals 4. Provincial ministries should undertake an ethnicity impact assessment of the interpretation of their privacy acts and offer guidance to staff to ensure that immigrant and ethno-racial groups are not discriminated against by their enactment.

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