Racial Discrimination and Mental Health:

Racialized and Aboriginal Communities

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ABSTRACT

Kwasi Kafele indicates that various social and economic impacts of racism have a negative impact on mental health prospects for racialized groups and Aboriginal communities. In addition, he reviews how racism affects the mental health system and severely impedes the availability of appropriate mental health services for these populations.

Many studies confirm that one of the cumulative outcomes of social inequities, systemic racial discrimination, sexism, poverty and marginalization of Aboriginal peoples and members of racialized groups (including immigrants and refugees) is the debilitating impact on the mental health prospects for members of these communities, including the multidimensional impact of intersections of poverty, race, gender and sexual orientation *(Across Boundaries: 1997; Surgeon General's Report: 1999; Report of the Canadian Task Force, 1988;Report of the Royal Commission on Aboriginal People: 1999, Krieger: 199l).*

Poverty and associated conditions such as unemployment, underemployment, low wage jobs, low education and homelessness, are more widespread, increasing and persistent in Canada, when related to race *(Galabuzi: 2001).* Socio-economic factors, such as high rates of poverty, low levels of education, limited employment opportunities, inadequate housing, and deficiencies in sanitation and water quality, also affect a disproportionately high number of Aboriginal people.

According to a number of studies *(Across Boundaries: 1997, Surgeon General's Report: 1999; Cummings: 1993, Fernando: 1991),* some of the specific mental health concerns for members of racialized groups and the Aboriginal community include:

- Higher levels of anxiety, stress and stress-related illness like high blood pressure, heart disease and nervous system problems
- Higher risk of depression and suicide
- Feelings of helplessness, hopelessness, fear, mistrust, despair, alienation and loss of control
- Damaged self-esteem, higher risk of addiction and violence

In addition, Aboriginal peoples specifically suffer from a range of mental health problems that have been well documented *(Royal Commission Report, 1999; Kirmayer, 1994, et al).* Extremely high rates of suicide, alcoholism and substance abuse, violence and demoralization have links to the history of land displacement, oppression, marginalization and social/cultural dislocation that so significantly define much of the Aboriginal reality *(Richardson, 1991; Royal Commission Report, 1999).* Some studies of Aboriginal people who have committed suicide have found that as many as 90% of victims had alcohol in their blood. Brain damage or paranoid psychosis as a result of the chronic use of solvents is reported as a major factor in suicides by youth *(Royal Commission Report, 1999).*

Gaps in Services

Culture, broadly defined as a body of common held world-views, belief systems, values and behaviours, influences many aspects of mental illness and mental health. It has an impact on how clients seek help and communicate, how symptoms get manifested, coping mechanisms and what the roles of family and community supports are. However, a history of racial discrimination, social exclusion, and poverty can combine with mistrust and fear to deter members of racialized groups and Aboriginal communities from accessing services and getting culturally appropriate care.

Although racialized groups and members of Aboriginal communities have mental health needs and issues that are extremely serious and warrant significant attention, few psychiatric services respond specifically with research, clinical support, programming, organizational change, health promotion or community collaboration that indicate cultural competence, understanding or awareness in a systemic manner[1]. In a psychiatric system that is still Eurocentric[2] in values, worldview and practice, it follows that there are systemic challenges at every stage of the system's interaction with people from racialized groups or the Aboriginal community.

Recent conferences on mental health and racialized communities *(Kafele: 2003; Hong Fook: 2000)* as well as a major community-based study *(Building Bridges, Breaking Barriers: 2003)* detail concerns regarding the lack of access, poor culturally appropriate access, services and low commitment to meaningful organizational change within the sector.

Most members of these communities have no knowledge of, or relationships with mainstream mental health services. Few programs provide any *culturally specific clinical support* reflecting specific needs and issues of particular communities. There are few staff from racialized groups in senior, decision-making positions to influence or impact the kind of broad organizational changes needed to make the system more responsive. A diversity report commissioned by Toronto's Centre for Addiction and Mental Health in 2000[3] identified racism (against both staff and clients) as one of the most significant diversity challenges at the Centre.

Anecdotal evidence in Ontario indicates that a disproportionately high number of those in our psychiatric forensic system are poor, immigrant men from racialized groups. According to Across Boundaries *(1996a),* failure to effectively diagnose and treat members of racialized groups and Aboriginal populations can increase health care costs through repeat visits to care facilities and unnecessary hospitalization. Workplace costs, which include low morale, reduced productivity, high staff turnover, time lost at work, and poor public relations, could be increased. This is money that could go to direct services.

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Systemic Barriers to Equitable Services

Institutional Issues:

Often the leadership of psychiatric institutions does not fully recognize racism as a systemic problem in organizational culture, human resources, clinical services, research and community partnerships. This is often part of a larger problem: the lack of coherent, comprehensive strategies, plans and resources, which address equity and access as a demonstration of serious commitment. This problem is also reflected in a culture of denial and avoidance. For example, staff complaints against racism and racist abuse by white clients to staff from racialized populations are often cited anecdotally as persistent problems that go largely unaddressed. As well, staff complements at the most senior decision-making levels are usually not representative of the broad diversity of communities.

Access:

According to the study *Building Bridges, Breaking Barriers (2003),* there are many issues, which affect equitable access to mental health services for members of racialized communities. These include:

- Information only in English and French.
- Few culturally specific outreach initiatives or service promotion to Aboriginal or racialized communities.
- Poor referral relationships with community agencies.
- Problematic physical location
- Lack of awareness of community and community needs and issues by mainstream institutions

These problems not only reinforce and exacerbate negative relationships between institutions and communities, but also create a greater service burden on community- based agencies with limited resources.

Pathway Problems: Intake, Assessment, Diagnosis

Racial profiling, racist assumptions and stereotyping in psychiatry are often believed to be strong determining factors in intake, assessment and diagnosis and misdiagnosis. Misdiagnosis includes underdiagnosis and overdiagnosis. This can account for the non-delivery of appropriate treatments because of an erroneous diagnostic label *(Fernando, 1991; Wilson 1997; Bui, 2002).* In some instances this leads to a deferred intervention, or in some groups, help-seeking is delayed for unnecessarily long periods. For example, culturally inappropriate instruments used by clinicians at intake and exceedingly high rates of diagnosis for schizophrenia for members of racialized communities are fairly common issues identified by anti-racism mental health advocates.

Treatment Planning and Treatment

While many front-line mental health service providers come from diverse backgrounds, the issue of cultural awareness and sensitivity continues to pose a significant challenge, given the usually limited cross cultural/diversity clinical training experience available, the lack of rigorous cultural competence standards and tools and often poor, uneven relationships with diverse communities. Some examples include:

- Staff not culturally competent or racially aware.
- Treatment services often not culturally relevant/ appropriate.
- Counseling, family therapy, occupational therapy very difficult to organize.
- Higher doses of medication.
- More likely to be medicated intra-muscularly

Health Promotion

For anti-racist mental health promotion strategies and initiatives to have value with racialized and Aboriginal

communities they must involve members meaningfully at every stage. Health promotion priorities have to be seen in the context of community development, enhancing resilience and capacity, mental health advocacy, equitable partnerships and local leadership. This has been a particular challenge for most mainstream agencies where racism has not been identified as an important problem, where there are no processes to identify specific mental health issues in different racialized and Aboriginal communities, and where racism is not recognized or validated as a critical determinant of health.

Research

There is an increasing acceptance that mental health research generally should be more inclusive, accountable and relevant. Mental health research should also be more deliberately linked to clinical needs generally and in particular, with those related to racism *(Bui, 2002; Fernando, 2003)*. There is a paucity of research on mental health and racism in Canada. Research has some specific challenges including:

- Orientation is generally Euro-centric
- Research focus is often on race, *not* racism in mental health
- Research methodologies are often blind to culture and effects of racism
- Assumptions made that data are "value free" and "objective"
- Racialized groups and Aboriginal Communities have little or no role in identifying issues, framing questions, designing instruments, collaborating meaningfully, transferring knowledge or building capacity

Addressing Serious Gaps in Psychiatric Services

The following are some of the critical issues to be addressed by the mental health system for Aboriginal community and racialized groups:

- Development of a provincial strategy specifically focused on improving the mental health outcomes for racialized and Aboriginal communities
- In mental health institutions, greater emphasis on anti-racist organizational change that is comprehensive (human resources – e.g. equity in hiring, clinical work, partnerships, resource allocation, systems support, public policy), transparent and accountable. This includes aggressive equity hiring practices, which target clinical and management staff from racialized and Aboriginal communities, who are culturally competent;
- Consistent monitoring and assessment of the mental health needs of the most vulnerable in these communities: the poor, women, youth and children and seniors;
- Research that is more respectful, culturally appropriate, equitable, inclusive, participatory (and has members of both racialized communities and Aboriginal populations involved at every stage) and; that builds community capacity, transfers new knowledge and leads specifically to better mental health care for community members;
- Culturally competent clinical care that incorporates:
  - Anti-racist/anti-oppression standards and Clinical Performance Accountabilities
  - The use of cultural brokers to support cultural interpretation and enhance service delivery where language support is an issue;
  - Acceptance of alternative and complementary care as legitimate and appropriate options for clients;
  - Services that more fully reflect the needs and wishes of the community;
  - Innovative and creative health promotion strategies which reflect the need to address issues like stigma, shame in association with mental illness that affects all racialized groups and the Aboriginal community;
  - Access that is informed by the best and most effective partnerships and collaboration with community agencies, organizations and key stakeholders;
  - Vigorous sectoral leadership in addressing and challenging racism in psychiatric services, programming, research and public policy development;
  - Greater systems advocacy and public policy pressure in addressing the devastating impact of poverty and racism on the mental health of the community;
  - Commitment to ensuring that mental health systems integration fully and carefully considers the range of options for engaging racialized and Aboriginal communities.

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Ontario Human Rights Policy, Mental Health, and Race

The OHRC policy framework should ensure that issues of *access to equitable, culturally appropriate health and mental health care* are clearly identified and articulated as a priority. In addition, such a policy needs to address the concerns of the most vulnerable populations in order to ensure adequate care and protection of human rights for institutionalized patients, including those with the most severe mental problems. In this regard, the following specific approaches are recommended:

- Service provision guidelines should be stringent and clearly articulate expectations related to issues like access and cultural competence in *clinical care. **Basic Standards of Cultural Competence*** should be referenced.
- Strategically, the policy framework might also frame accountability for equitable service delivery

in the context of patient safety and risk and liability management.

- The framework might also consider how strategic levers in the system could be aligned in order to ensure meaningful accountability and transparency by health institutions in addressing racism in service delivery, research and working with communities. For example, obligations/criteria of health/research funders, augmentation of the accreditation process to include specific anti-racism/equity metrics, alignment with provincial funding guidelines, etc, might be worth considering.
- Finally, clear guidelines and examples should be identified about what constitutes poor, inequitable care and what excellent care would look like (including best practices models and references) in order to provide clear expectations and references for institutions.

Conclusion

Because of disparities and racial discrimination in mental health services, a disproportionate number of racialized groups and Aboriginal populations with mental illnesses do not fully benefit from, or contribute to, the opportunities and prosperity of our society. Preventable disability from mental illness affects all of us and exacts an increasing economic and social toll.

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Endnotes

[1] A Diversity Health Practitioners' Network in the GTA was developed in 2002 with diversity and Aboriginal health experts working to develop Anti-Oppression Accountability Frameworks for health institutions in addition to organizational change tools and resources to support clinical work that is equitable and appropriate for clients from of racialized groups and other marginalized populations.

[2] "Eurocentric" refers to an orientation centred in an ideology, which asserts (implicitly and explicitly) that European-derived values, assumptions and worldviews generally have primacy over all others. This is reflected in Western institutions (including academia, science, law, medicine/health, media, literature, etc) in the construction, ownership and dissemination of knowledge and in popular culture

[3] Diversity Plan, Centre for Addiction and Mental Health, 2000