

**Suffering in Silence:  
Understanding the Underutilization of  
Mental Health Services Among  
South Asian Women with Depression**

by

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B.A. (Hons., Political Science), York University, 2010

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## **Abstract**

Major depressive disorder (mdd) is among the most prevalent mental illnesses in Canada. Though prevalence rates for depression are similar among minority and non-minority populations, recent empirical evidence has shown that ethnic minorities underutilize mental health services in Canada (Tiwani & Wang, 2008; Klimid et al, 2000; Mojtabi & Olfson 2006; Hu et al, 1991 & Gadalla, 2010). This trend is reflected in the persistent underutilization of mental health treatment services among South Asian women in the city of Vancouver (Peters, 1988; Johnson, 1992; & Chiu et al, 2005). This paper examines the underlying causes behind the underutilization of mental health services among South Asian women in Vancouver through an analysis of stakeholder perspectives on the issue. Nine semi- structured interviews with mental health service providers and immigrant settlement workers in the Vancouver area were conducted to identify the perceived reasons behind the underutilization of mental health services among South Asian women with depression. The stakeholders perceived stigma, lack of awareness, time and family obligations, language barriers and lack of culturally appropriate services for South Asian women to be the main reasons behind the underutilization of services among the South Asian female population. The paper also presents and evaluates a set of policy options to address the problem. These policy options include; a local media campaign coupled with annual information sessions for the South Asian community, cross cultural mental health seminars for general practitioners (gps) and other interested health care providers, and the provision of culturally appropriate group psychotherapy services for South Asian women. The implementation of all three strategies is recommended as a cost-effective and equitable approach to addressing the problem.

**Keywords:** Service Utilization; South Asian; Women; Depression; Vancouver; Minority

This work is dedicated to my parents. I would not have been able to pursue a master's degree without their unconditional support of my academic interests.

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## List of Acronyms

GP	General Practitioner (another term for a primary care or family doctor)
VCH	Vancouver Coastal Health
WHO	World Health Organization
CBT	Cognitive Behavioural Therapy
MDD	Major Depressive Disorder

## Glossary

Mental Health	General speaking, mental health refers to an individual's ability to live up to their potential, cope with stress, work productively and contribute to their community (WHO 2007).
Mental Illness	A broad term referring to a spectrum of disorders which hamper a person's ability to enjoy life or interact with family and surrounding environment and live independently (Stephens, Thomas et al., 1999, Mental Health Commission of Canada, 2009, & The Senate Standing Committee on Social Affairs, Science and Technology, 2004).
Mental Health Service	Any program or service designed to treat or manage mental illness. These services include visits to primary care physicians, hospitalization, outpatient clinics, and private counselling and therapy.
Major Depressive Episode	Two or more weeks of depressed mood (Stewart et al, 2002).
Major Depressive Disorder	The presence of at least one or more depressive episode(s) (Stewart et al, 2002).
Dysthmic Disorder	Chronically depressed mood that occurs for long periods of time (Stewart et al, 2002).
South Asian	Any individual with ancestral origins in a country within the South Asia Region. These countries include India, Pakistan, Afghanistan, Sir Lanka, Nepal, Bangladesh and Bhutan (Statistics Canada 2006).
Utilization Rate	The number of people in a catchment area using mental health services divided by the total population in the catchment area (Peter, 1988).
Underutilization	A utilization rate of below 100% (Peters, 1988).

## Executive Summary

The widespread impact of depression on the health, social and economic well-being of those affected, is a well documented phenomenon (Stewart et al, 2002; WHO, 2004; & BC Medical Association, 2009). In its latest estimates of global disease burdens worldwide, the World Health Organization (WHO) estimated that uni-polar depression accounted for 4.5% of the total global burden of disease in terms of lost Daily Adjusted Life Years (DALYs) (WHO, 2007). Further, the WHO estimates that uni-polar depressive disorders are the leading cause of lost DALYs in the Americans, accounting for 7.5% of the total (WHO, 2004).

Apart from the impact on general health and well-being, depression also carries a significant economic burden on society. In 2001, Health Canada estimated the total cost of depression associated with lost productivity and health care costs was \$14.4 billion annually (roughly \$18.7 in 2013 dollars) (Health Canada, 2001). In BC the estimated costs of depression to employers in terms of lost productivity is \$1.4 million a year to a company with 500 employees and \$2.7 to a company with 1000 employees (BC Medical Association, 2009).

Depression has also been shown to have intergenerational impacts in the form of diminished academic, social and health outcomes among children of mothers with depression (Turney, 2011; Halligan et al, 2007; & Luoma et al, 2001).

Though the economic, social and health impacts of depression are concerning, current treatments offered by health care providers (mainly, various forms of psychotherapy and pharmacological treatments) have been shown to be efficacious in managing the symptoms associated with depression (Khan et al 2012, Logsdon et al 2011, & Givens et al 2007). However, there is evidence to suggest that certain demographic segments of the population, including ethnic minorities, underutilize mental health services (Gadalla, 2010; Tiwani & Wang, 2008; Klimid et al, 2000; Mojtabi & Olfson 2006; Hu et al, 1991). Service underutilization is especially prevalent in the South Asian community in Canada. Data from the 2000-01 Statistics Canada Community Health Survey shows that South Asian people with depression have the lowest odds of seeking treatment than any other ethnic group (Gadalla, 2010).

Underutilization of mental health services has been especially prevalent in the South Asian community in Vancouver (Peters, 1988; Johnson, 1992; & Chiu et al, 2005). In 1988 the Interagency Mental Health Council estimated mental health service utilization rates to be the lowest among major ethnic groups in the city (Peters, 1988). Further research has shown that South Asian women are reluctant to seek treatment for mental illness through health care services in Vancouver (Johnson, 1992; & Chiu et al, 2005). These qualitative studies examined the treatment seeking behaviour of South Asian women with respect to mental health services in Vancouver and found that many South Asian women preferred not to seek treatment through the mental health system in Vancouver, and in some cases showed preference for alternative treatments outside of the health care system (Chiu et al, 2005).

The research from Vancouver, coupled with research from other jurisdictions experiencing similar issues with mental health service underutilization among South Asian women, reveals the following reasons underlying service underutilization among South Asian women:

- The stigma associated with mental health: The presence of mental health disorders is often considered a sign of weakness and inability to perform traditional household duties. This concern is heightened in single women, who feel that mental health disorders diminished their chances of finding a suitable partner. For these reasons, South Asian women may be inclined to not report their symptoms to health care professionals (Johnson, 1992, & Chiu et al, 2005).
- Language barriers: Language barriers are another commonly reported factor in the underutilization of mental health services among South Asian women. Several qualitative studies have revealed apprehension among South Asian women to use mental health services due to their inability to speak English and properly communicate their symptoms (Li & Browne, 2000; Chiu et al, 2005; & Johnson, 1992).
- Preference for alternative therapies: In at least two studies, many South Asian women expressed preference for alternative treatments that are more closely associated with their religious and cultural beliefs. This may include an emphasis on spiritual healing (mediation and praying) and/or traditional herbal medicine (Chiu et al, 2005; & Hilton et al, 2001).
- Perceived lack of cultural empathy among health care professionals: Another common theme found in the literature is the perception among South Asian women that health care professionals do not treat patients with respect. Some women felt they were being patronized by health care professionals and that

doctors did not clearly explain their treatments to them (Johnson, 1992; & Li & Browne 2000).

- Time constraints: Prescribed gender roles in the South Asian often require women to carry out household duties as well as earn an income for the household through paid employment. These obligations often have detrimental effects on health and prevent South Asian women from seeking treatment (Grewal et al, 2005; & Chiu et al, 2005).

These studies captured the perceptions of South Asian women with experience using mental health services. Professional stakeholder perceptions on the problem are largely missing from current scholarship on the issue. In order to address this gap, this study examines the perceptions of professional stakeholders in Vancouver. The study focuses on mental health service underutilization among South Asian women with depression, as depression is among the most prevalent mental illnesses in Canada and it appears to disproportionately affect women (Statistics Canada, 2002).

In total nine semi-structured interviews were conducted with various professional stakeholder groups in Vancouver. The majority of interviewees were mental health service providers in the Vancouver area with experience working with the South Asian community. The interview data was analyzed using thematic analysis. In general the perceptions of the professional stakeholders echoed the perceptions of South Asian women found in the literature (as outlined above). However, the majority of the stakeholders perceived many of the underlying reasons behind service underutilization among the South Asian community to be exacerbated by deficiencies in service provision in Vancouver. The following themes emerged from the analysis:

**Stigma:** The interviewees largely perceived this stigma to be derived from a fear among South Asian of being perceived as weak and unable to look after their families. This is associated with constructed gender roles in many South Asian cultures in which women are socialized to consider the needs of the family before individual needs (Singh & Hays, 2008).

**Lack of Awareness:** Several professional stakeholders noted deficient knowledge of the nature of depression, its symptoms and ways to seek treatment among the South Asian community. Some interviewees suggest that the level of awareness seemed to be associated with experiences with mental health treatment services in the client's country

of origin. It was also noted that adequate information about depression is not being provided to patients in primary care.

**Time and Family Obligations:** Many interviewees reported difficulties in scheduling appointments with South Asian women due to the limited availability of South Asian women. Gender roles which relegate household duties to women were perceived to be a major contributor to this lack of availability.

**Language Barriers:** The professional stakeholders perceived difficulties in verbal communication of symptoms to be a significant barrier to service use among South Asian women. The stakeholders suggest that these barriers are linked to limited translation services in the area and lack of clinical expression of the symptoms of depression in many South Asian languages.

**Lack of Culturally Appropriate Services for the South Asian Community:** Many interviewees indicated that the treatment services provided to the South Asian community in Vancouver do not reflect the cultural values in the South Asian community. Some stakeholders felt that they lack the cultural competency to provide services to the South Asian community.

These themes were used to create a set of policy options to address service underutilization. Three distinct policy options are proposed based on the interview data and literature review. The first option addresses the issues of awareness and stigma through a local media campaign and annual community information sessions for the South Asian community. The second option concerns issues around cultural awareness of service providers through an annual seminar for GPs and other health care professionals which addresses issues associated with service provision to South Asian women. The third option address the need for culturally appropriate mental health treatment service for the South Asian community through two 12 week group psychotherapy sessions for South Asian women.

The policy options are analysed using cost, effectiveness, equity and ease of implementation as evaluative criteria. The results of the analysis show no significant differences in the overall scores for each option. However, a few tradeoffs between policy options are apparent. While, awareness efforts through local media and

community information sessions can be implemented at low costs, awareness is not likely to be effective at increasing utilization in absence of culturally appropriate services. For this reason, it is recommended that all three policy options be implemented to address issues with awareness, and cultural appropriateness of services.

# 1. Introduction

Equal access to healthcare services is a vital aspect of any public healthcare system. Through the provision of health care services to individuals regardless of their ability to pay, the Canadian health care system ostensibly provides equal access to health care. Yet there is evidence to suggest that certain groups are less likely to utilize health services than others. It has been well documented that ethnic minorities have lower levels of health service utilization than non-visible minorities, despite similar rates of illness (Gadalla, 2010; Tiwani, & JianLi 2008; Klimids et al, 2000; Mojtabi, & Olfson, 2006; & Hu et al, 1991).

A prime example of this trend is the under-utilization of mental health services among South Asian women with depression (Johnson, 1992; & Chiu et al, 2005). Depression is one of the most prevalent mental disorders in Canada, with estimated 12 month prevalence's rates of 4.8% (Statistics Canada, 2002). If left untreated, depression can have a detrimental impact on the lives of those affected and their families. Untreated depression also places a large burden on the economy as a whole, with large costs associated with lost productivity and hospitalization (Stewart et all, 2002). In 2001 Health Canada estimated the annual costs of depression to by \$14.4 billion (approximately \$18.7 billion in 2013 dollars (Health Canada, 2001).

Despite the high rates of depression among South Asian women (Mumford et al, 1997 & Goyal et al, 2006), there is evidence to suggest that South Asian women underutilize mental health services in Vancouver (Johnson, 1992; & Chiu et al, 2005). In order to address the problem, the Vancouver Coastal Health Authority has initiated a Cross Cultural Mental Health program, with the intention of encouraging the use of mental health services among visible minorities and ensuring health care professionals are able to communicate and empathize with visible minority patients. In spite of these efforts, there is evidence that indicates widespread underutilization of mental health services among South Asian women with depression (Chiu et al, 2005). This

underutilization of services is significant public policy issue due to the myriad of social and economic costs associated with untreated depression (Turney, 2011; WHO, 2007; Halligan et al, 2007; Johnson & Flake, 2007; WHO 2001; & Luoma et al, 2001). This study will gather stakeholder perspectives to shed light on some of the reasons underlying the problem, and identify additional measures that Au can use to encourage the use of mental health services among South Asian women with depression in Vancouver.

## **2. Background**

This section will outline the underlying issues which provided the impetus for this research. The section will begin by defining key terms that are used in the study.

### **2.1. Defining Terms**

#### **2.1.1. *Defining Mental Health***

From a cross-cultural perspective it is extremely difficult to define the concept of mental health. The concept has varying meanings to people of different cultures and is defined according to the cultural beliefs of each distinct society (WHO, 2001). In spite of the subjective nature of the concept, the World Health Organization (WHO) offers the following definition of good mental health: “a state of well being in which every 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 community” (WHO, “What is Mental Health,” 2007). While controversial, this definition has been used by various public health agencies around the world.

To a large extent, public health organizations in Canada have adopted the definition offered by the WHO. For example, The Canadian Mental Health Commission- a non-profit agency set up by the Government of Canada in 2007 to oversee mental health issues- uses the WHO definition in its latest national mental health strategy report (Mental Health Commission of Canada, 2009). However, some organizations have elaborated on the definition to include more specific measures of *good* mental health. For instance, a recent report by a Senate Standing Committee defined mental health as: “various capacities including the ability to understand oneself and one’s life; relate to other people and respond to one’s environment; experience pleasure and enjoyment; handle stress and withstand discomfort; evaluate challenges and problems; pursue goals and interests; and explore choices and make decisions” (The Senate Standing

Committee on Social Affairs, Science and Technology, 2004, pp. 67). Regardless of the specific definition, there is general consensus that good mental health is associated with the mental capacity to achieve self actualization and contribute meaningfully to one's community.

By contrast, Canadian Health Agencies have described mental health *problems* as diminished mental capacities which hamper a person's ability to enjoy life or interact with family and surrounding environment and live independently (Stephens, Thomas et al, 1999; The Senate Standing Committee on Social Affairs, Science and Technology, 2004; & Mental Health Commission of Canada, 2009). These diminished mental capacities can come in the form of impaired cognitive, behaviour, intellectual, emotional, interpersonal, motivational or behavioural capacities (The Senate Standing Committee on Social Affairs, Science and Technology, 2004). Such impairments can be brought on by the presence of one or more clinical mental disorder.

Though the classification of mental disorders is a highly contentious issue, most public health organizations recognise classifications for mental disorder for diagnostic purposes. Two diagnostic manuals for mental illness are used by medical associations in several countries to classify mental disorder, these are; Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatry Association and the Mental Health section of the International Classification of Diseases (ICD) published by the WHO. These two manuals identify several distinct groups of mental disorders (The Senate Standing Committee on Social Affairs, Science and Technology, 2004). These include:

- Mood disorders: depression and bi-polar disorder
- Anxiety disorders: phobias, panic disorder, obsessive compulsive disorder, and post traumatic stress disorder.
- Psychotic disorders: schizophrenia, and schizoaffective disorder
- Eating disorders: anorexia nervosa and bulimia.
- Personality disorder
- Pervasive developmental disorders: autism and Asperger's disorder.
- Attention deficit and disruptive behaviour disorder
- Cognitive disorders: dementia and delirium.

Among these disorders, unipolar depression is among the most prevalent in Canada (Statistics Canada, 2002). The following section will provide a more detailed definition of depression.

### **2.1.2. Defining Depression**

Among these classified disorders depression has become a high priority in many countries due to its high lifetime prevalence and its pernicious effects on the quality of life of those affected. Depression can come in many forms, but it commonly leads to feelings of worthlessness, sadness and emptiness. These symptoms can lead to a loss of interest in day-to-day activities, changes in appetite, chronic fatigue and lethargy (Stewart et al, 2002). There are two major classified disorders associated with depression in the DSM; Major Depressive Disorder (MDD) and Dysthymic Disorder. Major Depressive Disorder is characterised by the presence of at least one or more depressive episode(s) (two weeks of depressed mood). By contrast, Dysthymic Disorder is defined by chronically depressed mood that occurs for long periods of time (Stewart et al, 2002). Any reference to depression in this study will refer to both MDD and Dysthymic Disorder. In other words, depression in this study is defined as the presence of at least one depressive episode in a given year.

### **2.1.3. South Asian**

A person of South Asian origin refers to any individual with ancestral origins in the South Asia region.<sup>1</sup> This region consists primarily of countries within the Indian Subcontinent (India, Pakistan, Afghanistan, Sri Lanka, Nepal, Bangladesh and Bhutan). However, the official UN geographic classification also includes Iran and Maldives.<sup>2</sup> Any reference made to people of South Asian origin will refer to individuals that trace their ethnic origins to one of the above mentioned countries. It should be noted however, that there are large cultural variations both within and between each of the above mentioned

<sup>1</sup> Statistics Canada <http://www.statcan.gc.ca/pub/89-621-x/89-621-x2007006-eng.htm>

<sup>2</sup> UN Statistics Division- Composition of Macro Geographical regions, geographical sub-regions, and selected economic and other grouping. <http://millenniumindicators.un.org/unsd/methods/m49/m49regin.htm#asia>

countries. Thus the term “South Asian” encapsulates a broad range of cultural traditions and practices that exist within the region (Patel, 2007).

The next sections will explore the issue of mental health service underutilization among South Asian women in Vancouver. This discussion begins with a brief overview of the broader prevalence and socioeconomic impact of depression.

## **2.2. The Prevalence of Depression in Canada and BC**

High rates of depression can be found in the population of Canada. Canadian studies have estimated the lifetime prevalence<sup>3</sup> of major depressive symptoms among people aged 18 and over to be between 7.9% and 8.6% (Stewart et al, 2002). The prevalence rate estimated by the 2002 Community Health Survey of Mental Health and Wellbeing revealed a more modest 4.9% prevalence rate among people aged 15 and over (1, 210 000 people) (Statistics Canada, 2004). According to the survey 4.8% of the population experienced major depressive episodes in 2002 (Statistics Canada, 2004).<sup>4</sup> The survey also shows that rates of depression are higher among the female population, a difference of 2.2%. While the rates reported in this survey may not reflect current prevalence rates in the population, it is the most recently reported survey on mental health prevalence in Canada. Statistics Canada conducted a similar survey in 2011; however, the results are not publically available at the time of this study.

<sup>3</sup> Lifetime prevalence rates refers to the percentage of the population that will experience the presence of an illness during their lifetime. It differs from point prevalence which measure the presence of an illness over a specific period of time (see Rothman, Kenneth J. (2012). *Epidemiology: An Introduction*. Oxford University Press).

<sup>4</sup> The Survey was conducted in 2002 with 36 984 randomly selected respondents aged 15 and over. Another survey was administered in 2011; however the results have not yet been published.

**Table 1. Mental Health Illness One Year Prevalence Rates Among The Population Aged 15 and Over (Canada 2002)<sup>5</sup>**

	Total		Male		Female	
	Number	Rate (%)	Number	Rate (%)	Number	Rate (%)
Major Depressive Episode	1,195,955	4.8	451,618	3.7	744,337	5.9
Manic Episodes	239,350	1.0	116,757	1.0	122,593	1.0
Panic Disorder	375,973	1.5	125,430	1.0	250,543	2.0
Social Phobia	746,103	3.0	313,485	2.6	432,618	3.4
Agoraphobia	183,448	0.7	44,214	0.4	139,234	1.1

Similar rates of depression are also seen in the population of British Columbia. Table 2 shows prevalence rates for major depressive episodes in BC from the 2002 Community Health Survey of Mental Health and Wellbeing. The prevalence rates in BC mirror the national figures.

**Table 2. Prevalence of Major Depressive Episodes in BC Among the Population Aged 16 and Over (2002)**

	Total		Male		Female	
	Number	Rate (%)	Number	Rate (%)	Number	Rate (%)
Major Depressive Episode	160,816	4.8	60,790	3.7	100,026	5.9

## 2.3. The Socio-Economic Impact of Depression

The overwhelming pervasiveness of depression represents an alarming problem at the individual and societal level. Depression is one of the leading causes of lost Disability Adjusted Life Years (DALY) worldwide.<sup>6</sup> In 2002 depression accounted for 4.5% of the total global burden of disease in terms of lost DALYS (WHO, 2007). This

<sup>5</sup> The Survey does not include the population in the Territories.

<sup>6</sup> DALYs measure the total number of years lost as a result of premature death and the years of productive life lost due to disability caused by a disease.  
[http://www.who.int/mental\\_health/management/depression/daly/en/](http://www.who.int/mental_health/management/depression/daly/en/)

makes depression the fourth leading cause of lost DALYS worldwide (WHO, 2004). When estimating the disease burden in terms of DALYS for the 15-44 age group, depression represents 8.6% of DALYS lost, making it the second largest disease burden in that age group. The WHO projects this trend will continue, with depression accounting for 5.6% of DALYS lost by the year 2020, making it the second leading cause of DALYS lost in all age groups (WHO, 2004). It is likely that the large impact on DALYS is due to the high rates of suicide among patients with depression. Approximately 15-20% of patients with depression end their lives by committing suicide (WHO, 2001).

The high rates of depression in the Canadian population also have a large impact on the economy. This economic impact of depression is attributed to the lost productivity of those affected by the disease and the health care costs associated with treatment (Stewart et al, 2002). A 2001 study by Health Canada estimated the cost of depression in terms of lost productivity and health care costs is \$14.4 billion (roughly \$18.7 billion in 2013 dollars) (Health Canada, 2001). In BC, a recent report by the BC Business and Economic Roundtable on Mental Health estimated the cost of untreated depression for an average BC company with 500 employees to be \$1.4 million a year in lost work days and reduced productivity. This number increases to \$2.7 million for companies with 1000 employees (BC Medical Association, 2009).

There are also additional costs associated with diminished health and social outcomes of the children of depressed patients. Several longitudinal studies have assessed the impact of maternal depression on child health and wellbeing outcomes and found that maternal depression is associated with a higher risk of developing unfavourable psychosocial and health outcomes (Turney, 2011, Halligan et al, 2007, Luoma et al, 2001). The outcomes measures for these studies vary, but they have demonstrated that low social competence, affective disorders, depression, and general poor health in children and adolescents are all associated with maternal depression.<sup>7</sup> Some of these negative outcomes manifest themselves as early as the first few months of life through the form of decreased response to stimulation indicated by fewer smiles, and less playfulness (Johnson & Flake, 2007). There is also evidence to suggest that

<sup>7</sup> Each of studies use regression methodologies which hold other factors such as child's prior health and socioeconomic status constant.

school aged children under-perform in school. Some studies have noted higher rates of conduct disorder, ADHD, and other disruptive behaviours among children of depressed mothers (Johnson & Flake, 2007). This research points to the fact that the social and financial costs of untreated depression are present not only in the lost productivity and health care costs of the patients, but also, the poor health and social outcomes of children of depressed mothers also represents a large cost to society.

## **2.4. Management and Treatment of Depression**

Currently, the most widely used approaches to manage the symptoms of depression are pharmacological treatments, mainly through the uses of Selective Serotonin Reuptake Inhibitors (SSRIs), psychotherapy and alternative therapies (support groups, counselling, and other therapeutic support) or some combination of those options (Khan et al, 2012; Logsdon et al 2011; & Givens et al, 2007). Though these are the most commonly used treatments for depression, there is no definitive evidence suggesting that one is more effective than the other (Khan et al, 2012). Using a meta analysis of 62 antidepressant trials and 115 studies evaluating the efficacy of psychotherapies and alternative therapies, Khan et al find that the outcomes for treatment with antidepressants, psychotherapy and alternative therapies are not significantly different (Khan et al, 2012). However, this research does not rule out the potential of increased efficacy as a result of combined treatments.

## **2.5. Ethnic Minorities, Mental Health and Service Use.**

Despite the efficacy of depression treatment options, there is evidence which suggests that mental health services and the treatments they offer may not be fully utilized by every segment of the Canadian population. Several studies have concluded that ethnic minorities are less likely to use mental health services than non-minority cultures (Tiwani & Wang, 2008; Klimid et al, 2000; Mojtabi & Olfson 2006; Hu et al, 1991). A recent study to reach this conclusion (Tiwani & Wang, 2008) examined data from the Canadian Community Health Survey to estimate the 12 month prevalence of mental health service use by several ethnic groups overall, and among those with major

depressive episodes (MDEs). The study employed logistical regression analysis of the data to reach the following conclusions about the prevalence of mental health service use among ethnic groups in Canada:

- Among immigrants the prevalence of MDEs increased with each increase in the number of years since immigration.
- White respondents were more likely to have used mental health services than Asian groups (adjusting for gender and age).
- Among participants with MDE white respondents were more likely to have used mental health services than Chinese respondents.
- Among individuals without MDEs, white participants were more likely to have used mental health services than Asian groups. (Tiwani & Wang, 2008)<sup>8</sup>

This study dispels the commonly held notion that the discrepancy in mental health service use between ethnic minorities and majority cultures is due to lower rates of mental disorders among ethnic minority populations, because it shows that even among respondents that reported symptoms of MDE, white respondents were more likely to use mental health services than visible minorities. Other studies have shown that rates of mental illness among immigrant populations approximate those of non-immigrant populations (Besier & Hou, 2001). However, this study is among the first to examine the use of mental health services in Canada among visible minorities and majority populations that have experienced symptoms of depression.

The underutilization of mental health services among ethnic minorities is also seen in the Canadian population. Gadalla (2010) uses data from the 2000-01 national Community Health Survey to determine whether race and ethnicity is a significant factor in treatment seeking behaviour. The results show that ethnicity is a significant factor in determining treatment seeking behaviour. Ethnic minorities were less likely to seek treatment for MDE. The odds of seeking treatment varied by ethnicity. Compared to non-minority respondents, South Asians had the lowest odds of seeking treatment. South Asian respondents also had the highest reported rate of unmet mental health care needs, with 48.2% of South Asian people suffering from MDE reporting unmet mental health needs (Gadalla, 2010). These results indicate that the underutilization of mental

<sup>8</sup> All of the results are statistically significant odds ratios at the 95% confidence level.

health services is a significant problem in many ethnic communities. It also suggests that the South Asian community is particularly susceptible to service underutilization.

With respect to preference for treatment among ethnic minorities, some research suggests that minorities are more likely to prefer therapy over pharmacological treatments. Givens et al (2007) examined attitudes towards depression treatments among several ethnic groups through an internet survey of 78, 753 persons in the US with significant depressive symptoms. The resulting multivariate regression analysis found that African Americans, Asian/Pacific Islanders, and Hispanics were more likely to prefer counselling to medications.<sup>9</sup> The survey results show that ethnic minorities were less likely to view depression as a physiological problem, less likely to believe that medications are effective treatments for depression and more likely to believe that antidepressant medications are addictive (Givens et al, 2007). Mental health service providers in many jurisdictions have attempted to address these differences in treatment seeking behaviour and preference among ethnic minorities through the provision of culturally appropriate services.

## 2.6. Culturally Appropriate Service Provision

There is a growing recognition that health care systems need to address the challenges associated with providing care to ethnically and culturally diverse populations (Bhui et al, 2007; & Anderson et al, 2003). Many jurisdictions now include lectures and course work on cultural competency in training curriculums for medical, nursing and social work students (Bhui et al, 2007). However, there is no consensus on the definition of cultural competence. It can be interpreted as increased knowledge of cultural beliefs and practices of specific cultural groups and/or recognition of the impact of culture on perceptions of illness and treatment seeking behaviour (Bhui et al, 2007). In their meta analysis of studies examining the effectiveness of cultural competency on mental health service provision improvement, Bhui et al (2007) found that in most jurisdictions cultural competence is defined as an ability to provide culturally *appropriate* services to the diverse populations that they serve. Culturally appropriate service provision entails

<sup>9</sup> All of the results are statistically significant odds ratios at the 5% confidence level.

showing respect for patients' cultural beliefs and attitudes as well as showing a genuine desire to learn about other cultures (Bhui et al, 2007).

The effectiveness of culturally appropriate service provision in improving service use and quality among ethnic populations is largely unclear. The main concern with the effectiveness of culturally appropriate services surrounds the genuineness of service provision. Opponents of cultural competency argue that competency training is normally completed to fulfill managerial requirements as opposed to a genuine willingness to learn about cultural differences, and thus the training is not associated with improvements in service use (Bhui et al, 2007). However, this hypothesis has not yet been tested because most jurisdictions have focused on the experiences of service providers rather than patients of such services when evaluating the effectiveness of culturally appropriate service provision. For example, Bhui et al (2007) found that most evaluations of culturally appropriate services find satisfaction with culturally appropriate service provision among service providers, but most studies lack evidence of user experiences.

Regardless of the effectiveness of culturally appropriate service provision there is a clear need to recognize and address the cultural differences in treatment seeking behaviour among ethnic groups, given the high rates of mental illness in certain minority populations. For example, there is evidence to suggest that, despite high rates of depression among South Asian women, this group persistently under-utilizes mental health services. Many qualitative studies examining service underutilization among South Asian women have found that cultural differences in treatment seeking behaviour is an important component of service underutilization in this group. These issues will be discussed in the sections below, beginning with an assessment of the prevalence of depression in South Asian women.

## **2.7. Prevalence of Depression Among South Asian Women**

### **2.7.1. *The Prevalence of Depression Among South Asian Women***

One of the first major studies of the prevalence of depression in the South Asian population sampled 191 households in rural Punjab.<sup>10</sup> Health care professionals administered self reported questionnaires to all members of each household aged 18 and over (approximately 700 individuals). Further psychiatric assessments were undertaken on those individuals that indicated symptoms of major depressive disorders in the questionnaire. The researchers concluded that 66% of women and 25% of men in the sample suffered from some form of anxiety or depressive disorder, though the design to the study did not allow for an estimate the prevalence of specific mental illnesses (Mumford et al, 1997).

There is also evidence to suggest that the depression and other mental health disorders are highly prevalent in immigrant South Asian women. A meta-analysis of studies examining the suicide rates of among immigrants from the Indian Subcontinent revealed that suicide rates among immigrant women were much higher than their male counterparts and women of the mainstream populations (Patel & Gaw, 1996). The researchers also point out that psychiatric disorders are rarely identified as the cause of suicide, which could suggest that depression is often undiagnosed, undertreated or not treated at all (Patel & Gaw, 1996).

In their study of post-partum depression among Immigrant South Asian Women Goyal et al (2006) find that South Asian women living in the United States are just as likely to experience postpartum depression as white women. In a sample of 58 self selected immigrant South Asian women between 2 and 12 weeks post partum, 28% showed minor depressive symptoms and 24% showed major depressive symptoms (Goyal et al, 2006). Though the study is limited by its small non-random sample, it is one of the only studies to examine the prevalence of post partum depression in South Asian women in the US.

<sup>10</sup> Punjab is a state in Northwest India with an estimated population in excess of 28 million (2011 Census of India).

This trend is also reflected in a recent study conducted in Canada. In this study, researchers analysed random telephone survey responses of South Asian immigrants aged 55 and older. It found that over one in five (21.4%) had mild levels of depression or worse. The researchers employed a logistical regression analysis of the survey data to identify the effects of certain explanatory variables on the probability of reporting symptoms of depression. The results indicated a statistically significant difference in the probability of reporting symptoms of depression between men and women. The probability of female participants reporting symptoms of depression was much higher than males. Specifically, the probability that male participants reported symptoms of depression was 0.26 times that of women (Lai & Surood, 2008).

### **2.7.2. *Estimated 12 month Prevalence of Depression Among South Asian Women in Vancouver.***

The studies cited in the previous section showed large variations in the prevalence rates of depression among South Asian women. These variations are likely due to the subjective nature of diagnosis of depressive disorders. Rates of depression are measured using standardized questionnaires. Interpretation of the questions will likely vary based on a variety of cultural and social factors (Bromet et al, 2011). For this reason the estimation of the prevalence of depression among South Asian women will take a series of prevalence rates into account. Table 3 shows estimated 12 month prevalence of depression based on the national prevalence rates among women (see table 2). The totals were estimated for prevalence rates two percentage points above and below the national figure in order to account for variations in prevalence estimates for South Asian women. The results show that between 647 and 1311 South Asian women in Vancouver will experience at least one major depressive episode in a given year.

**Table 3. Estimated 12 Month prevalence of depression among South Asian Women in Vancouver**

Prevalence Rate	Total
3.9%	647
5.9%	979
7.9%	1311

## **2.8. The Policy Problem- The Underutilization of Mental Health Services Among South Asian Women in Vancouver.**

### **2.8.1. The Underutilization of Mental Health Services in Vancouver**

The problem of underutilization of mental health services among ethnic minorities in the lower mainland first came to light in the late 1980s. In order to study the issue, the now defunct Interagency Mental Health Council set up a Committee on Multiculturalism and Mental Health. After identifying that there were no statistically significant differences in the percentage of diagnoses of mental illness among people of different ethnic groups, the committee sought to determine whether the proportion of people of various ethnic backgrounds utilizing mental health were proportionate to the overall percentage of people in various ethnic backgrounds in the population. Table 1 shows the results of the analysis. Column two denotes the proportions of ethnic groups in the Greater Vancouver Mental Health Services (GVMHS) caseload, and the second column shows the proportion of people in the GVMHS catchment area. The third column represents the utilization rate for each group (derived by dividing columns one and two). A utilization rate of 100% would mean that a given group is represented equally in the GVMHS caseload (or that the proportion of people in each group using GVMHS services is roughly equal to the proportion of people from each group living in the catchment area). Finally, the last column shows utilization rates relative to that of Anglo Canadians (derived by dividing each group's utilization rate by that of Anglo Canadians) (Peters, 1988).

The results indicated that the South Asian and Chinese communities were significantly underutilizing mental health services, with South Asian groups showing the lowest utilization rate. The percentage of South Asians in the GVMHS caseload represented only 54.5% of the proportion of the total South Asian population in the catchment area. The relative utilization rate reveals that both the South Asian and Chinese communities utilized GVMHS at less the half the rate of Anglo Canadians (Peters, 1988). Though the results of this study are dated (the data for the study was gathered in 1987), the results represent the first empirical documentation of the underutilization of mental health services in the South Asian community, and there appears to be no more recent publically available information on service utilization rates among ethnic groups.

**Table 4. Mental Health Service Utilization Rates**

Ethnic Group	Percent in Caseload	Percent in Catchment Area <sup>11</sup>	Utilization Rate <sup>12</sup>	Relative Utilization Rate <sup>13</sup>
Anglo Canadian	81.00%	68.00%	119.0%	100.0%
South Asian	2.03%	3.66%	54.5%	45.8%
Chinese	7.57%	13.08%	57.9%	48.6%
Vietnamese	0.58%	0.39%	148.7%	125.0%
Latin American	0.93%	0.27%	344.4%	289.4%

Though the sex of the participants was not reported in the previously cited study, other research has shown pervasive underutilization of mental health services among South Asian women in Vancouver (Johnson, 1992 & Chiu et al, 2005). Both of these studies were qualitative in nature and both revealed a persistent underutilization of

<sup>11</sup> The percentage of people utilizing mental health services in the catchment area.

<sup>12</sup> Utilization rates measure the percentage of people in a population that utilize a service. In this case the rate represents the percentage of people in the catchment area divided by the percent in the caseload.

<sup>13</sup> The relative utilization rate is a measure of how well ethnic minority groups utilize mental health services relative to Anglo-Canadians. It is calculated by dividing the utilization rates of each minority group by that of Anglo Canadians.

mental health services among South Asian women in Vancouver. A 1992 study conducted by a researcher at UBC's School of Social Work sampled ten immigrant South Asian women with a range of mental health disorders. All of these ten women were referred to mental health services because their symptoms had become too severe to ignore. There was a general consensus among participants that it was not in their place to complain about mental health problems and create a burden on the health care system (Johnson, 1992).

A more recent study conducted in 2005 reached similar conclusions about the use of mental health service among South Asian women in Vancouver. The researchers interviewed thirty first generation immigrant women diagnosed with severe mental illness, of which 15 were South Asian and 15 were East Asian, in order to gauge their treatment seeking behaviour. The South Asian women in the study commonly reported reluctance toward the use of mental health services for a variety of reasons (potential causes is discussed below) and many of these women preferred to use alternative treatments based on their spiritual and cultural beliefs (Chiu et al, 2005).

### ***2.8.2. The Present Value of the Lost Productivity due to Depression Among South Asian Women in Vancouver.***

The underutilization of mental health services among South Asian women represents large annual costs to society with respect to the productivity lost due to symptoms of depression. The following chart outlines annual lost wages due to depression among South Asian women in Vancouver.

**Table 5. Estimated Lost Productivity Costs of Depression Among South Asian Women**

South Asian Female Population in Labour Force	Prevalence of Depression in Labour Force	Total South Asian female population in Labour Force with depression	Average Daily Income	Average Lost Work Days	Lost Wages Per Person	Total Lost Wages
10,286 <sup>14</sup>	5.1% <sup>15</sup>	525 <sup>16</sup>	\$159.92 <sup>17</sup>	32 <sup>18</sup>	\$5 117.44	\$2 686 656

The total estimated annual loss in wages due to depression in Vancouver is roughly \$2.6 million. If the onset of depression is not addressed within an individual's working years, total lost wages represents a large economic burden on society. The follow table outlines the present value of lost productivity among South Asian women in Vancouver due to depression over the course of an individual's productive working years, using a 3% discount rate.

<sup>14</sup> According to Statistics Canada 2006 community profiles, 62% of the total female population over 15 in Vancouver were in the labour force in 2006. This estimate assumes that labour force participation among South Asian women is similar to that of the total population. The total South Asian female population in Vancouver according to the 2006 census is 16,590.

<sup>15</sup> The prevalence of major depressive episodes in 12 month period among employed 25-64 year olds in Canada according to statistics Canada Community Health Survey, cycle 1.2, Mental Health and Well-being, 2002. Data retrieved from: Statistics Canada. (2007). Depression at Work.

<sup>16</sup> (Total South Asian female population in labour force) (prevalence rate).

<sup>17</sup> Average Income among South Asian women in Canada in 2000 was \$31,899, (this figure was adjusted for inflation using the Bank of Canada CPP calculator in order to account for inflation. Average income in 2012 terms is \$39,981). Human Resources and Skills Development. (2012). A Profile of South Asians in Canada. Retrieved from: [http://www.hrsdc.gc.ca/eng/labour/equality/employment\\_equity/tools/eedr/2001/DGProfiles/SouthAsiansProfile.shtml#Chart6](http://www.hrsdc.gc.ca/eng/labour/equality/employment_equity/tools/eedr/2001/DGProfiles/SouthAsiansProfile.shtml#Chart6) Average daily income was derived by dividing annual income by 260 working days a year.

<sup>18</sup> The average lost work days due to depression among respondents of the 2001 Community Health Survey. Data Retrieved from: Statistics Canada. (2007). Depression at Work.

**Table 6. The Present Value of Lost Productivity Over Working Years**

Year	Present Value of Lost Productivity
5	\$12,304,097.79
10	\$22,917,720.63
15	\$32,073,124.93
20	\$39,970,657.10

While the costs associated with lost productivity due to depression are significant, they represent only a small portion of the total costs associated with depression. Other costs associated with depression that are not accounted for here, but have been used in other studies estimating the economic burden of depression are, treatment costs, depression related suicide costs and the costs of government benefits associated with depression (disability payments, and employment insurance due to individuals inability to work) (Greenberg et al, 2003). Taking all of these costs into account is a worthwhile endeavor for future research; however, a complete accounting of the costs associated with depression among South Asian women in Vancouver is outside the scope of this study.

### **2.8.3. The Policy Response**

In response to the underutilization of mental health services among visible minority populations in Canada, the Vancouver Coastal Health Authority adopted several initiatives to encourage visible minority populations to use mental health services. Among these measures is a public education campaign, and specialized training for service providers through the Cross Cultural Mental Health Program (Ganasan & Janze, 2005).

In sum, the Cross Cultural Mental Health program aims to enhance service provision to aboriginal and immigrant populations by providing education workshops for service professionals and community members, consultation and service referral for community members and clinical services, usually in the form of group psychotherapy services, for community members. The services are offered through various clinics across Vancouver. The following table outlines the clinics which offer cross cultural mental health services and the languages in which they are offered.

**Table 7. Cross Cultural Mental Health Clinics<sup>19</sup>**

Clinic	Neighbourhood	Service Languages
Raven Song Community Health Centre	Mount Pleasant	English, Spanish and Portuguese
Child and Youth Cross Cultural Mental Health Program	Hastings Sunrise	English, Mandarin and Cantonese
Cross Cultural Clinic- Vancouver General Hospital (VGH)	Mount Pleasant	English, Cantonese, Farsi, French, Hindi, Hungarian, Japanese, Mandarin, Punjabi, Russian, Urdu and Vietnamese <sup>20</sup>

Though this information is reported on the VCH website, the service languages may not necessarily reflect actual service languages offered due to changes in service provision. For example, according to Dr. Ganesan- the director of the Cross Cultural Clinic at VGH, the Cross Cultural Clinic does not offer clinical services in Punjabi due to resource constraints (see section 4.2.5). Taking this information into account, it is apparent that the South Asian community is underserved by the Cross Cultural Mental Health Program. This is evidenced by the fact that no cross cultural services are offered in the South Vancouver area where the majority of South Asian people in Vancouver reside (see Appendix C), and there are no services offered in Punjabi, the most commonly spoken South Asian language in Vancouver (see Appendix E). This lack of culturally appropriate services is problematic because it has been identified as one of the reasons behind service underutilization among South Asian women in several academic studies on the issue. The next section will outline the results of these studies.

<sup>19</sup> The information provided in the tables is derived from the Vancouver Coastal Health website. See [https://www.vch.ca/?section\\_id=403&section\\_copy\\_id=7676](https://www.vch.ca/?section_id=403&section_copy_id=7676)

<sup>20</sup> These service languages are outlined on the VCH website. However, an interview with Dr. Soma Ganesan- director of the cross cultural clinic at VGH- the clinic no longer offers services in Punjabi due to resource constraints (see section 4.2.5).

## 2.9. Current Research and Gaps in Knowledge

### 2.9.1. *Possible reasons Behind the Under-Utilization of Mental Health Services Among South Asian Women.*

Several qualitative research studies have shed light on the causes of the underutilization of mental health services among South Asian women (Ahmad et al, 2005, Kumari, 2004, Grewal et al, 2005, Li and Browne 2000, Chiu et al, 2005 & Johnson, 1992). These studies vary in geographical location and many do not focus on underutilization in South Asian women with depression, but they provide a good framework for understanding the broader issues underlying limited use of mental health services among South Asian women. Common themes to emerge from these studies with respect to the reasons behind underutilization of health care services are:

- The stigma associated with mental health: Mental health problems are stigmatized in the South Asian community. The presence of a mental health disorders is often considered a sign of weakness due to the depressed individual's inability to perform traditional household duties. This concern is heightened in single women, who feel that mental health disorders diminished their chances of finding a suitable partner. For these reasons, South Asian women may be inclined to not report their symptoms to health care professionals (Johnson, 1992, & Chiu et al, 2005).
- Language barriers: Language barriers are another commonly reported factor in the underutilization of mental health services among South Asian women. Several qualitative studies have revealed apprehension among South Asian women to use mental health services due to their inability to speak English and properly communicate their symptoms (Li & Browne, 2000; Chiu et al, 2005; & Johnson, 1992).
- Preference for alternative therapies: In at least one study, many South Asian women expressed preference for alternative treatments that are more closely associated with their religious and cultural beliefs. This may include an emphasis on spiritual healing (mediation and praying) and/or traditional herbal medicine (Chiu et al, 2005; & Hilton et al, 2001).
- Perceived lack of cultural empathy among health care professionals: Another common theme found in the literature is the perception among South Asian women that health care professionals do not treat patients with respect. Some women felt they were being patronized by health care professionals and that doctors did not clearly explain their treatments to them (Johnson, 1992; & Li & Browne, 2000).
- Time constraints: South Asian women are often expected to carry out household duties as well as earn an income for the household through paid employment. These obligations often have detrimental effects on health and

prevent South Asian women from seeking treatment (Grewal et al, 2005; & Chiu et al, 2005).

- Awareness: Some studies reported that many South Asian women are unaware of how to access mental health services (Li and Browne, 2000; & Ahmad et al, 2005). Li and Browne (2000) report not knowing how to access mental health services as the third most frequently reported barrier to mental health service use in their interviews with Asian Canadians in Northern BC. 50% of South Asian participants reported lack of knowledge as a barrier to service use (Li and Browne, 2000).
- Financial constraints: Many South Asian women are financially supported by their families because they're mental disorders prevent them from working. For this reason, paying out of pocket for medication is often not an option. As a result, some women may turn to herbal medicines instead or opt not to seek treatment at all (Chiu et al, 2005; & Johnson, 1992).

These studies have examined the issue of mental health service underutilization through the perspectives of South Asian women with some experience with mental health systems. The perspectives of professional stakeholders are largely missing from the current literature on the issues.

### **2.9.2. *The Value of Professional Stakeholder Perspectives***

The current academic literature on mental health service utilization among South Asians focuses on the perspectives of South Asian women with experience using mental health services. The perspectives of professional stakeholders (health care professionals, case managers, and community and settlement workers) are missing from the academic literature on the issue. These stakeholders can provide valuable insights into the access barriers that prevent individuals from accessing services. These stakeholders play a vital role in providing mental health treatment services and helping individuals gain access to treatment (Hensley, 2012; & Kirchner et al, 2012). Professional stakeholder perspectives also allow for a more in-depth discussion of feasibility policy options than patient perspectives would offer, because they are responsible for implementing any changes to service delivery which may be recommended to address the situation (Hensley, 2012; & Kirchner et al, 2012). For these reasons, this study will contribute to the existing literature on mental health service underutilization among South Asian women by gathering stakeholder perspectives on the issue.

## 2.10. Conclusion

The social and economic costs of depression have been well documented. Depression is associated with large economic costs in terms of lost productivity, decreased labour force participation and increased health care costs (Stewart et al, 2002; WHO, 2004; & the BC Medical Association 2009). There are also significant intergeneration effects associated with depression, in the form of decreased academic and social functioning of children of depressed mothers (Luoma et al, 2001; Halligan et al, 2007 & Turney, 2011). Medical interventions in the form of pharmacological and therapeutic treatments have been found to be efficacious in managing the symptoms of depression (Givens et al 2007; Logsdon et al 2011; & Khan et al 2012). Yet, there is evidence to suggest that certain visible minority groups underutilize mental health services which provide access to evidence based treatments (Tiwani & Wang, 2008; Klimid et al, 2000; Mojtabi & Olfson 2006; & Hu et al, 1991). This trend is reflected in the underutilization of mental health services among South Asian women in Vancouver (Peters, 1988; Johnson, 1992; & Chiu et al, 2005). This is a pertinent public policy issue due to the large economic and social costs of untreated depression in this group. The cost associated with lost productivity among South Asian women with depression is estimated to be \$2.6 million a year (see section 2.6.3).

Though the issue has been understood through the perspective of South Asian women, stakeholder perspectives on the issue are largely unknown. Stakeholders play a vital role in service delivery and are responsible for implementing changes to service delivery. This study will address this gap in the existing literature by gathering stakeholder perspectives on the issue. The aim of the study is to determine stakeholder perspectives on the underutilization of mental health services among South Asian women with depression in Vancouver and derive a set of policy options to address the problem.

## **3. Methodology**

### **3.1. Research Questions and Objectives**

The central goal of this study is to identify perceived causes of the underutilization of mental health services in Vancouver among professional stakeholders and derive some additional strategies that can be used by the Vancouver Coastal Health Authority to increase the utilization of mental health services among South Asian women with depression. The study seeks to answer the following research questions:

Why do some South Asian women that are experiencing depressive symptoms not seek treatment? And;

What measures can be taken to encourage South Asian women with depressive symptoms to utilize mental health services?

### **3.2. Theoretical Perspective**

This research is informed by a feminist perspective on mental health service utilization for depression, because the researcher holds the view that treatment seeking behaviour cannot be adequately understood without accounting for the social structures which impact individual behaviour. In this context, it is important to acknowledge the marginalization of women through submissive gender roles that are often constructed for women within the context of patriarchal societies (Stoppard, 1999); and how this might impact service utilization. That is to say, the societal context within which women find themselves is an important component of any understanding of mental health service utilization because it creates a more robust understanding of treatment behaviour than

mainstream bio-medical approaches<sup>21</sup> can offer (Stoppard, 1999). This study will seek to understand the issue of service underutilization through a feminist perspective by engaging research participants in a discussion of the societal impacts of service underutilization, rather than a focus on the psychological symptoms of depression which may cause service underutilization.

### 3.3. **Semi-Structured Interviews with Stakeholders**

Given the complexity of the issue this study seeks to gather professional stakeholder perspectives through semi-structure interviews. A semi structured interview process entails asking participants the same questions but with a flexible framework; with no specific ordering of questions and the inclusion of open ended questions aimed at understanding the participants experiences (Dearnley, 2005). The methodological freedom of semi structured interviews allows the researcher to delve further into the participant's opinions and the underlying reasons behind them than surveys, questionnaires and structured interviews (Carruthers, 1990). Semi structured interviews facilitate in depth discussion which allows the researcher to gather a rich data set with a diversity of opinions on a given issue (Diefenbach 2009).<sup>22</sup>

In total nine semi-structured interviews are conducted for this study. The researcher recruited several professional stakeholder groups from the Vancouver area to participate in the study. These groups include outpatient mental health case workers, immigrant settlement workers, private counselling service providers, and mental health specialists with experience working with the South Asian community. The interview participants were identified based on their involvement with organizations with an interest in mental health service provision to the South Asian community.<sup>23</sup> The

<sup>21</sup> Mainstream approaches to understanding depression consist of traditional bio-medical approaches which focus on the physiological aspect of the disorder without addressing societal issues (see Stoppard, 1999).

<sup>22</sup> For a discussion of the major methodological issues associated with semi structured interviews see the Limitation section.

<sup>23</sup> The organizations initially identified included the Mood Disorder Association of BC and the Cross Cultural Mental Health Clinic at VGH.

recruitment process entailed cold calling and snowball sampling.<sup>24</sup> Initial participants were contacted through cold calling and these participants subsequently recommended colleagues that would be fit to participate in the study. For a complete list of interview participants see Appendix D.

Once the professional stakeholder interviews had been completed, analysed and used to derive policy options, two service providers were contacted for additional semi structured expert interviews on the feasibility of the proposed policy options. Experts provide a unique source of information about the policy making process due to their knowledge and experience in their respective fields (Dorussen et al, 2005). These service providers were contacted to discuss policy options due to their knowledge of the administrative aspects of service delivery.

### **3.3.1. Interview Schedule**

The interview questions were constructed to gauge stakeholder experiences working with South Asian clients and facilitate discussion about service underutilization among South Asian women and possible reforms to address the problem. The questions were informed by the existing literature on the issue; however, in order to ensure unbiased responses, none of the questions make explicit reference to any of the findings from the literature. The interview schedule covered the following topics: utilization of mental health services among South Asian women with depression, treatment seeking behaviour among South Asian women, and policy interventions to address underutilization. The complete interview schedule can be found in Appendix E.

### **3.3.2. Interview Process**

The majority of the professional stakeholder interviews were conducted in person in the participants' place of work. Certain participants expressed interest in telephone interviews due to time constraints, for these participants the interviews were conducted

<sup>24</sup> Snowball sampling is a sampling process which occurs in multiple stages. Participants in the first stage are randomly drawn from the population and these participants are asked to name colleagues and acquaintances for subsequent sampling stages ( see Godman,1961).

via telephone. The telephone interviews may have impacted the overall quality of the data, as conducting interviews over the phone increases the chances of misinterpretation of interview questions. The interviews ranged in length from twenty to forty minutes. Each interview was audio recorded in order to allow for accurate transcription of the data.

Both expert interviews were conducted over the phone and ranged in length from five to ten minutes. No formal interview schedule was developed to for the expert interviews. Participants were asked to comment on the feasibility and cost projections of the proposed policy options.

### **3.4. Thematic Analysis**

The data provided by the interview participants was transcribed and analysed using thematic analysis. Broadly speaking, thematic analysis entails analysing qualitative data through the identification of specific themes and patterns within the data, however there is no consensus on a specific definition or the specificities of the approach (Braun and Clarke 2006). This theoretical freedom allows the methodology to fit within various theoretical approaches. For example, Braun and Clarke (2006) argue that thematic analysis fits within both essentialist/realist and constructionist paradigms, though the focus of the analysis changes depending on which paradigm is used<sup>25</sup>. Realists analyze the data by identifying the themes that emerge directly from the data. On the other hand, constructivists are much more interested in how the data is impacted by the socioeconomic context and thus are more likely to focus on latent themes within the data. This report uses an essentialist paradigm to highlight themes that emerge from the participant interviews. The study uses the analytic process for thematic analysis outlined by Barun and Clark (2006). The process involves: transcribing the data, coding interesting elements of the data, pooling the coded data into themes, ensuring themes

<sup>25</sup>The distinction between realist and constructivist paradigms lies in the philosophical beliefs about the nature of reality. Realist argue that reality can be understood through objective observation (i.e. meaning and experience can be expressed through language). Constructivists hold that reality is largely socially produced thus meaning and experience cannot be directly observed through language.

are consistent with the coded data set, refining the themes (identifying clear definitions and names for each theme), and finalizing the analysis in the write up stage (Braun and Clarke, 2006).

The results of the thematic analysis are used to derive policy options. The policy options address the perceived causes of the underutilization of mental health services among South Asian women. In this way, the policy options are informed by the knowledge and experience of professional stakeholders currently working in the field. Expert interviews enabled expert input into the feasibility of the policy options derived directly from the thematic analysis.

### **3.5. Study Ethics**

In order to ensure that the participants were aware of that their participation in the study was voluntary, and that they reserved the right to remain anonymous in the report, participants were asked to sign an informed consent form prior to participation. The majority of participants agreed to have their names used in the study and signed a consent form to that effect. Where the interviews were conducted by telephone, consent was collected verbally. This study was approved by the research ethics boards at Simon Fraser University and Vancouver Coastal Health.

## 4. Data Analysis

### 4.1. Underutilization of Services

Each of the professional stakeholders interviewed for the study were asked if they felt South Asian women were in fact underutilizing mental health services in the Vancouver area. Each of the participants indicated that they felt that South Asian women were not fully utilizing mental health services in the area, despite the presence of the Cross Cultural Mental Health Clinic and various efforts to raise awareness about mental health issues in the community over the last decade. One of the first mental health professionals to advocate for mental health awareness in the South Asian community in Vancouver, Dr Rajpal Singh, sums up the problem:

“We are educating the community for the last 22 years or so. We have written books went on radio and TV. But still there is a big stigma attached, so in spite of continuous education still people don't utilize these services.”

This sentiment is echoed by Dr. Soma Ganesan, the current medical director of the Department of Psychiatry at Vancouver General Hospital. Dr. Ganesan argues that certain groups face barriers when accessing health services despite the intended universality of the system. He cites a situation which arose in Northern BC to demonstrate his point:

We have a universal healthcare mandate in Canada. However, universal doesn't mean equal. When I bring it up to a lot of people offering service I say, 'It's open to all why don't you go to get help.' I give you this example: several years ago when I used to go up north to... (the) Quenel, area to provide mental health service there and Dr. Rainia...was my resident and I took him up there because he speak(s) Punjabi and Hindi. 15% of the population living in Quenel area (have a) Punjabi background, but when I asked the mental health staff at the clinic how many people from the Punjabi community come here for help they said: 'One'. I said: 'How is it possible that you have more than 1500 (people who speak Punjabi and Hindi) here and there's only one?' They say, 'Oh well sometime(s) they go to (the) emergency room and they get help quickly and then they are sent and asked to come here for help but they don't show up.' I say: 'did you

follow it up', and they say: 'No, if they don't show up I don't call them.' So that mean(s) the service is open to all but because it's not accessible people don't access that (service).

These perspectives suggest that there is a tendency among the South Asian community to not access mental health services, even when there is a demonstrated need for treatment, and that service providers may fail to identify and address this situation. The example provided by Dr. Ganesan further suggests that in some instances local health authorities may fail to recognize and address the problem. This is problematic given the nature of the symptoms of depression. Depressed patients often experience hopelessness, and thus need more proactive approaches of care rather than reactive interventions.

## **4.2. The Perceived Reasons Behind the Underutilization of Mental Health Services Among South Asian Women.**

The stakeholders were asked for their views on some of the possible reasons behind the underutilization of mental health services among South Asian women. The following themes emerge from the responses: stigma, lack of awareness, time and family obligations, language barriers, and lack of culturally appropriate services. All of these themes are consistent with the themes derived from qualitative studies involving the perspectives of South Asian women (see section 2.8.1), with the exception of lack of culturally appropriate services, which highlights issues with service provision in Vancouver. The interviewees generally perceived many of these barriers to be exacerbated by inadequate service provision to the South Asian community. For example, lack of awareness is viewed by many professional stakeholders as a failure by the health system to provide patients with adequate information.

Each of these themes will be discussed individually below.

### **4.2.1. Stigma**

Many of the participants felt that South Asian women are reluctant to disclose symptoms of depression due to the stigma associated with mental health. While this stigma is present across cultures (Roleloffs et al, 2003; Lazear et al, 2004), it remains a

significant factor in preventing mental health service utilization among South Asian women with depression. Specifically, mental illness is often perceived as a weakness within the South Asian community and in many cases the presence of depression or other mental illnesses can be perceived as laziness and reluctance to carry out family duties. Katherine Ingham, a case manager from the South Mental Health team elaborates on this point:

“You know there are huge myths that being mentally ill or dealing with a mental health issue is a sign of weakness, and if you admit to being weak there’s a lot of shame, a lot of shame in families around: ‘Oh you need help or you can’t manage on your own’.”

This shame that the case manager alludes to is associated with gender socialization in many South Asian cultures<sup>26</sup>. Research has shown that in many South Asian cultures women are socialized to emphasize the needs of family in interpersonal relationships (Singh & Hays, 2008). Thus, depressed South Asian women may fear being perceived as “weak” due to their diminished ability to attend to the needs of her family. The interviewees perceived family obligations to be a major barrier preventing many South Asian women with depression from seeking help. This theme will be discussed in detail below.

This sentiment was echoed by another case manager from the South Mental Health team, Jennifer Glasgow:

I think cross culture but I’ve definitely seen in this particular culture (*South Asian*<sup>27</sup>), mental health can be seen as a weakness. You know something that the person isn’t strong enough to get through, maybe their faith isn’t strong enough in their religion, and there’s a sense that people could get over it if they just kind of toughened up. And so I’ve certainly seen that in South Asian families, it’s not unique to South Asian families but I’ve seen it there.

<sup>26</sup> Though strict gender roles have been observed in many South Asian cultures (see Patel, 2007; Fikree & Pasha, 2004; & Singh & Hays, 2008); many other cultures exhibit similar behaviour with respect to gender roles. As Patel (2007) points out, South Asian culture has been labeled as a “sexist” by mainstream American society, when at the same time; “sexist” tendencies can also be found in mainstream American society through domestic violence, and employer discrimination.

<sup>27</sup> The information provided in italics is contextual information meant to give the reader a better understanding of the context of the quote, and not a quotable remark from the interview.

Several participants also noted that the stigma seems to be present in the community regardless of socioeconomic status and the amount of time since immigration. As, a private mental health consular who wishes to remain anonymous, notes:

“I think the stigma issue (is) still really relevant even if the person has been in Canada for a long time. And sometimes the new women, they are holding on to the same stigma that women that have been here for a long time are.”

This comment point to the prevalence of perceived stigma associated with mental illness both within the South Asian community and in society at large. More research is needed to develop a better understanding of how this stigma perpetuates itself in various cultures.

#### **4.2.2. Lack Of Awareness**

The treatment and management of depression requires considerable commitment on the part of those undergoing treatment. For example, it is estimated that treatment with anti-depressants requires at least 26 months of daily dose intake to prevent relapse (Reimherr et al, 1998). Further, acute treatment for depression using psychotherapy normally lasts 6 to 12 weeks and requires active participation from patients (Agnes et al, 2002). For this reason, a good understanding of the nature of the illness and the types of treatments available among the clients and their family is important. However, several stakeholders involved in this study noted that this awareness with respect to the symptoms of depression and treatment options is lacking among South Asian women and in the broader South Asian community. Though the interviewees perceived this lack of knowledge to be fairly widespread, some felt that an individual's level of awareness is directly related to education and prior experiences with mental health treatment. Dr. Ganesan explains:

The way people see mental health and mental illness is largely, especially when they first come to Canada, relate(d) to their notion of what mental health is back home. Then you can see that the perception of what mental health is back home affects how they ask for help and where they go for help, and that go(es) along with what we say about stigma and all others. Of course if we talk specifically about South Asian whether it is Indo-Pakistani, that area, the mental health service there is available differently depend(ing) on where people come from, if they come from big city there is a lot of access if they come from small city most

of the access to mental health goes through primary care, there's no well trained staff in remote area(s).

As such, the level of awareness will depend on the mental health services available in the area from which the individual immigrated. For example, Dr. Ganesan points out that people emigrating from smaller cities with limited mental health services are at a disadvantage with respect to awareness of mental health disorders and available treatment.

Interestingly, Dr. Ganesan goes on to argue that people from larger cities with higher levels of education are likely the ones benefiting from public education campaigns in the South Asian community:

There's a lot of work done in terms of public education and de-stigmatization that help a lot of people, however, people who have access to that are educated people (in) my experience (they) go for help earlier, but other people for example house wife, elderly population and people that come from rural areas in India would not look at that all as part of issue in mental health.

This point suggests that there is a need for public education on mental illness in Vancouver which targets people with lower levels of education.

Greater awareness of mental health issues is also important for family members of those experiencing mental illness. The interviewees suggest that in many cases family members may mistake symptoms of depression for laziness or an unwillingness to perform household duties. Two service providers reported observing this trend within the South Asian community. A case manager at South Mental Health Team who chose to remain anonymous, suggest that the families of the South Asian clients she sees often lack awareness of the illness for which their family member is being treated:

...just educating the family members about the illness, often times they stigmatize the client quite often and so it's just educating them. It's like: 'No he's not lazy he just has an illness for which he has negative symptoms.' So I think those are things that I struggle with it's just educating them on the illnesses and it's not usually the client its more the extended family or the family members.

The case manager sheds light on the notion that awareness about mental illness needs to be present in the entire household in order for the person affected by the illness to receive adequate support and encouragement to receive treatment. Dr. Ganesan extends this point:

I think we have to focus a lot on educating family because the barrier of accessing service started right from the family. The husband need(s) to know, (and) need(s) to agree to get the wife (*help for her depression*), you know a lot of South Asian women live with the family unless its younger generation and (it's a) different story child and youth. But we need to educate the parents, parents in law and the husband in having in open mind to help them. Let's say a women is not performing, cannot do thing(s) because of lack of concentration. (She's) Not sleeping, not eating well, sitting the corner crying all the time; this is not a sign of laziness this is a sign of something unstable and help that person instead of criticising her that you are lazy.

Here Dr. Ganesan touches upon another issue; that of the inability of South Asian women to advocate for their own treatment as a result of their role within the family. This issue will be discussed at length in the next section.

Another aspect of the lack of awareness about mental health issues and its role in preventing service utilization concerns the role that primary care physicians play in imparting important information about mental illness. Many participants alluded to the fact that South Asian women are being given inadequate information about their illness and treatment options from their family doctors. This point is summed up the case worker from South Team:

Well in primary care for example, the doctor is not focusing on mental health and I mean yes its part of the assessment but they're not experts in the field. So they're just sort of dealing with any crisis that comes up and once it's out of hand that's when we get the phone call. And (the) same with hospitals; once somebody is hospitalized they're focus is on is just getting them out of the hospital and dealing with the acute crisis and that education piece doesn't really happen. (Or) Like it happens on a cursory level but there's no in depth like... family meetings (to) educate you on the illness that's something that the community would have to do.

Here, the case worker points out that family doctors and hospitals do not provide mental health education because it is not within their area of expertise. The case worker does not feel that the health care system should be responsible for educating the public, and that this need should be fulfilled by community organizations. However, other participants felt that the onus for education falls to primary care physicians and many may not be aware of current programs and services available for treatment. Dr. Shimi Kang expresses concern over this:

I think even if you ask family doctors who see this population many of them aren't aware of the program (cross cultural mental health program), (or) many might be aware but have a bit of this therapeutic nihilism, like: 'well this person's not going to go (to a mental health specialist) even if I ask them to or there's too long of a wait list.' So I think that sometime, even if the programs are in place the awareness and knowledge issue goes even to front line staff like front line workers particularly the family doctors.

Regardless of the level of awareness of primary care physicians, it is apparent that family doctors can play a vital role in the management of depression, so it is vital to keep them abreast of the programs and services available for treatment of depression.

A final point concerning awareness is the issue of confidentiality and possible fear of the repercussions of receiving treatment for depression or other mental health issues. A number of participants interviewed for this study observed a trend among South Asian women to be reluctant to access services because they are unclear about confidentiality rules and fear that the recognition of their condition will lead to negative consequences such as having their children removed from the home by the Ministry of Child and Family Services. Dr. Rajpal Singh explains the concern among many South Asian women about confidentiality in mental health treatment:

Confidentiality is a big thing for providing service for depression. For our community we have to explain really in detail what confidentiality mean(s) and also we remind them after a couple of sessions also that we talk about confidentiality so don't worry about it. So they don't understand, they worry that a professional might talk about them in the community. So we have to really explain we are trained it is part of our ethical behaviour but also a law in BC and so confidentiality doesn't mean until you're getting the services it's for life we have to really explain that. And that helps a lot, then they open up then they talk about all these issues.

Here, Dr. Singh points out that lack of knowledge of confidentiality laws prevents his clients from fully opening up. This lack of awareness may also prevent women from accessing services because they may fear that what they talk about may be leaked to the community.

Another source of fear is the misguided notion that accessing treatment for depression may have severe negative consequences such as having children removed from the home. Dr. Ganesan describes this problem:

Especially a mother, there's a lot of issue here, especially with women with child(ren) because the perception out there is if the women is identified as having mental illness there's a potential that the children will be taken away by the ministry of family and children because the women is not competent in providing care to the child. And I see that here at the clinic here with a lot of Asian women and some of my patients also South Asian.

This fear of mental health services may be a significant factor in preventing South Asian women from seeking treatment. These fears are heightened by the family obligations that are placed upon South Asian women through prescribed gender roles.

### **4.2.3. Time and Family Obligations**

While awareness of mental health illnesses and treatment options is an important factor in determining service use, many South Asian women may not get the opportunity to access services due to time and family obligations. This is due in large part to the role that many South Asian women play within the family. Dr. Rajpal Singh elaborates on this point:

And in women especially South Asian women when they get depressed family members don't recognise it and support it. Though the fact is that women get depression more than men, like double almost, so it effects the female population double but less recognition and less support in the family especially South Asian (families). In our families women play the role of the caretaker of the whole family. Their health needs, their mental health needs, their emotional needs and when she gets depressed or sick other people don't know how to play that role. So this is a big thing because she recognizes okay this family member is doing well we should do something, but when she gets sick other people don't recognize and sometime especially with depression, husbands and other family members don't recognize it because we (*South Asians*) don't know about depression.

Dr. Singh points to a significant barrier preventing many South Asian women from accessing mental health services: the traditional role of women in many South Asian cultures as the primary care giver within her family. This role often results in the women prioritizing the health of others in her family over her own health (Singh & Hays, 2008). This can be especially problematic when the symptoms of depression cause feelings of hopelessness, because other members of the family are not able to recognize the disorder and encourage the individual to seek treatment. This phenomenon is certainly

not unique to South Asian cultures, but it does pose a significant barrier to accessing of mental health services.

Though not necessarily the case in all South Asian families, another significant barrier to mental health service access with respect to family obligations is the patriarchal nature of many South Asian communities which prevents the females within that culture from advocating for their own health and well being (Fikree & Pasha, 2004). A prime example of this is provided by Dr. Ganesan who describes an outreach session he and other psychiatrists organized at a Sikh temple in Northern BC:

So we called and the temple committee (they) were so happy because we are both from Indian background. So we came in, we sit there they make chai and samosa and everything it was beautiful. And then we look around it's only men, no women, no young aged. So we ask what happened to the women, (they said) 'Oh they're in the kitchen they make tea and samosa they're busy.' I say 'You know we're coming here to talk about mental health and mental well-being we would like to have women around'. They say, 'No you tell me and I will tell them.' I say, 'What about the younger generation?' and they say, 'Oh those kids leave them alone I will tell them what to do.' Do you see the intra ethnic group themselves; because of the hierarchical society the men will get help earlier than women. And also that will also affect the older generation, the older generation will get helped the least.

Here it becomes apparent that from the perspective of the interviewees South Asian males are often making crucial decisions about the types of treatments sought by females and children. This trend is also reflected in the manner in which treatment is provided to South Asian women. Many services providers pointed out that husband and other family members are usually heavily involved in the treatment of South Asian women. Though involvement of family members is not unique to South Asian cultures, and it is often considered a positive step toward treatment compliance, in some cases family members can have an overbearing presence in treatment preventing the client from openly revealing her inner thoughts. This is reflected in the observations of a case worker from South Team:

There's other times when like I have client with whom I wanna just meet with her and just sort of figure out what kind of stresses are going on with her and what kind of family obligations she has, but the husband would always come in to the appointment with her so we never got that one on one time. So I guess maybe in that case the husband was reluctant to have her in the appointment alone because maybe he thought that she would say stuff that he wasn't okay with I

don't really know. We even explicitly said we want to see you alone but she would always bring him in and he would always come as well.

The active presence of family members in treatment further demonstrates the tendency of males of exert control over the health and well being of females in many South Asian cultures. This may prevent South Asian women from presenting their illness and actively seek treatment.

Another aspect of family obligations that professional stakeholders felt may prevent South Asian women from accessing services is the reduced amount of time available to receive treatment due to work and family duties. Many of the service providers interviewed observed that South Asian women were less likely to pursue time consuming treatments because of busy schedules. Dr. Rajpal Singh describes the difficulty in organizing group therapy sessions for South Asian clients:

So we started a group for women 6 or 7 years ago it's still going. And the day before yesterday we had 26-27 women in the group. It's a lot of psycho-education modern techniques (like) CBT, but they're coming now. But there are still barriers, one of the barriers is that they also have children (and) who's going look after the children at that time. So they are asking for child minding and things like that, so we need that and that's not in place. Rides to the group and also the timing of the group. We are doing it in the evening Tuesday and some women can't come because they are coming from work and they are cooking and all of those things. But we could not find any suitable time.

It goes without saying that time constraints are usually a greater issue for those women that are contributing to the household through both paid labour and other household duties. A clinical consular from surrey elaborates on this point:

"I think definitely time and work schedules do play a factor, so if a woman does not have financial concerns she can take time off work to attend appointments. But a woman who is contributing to the household is just not an option for her."

These perspectives point to the necessity of service provision which reflects the family and work obligations (for those in the labour force) of South Asian women in order to encourage participation in treatment.

#### **4.2.4. Language Barriers**

Another common observation from the participants is the notion that many South Asian women find it difficult to convey their symptoms using the language that is best known to them. This is particularly problematic for clients with depression as diagnosis and treatment of depression involves high degrees of verbal communication. Dr. Ganesan points out the significance of verbal communication in treatment for depression:

The worst thing is for the woman to go and ask for help and to have her children or husband or parents as the interpreter. This is a taboo. The health care system should be responsible in providing interpreter service so that the woman is free to talk about her issue. Instead of looking around and looking around and then the husband (says) 'She doesn't make sense of what she's say', or 'Oh no she's fine.' And don't put the children in a very awkward position, at 18 years old has to interpret for her mother or his mother, that's not right. This is okay for emergency room five minute assessment about your heart your brain.... but not for mental health assessment.

Dr. Ganesan speaks about the importance of translation services to ensure that individuals that are unable to communicate effectively in English are able to talk about their symptoms. Given the concerns over confidentiality described in section 4.2.2 it is certainly understandable that some women may be reluctant to access services because they do not feel comfortable relying on their family members for translation.

Another interesting aspect of the language barrier issue is the idea that many clinical terms for depression may not have expression in many South Asian languages. For example, most South Asian languages do not have a clinical term for depression. Instead, the individual may use alternative terms like sadness, or favour expressing the physical symptoms as opposed to describing the psychological symptoms. Dr. Singh explains:

Also, one thing we noticed, and then there is research that came from the UK and some from other countries regarding South Asians, that when South Asians get sick, especially women, that when South Asians go to GPs they complain about aches and pains and not about feelings not about mood. Research has shown that when South Asians get depressed the expression of depression also comes as aches and pains in the body which don't have physical reason. So when we assess people and we ask questions related to depression we generally ask also do you have any aches or pains which your family doctor can't

find a cause, so its expression comes in the form of physical symptoms so there is a lack of knowledge about it.

These language barriers may cause misdiagnosis of depression which may explain why utilization rates for mental health services among South Asian women are lower than other groups.

#### **4.2.5. *Lack of Culturally Appropriate Services***

While it is clear that mental health services need to account for the diversity of languages in the Vancouver area; many of the participants interviewed for this study point out that mental health services also have to be provided in a manner that works with and respects the cultural beliefs of those undergoing treatment. This is particularly problematic in relation to the Western model of medicine and care, as Dr. Ganesan points out:

...even if the person was referred to psychiatric or mental health service for help, 50% of them do not show up in the second time. The reason is they do not perceive that people are sensitive to their needs. If people go for assessment on the western model of assessment, asking a lot of question to make sure they can diagnose a person instead of creating a relationship with that person. For example, asking a woman have you ever thought about suicide, they lie. That is a very forward question to ask at the first contact, but we were trained to ask that question otherwise psychiatry resident(s) will fail (their) exams. Asking questions about sexual development, this is not something that one should ask, but that was the thing, when people see it that way they perceive that the person providing service is not sensitive to their needs so they don't show up.

According to Dr. Ganesan it is absolutely imperative to provide culturally responsible mental health services in order to create an environment in which people of various backgrounds feel a sense of comfort. Failure to do this will result in poor retention rates and perhaps a lack of service utilization among certain ethnic groups altogether.

While the Vancouver Coastal Health Authority has attempted to address this problem through its Cross Cultural Outpatient Mental Clinic, which strives to provide culturally appropriate services to members of various backgrounds, the clinic lacks the resources to provide services which cater to the needs of a variety of different ethnic groups. Dr. Ganesan, the director of the clinic, illustrates this point:

The mandate of the clinic is to provide culturally responsible services either through language or through understanding of culture. That (is) also used as a training site for medical student(s) for resident(s) for social work student(s), psychology counselling, whoever wants to do their rotation there. We also link very well, the mandate of clinic is assessment treatment and supporting GP, so we have now a counselor who speak Cantonese or Mandarin, we don't have counselor who speak Punjabi yet because of the lack of resource, however, the key thing is that a short term treatment program and link it back to the community in supporting GPs to do the job.

In not being able to provide services in Punjabi, the most commonly spoken language among the South Asian population in Vancouver (see Appendix E), the Cross Cultural Clinic is unable to adequately provide services to the South Asian population in the area. Several other service providers had pointed to this lack of culturally appropriate services for South Asian clients as a major barrier towards service access. The South Team receives a large number of South Asian clients, however, the case managers at the clinic struggle to accommodate the needs of those clients. Jennifer Glasgow, a senior mental health worker at the South Team, explains:

You know, I think that for individuals that are newer to Canada, our mental health system works quite a bit differently than India or other places in South Asia that they may have come from. So, our way of treating things sometimes doesn't fit also with their kind of world view and that also makes it difficult for them to comply and see things the way that we see them. Although we wouldn't necessarily assume that they would see things through a North American lens, I think it behoves us to try and look at it through their lens as well.

Another case manager at the clinic, Katerine Ingham, revealed the difficulties she faces when speaking to clients of various cultural backgrounds:

If we're looking at doing like therapeutic interventions such as CBT or rational motive behavioural therapy we need to know more about, like me being white, I need to know more about the culture, I need to know what is acceptable what's not acceptable and like I need more education.

She goes on to provide an example of how this lack of cultural understanding creates difficulties when trying to empathize with the family situation of a South Asian client:

I am struggling so much with her relationship with her ex-husband. I don't get it, and I don't get her dedication to her children, this is a huge piece of my understanding that is lacking. It's not just an intellectual understanding but it's kind of like a heart understanding. Like it's, I have a lot of trouble kind of being on side with it. And I would really like to know how to support her better and it irritates me no end that I don't know how to.

These poignant remarks clearly demonstrate the need for culturally appropriate mental health services, both from the perspective of the clients and the service providers who may require a greater understanding of certain cultural values prior to providing treatment.

#### **4.2.6. Summary**

The perceptions of the professional stakeholders with respect to the reasons underlying the underutilization of mental health services among South Asian women are consistent with the views of South Asian women with experiences with the mental health systems (see section 2.8.1). Stigma, lack of awareness, time and family obligations, and language barriers were commonly cited by interviewees as the reasons behind mental health service underutilization among South Asian women with depression, and these are consistent with the major themes found in qualitative studies on the subject which seek to highlight the perceptions of South Asian women. However, the majority of the stakeholders perceived many of the underlying reasons behind service underutilization in the South Asian community to be exacerbated by deficiencies in service provision in Vancouver. The interviewees highlighted the need for a greater understanding and respect for the South Asian cultural context in mental health service provision. The next section will outline a set of policy options based on the themes which emerged from the professional stakeholder interviews.

## **5. Policy Options**

This section will outline three distinct policy options designed to increase mental health service utilization among South Asian women with depression in Vancouver. The options are derived from the perceived reasons behind the problem as outlined by the existing literature on the subject and by the professional stakeholder interviews. The stakeholders were also asked for their opinions on what they perceived to be practical policy interventions that would address the problem. Those insights are also used to derive the following policy options.

### **5.1. Local Media Campaign and Information Session**

Lack of awareness about the symptoms and treatments options for depression is identified as a key barrier towards mental health service access among South Asian women by the professionals stakeholders interviewed for this study and other studies that have gathered the perspectives of South Asian women (Li and Browne 2000; & Ahmad et al, 2005). A local media campaign and annual community would addresses these awareness issues. This option would entail a carefully designed local media campaign aimed at increasing awareness of the symptoms of mental illness and treatment options that are available within the city of Vancouver, and the provision of annual information sessions for the South Asian community. The media campaign would entail monthly local South Asian radio and television program appearances and ads in local Punjabi, Hindi and Urdu newspapers as well as brochures written in Punjabi, Hindi and Urdu that can be distributed by family doctors and community health centres in the South Vancouver Area.<sup>28</sup> These sessions should be augmented with annual information sessions where members of the South Asian community can actively participate in the

<sup>28</sup> The largest proportion of South Asian residents of Vancouver live in the South Vancouver area (see Appendix C).

learning process through question and answer and discussion periods. In order to incentivize attendance the sessions should be hosted in a banquet hall with catering. It is also vital that the information is presented by a health care professional from the South Asian community in order to give the information legitimacy.

A cost effective way to deliver this option would be through partnerships with an existing organization that currently conducts outreach in the South Asian community. The Mood Disorder Association of BC (MDS) currently conducts outreach through media and offers annual information sessions in the Fraser Valley area. Vancouver Coastal health may wish to partner with MDS in order to deliver information sessions in the Vancouver area and include information about treatment options in the Vancouver area during media appearances.

## **5.2. Cross Cultural Mental Health Seminars**

The public awareness campaign addresses the need for greater awareness of mental health within the South Asian community. There is, however, also a need for increased awareness about the provision of culturally appropriate services within the health care community in Vancouver. Many of the stakeholders interviewed identified a need for a greater awareness around the provision of cross cultural mental health services among primary care physicians, case workers, counsellors, psychiatrists and medical students. Cultural empathy was also identified as a key theme in other qualitative studies gathering the perceptions of South Asian women (Johnson, 1992; & Li & Browne 2000). A policy intervention which will help address the need is a dedicated annual cross cultural mental health seminar for primary care physicians, students and other interested parties, funded and organized by the Cross Cultural Mental Health Program in conjunction with other interested organizations.

This option builds on the success of the annual Cross Cultural Mental Health conferences held in by the Vancouver Coastal Health, Fraser Health, Provincial Health Services in partnership with Immigrant Settlement Services of BC and S.U.C.C.E.S.S. Held annually, the conference works to facilitate dialogue about the practices of Cross Cultural Mental Health and is open to front line workers, mental health practitioners and

students. According to Dr. Soma Ganesan, one of the co-chairs of the conference, more than 200 people attend the conferences every year.

In spite of this effort there remains a perception that knowledge of cross cultural mental health is lacking among health care professionals. Lack of cultural understanding among health care professionals can cause a variety of issues when providing treatment to minority populations. These include: incomplete assessments, incorrect diagnosis, and inadequate or inappropriate treatment (Kirmnayer et al, 2003). For this reason, it is imperative to continue the education process by offering annual seminars which seek to share the latest research and developments in cross cultural mental health. Smaller localized seminars allow organizers to focus on mental health issues in a specific ethnic community. For example, a workshop held in the South Vancouver area, would focus mental health issues in the South Asian community. This would facilitate dialogue about common mental health issues in the South Asian community, and encourage greater cultural understanding among health care professionals in the area. Greater cultural understanding is the best way to erase the perception among the South Asian community that mental health services are not sensitive to their cultural beliefs, and thus will increase utilization rates among South Asian women. The professional stakeholders interviewed for this study reveal the following subject areas for a cross cultural mental health seminar.

- Family dynamics in various South Asian cultures.
- The stigma of mental health in the South Asian community.
- Effective use of interpreters.
- General issues surrounding mental health service use among South Asian people (awareness, confidentiality concerns, and language barriers)
- Education and awareness about depression symptoms and treatment options.

It may be the case that health care professionals may not be able to attend a three to six hour workshop due to time constraints. In this situation the workshops can be provided through web conferencing or “webinars.” Web seminars are a cost effective method of workshop delivery while maintaining the quality, value and relevance of traditional seminars (Buxton et al, 2012). In order to incentivize attendance to seminar should strive to receive accreditation by the College of Family Physicians and Surgeons

Canada, in order to provide MAINPRO (maintenance of proficiency) Credits for attendees.<sup>29</sup>

Similar seminars have been used with success in other jurisdictions to train and support GPs in the provision of mental health care services. Local health care authorities in Victoria, Australia provided such workshops through the Better Outcomes in Mental Health Care initiative. The initiative entails day long (6 hours) workshops which cover mental health assessment and management planning. The effectiveness of these workshops were evaluated in 2007 through pre and six week post questionnaires measuring the attitudes and practices with regards to mental health treatment. The results show an increase in the use of psycho-education for patients with depression, use of CBT for patients with anxiety and better ease in receiving advice for management of psychosis. The researchers suggest the success of the initiative points to the need for GP mental health education which takes into account the local context, deals with systemic issues as well as skills development, and facilitates positive dialogue and relationships building between GPs and mental health professionals (Hodgins et al, 2007).

### **5.3. The Provision of Group Psychotherapy Services in Predominant South Asian Languages.**

Another prevailing issue that was mentioned frequently by the stakeholders interviewed for this study is the dearth of culturally appropriate mental health services for the South Asian community in Vancouver. Culturally appropriate service provision entails accounting for and respecting cultural differences in language, beliefs, values, attitudes towards treatment, and expressions of symptoms (Bhui et al, 2007). The lack of group or individual services specifically geared to the South Asian community in Vancouver suggests that many South Asian women in Vancouver are not receiving services in a culturally appropriate manner. This is seen as a major barrier towards the utilization of mental health services among South Asian women (see section 4.2.5).

<sup>29</sup> The College of Family Physicians and Surgeons of Canada requires physicians to complete a certain amount of MAINPRO (maintenance of proficiency) credits each year to retain licence to practice. See: <http://www.cfpc.ca/MAINPRO/>

This issue can be addressed through the provision of individual counselling and group psychotherapy sessions in a manner that is culturally appropriate for the South Asian community. While a large proportion of patients with depression are treated in primary care, several professional stakeholders interviewed have noted that individual and group psychotherapy can be highly effective in managing depression and anxiety. This is supported by the academic scholarship on the efficacy of group psychotherapy for managing depression (Baines et al, 2004; McDermut et al, 2001; & Payne and Marcus, 2008).

In order to accomplish this task, the Vancouver Coastal Health Authority should strive to organize group psychotherapy sessions for South Asian women with depression in conjunction with community agencies such as Mosaic and S.U.C.C.E.S.S, as well as other prominent cultural and religious groups within the South Asian community in Vancouver. These group sessions should be offered in the most commonly spoken South Asian languages in Vancouver (see Appendix E), and be run by Psychiatrists and/or case workers with the appropriate language skills and experience providing culturally appropriate services to the South Asian community. To the extent possible these sessions should take into account the work and family obligations of South Asian women in order to schedule sessions at times that are suited to the community. Working with community organizations will help organizers schedule sessions at optimal times and in the appropriate geographical settings, by allowing organizers to schedule sessions at times and in locations that suit the needs of the community. Ideally, two sets of 12 week group sessions should be provided in order to provide effective acute treatment of depression (Agnes et al, 2002).

The Mood Disorder Association of BC currently funds weekly group psychotherapy sessions in the Fraser Valley area. The funding is provided for two sets of groups which meet weekly for twelve weeks. In order to control costs, Vancouver Coastal Health may choose to contract MDA to deliver the sessions in the Vancouver area. However, it is imperative that the service provision practices of MDA be thoroughly reviewed in order to ensure that the sessions meet reasonable quality of care and effectiveness standards.

## 6. Criteria and Measures

In order to ensure the optimal use of resources it is vital to evaluate policies based on their feasibility and likelihood of success (Funk & Freeman, 2011). The following table outlines the criteria used to evaluate the proposed policy options. Each criterion has a corresponding measurement tool used to measure the policy options against each criterion. These set of criteria and measures are designed to provide a basis for the evaluation of each proposed policy option, based on their feasibility and efficacy in increasing utilization rates among South Asian women (Funk & Freeman, 2011). Each criterion and corresponding measure is defined in table 7.

**Table 8. Criteria and Measures**

Criterion	Definition	Measure
Cost	The projected capital and annual operational cost of the policy option to the Vancouver Coastal Health Authority.	<ul style="list-style-type: none"> <li>• High: Under \$20,000 in annual operating costs</li> <li>• Medium: Between \$20 000 and \$40 000 in annual operating costs</li> <li>• Low: Over \$40 000 in annual operating costs.</li> </ul>
Effectiveness	The degree to which the policy is able to increase service utilization.	<ul style="list-style-type: none"> <li>• High: Large increase in utilization rates.</li> <li>• Medium: Moderate increase in utilization rates.</li> <li>• Low: Small increase in utilization rates.</li> </ul>
Equity	Vertical Equity: The degree to which the policy option is likely to disproportionately impact South Asian women of different socio-economic backgrounds.	<ul style="list-style-type: none"> <li>• High: The option has equal impact on all South Asian women regardless of socioeconomic status.</li> <li>• Medium: The option affects most South Asian women equally.</li> <li>• Low: The option impacts a certain segment of the South Asian population at the expense of others.</li> </ul>
Ease of Implementation	The level of institutional complexity involved with implementing the policy.	<ul style="list-style-type: none"> <li>• High: The option can be implemented with relative ease.</li> <li>• Medium: There are slight complexities involved with implementation.</li> <li>• Low: The policy is likely to be fairly complex to implement.</li> </ul>

## 6.1. Effectiveness

Typically, quality adjusted life years (QUALYs) are used as the measure of health outcomes in cost-effectiveness analysis. QUALYs measure the number and quality of years added by the medical intervention (National Institute for Health and Clinical Excellence, 2010). Evidence suggests that pharmacological and therapeutic treatments for depression are likely to be highly effective in improving QUALYs (Kessler et al, 2003). However, it is not possible to measure the potential impact of each policy option on QUALYs (this endeavour would require a placebo controlled clinical study of the impact of each treatment option on the patients). Thus, for the purposes of this analysis, effectiveness will be measured by the expected increases in mental health service utilization as a result of each policy option, under the assumption that the additional treatments represent increased QUALYs for patients.

## 6.2. Costs

The projected costs of the policy interventions are an important evaluative criterion in the analysis of policy options, as it assesses the financial viability of each intervention. The cost measures are split into three categories based on the average annual expenditures on mental health in BC. It is estimated that public expenditures on mental health treatment is \$308<sup>30</sup> per person (Jacobs et al, 2008). The cost measure for this study was derived under the assumption that spending on education, awareness and acute treatment for depression should be approximately 10%<sup>31</sup> of total spending on mental health treatment. A policy intervention with costs above 10% of total public expenditures on mental health is deemed high, and costs below 10% are considered low. Using the estimated 12 month prevalence rates for depression among South Asian women (see section 2.6.2), it is estimated that the costs for mental health awareness to the South Asian female population at 10% of the total expenditures on treatment is

<sup>30</sup> The figures estimated by Jacobs et, al (2008) is \$258 in 2003 dollars. The \$308 is adjusted for inflation using the Bank of Canada CPI calculator.

<sup>31</sup> While it has been demonstrated that community awareness is an important component of treatment provision (Grewal et al, 2004), the optimal amount of spending on awareness is poorly understood.

between \$20 000 and \$40 000. Thus any interventions with costs between \$20 000 and \$40 000 is considered “medium”; below \$20 000 is considered “low”; and above \$40 000 is considered “high”.

### **6.3. Equity**

In health economics a distinction is made between vertical and horizontal equity. Horizontal equity refers to the equitable treatment of those who are the same in certain respects (such as the having the same health care needs) and vertical equity refers to equitable treatment of those who are different in certain respects (such as having different health care needs) (Culyer, 1995). Culyer defines health need as the “minimum amount of resources required to exhaust a person’s capacity to benefit,” (1995, 728). In other words; horizontal and vertical equity distinguish between an individual’s need for treatment. Horizontal equity refers to equitable treatment of people with the same need for treatment and vertical equity refers to equitable treatment of people with different needs for treatment.

In this case, the policy interventions will have the largest impact on the South Asian female population with depression. It may be presumed that this segment has the same need for treatment (management and alleviation of depressive symptoms). Thus the equity criterion will deal with horizontal equity by assessing the ability of each policy option to reach each segment of the South Asian female population equally (i.e. equitable treatment of people regardless of socioeconomic status, immigration status, language ability, and social capital). The principle question asked when using this criterion is: will this policy disproportionately impact certain segments of the South Asian population at the expense of others (i.e. socioeconomic status or age)? In order to measure this, the interview data and academic literature will be used to surmise the likelihood that the policy will be more effective at increasing mental health service utilization among a certain segment of the population.

## **6.4. Ease of Implementation**

The ease of implementation criterion is used to assess the level of complexity involved in implementing each policy option. Governments often deal with large mandates with limited resources. Thus, those policies which place an unnecessarily high burden on resources are less attractive options than those which use health resources more efficiently (Funk & Freeman, 2011). Each policy option proposed in this paper will be evaluated based on the level of complexity associated with implementation based on the amount of labour and time involved with implementation. The standards used to assess a policy's level of complexity are: the amount of human resources required, the amount of time required, and the amount of preparation work required before each option can be implemented.

## 7. Policy Analysis

### 7.1. Policy Analysis Matrix

The following chart will outline how each policy option ranks against the criteria. Each policy is given a score between 1 and 3 for each criterion. A discussion of how each score was derived will follow in the next subsection.

**Table 9. Policy Analysis Matrix**

	Costs	Effectiveness	Equity	Ease of Implementation	Total Score /12
Local Media Campaign and Annual Information Sessions	3	1	2	3	9
Cross Cultural Mental Health Seminar	3	2	2	2	9
Provision of Culturally Appropriate Group Psychotherapy Services.	2	2	2	3	9

### 7.2. Local Media Campaign and Information Sessions

#### 7.2.1. Cost

The cost associated with educational outreach through local media and information sessions are projected to be below \$20 000 annually. Advertising in local South Asian media outlets is relatively inexpensive, and many South Asian radio and television producers welcome professionals from various disciplines to speak on their programs.

In order to control costs, Vancouver Coastal Health may wish to partner with The Mood Disorder Society of BC which has an existing media campaign aimed at creating awareness of in the South Asian community and delivers annual information sessions in the Fraser Valley area. Partnering with MDC would save the administrative costs associated with designing and implementing the outreach campaign. According to Dr. Rajpal Singh, the psychiatrist who heads the awareness campaign at MDS, a complete education campaign with two information session a year and regular media appearances costs roughly \$6000 annually. This amount would suffice to rent a suitable space and cater the information sessions, as well as advertising and media appearances. The costs for staffing would not be an issue since the media appearances and information sessions are currently carried out by a group of volunteers.

### **7.2.2. Effectiveness**

This option is likely to have only a small impact on the awareness of mental health disorders and treatment options among the South Asian community in Vancouver. In the absence of culturally appropriate services for South Asian women awareness campaigns can only be expected to have a small impact on increasing utilization rates. Though evidence from other jurisdictions (Meadows and Foxwell 2011 & Kifton, 2012) would suggest that a local media campaigns are effective in challenging the stigma of mental health and encouraging service use among visible minority populations, awareness does not address the issue of lack of culturally appropriate services in Vancouver. For this reason some women may continue to be reluctant to access services due to the perception that such service providers will not be sensitive to their cultural beliefs and values. Evidence from the South Asian PAP Test Clinic reveals that the provision of culturally appropriate service is an important factor in increasing service utilization (Grewal, 2004). Thus, a media campaign without the provision of culturally appropriate services will only be moderately effective in improving utilization rates among South Asian women in Vancouver. The evidence cited above is reviewed below.

Evidence of the effectiveness of mental health awareness initiatives on local community radio and television broadcasts has shown that awareness campaigns lead to a better understanding of the symptoms associated with various mental illnesses and the treatments available to manage mental illness among visible minority populations

(Meadows and Foxwell 2011 & Kifton, 2012). In a review of the effects of local mental health media campaigns on Indigenous populations in Australia, Meadows and Foxwell (2011) found that Indigenous radio and television sectors play a positive role in managing community mental health by creating awareness about the ways in which individuals can better understand and control the issues that impact their mental health (Meadows and Foxwell, 2011).

Kifton (2012) examined the effectiveness of national mental health awareness campaigns on minority groups in Scotland. Through focus group discussion, Kifton finds that minority groups have not responded to national media campaigns due to use of language, images, media and assumptions of western medial concepts of illness that are not identifiable by minority groups (Knifton, 2012). These two studies point to the ineffectiveness of national media campaigns on increasing awareness among minority groups and the effectiveness of localized media campaigns which encompass the language, beliefs and values of the targeted minority communities.

Though the above mentioned studies shed light effectiveness of public awareness campaigns, an interesting case study from Vancouver suggests that the effectiveness of media campaigns on service utilization is dependent on the provision of culturally appropriate services. The South Asian PAP Test Clinic in Vancouver was developed to provide culturally appropriate cervical cancer and PAP testing for South Asian women.<sup>32</sup> The clinic was launched in conjunction with a local media campaign in which doctors from the clinic appeared on local South Asian television and radio programs. The clinic saw steady increases in utilization in the initial five years of operation, but rates declined sharply in the year after the awareness campaign was disbanded and have since leveled off. Clinic organizers cite lack of community engagement as the reason behind this decline in utilization. However, the increases in PAP and Cervical cancer test utilization is directly associated with the provision of the clinic itself, this is evidenced by the fact that utilization rates have leveled off since the

<sup>32</sup> The South Asian PAP Test Clinic will be discussed in more detail in section 7.4.2, with respect to its use in increasing cervical cancer and PAP test utilization rates among South Asian women.

initial decline after the awareness campaign was disbanded. Organisers cite community networking as a crucial aspect of sustained utilization rates (Grewal et al, 2004).

### **7.2.3. Equity**

Though the media campaign would be designed in a manner that allows South Asian audiences to associate with the message, there is always a danger that public health awareness campaigns fail to reach certain segments of the population. Individuals with lower levels of education may not be able to fully understand the messages behind the awareness campaign. Dr. Ganesan points notes that it is often the case that public awareness campaigns tend to reach those with higher levels of education with greater frequency than those with lower levels of education (see section 4.2.2).

Though there are no published studies which confirm this effect, Meadows and Foxwell (2011) find that local media programmes do on occasions stir up political and social cleavages within local communities. For example, focus group discussions revealed that many in the Sudanese community did not engage in local media because the political stance of certain programs on that country's North South conflict (Meadow & Foxwell, 2011).

Though it is unclear if such issues arise in local South Asian media in BC, Murray (2008) finds that substantial portion of local Punjabi media content in BC focuses on local and international issues concerning the Punjabi community, with very little National, Provincial and Global content outside the context of the community (Murray, 2008). This may alienate individuals in the community that prefer less localized content. For these reasons, the local media campaign and information sessions rank "medium" for the equity criteria.

### **7.2.4. Ease of Implementation**

The implementation of a local media campaign will entail the identification and careful articulation of specific pieces of information that need to be conveyed. It will also require regular consultations with local South Asian media outlets in order to organize the campaign around appearance on local television and radio programs. However, VCH

has the resources in house to accomplish these tasks with relative ease. South Asian media outlets have been accessible to VCH staff in the past, and at least one staff member, Dr. Shimi Kang, regularly appears on a local South Asian radio program on RED fm. Though, this policy option does require some organizational and time commitments on the part of existing VCH staff, it will not require the outsourcing or hiring additional staff. Further, the information sessions can be outsourced to the Mood Disorder Association of BC, which has demonstrated the administrative capacity to do so though the provision of similar sessions in the Fraser Valley area. Thus, the option is ranked as “high” for ease of implementation.

### **7.3. Cross Cultural Mental Health Workshops**

#### **7.3.1. Cost**

The cost implications of annual workshops for primary care physicians and mental health professionals are moderate. In most circumstances the costs for the conferences, seminars and workshops are associated with remuneration of the conference organizers, venue, catering, speaker fees and promotional materials. Based on the cost-estimates below, a one day seminar with approximately 100 attendees<sup>33</sup> is projected to cost approximately \$26, 170 annually, however, \$18 000 can be recouped through an \$180 attendance fee. Thus this option ranks as high for the cost criterion.

<sup>33</sup> 100 attendees would be half the size of the Cross Cultural Mental Health Conference.

**Table 10. Projected Cost of Cross Cultural Mental Health Seminar**

Item	Costs
Venue Rental	\$1,000 <sup>34</sup>
Catering	\$ 6,650 <sup>35</sup>
Staff Remuneration	\$ 16,800 <sup>36</sup>
Speaker Remuneration	\$ 1,500 <sup>37</sup>
Marketing Materials	\$ 220 <sup>38</sup>
Attendance Fee	-\$18,000 <sup>39</sup>
Total	\$8,170

### **7.3.2. Effectiveness**

There is evidence to suggest that cultural competence among health care professionals is associated with an increase in perceived multicultural treatment competence, communication, and cultural empathy among service providers (Bhui et al, 2007; Smith & Constantine, 2006; & Constantine, 2000). Improved treatment quality provided in a culturally appropriate manner can increase utilization rates through a networking effect where patients inform their friends and family of the quality and cultural competency of the service (Grewal et al, 2004). However, in absence of community awareness efforts, service utilization will only increase marginally, as was the case with

<sup>34</sup> The rental costs for the Italian Cultural Centre where the previous Cross Cultural Mental Health Conference was held, costs include audio video equipment and set up costs.

<sup>35</sup> Cost for catering provided by the Italian Cultural Centre. The Cost for the breakfast buffet is 27.50 and lunch buffet is \$39.00 a head for an estimated 100 attendees (half that of the cross cultural mental health conference). <http://italianculturalcentre.ca/banquets-meetings/catering/>

<sup>36</sup> According to Service Canada The average salary for event planners earn \$17.50/hr for a conference/event planner in Canada ([http://www.lambton.on.ca/uploadedFiles/wwwLambton/Programs\\_and\\_Courses/Files/Occupational\\_Profiles/HATH%20-%201226%20Conference%20and%20Event%20Planners.pdf](http://www.lambton.on.ca/uploadedFiles/wwwLambton/Programs_and_Courses/Files/Occupational_Profiles/HATH%20-%201226%20Conference%20and%20Event%20Planners.pdf)). \$16, 800 is the rough costs for hiring a conference planner for a six month contract at \$17.50/hr

<sup>37</sup> Roughly half the costs of the speaker fees for the Cross Cultural Mental Health Conference.

<sup>38</sup> The costs per poster from Vista Print is \$7. The price per 25 brochures is \$20. The above costs include budget for 20 promotional posters and 100 brochures for the conference program.

<sup>39</sup> Based on average attendance fee of \$180 for the Cross Cultural Mental Health Conference and 100 projected attendees.

the South Asian PAP clinic after community outreach was phased out (Grewal et al, 2004). Thus, the workshops will empower primary care physicians and other health care providers to improve treatment competence and impart greater information of the symptoms and treatments available to their patients, and this may have a networking effect which increases utilization, however, this effect will only be moderate due to the limited community outreach. In other words, through this policy, GPs will be better equipped to help South Asian women manage depression which may encourage more women to come forward, but it is not expected to result in a significant increases in mental health service utilization rates due to limited community outreach. In spite of this lack of outreach, moderate increases in utilization should be seen as a result of networking effects. For these reasons this options ranks at “medium” for the effectiveness criterion.

### **7.3.3. Equity**

Improved primary care treatment for depression and other mental illness will benefit every segment of the South Asian community that has access to primary care doctors that have received seminar training. A review of the BC College of Physicians and Surgeons website reveals several GPs with the appropriate language skills to treat the South Asian population, and many of these doctors are accepting new patients. In total there are fourteen female physicians with Punjabi or Hindi language skills. These GPs are located in various locations in Vancouver, but the majority have offices in the South Vancouver area, where the largest portion of the South Asian population in Vancouver resides (see Appendix C).

Further, the vast majority of Canadians have access to primary health care. A recent national survey conducted by statistics Canada on behalf of the Canadian Institute for Health Information<sup>40</sup>, found 85% of the population aged 12 and over have access to a regular medical doctor and 91% have a regular place to go for primary care (Canadian Institute for Health Information, 2009).

<sup>40</sup> The survey randomly sampled 11,582 adults, but did not include residents of First Nations Reserves and Crown Land, full time members of the Canadian forces, inmates of institutions and residents of isolated areas.

Canadian research has also shown that immigrant populations have equal access to primary care. Using the Comparison of Models of Primary Care Study,<sup>41</sup> Muggah et al (2012) find that overall immigrant respondents reported equal access to primary care services compared to Canadian born respondents.

Though access to primary health care is fairly widespread, inequities in access continue to be found. Muggah et al (2012) find recent immigrants that use fee-for-service clinics reported poorer access to primary care. Moreover, the Provincial Services Health Authority in BC reports barriers to primary care access among recent immigrants and refugee populations in BC (Provincial Services Health Authority, 2011).

To sum, access to primary care physicians is not an issue for many Canadians, however, certain segments of the population do experience difficulties accessing primary care. For these reasons this option ranks medium for the equity criterion.

#### **7.3.4. *Ease of Implementation***

The organization of training workshops require considerable amounts of work for organizers. Broadly speaking, conference planning requires the following tasks: site selection, identifying conference theme and program (selecting guest speakers and conference topics), equipment procurement, catering, promotion and design of a registration mechanism (Kuhr & Jensen, 1993). Typically, conferences are organized by full time or part time staff dedicated to conference planning, or through external conference planning companies (Khur & Jensen, 1993).

Regardless of which approach is used by VCH, conference planning and implementation will require a substantial amount of resources. Hiring part time or full time staff would drain financial resources through remuneration of planning staff. If conference planning is outsourced, resources will need to be put into tendering a contract with a conference planning company. In order to find an appropriate company, Vancouver Coastal would need to annually review proposals by firms and ensure the

<sup>41</sup> The Comparison of Models of Primary Care Study is a cross sectional study which collected information from patients and providers of 137 primary care practices in Ontario between 2005-2006.

event is being provided in a cost effective manner. For these reasons this policy option ranks as “medium” for ease of implementation.

#### **7.4. Provision of Culturally Appropriate Group Psychotherapy Sessions for the South Asian community.**

##### **7.4.1. Cost**

The costs associated with the provision of group psychotherapy sessions for the South Asian community are moderate. The Mood Disorder Association of BC currently provides two sets of weekly group sessions in Punjabi in the Fraser Valley area. According to Dr. Rajpal Singh, the association spends approximately \$10 000-\$12 000 annually to hold the sessions. This includes staff remuneration and space procurement for the sessions. If VCH were to provide the service through in house resources, the sessions would cost roughly \$30 000 annually for staff remuneration and materials.<sup>42</sup> In this scenario the cost of the service is between \$20 000 and \$40 000, and thus ranks as “medium” for the cost criterion.

##### **7.4.2. Effectiveness**

Though the provision of culturally appropriate group psychotherapy services is essential to increase awareness and legitimacy of mental health treatment options within the South Asian community, in absence of any community outreach these services will not have a significant impact on service utilization rates among South Asian women. Evidence of this is found in the challenges faced by the South Asian Pap Test Clinic in Vancouver. This clinic was organized to provide monthly cervical cancer screenings for South Asian women in Vancouver. The launch of the clinic was coupled with a community awareness campaign which included local media appearances and presentation’s to local community groups. These efforts proved fruitful as utilization of

<sup>42</sup> These costs projections were provided by Jennifer Glasgow, senior mental health worker at the South Mental Health team. Estimates include the remuneration of two mental health workers for 12 weeks at \$40/hr and an additional \$2000 for materials.

the clinic rose from 61 visits in 1995 (the year of the clinic's inception) to 235 in 1999. However, rates began to fall in the year 2000 when, among other changes, the clinic's community outreach committee was disbanded and community outreach efforts were drastically decreased. Since then the clinic has struggled to maintain involvement with community groups in order to increase community awareness of cervical cancer. Though clinic utilization rates have stabilized they have not increased at the rate seen between 1995 and 1999 (Grewal et al, 2004). The experience of the South Asian Pap Test Clinic reveals the necessities of community outreach in addition to the provision of cultural appropriate medical services in order to realize significant increases in utilization rates among target populations.

The provision of culturally appropriate services to ethnic communities, do however, increase utilization through networking effects within target communities. If the services are effective, the users will serve as ambassadors for the service by promoting the service among friends and family (Grewal et al, 2004). This effect is likely to occur with the provision of culturally appropriate psychotherapy services due to the efficacy of the approach in reducing symptoms of depression. The efficacy of group psychotherapy in helping patients manage the symptoms of depression has been demonstrated in various studies (Baines et al, 2004; McDermut et al, 2001; Payne and Marcus, 2008). McDermut et al conducted a meta-analysis of forty-eight studies which tested the efficacy of group psychotherapy sessions in reducing depressive symptoms of test patients. Forty-five of the forty-eight studies analyzed concluded that group psychotherapy was effective at reducing symptoms of depression. Forty-three of these studies showed statistically significant decreases in depressive symptoms. The researchers also compared mean pre and post treatment BDI<sup>43</sup> scores among the fourteen studies that measured depressive symptoms with the BDI. This comparison revealed a decrease in mean BDI scores from pre to post treatment. More specifically, mean BDI scores during the pre treatment period were in the moderate depression range, and these scores fell in the mild depression range after group psychotherapy treatment (McDermut et al, 2001).

<sup>43</sup> The Beck Depressive Inventory (BDI) is a widely used self reported questionnaires which measures the severity of depressive symptoms.

Evidence also suggests that group psychotherapy sessions are as efficacious as individual therapy. McRoberts et al (1998) demonstrated no difference in outcomes between group and individual therapies through a meta analysis of twenty-three studies which compared the effectiveness of group and individual therapy (McRoberts et al, 1998).

Overall, the provision of culturally appropriate services will only be moderately effective in increasing mental health service utilization rates among the South Asian population unless a concerted effort to increase community awareness is pursued.

### **7.4.3. Equity**

The provision group therapy sessions will be available to those that require the service, regardless of socioeconomic status or other such barriers. However, the sessions will only benefit those in the community that are made aware of the service through media campaigns, information sessions, community networking and or referral by their doctors. It is possible that some South Asian women in need of treatment will not be made aware of the service through the above mentioned channels. The experience of the South Asian PAP test clinic suggests that service support by family physicians is a crucial aspect of raising awareness about culturally appropriate services for South Asian women<sup>44</sup>. If family physicians are not informed about the service, or fail to inform their patients about the service for other reasons, some South Asian women may not be informed about the service (Grewal et al, 2004). This lack of awareness is heightened in refugee and recent immigrant populations which experiences difficulties accessing health services in BC (Provincial Services Health Authority, 2011). Thus, this policy option is ranked as medium for the equity criterion.

<sup>44</sup> The importance of family physician support for services is associated with the high levels of respect of physician advice that is seen in the South Asian community (Grewal et al, 2004)

#### **7.4.4. Ease of Implementation**

VCH possess the staff with the knowledge and ability to run culturally appropriate group therapy sessions for the South Asian community.<sup>45</sup> This suggests that this policy option can be implemented with relative ease. Organizers will need to schedule appropriate times for the sessions based on staff, participant and location availability, and ensure that community organizations, primary care physicians and other health care professionals are aware of the program. It is estimated that organizers would need ten hours to prepare for the sessions prior to delivering the two hour sessions. This would amount to a total fourteen hours of work a week for approximately 24 weeks.<sup>46</sup> However, Jennifer Glasgow of the South Mental Health Team confirmed that the provision of the service is well within the capacity of South Team and additional staff would not need to be hired. For these reasons, this policy option is ranked high for ease of implementation.

<sup>45</sup> Jennifer Glasgow of the South Mental Health team confirmed that at least two caseworkers from the Team possess the relevant knowledge and expertise to provide culturally appropriate psychotherapy services for the South Asian community.

<sup>46</sup> These estimates are based on projections from Jennifer Glasgow of the South Mental Health Team.

## 8. Recommendation

Based on the analysis of the policy options it is recommended that the Vancouver Coastal Health Authority implement all three policy interventions derived in this report: a local media campaign, cross cultural mental health seminars, and culturally appropriate group psychotherapy sessions for the South Asian community. When ranked against the each of the four criterion established for analysis (cost, effectiveness, equity and ease of implementation) all three policy options receive similar total scores. The similarity in total scores suggests that no single policy option stands out as a more attractive option than the other. While each option will likely have positive impacts on mental health service utilization rates among South Asian women, the overall impact on utilization rates will be greatest if all three options are implemented. The underlying causes behind the problem are extremely complex, and no single policy intervention on its own can fully address the issue. For this reason, it is recommended that all three options be implemented in order to effectively address the myriad of issues preventing many South Asian women from utilizing mental health services.

The costs and administrative complexity associated with the implementation of the policy options identified in this report will undoubtedly be an issue moving forward. It does stand to reason however, that a significant investment in mental health treatment is warranted. The annual societal costs associated with untreated depression in terms of lost DALYs, lost productivity and inter general impacts are staggering (see section 2.2). It is estimated that the total costs due to lost wages caused by depression among South Asian women in the labour force in Vancouver is \$2.6 million a year. The present value of these costs (at a 3% discount rate) over a twenty year working period is roughly \$40 million. These costs are well above the estimated annual investment of around \$50 000 to address the issue through implementation of the proposed policy options.

## 9. Limitations

A major limitation of this study surrounds the recruiting of stakeholder for participation. In total only nine stakeholders participated in the research. Though these stakeholders provided valuable insights based on their work with South Asian women, the perspectives of these stakeholders may not be representative of all professional stakeholders interested in the issue. Key stakeholders that were not included in the study due to time constraints are GPs and central intake workers. GPs provide primary care for patients and thus are in many cases treating South Asian women with depression. Central intake workers assess and screen people who call a central intake line in order to refer them to the appropriate treatment services. It is recommended that future research on service utilization among South Asian women include these professional stakeholder groups.

The use of semi-structured interviews and thematic analysis also carry certain methodological problems which may impact the validity of the findings. The use of these research approaches carry the risk of conscious and un-conscious bias that influences both the interview questions and the responses provided by the participants. In designing the research questions and the corresponding interview questions that are designed to answer the research question; the researcher is influenced by his or her own theoretical position, interest and political perspectives (Diefenbach, 2009). In order to avoid this issue, the researcher in this study attempted to develop the interview schedule in a manner that did not reveal his position on the issue, however, it is entirely possible that such biases unconsciously impacted the design of the questions.

Similarly, the responses provided by the interview participants can be influenced by the interview situation. That is to say, the participant may provide responses that he or she believes the interviewer wants to hear, instead of objective answers to the questions (Diefenbach, 2009). In order to avoid this and improve the validity of the data the data was subject to members checking after completion. After the data analysis was

completed participants were contacted to reaffirm their views. This method is a commonly used approach to manage research bias and test the credibility of results (Cohen & Crabtree, 2008).

It is unclear the extent to which these methodological issues impacted the results of this study, however, these sampling and bias issues should be taken into account when assessing the validity and credibility of the study's results.

## **9.1. Recommendations for Future Research**

In order to develop a more robust understanding of mental health service utilization rates among South Asian women with depression in Vancouver, it is vital that researchers gain access to detailed empirical data on service utilization rates among South Asian women. The last attempt to empirically track mental health service utilization rates among ethnic minorities was in 1988. This information is vital in tracking the progress of any policy interventions designed to improve utilization rates. It will also allow researchers to apply regression analysis to determine important socioeconomic factors associated with service utilization among South Asian women.

Additionally, it is also recommended that the perspectives of South Asian women are included in future research on service utilization rates in the community. These perspectives are extremely important in developing a fuller understanding of mental health service underutilization and the policy interventions which may work to address the problem.

Though this research uses a feminist theoretical approach to understanding utilization rates among South Asian women, due to higher rates of depression among women, it is also imperative to examine utilization rates among South Asian men using a gendered approach. Other studies have shown that failure to embody masculine ideals may trigger symptoms of depression (Olliffe et al, 2010) and that diagnostic screening tools and current diagnostic criteria are not reflective of the way in which men

may experience depression<sup>47</sup> (Olfiffe & Phillips, 2008). Thus, future research should strive to understand how masculine identity in South Asian culture informs attitudes toward the symptoms and treatment of depression among South Asian men.

<sup>47</sup> Olfiffe et al (2008) point out that one of the diagnostic criteria for depression entails assessing personal feelings of inadequacy, which represents a feminine pattern of thinking as men are socialized to “act out” as opposed to inward reflection.

## 10. Conclusion

The overwhelming socioeconomic and health consequences of depression are well documented. Services for mental health treatment have been shown to be efficacious in the management of the symptoms of depression; however these services are underutilized by South Asian women in Vancouver. In order to understand the reasons behind this service underutilization, this study gathered stakeholder perspectives on the issues through semi structured interviews with nine mental health service providers and an immigrant settlement worker. A thematic analysis of the data revealed that stakeholders perceive stigma, lack of awareness, time and family obligations, language barriers, and lack of culturally appropriate services as the major reasons underlying mental health service underutilization among South Asian women in Vancouver with depression.

Based on this data the following policy options are proposed to address the problem: a local media campaign and information sessions, cross cultural mental health seminars, and the provisions of culturally appropriate group psychotherapy for South Asian women. These options were analyzed using the following criteria: costs, effectiveness, equity and ease of implementation. The analysis revealed no significant differences in total scores between each option, however the implementation of all three policy options would be most effective at address all facets of the problem (awareness, service provider training and cultural appropriateness).The final recommendation based on this research is the implementation of all three policy options. The research has shown that implementing the policy suite is a cost effective approach to addressing the issue.

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## **Appendices**

## Appendix A. Visible Minority Population in Vancouver

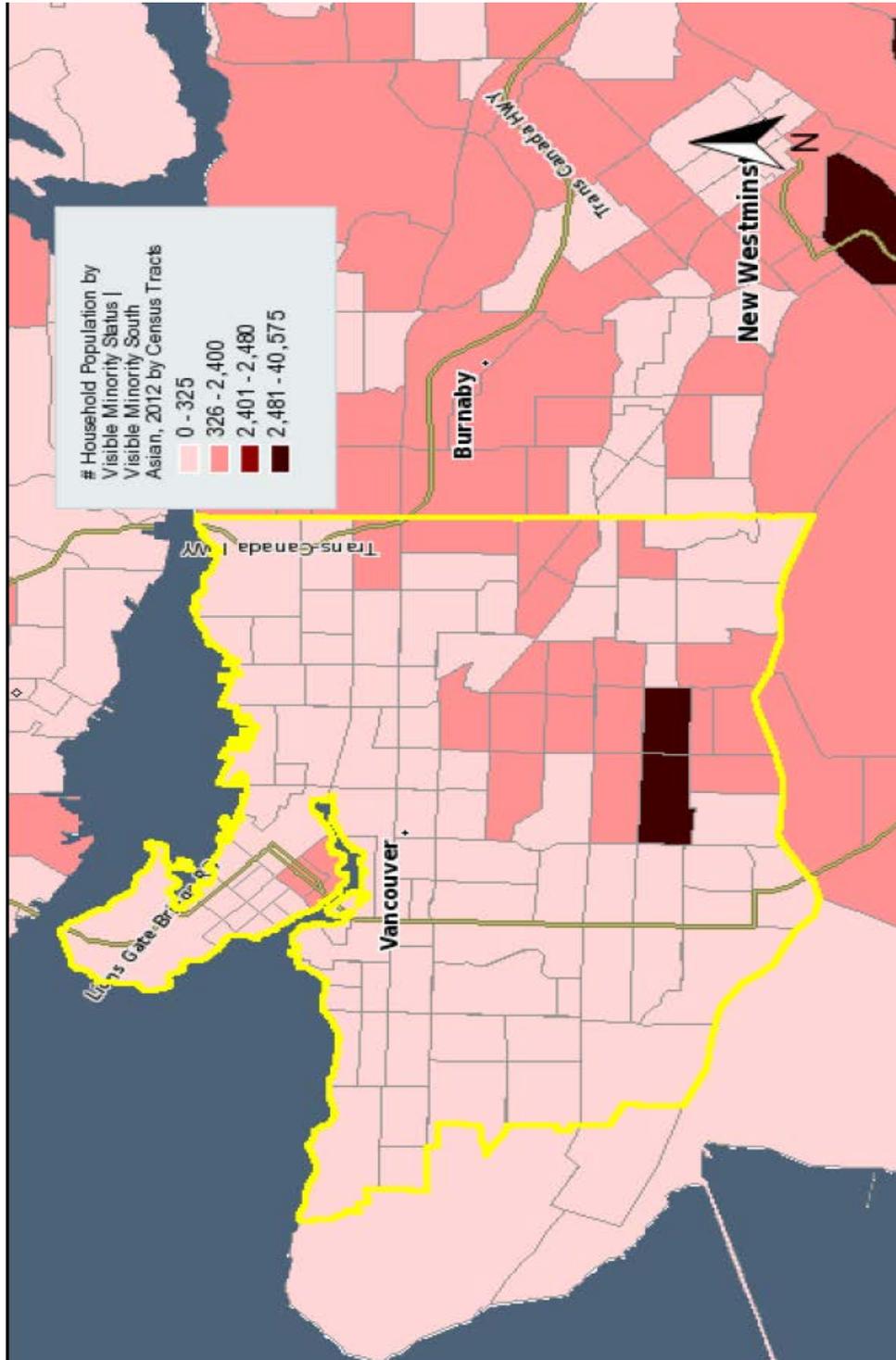
Visible Minority Groups	Population	Percentage of Total
Chinese	168,215	29%
South Asian	32,515	6%
Black	5,290	1%
Filipino	28,605	5%
Latin American	8,225	1%
Southeast Asian	14,850	3%
Arab	1,875	0%
West Asian	5,355	1%
Korean	8,780	2%
Japanese	9,730	2%
Visible Minority n.i.e. <sup>48</sup>	990	0%
Multiple Visible Minority	7,320	1%
Not a Visible Minority	279,860	49%

Source: Statistics Canada. 2007. Vancouver, British Columbia (Code5915022)

<sup>48</sup> Visible Minority Groups that are not included in any of the defined categories. i.e. Guyanese, Pacific Islander, Tibetan ect...



### Appendix C. Number of South Asian Households in the City of Vancouver by Census Tract



## Appendix D. List of Interview Participants

Participant	Organization	Interview Date
Dr. Rajpal Singh	Mood Disorder Association of BC/ Fraser Health	November 29, 2012
Samina Bashir	Mosaic BC	December 14, 2012
Dr. Soma Ganesan	Cross Cultural Clinic- Department of Psychiatry VGH.	January 17, 2013
Dr. Shimi Kang	Kitsilano Neighbourhood Health	January 22, 2013
Anonymous Private Counsellor		January 25, 2013
Katherine Ingham	South Mental Health Team	February 6, 2013
Jennifer Glasgow	South Mental Health Team	February 6, 2013
Nishi Bainpal	South Mental Health Team	February 6, 2013
Anonymous Case Worker		February 6, 2013

## **Appendix E. Interview Schedule**

### **Research Questions**

Why do some South Asian women that are experiencing depressive symptoms not seek treatment from the Vancouver Coastal Health Authority? And;

What measures can the Vancouver Coastal Health Authority take to encourage South Asian women with depressive symptoms to utilize mental health services?

### **Interview Questions**

Do you believe that South Asian women with depression are underutilizing mental health services in Vancouver?

Based on your experience working with South Asian women, why do you think South Asian women with depression might choose not to use mental health services?

Do you think that South Asian women are aware of the fact that Vancouver Coastal Health Authority offers cross-cultural mental health services?

How can the Vancouver Health Authority improve access to mental health services to South Asian women with depression?

Do you think there are other policy measures or initiatives that can be taken by Vancouver Coastal Health Authority to encourage South Asian women with depression to use mental health services?

## Appendix F. Lost DALYS by Cause in the Americas-2004

Cause	DALYs (millions)	Percent of Total
Unipolar Depressive Disorders	10.8	7.5
Violence	6.6	4.6
Ischaemic Heart Disease	6.5	4.6
Alcohol Use Disorder	4.8	3.4
Road Traffic Accidents	4.6	3.2
Diabetes Mellitus	4.1	2.9
Cerebrovascular Disease	4.0	2.8
Lower Respiratory Infections	3.6	2.5
COPD	3.1	2.2
Congenital Anomalies	2.9	2.1

Source: WHO. (2004). The Global Burden of Disease-2004 Update.

**Appendix G. Number Residents in Vancouver with non- English French or Aboriginal Mother Tongue (Top Ten Languages from 2011 Census)**

Language	Total	Male	Female
Cantonese	63220	29170	34055
Chinese; n.o.s	44880	20730	24150
Mandarin	23675	10715	12955
Tagalog	18805	7300	11505
Punjabi	15235	7485	7745
Vietnamese	10585	4985	5600
Spanish	10500	5230	5270
Korean	7825	3300	4525
Japanese	6730	2235	4495

Source: Statistics Canada. (2012). Vancouver Census Profile 2011 Census.

## Appendix H. VCH Research Ethics Approval



**W. Robert McMaster, D. Phil.**  
Vice President Research, Vancouver Coastal Health  
Executive Director, Vancouver Coastal Health Research Institute  
Associate Dean Research, Faculty of Medicine  
The University of British Columbia

February 1, 2013

Dr. Judith Sixsmith  
School of Public Policy  
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**Vancouver Coastal Health Authority Research Study #SFU2012s0919**

### **FINAL CERTIFICATE OF APPROVAL**

**TITLE:** Suffering in Silence: Understanding the Underutilization of Mental Health Services Among South Asian Women with Depression

**SPONSOR:** Unfunded

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This is to inform you that your project has been approved and can start immediately. Approval has been granted until **February 1, 2014** based on the following:

1. SFU Research Ethics Board Certificate of Approval #2012s0919 (Sandip Basi)
2. Vancouver Coastal Health approval