

Engaging Newcomers in Mental Health Promotion: Suggestions for Service Delivery

Mental health service underutilization by immigrant and refugee (IR) populations in Vancouver, and Canada-wide, is both an accessibility and equity issue (Hansson, E. et al, 2009). The lower rate of mental health service use by IRs does not necessarily reflect a lower need. This population is more vulnerable to mental health problems as a result of stressors associated with migration such as unemployment, poverty, poor housing, and a lack of social supports (McKenzie, K. et al, 2011). In addition, refugees face pre-migratory stressors such as war, torture, and natural disasters that exacerbate their vulnerability to mental illness post-migration. Studies worldwide have shown that migrant groups have twice the risk of schizophrenia compared to non-migrant groups, and that post-traumatic stress disorder, anxiety and depression are prominently higher in refugees (Hansson, E. et al, 2009; Kirmayer, L.J. et al, 2011).

According to a report published by the Mental Health Commission of Canada and the Centre for Addiction and Mental Health (CAMH) in 2009, little research has been done in Canada to improve pathways to the mental health care system for IR groups. The report stated that there was national urgency for information on the mental health needs of IR populations. Among the recommendations were the following: (1) for service users to be included in the decision-making and development of mental health programs; and (2) to ensure that cultural models of care are recognized, understood, and respected in the provision of mental health services (Hansson, E. et al, 2009).

At the provincial level, the Ten-Year-Plan to Address Mental Health and Substance Use in British Columbia was developed in 2010 to provide guidelines on effective outreach, prevention, and treatment of mental illness among vulnerable populations. Vulnerability was defined as a genetic predisposition/family history, exposure to violence or trauma, and a lack of social support. The document clearly identifies that *strategic intervention at transition points* in their lives, such as migration, could effectively reduce the emergence of mental health problems later on.

In the City of Vancouver, leading health care practitioners have also identified the need for strategic interventions for vulnerable IRs to mitigate the risk of developing mental health disorders later on. According to Norma Sanchez, a former VCH clinician, in her article on the gaps in treatment for new immigrants, “one of the biggest challenges for those working with this population is finding services for those who are not ill enough to meet the eligibility criteria of most community mental health services, but who are not well enough to go untreated” (Sanchez, N., 2009). The costs associated with new immigrants going untreated are immense. Lin Fang, in her research on Chinese immigrant access to mental

health services, found that by the time Chinese immigrants do access formal mental health treatment, they often present with more severe and persistent symptoms than non-migrant users, and have a higher rate of hospitalization (Fang, L., 2010).

Bob Martin, M.D. at Bridge Refugee Clinic, has named anxiety and depression as the most common diagnoses in their clinic. According to Dr. Martin, treating refugees poses a unique challenge in that many of their post-traumatic stress symptoms present as physical, or somatic complaints. A tremendous amount of skill is required of clinicians to educate patients on the psychological dimension of their suffering, in order to provide them with diagnoses, treatment and care. Some patients get missed, which can have severe ramifications: "Some of the patients we discharge without proper diagnosis or treatment end up languishing in unfortunate circumstances, and a few drift to the downtown eastside" (Martin, 2011).

In light of these gaps in service delivery, and in response to this national call to action for more appropriate mental health interventions for immigrants and refugees, MOSAIC sought funding to conduct action research with IRs.

Project

This article presents the processes and outcomes of a demonstration project that used community action research to learn about the mental health needs of IRs in the City of Vancouver. In collaboration with Vancouver Coastal Health's Bridge Clinic, MOSAIC engaged service users and frontline workers in action research in order to learn about IR barriers to access mainstream mental health services, and their cultural models of care. Funded by the City of Vancouver's Social Innovation Project Grant, the project targeted Chinese, Filipino and South Asian immigrants, as they comprise the largest immigrant populations in the City of Vancouver. The primary goal of the project was to discover common cultural practices among these three ethnic populations in Vancouver to inform the development of more accessible and culturally appropriate mental health services.

Approach

From beginning to end, the project used two complimentary approaches –Mental Health Promotion (MHP) and Community Action Research (CAR). These approaches foster collaboration, capacity building and practice. MHP enhances the capacity of individuals and communities to "take control of their lives and improve their mental health" (Mid Central District Health Board, 2014). The project targeted service users and service providers in order to learn from their lived experiences. Through the establishment of a Project Advisory Committee, MOSAIC engaged with VCH Bridge Clinic and independent researchers to share knowledge and best practices, and to strengthen community networks.

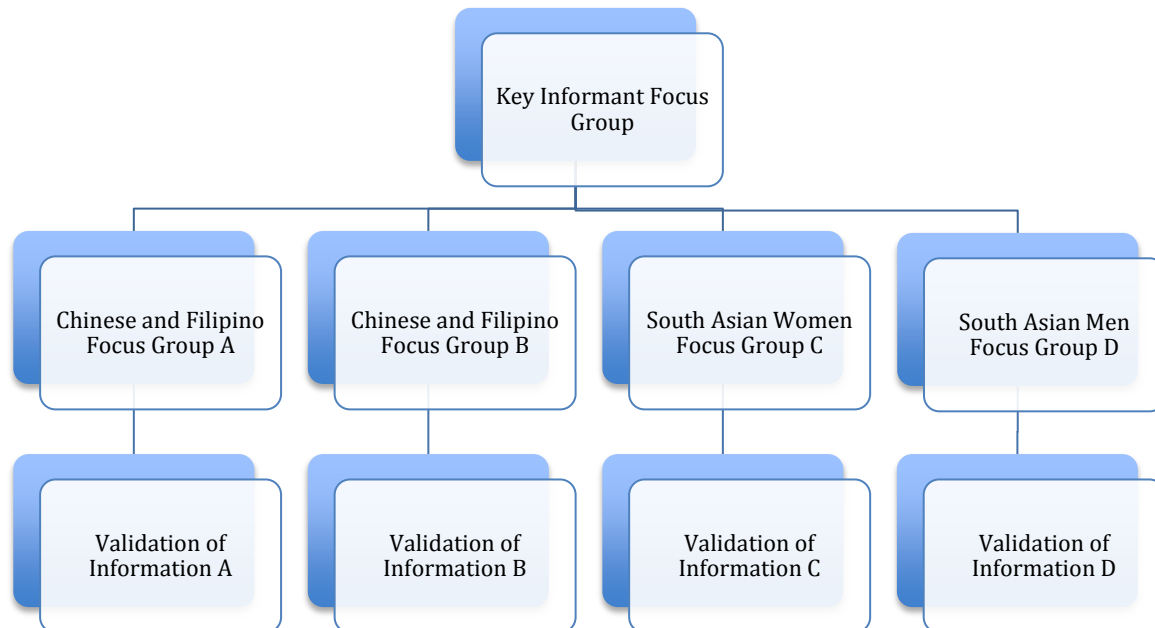
Method

Effective mental health promotion begins with engaging community members. MOSAIC ran a total of 5 focus groups with participants from Chinese, Filipino and South Asian immigrant communities. Initially, a focus group was held with cultural key informants to learn the most appropriate recruitment methods, focus group structures, and questions.

To recruit participants, flyers were distributed to local settlement services and community centers. In addition, flyers were sent out electronically to a vast network of settlement workers across the City of Vancouver. Participant criteria were minimal: Self-identifying as a member of the targeted populations, 19 years of age or older, and proficient in English (screened via phone interviews).

Based upon key informant feedback, focus groups were structured according to culture and gender. The first two focus groups were held with Chinese and Filipino participants of mixed genders; the third group was held with South Asian women; and, the fourth focus group was held with South Asian men. There were a total of 35 participants in the 5 focus groups with an average of 6 participants in each group. In order to ensure that data from the focus groups accurately represented participants' views, participants were asked to attend a follow up group for validation of information.

Graph 1: Project Flow



Outcomes

Focus group discussion questions addressed the following issues: Accessibility of current mental health services, cultural healing practices, and suggestions for future programs and services. Below is a summary of the discussions from all five focus groups.

Factors that Affect Accessibility

Each of the focus groups identified *stigma* as a primary barrier to accessing mental health services. Participants shared that in their home countries, there are no degrees of mental health, people are either healthy or “crazy”. If a community member seeks help from a psychiatrist, they are quickly judged and labeled. Chinese focus group participants explained that the stigma is much greater in rural areas, and that people with severe mental illness are restrained and hidden in their family’s home or restrained and medicated at the hospital. This treatment of mental health patients only further exacerbates people’s fears of mental illness, and the stigma associated with it.

Groups also identified *cultural understanding of mental illness* as a potential barrier to accessing services. Cultural explanations included an imbalance of energy, negative forces from the supernatural world, a poor connection to God, and environmental stressors.

The cultural view of health as an interconnected system between body, mind and spirit was unanimously shared in focus groups. Groups discussed the weighted importance placed on spirituality in their cultures; a lack of spiritual connection could bring about mental illness. Filipino participants shared that illness can be understood as having a poor connection to God, and from not praying enough.

Participants also identified supernatural forces as potential causes for mental illness in their cultures. Chinese participants shared the belief that a spirit could possess a person, causing them to be mentally ill. South Asian participants shared that mental illness is mostly understood as a person “going crazy”, and that supernatural forces are at play (i.e. a person could be cursed).

Another view shared by Chinese participants was that mental illness could be caused by a lack of balance between yin and yang. Participants discussed how it is common in the Chinese culture for emotional problems to manifest into physical symptoms. As a result, people seek physical treatments and care.

All participants identified environmental stressors as potential catalysts for mental illness. Participants primarily discussed stressors related to migration such as lack of employment and income, being in an unfamiliar environment, adapting to new systems and norms, familial pressures, and discrimination.

Participants also talked about some of the practical barriers that prevent new immigrants from seeking mental health care. For one, new immigrants suffering from depression are more likely to isolate themselves at home, and avoid contact with any services. In addition, there is a lack of awareness in their communities of the range of services that support mental health.

Table 1: Factors that Affect Accessibility

Stigma	Cultural Understanding of Mental Illness	Environmental Stressors	Practical Barriers
Poor treatment of mental health patients in home country	Health viewed holistically as an interconnected system between body, mind and spirit	Lack of employment and income	Isolation; difficulty leaving home to seek help
No degrees of mental health; people are either well or “crazy”	Illness can be understood as a poor connection to God	Learning a new language, system, and cultural norms	Lack of awareness of services
People are labeled for seeing a psychiatrist	Supernatural forces can cause mental illness (i.e. curse)	Discrimination	Language
Lack of knowledge about mental health creates underlying fears	Lack of balance between yin and yang impacts mental health Mental health problems often manifest as physical symptoms, and are understood as bodily issues	Competition and familial pressures to succeed	

Cultural Healing Practices

All of the factors listed above impact treatment decisions, and *patterns of help seeking* in different cultures. Focus group participants unanimously agreed that stigma around mental illness causes people to isolate themselves when they have emotional difficulties. As a result of stigma, there is a strong drive towards self-help methods of coping. One participant clearly stated that people tend to keep their problems to themselves to avoid being labeled.

Focus group participants shared that the use of proverbs as a self-help strategy was highly effective during the challenging adjustments post-migration. In light of the difficult stressors that immigrants face, the use of proverbs helps to restore their connection to their culture and faith. Proverbs also serve as reminders of their identity.

The cultural value of spirituality influences many individuals to engage in prayer/meditation, or to attend their place of worship as a means of healing. All of the groups discussed the importance of maintaining a strong connection to God, as a protective factor from mental illness.

Filipino participants shared that mental illness, especially depression, is normalized in their culture as part of life. There is an expectation of suffering in life, and a corresponding

acceptance of emotions such as sadness, hopelessness, and despair. Treatment is family support and going to Church/engaging in prayer. Illness, thus, can be understood as having a poor connection to God.

Chinese participants shared that an individual with mental illness may see a spiritual healer to exorcise their demon/bad spirit. Similarly, South Asian participants reported that treatment rituals such as black magic, evil eye, and red chili pepper burning, are performed in their culture to cure mental illness.

Due to the physical presentation of mental health symptoms, as reported by participants, help is often sought from medical care and alternative care rather than mental health care. Chinese participants shared that people go to Traditional Chinese Medicine (TCM) doctors for herbs, to balance yin and yang, and for long-term treatment. Filipino participants discussed the common practice of seeking a healing massage. Seeing a psychiatrist was unanimously described as a “last resort” because people do not want to be labeled.

All focus group participants agreed upon the importance of self-care practices such as exercising, eating healthy foods, socializing, breathing fresh air, and being in nature. These self-care strategies serve as protective factors against mental illness.

Table 2: Cultural Healing Practices

Mental health	Physical health	Spiritual health
Self-help: reading books about emotional wellness, using proverbs	Traditional Chinese Medicine (TCM) for herbs, to balance yin and yang, and for long term treatment/maintenance of health	Going to Church/Temple
Self-care: exercising, good nutrition, socializing, being in nature	Acupuncture, healing massage	Engaging in prayer/meditation
Seeking counselling support or speaking with trusted family and community members	Exercise (i.e. yoga, walking)	Seeing a spiritual healer to rid oneself of a bad spirit
Seeking psychiatric support as a last resort		Engaging in rituals such as black magic, evil eye, and red chili pepper burning to cure mental illness

Suggestions for Programs and Services

Positive mental health campaigns. In order to increase awareness of services among new immigrant communities, participants suggested using positive mental health campaigns to garner interest. Because of the shame and stigma associated with seeking help, promoting services as wellness programs would increase interest and engagement.

Psycho-educational groups. Participants expressed concern about the lack of education in their cultures on the signs and symptoms of mental illness. They shared their fears of mental illness going undetected, and the potential risk of suicide. They stated that psycho-education groups would be important for new immigrants to learn how to recognize mental illness.

Therapeutic group activities. In the interests of promoting wellness, it was suggested that group activities be offered to provide peer-to-peer support. Structured outings in the community, with a counsellor present, would provide participants with the opportunity to talk about their social/emotional problems in a more relaxed environment while also being physically active.

Counselling services in the community. Participants unanimously stated that counselling services are not stigmatizing like psychiatric services. They stated that the availability of free or government funded counselling services in the community would be hugely beneficial. By offering counselling services at community centers and/or settlement agencies, immigrants are far more likely to access the services. In addition, the provision of outreach workers would ensure that new immigrants who are more socially isolated get the support they need.

Building linkages with temples and churches. In order to improve the flow of information and resources regarding mental health, participants suggested liaising with and building partnerships with religious affiliations. Because faith plays an integral role in the lives of most immigrants, it is important for community and settlement services to build relationships with faith communities, so that new immigrants have better access to mental health care services and programs.

Provider education. Focus group participants discussed the importance of family doctors having better training and education on recognizing mental health symptoms in their patients. Due to the physical manifestation of mental health problems, it is critical that doctors are able to recognize symptoms to provide appropriate treatments and referrals.

Discussion

The growing cultural diversity in the City of Vancouver poses unique challenges for mental health service delivery. As this project demonstrated, culture plays an important role by informing the understanding, expression, and treatment of mental health problems (Kirmayer, L.J., 2012).

Mainstream mental health services reflect the cultural beliefs and priorities of the dominant culture – including what problems are deemed as important and requiring

treatment (Kirmayer, L.J., 2012). Services are heavily weighted in the treatment of severe and persistent mental illnesses, with little funding in prevention and early intervention. With the allocation of more resources to prevention and mental health promotion –goals outlined in B.C.'s 10-Year Plan to address mental health and substance use (Ministry of Health Services, 2010) – IRs are more likely to receive services that fit with their cultural beliefs.

Researchers are recommending a more holistic approach to prevention and early intervention in mental health care that embraces the strengths and wisdom of clients' cultural models of care (Murray, K.E. et al, 2010). Participants in this project unanimously stated that they believe in the interconnection of body, mind and spirit in their understanding of mental health. The acknowledgement of this cultural model of care in service settings may increase service use, and overall markers of good mental health among IR populations.

The recognition, diagnosis and treatment of severe mental illnesses will always remain a critical service delivered by our mental health care system. Mainly due to stigma, IR populations underutilize these services. As participants in this study clearly voiced, the lack of knowledge in their communities of the signs and symptoms of mental illness and suicidality is a big concern. The need for psycho-educational groups for IRs on mental illness, thus, is great. Such interventions could reduce stigma around mental illness and increase IR access to psychiatric care.

A mental health service delivery model that includes services at the prevention, early intervention, and treatment stages of care is idyllic (Ministry of Health Services, 2010). Currently, VCH and the Provincial Health Services Authority (PHSA) are responsible for the delivery of mental health services for patients with diagnoses in Vancouver. Through collaboration with settlement service agencies for the delivery of early intervention services such as individual and group counselling, the service delivery model in Vancouver would be closer to addressing the needs of new IRs. By developing services based upon the recommendations provided in this focus group, and supported in the cross-cultural mental health literature, we may begin to see better engagement, service use, and recovery among IR populations.

Conclusion

MOSAIC's action research with IR populations provided information on participant barriers to access local services, cultural understandings of mental health, healing practices, and recommendations for service providers. Focus group outcomes were consistent with current themes in the cross-cultural mental health literature. Although there are significant challenges to providing mental health services that are accessible and culturally safe for IRs, this project has provided suggestions for interventions that could be delivered in the community at settlement service agencies or community centers. By integrating prevention and early treatment services for IRs into our mainstream mental health services that recognize and respect IR cultural models of care – we are getting closer to mental health service delivery that is inclusive.

References

1. Fang, L. (2010). Mental health service utilization by Chinese immigrants: Barriers and opportunities. *Metropolis: Canadian Issues*, Summer 2010, pp.70-74.
2. Hansson E, Tuck A, Lurie S and McKenzie K, for the Task Group of the Services Systems Advisory Committee, Mental Health Commission of Canada (2010). Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups: Issues and options for service improvement.
3. Kirmayer, L.J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, 49(2), pp.149-164.
4. Kirmayer, L.J., Narasiah, L. et al (2011). Common mental health problems in immigrants and refugees: general approaches in primary care. *Canadian Guidelines for Immigrant Health*, 183(12).
5. Martin, B. (2011). Guide to mental health work with refugees. Retrieved from: <http://www.refugeehealth.ca/guidelines/guide-mental-health-work-refugees>
6. Midcentral District Health Board, New Zealand (2014). Retrieved from: <http://www.midcentraldhb.govt.nz/HealthServices/PublicHealth/Pages/Mental-Health-Promotion.aspx>
7. McKenzie, K., Hansson, E., Tuck, A., & Lurie, S. (2011). Improving mental health services for immigrant, refugee, ethnocultural and racialized groups. *Metropolis: Canadian Issues*, Summer 2010, pp.65-70.
8. Ministry of Health Services (2010). Healthy minds, healthy people: A 10-year plan to address mental health and substance use in British Columbia. Retrieved from: http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf
9. Murray, K.E., Davidson, G.R., & Schweitzer, R.D. (2010). Review of refugee mental health interventions following resettlement: Best practices and recommendations. *American Journal of Orthopsychiatry*, 80(4), pp.576-585.
10. Sanchez, N. (2009). Gaps in Service: Prevention, early intervention & treatment. *Cultures West*, 27(1), pp.20-21.
11. Vancouver Coastal Health (2013). A Health and Social Profile, Vancouver Citywide Summary. Retrieved from: https://www.vch.ca/media/VCH-Profile_VanSummary-Nov-2013.pdf