

- What are Mental Disorders?
- What is Addiction?
- Depression
- Bipolar Disorder
- Postpartum Depression
- Seasonal Affective Disorder
- Anxiety Disorders
- Obsessive-Compulsive Disorder
- Post-traumatic Stress Disorder
- Panic Disorder
- Schizophrenia
- Eating Disorders and Body Image
- Alzheimer's Disease and Other Forms of Dementia
- Concurrent Disorders: Mental Disorders and Substance Use Problems
- Fetal Alcohol Spectrum Disorder
- Tobacco
- Suicide: Following the Warning Signs
- Treatments for Mental Disorders
- Alternative Treatments for Mental Disorders
- Treatments for Addictions
- Recovery from Mental Disorders
- Addictions and Relapse Prevention
- Harm Reduction
- Preventing Addictions
- Achieving Positive Mental Health
- Stress
- Mental Disorders and Addictions in the Workplace
- Seniors' Mental Health and Addictions Issues
- Children, Youth and Mental Disorders
- Youth and Substance Use
- Childhood Sexual Abuse: A Mental Health Issue
- Stigma and Discrimination Around Mental Disorders and Addictions
- ▶ Cross Cultural Mental Health and Addictions Issues
- Unemployment, Mental Health and Substance Use
- Housing
- Economic Costs of Mental Disorders and Addictions
- Personal Costs of Mental Disorders and Addictions
- The Question of Violence
- Coping with Mental Health Crises and Emergencies
- What Families and Friends Can Do to Help
- Getting Help for Mental Disorders
- Getting Help for Substance Use Problems

Cross Cultural Mental Health and Addictions Issues

Mental illness and addiction know no colour, affecting the one in five British Columbians who identify as a visible minority equally as much as the population at large. They are equal-opportunity disablers, affecting anyone, regardless of culture or ethnicity. But as our communities reflect increasing cultural diversity, few of BC's mental health and addiction services are able to adequately respond to this diversity, although some efforts to make services more responsive *are* underway, for example the Multicultural Mental Health Liaison and the Cross Cultural Psychiatry Outpatient programs, run by the Vancouver Coastal Health Authority.

While there are a number of factors that make services less likely to respond—e.g. lack of awareness about the need, or uncertainty over how to proceed—increasing the “cultural competence” of our mental health and addictions services is a necessary step to improving the well-being of a significant and growing portion of the population.

Data from the 2001 census reveal that over one million citizens of BC's 4-million population are immigrants—60% of whom are from a visible minority. Of the almost 40,000 immigrants who arrived in BC in 2004, nearly three quarters of them were from an Asian country.

Immigrant and refugee populations are often grouped together, but have been shown to have different risks for poor mental health and mental disorder.

For example, refugees and those seeking asylum are at increased risk for mental health problems because of the physical, emotional, social and economic stresses involved in migration, resettlement and adaptation to a new community and a new life. As they have often lived in regions in conflict, they may have lost their families, friends, home, status and income. They may also face post-traumatic stress, unemployment and poverty, social isolation, cultural misunderstanding and shock, racism, feelings of worthlessness and language difficulties.

On the other hand, researchers are still studying a trend known as the “healthy immigrant effect” which finds similar rates for major health conditions between immigrants and Canadian-born groups, but much lower depression and alcohol use problems in the immigrant community, particularly Asian and African immigrants. In fact, they are around 20% less likely to report mental health problems. This disparity seems to disappear the longer immigrants are in Canada. It's thought that health requirements for entry into Canada as well as personal characteristics account for this phenomenon.

The one exception to the healthy immigrant effect seems to be with young people. In one recent BC survey, young people new to Canada reported the same levels of psychological distress as Canadian-born youth. They are also more likely to face discrimination.

Racism is a real factor in the daily lives of people of colour and has mental health consequences. According to researchers, racism contributes to increased emotional problems and psychiatric symptoms, particularly those of depression.

The stresses of daily living and discrimination increase vulnerability to mental disorders or emotional difficulties, but cultural attitudes themselves can work to delay the help-seeking process. Mental illness and addiction are generally talked about more openly in the West, leaving many non-Western cultures more prone to burying or denying such problems altogether or until they get severe. According to Stella Lee who works with the Chinese Outreach Education Program of the Canadian Mental Health Association (CMHA), “There's a fear of mental illness because of the stigma attached to it. The families tend to cover it up. They don't want to let other people know.”

Indeed, there is evidence that ethnic minorities experience mental health stigma more harshly than those from the majority group. Though it's not fully understood why, a greater sense of group identity in Asian and African

Well-Being is Universal

The definition of mental health and well-being is culturally bound. However, an Australian refugee project found that there are many components of well-being which are similar despite the cultural, religious, gender, and socio-economic status of individuals. These include:

- feeling and being safe and secure
- having meaningful and trusting relationships
- having a sense of belonging to a social group
- having a sense of identity
- having basic needs of life met in terms of housing, food, clothing, water
- being in control of one's own life
- being independent
- feeling good about one's self
- having physical and psychological health needs attended to
- having traumatic experiences validated
- having a sense of optimism or hope for the future

cultures seems to extend stigma to the extended family more than in the Western world. As a result of this family-shared shame, coupled with different cultural perceptions of causes and treatments for psychological problems, research confirms that some minority groups in Canada delay longer in seeking any kind of treatment than Euro-Canadians. For example, in Statistics Canada's most recent mental health survey, people born outside Canada were less likely to use a health service for mental health reasons. This ethnic difference held true even after accounting for language or acceptability barriers (for example, people who prefer to manage on their own or who do not think mental health services will help). The authors suggest that perhaps there is a specific issue around level of awareness of mental health issues and available resources in ethnocultural communities. In cases where a would-be client is reluctant to seek help, Stella Lee encourages others such as family members to approach the person's family doctor.

A major part of the problem is a lack of appropriate multilingual, culturally- and spiritually-sensitive mental health and addiction services and a lack of active marketing of all mental health and addiction services to non-English-speaking minority groups. For example, in an Australian survey, people who came from a non-English background—especially those from Southern and South-East Asia, the Middle East, and Africa—were less likely to use any health services than their Caucasian peers despite the fact they reported higher levels of psychological distress.

Racism within the mental health and addiction system can leave many who do seek out services struggling to integrate a medical diagnosis of mental illness or addiction with their different cultural, spiritual worldview and conceptions of health, illness and healing. For example, what may be a spiritual experience to a patient may be psychosis to a clinician unfamiliar with the person's cultural and spiritual views. In fact, it has been acknowledged in studies that mental health practitioners are generally more inaccurate in diagnosing persons whose race does not correspond with their own.

Cultural differences often make it difficult for doctors and patients to communicate with one another. For example, Ethiopian people might consider frank discussions of medical problems inappropriate and insensitive and would expect bad news from doctors to be relayed to them through friends. A Chinese person may report bodily symptoms in a doctor's office and only offer emotional information about sadness and hopelessness if directly asked. If a person does communicate about emotions, it may be

expressed in terms of metaphors. For example, in Chinese society, talking about "fatigue" or "tiredness" is often an indication of despair. Many First Nations people—who face similar challenges to foreign-born cultural groups—may be reluctant to seek help from mainstream mental health and addiction services because of the history of the way the community has been treated by white institutions. These communication barriers restrict access to care for many people from different cultural backgrounds. Moreover, immigrants in rural areas may ignore their mental health needs because they are isolated from the few services available that are aimed at their cultural groups.

Local mental health and addiction services in BC need to bridge the cultural gap and meet the needs of these much-neglected Canadians. Perhaps most importantly, a dialogue needs to be found around cross cultural mental health and addiction issues, particularly about how social networks need to be supports, rather than

Contacts for Immigrant Mental Health Services

- Education Program, Chinese Outreach CMHA, Vancouver/Burnaby Branch.
Tel: 604-872-4902
- Vancouver Community Mental Health Services, Multicultural Mental Health Liaison Program, Asian & Latin American Services
Tel: 604-874-7626
- Chinese Crisis Line: Richmond
Tel: 604-279-8882 (Mandarin)
604-278-8283 (Cantonese)
- Family Services of the North Shore
Tel: 604-988-5281
- Immigrant Services Society of BC
Tel: 604-684-2561
- Surrey Delta Immigrant Services Society
Tel: 604-595-4021
- Mood Disorders Support Group: Vancouver
Tel: 604-738-4025 (Cantonese)
- SUCCESS (United Chinese Community Enrichment Services Society)
Tel: 604-684-1628
- SUCCESS Burnaby-Coquitlam Office
Tel: 604-936-5900
- SUCCESS Vancouver Family and Youth Program (Richmond Alcohol and Drug Action Team)
Tel: 604-408-7266
- Taiwanese Canadian Cultural Society
Tel: 604-267-0901
- Surrey Delta Progressive Intercultural Community Services
Tel: 604-596-7722
- Alcohol and Drug Referral Service
Tel: 1-800-663-1441 (toll free in BC)
Tel: 604-660-9382 (Lower Mainland)

Partners:

Anxiety Disorders Association of British Columbia

British Columbia Schizophrenia Society

Canadian Mental Health Association, BC Division

Centre for Addictions Research of BC

FORCE Society for Kids' Mental Health Care

Jessie's Hope Society

Mood Disorders Association of BC

For more information call the Mental Health Information Line toll-free in BC at 1-800-661-2121

or email bcpartners@heretohelp.bc.ca

web: heretohelp.bc.ca



substitutes, for mental health services. When we move away from the misconception that “people look after their own,” we can start to talk about the way such services are planned, formed, and delivered so that more ethnocultural groups in BC know that there *are* places they can go to for help.

This dialogue can also help us understand different cultural approaches to healing that promote recovery. For instance, the World Health Organization has found that schizophrenia has a better prognosis, or outcome, in developing nations not because of better medical treatment but because of community reaction and integration of the person into the community. Many Asian, African and Aboriginal philosophies and remedies also value balance and harmony, appreciating how spiritual, emotional, physical and social elements work together and help or hinder physical and mental health; this interaction between mind, body and environment is too-often lacking in traditional Western-based clinical settings. The more knowledge-sharing that can take place around mental health promotion among cultures, the better care for the person needing help.

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