IMPROVING MENTAL HEALTH SERVICES FOR IMMIGRANT, REFUGEE, ETHNO-CULTURAL AND RACIALIZED GROUPS

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ABSTRACT

Canada is one of the most diverse countries in the world but its mental health policy and services do not embrace that diversity. People from immigrant, refugee, ethno-cultural and racialized (IRER) groups often have poorer access to care and poorer treatment. The size of the population and specific issues may differ in each province or territory but all jurisdictions will have to provide mental health services to their multi-cultural population, and develop health promotion strategies that improve the health status of IRER groups. With this in mind, the Service Systems Advisory Committee of the Mental Health Commission of Canada established a project to consider the issues and options for service improvement for IRER groups in Canada. The emergent issues and options will help the Commission to develop an equitable Mental Health Strategy for Canada.

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INTRODUCTION

Improving services and outcomes for immigrant, refugee, ethno-cultural and racialized groups (IRER), is now a common issue for mental health systems in high income countries (Hansson et al, 2009). Worldwide there are 20 major cities with over half a million residents that were born in a different country. The Canadian Senate investigated the response of health systems in selected countries, (Australia, New Zealand, the UK and USA) to the needs of their diverse populations (Standing Senate Committee, 2004). They concluded that there was often poorer access to mental health care and this was associated with: increased use of crisis and emergency care, increased use of the police and prison justice system, increased hospitalization (involuntary), poorer outcomes, and an increased community burden of mental illness. The picture is however complex and dependent on context. For instance, the reasons for migration in different groups, the reception of the host population, the socio-economic position of a group, differences in culture and language, and the structure of the health system are just a few of an intersecting array of variables which may be important and make importing ideas and practices from other countries difficult.

Canada is becoming more diverse each year because immigration is the driver of population growth. The size of the population, the rate of increase, and specific issues may differ in each province or territory but all jurisdictions will have to provide mental health services to their multi-cultural population, and develop health promotion strategies that improve the health status of IRER groups.

With this in mind, the Service Systems Advisory Committee of the Mental Health Commission of Canada established a project to consider the issues and options for service improvement for IRER groups in Canada.

WHO WAS CONSIDERED BY THE PROJECT?

Canada is one of the most diverse countries in the world. The study did not attempt to deal with all diverse groups. It was limited to assessing the mental health needs and services for those who are from an immigrant, refugee, ethno-cultural, or racialized group (IRER).

It quickly became apparent that there was no one term that encompasses all of these categories so the acronym was coined. Canada's IRER groups are comprised 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. Diversity within groups includes different national heritages and cultures as well as social location due to gender, sexual orientation and physical ability. For every statement where a group is considered as a collective there will be particular sub-groups and individuals to whom the statement does not apply. However, one thing that all IRER groups have in common is that they are on average younger than other population groups in Canada.

The challenges faced by 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 who have been in Canada for some time.

The study did not specifically investigate the diversity within diverse populations because it was considered that separate targeted studies were needed to do justice to the issues of service development for IRER Lesbian, Gay, Bisexual, Transgender, Transsexual, Two-spirited, Inter-sexed, Queer, and Questioning (LGBTTTIQQ) population and age or gender groups. Some of these groups are marginalized within already marginalized groups and analysis may indicate significant increased risk for the development of mental health problems and illnesses and a need for service improvement.

METHODS

The study used a number of different lines of investigation and consultation.

An analysis of the data from the 2006 Census supplemented by available data from different provinces was used to produce a statistical picture of Canada's IRER groups. A literature review of published papers was then performed with the guidance of a specialized mental health librarian. These two sources of information and the experience and knowledge of a steering group of experts in multicultural health from across Canada was used to help develop a paper outlining the issues and some potential options for service improvement for IRER groups. Consultation on this paper took a number of forms. The paper was posted on the Mental Health Commission of Canada website and on the Centre for Addiction and Mental Health's website. A "survey monkey" tool was developed so that the public could give their opinions on the paper and more specifically the options for service improvement. The electronic postings were widely advertised at face-to-face presentations, through professional networks and through community networks. The paper was sent to bodies that govern health in provinces, territories and cities, to Federal Government offices involved in health in general, and in settlement and welfare services for immigrants and refugees. Face-to-face focus groups of professionals, service providers, community organizations, and settlement and education services were undertaken in seven centres across Canada from Vancouver to St. John's.

Feedback from the face to face and electronic consultations was incorporated in the paper.

Because people with lived experience of mental health problems and illnesses were under-represented in the focus groups, extra focus groups specifically for this sector of the population were undertaken to ensure that the recommendations were in line with the aspirations of people who use current services. Finally, there was a national consensus meeting to review the findings and recommendations which was attended by a diverse group including people with lived experience, clinicians, academics, policy makers and members of the Mental Health Commission of Canada.

RESULTS

Census data: The analysis of the Census data offered a snapshot of Canada's diversity. Every province, territory and region has an IRER population; the populations are all growing but at different rates. The demographic changes vary with some areas having substantial existing IRER populations that need to be served and others having small populations that are growing quickly. Within IRER groups there is significant diversity and intersecting issues such as older age, youth, sexual preference or gender issues which add a further level of complexity of need when considering service development. Over 200 different languages are spoken in Canada and 20% of Canadians have a non-official language as their mother tongue (Statistics Canada, 2006).

Canadian literature: There is growing Canadian academic and grey literature investigating IRER mental health. It focuses on three areas: social determinants, the rate of mental illness, and barriers to and facilitators of care. There have been a few national studies but these are not detailed enough to form the basis of service development. The research has mainly been undertaken in British Columbia, Ontario and Quebec (Hansson et al., 2009). Most provinces, territories and regions do not have a local evidence base to use for developing services.

Social determinants: The literature reports that IRER groups are more exposed to the known social factors that promote mental health problems and illnesses as well as other social factors such as migration, discrimination and language difficulties (Hansson et al., 2009). Those from IRER groups in general are more likely to live in poverty, to be unemployed or underemployed, to be socially isolated and to live in neighbourhoods that are disadvantaged (Clarke et al., 2008). In addition, pre-migration factors (such as war and torture), post migration factors (such as acculturation and uncertainty because of the immigration system), exposure to racial discrimination and difficulties due to language are significant issues in the generation of mental health problems and illnesses and in the receipt of services (Hansson et al., 2009). Other studies report that a positive ethnic identity (Fenta et al., 2004), employment (Beiser et al., 2004) and social networks (Dyck, 2004) decrease the risk of mental illness.

The balance of influence of these issues is different for different groups, for instance: refugee groups are more likely to be exposed to pre-migration problems, whereas poverty and under-employment may be more important in recent immigrants (Hansson et al., 2009). Information on existing ethno-cultural and racialized groups is not well captured in the census.

Rates of mental health problems and illnesses: National studies report lower rates of anxiety and depression in immigrant groups (Ali, 2002). This may reflect true lower levels of illness which is expected because immigration practices may screen out entry for people with existing physical or mental illness. However, it could also be due to concern about getting permanent residency, could be inaccuracy in the disclosure of mental health problems and illnesses in official surveys. Studies report that over time the lower rates of common mental disorders rise to the level of the general population (Ali, 2002).

There are significant differences between groups as well with specific groups in particular areas reporting high rates of mental health problems and others reporting lower rates (Hansson et al., 2009).

Barriers to care: Access to care is a major issue. Where particular IRER groups have higher or lower rates of illness is a moot point given they all have difficulty getting care. Equity of service provision is a particular concern. Canadian literature cites barriers to care such as stigma, awareness of services, language difficulties, transportation costs, socio-economic factors and differences in illness models between services and clients as factors that delay treatment (Hansson et al., 2009). There are a number of studies which also list factors that have been demonstrated to facilitate service use. These include literacy, trust in services, cultural competence, targeted health promotion, an increased diversity of services, and links between different types of services.

Policy analysis: National responses to these 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. There has not been a similar consideration of the mental health needs of existing ethno-cultural and racialized groups.

ISSUES AND OPTIONS: A STRATEGY FOR SERVICE DEVELOPMENT

The service improvement recommendations that were developed from the data and the consultation have a firm foundation in the goals of the Mental Health Strategy

for Canada. The Strategy will be based on the principle that everyone can benefit from improved mental health and well-being, while also acknowledging that people living with mental health problems and illnesses will need special services and supports. This includes helping adults recover, children and youth to maximize their mental wellness as they pass through different developmental stages, seniors to maximize their quality of life and dignity as they age, and for all people living in Canada to achieve greater well-being.

The Commission is firmly convinced that a focus on recovery, including hope, empowerment, choice, 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 of all ages 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 be comprehensive, the strategy 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 of the whole population. The challenges in this regard are many, but the potential benefits are enormous. 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 impact of mental health problems and illnesses.

The study outcomes took the position that the challenges faced by IRER populations need a mainstream service response. All services will need to be capable of offering equitable care to Canada's diverse population. Such a response would need to recognise the extensive diversity that exists within these groups. It will also need to recognise that the direction of travel is towards a position where service providers are working alongside groups and communities to improve mental health and where services that are capable of offering equitable treatment to Canada's diverse population are a fundamental building block of the health system. In line with the Mental Health Strategy for Canada, mental health promotion and illness prevention are considered as important as service improvement.

The plan for moving towards the vision of improved services for IRER groups has three intertwined actions:

1. Better co-ordination of policy, knowledge and accountability;
2. The involvement of communities, families, and people with lived experience; and,
3. More appropriate and improved services.

Better coordination of policy, knowledge and accountability recognises the need for there to be specific written plans to improve the mental health of IRER groups and services for mental health problems and illnesses. If these are coordinated at the various levels of government and across different sectors then they will be more effective. Plans will need data streams and initiatives will need to be evaluated. One approach which 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.

The involvement of communities, families and people with lived experience is key. 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, improve awareness and access to care.

With a plan in place, a data stream and an engaged community, services can forge a path of collaboration and internal development. There are five groups of actions required to improve mental health services for IRER groups:

1. Changed focus—an increased emphasis on prevention and promotion
2. Improvement within services—organizational and individual cultural competence
3. Improved diversity of treatment—diversity of providers, evaluation of treatment options
4. Linguistic competence—improved communication plans and actions to meet Canada's diverse needs
5. Needs linked 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

The study included 16 recommendations for service improvement as well as some examples of how these ideas are being implemented in various parts of Canada. Neither is exhaustive nor prescriptive. They offer an outline of the issues that planners will have to face when moving forwards. Across Canada pockets of good practice exist but to date there is no area whose respondents say their services are meeting the mental health needs of their IRER populations.

CONCLUSIONS

The strategies for service improvement outlined in the final report are an attempt to fuse the data, the views

of a diverse group of people with interest in the issues and those of governance bodies across Canada. It is not a protocol for service development but an outline of the issues that policy makers, health planners, and service providers may find beneficial to consider when embarking on improving mental health services for IRER groups.

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