Emerging Research

Community in Distress: Mental Health Needs and Help-seeking in the Tamil Community in Toronto

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INTRODUCTION

According to the United Nations High Commissioner for Refugees (UNHCR), 20 million of the world's people are refugees, asylum seekers, refugees in the process of repatriation, or internally displaced. Although more than 150 United Nations' member countries have agreed to protect refugees, only 20 – led by the United States, Canada, Norway, and Sweden – offer permanent resettlement to refugees and asylum seekers. Canada's annual quota is approximately 20,000, about half of whom are people who have been accepted abroad in collaboration with UNHCR, the rest are people who have come to Canada, claimed refugee status, and had their claim upheld.

By definition, refugees have traumatic pre-migration and pre-settlement histories, and it is widely assumed that their experiences jeopardize mental health (Canadian Task Force, 1988). Although mental health need and the availability of services to meet that need should be a matter of concern for resettlement countries, relatively little large-scale epidemiological research has documented the amount of psychological distress in refugee populations; the mental health effects of post-migration, as well as pre-migration stressors; the individual and community factors which can protect mental health; or the fit between need on the one hand, and the utilization and availability of services on the other.

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Community in Distress is a collaborative study, initiated by the Tamil community of Toronto, and carried out by a team of community leaders and University of Toronto researchers. The project's aims are:

1. To assess the prevalence of mental health problems among adult Tamils living in Toronto, with a specific focus on depression, suicidal ideas and impulses, anxiety, post-traumatic stress disorder (PTSD), and perceived quality of life;
2. To identify correlates of mental disorder as well as mental health;
3. To identify patterns of help-care seeking from the survey and to compare these with data available for the general population; and
4. To study perceptions of the formal mental health care system and barriers both to access and to equitable care.

THE TAMIL REFUGEE EXPERIENCE

After Sri Lanka gained independence from Britain in 1948, hitherto latent hostilities between the country's Sinhalese majority and Tamil minority became increasingly overt, and finally, in 1983, erupted into a civil war which was to last for almost 20 years. During these years, almost 1 million Tamils fled the country. Canada admitted Tamils from refugee camps abroad and also granted refugee status to relatively large numbers of asylum seekers who landed on Canadian soil and claimed refugee status. During the last two decades of the twentieth century, Tamils were second only to the Chinese in sheer numbers of newcomers resettling in Toronto, Canada's largest city and most popular immigrant destination. Today, more than 160,000 Tamils live in Toronto.

For the past several years, Toronto's Tamil community has been sounding alarm bells. Although their problems rarely arouse wide attention, the particularly tragic story of a young father who leaped from a subway platform to his death with one of his children in his arms became front-page news during the fall of 1999. The attention was short-lived. Like other incidents of self-destruction and despair that touch many Tamil families, the story quickly faded from public consciousness.

Subsequent to the tragedy, a group of Tamil community leaders approached Dr. Morton Beiser and his research team at the Culture, Community, and Health Studies programme of the University of Toronto, Department of Psychiatry with a request to develop a collaborative investigation of mental health needs, determinants of mental ill health, and factors influencing service use. The community felt a need to understand the factors contributing to the despair of people like the young father in the subway station, a despair that they felt was widespread. The mental health effects of pre-migration trauma and of anti-Tamil sentiment in Canada were among the community's top concerns.

There were reasons for their concerns about discrimination. Not only are the Tamils a visible minority, but many arrived in Canada by whatever means they could and claimed refugee status once on Canadian soil. In the eyes of some Canadians, this raised a suspicion that the Tamils were bogus refugees and, at the very least, queue jumpers. Repeated news stories about atrocities committed by the Tamil Tigers in Sri Lanka also ignited concerns about terrorist activity, even in the pre-September 11 era. The Tamil leaders also felt that mental health needs of the community grossly outstripped available services.

The team prepared a research proposal and submitted it for funding to the Canadian Institutes of Health Research. After favourable review, the project received funding in 2001, with March 2004 designated as its completion date.[1]

STUDY METHODS

From its very beginning, the Community in Distress study did not follow a typical path. The community had defined the research objective, and then invited academic collaboration, a sequence which is the reverse of what usually happens. Formalized collaboration took place through the medium of bimonthly team meetings involving representatives from ten leading Tamil community and service organizations and University of Toronto scientists. The Tamil community and service organizations represented on the team suggest the breadth and potential of the collaboration: Senior Tamils' Centre, Providence Centre Tamil Caregiver Project, Family Service Association of Toronto, South Asian Women's Centre, Society for the Aid of Ceylon Minorities, St. Joseph's Women's Health Centre, Canadian Tamil Youth Development Centre, Vasantham Tamil Senior's Wellness Centre, Community Resource Consultants of Toronto, and Mt. Sinai Hospital Assertive Community Treatment Team. This community-university partnership grounded the project in salient issues, without in any way compromising scientific rigour.

With funding in place, the team turned its attention to identifying a study sample, developing appropriate measures, and engaging the community in the project.

Sampling

Creating a sampling frame is a major challenge in any study of immigrants or refugees. Although Canada's Department of Citizenship and Immigration knows where new arrivals initially settle, privacy laws prohibit release of this information for research purposes. Even if researchers could have access to these data, they would likely be of limited use because immigrants and refugees are highly mobile. The 160,000 Tamils living in Toronto are not just people who arrived in

the city and stayed, but also people who initially settled elsewhere and then relocated. There is also a great deal of population movement within the city, particularly during the first ten years of resettlement.

The team confronted this problem by creating an inventory of all Tamil households in Greater Toronto. Listings were compiled from various sources: places of worship, settlement service organizations, student associations, business listings, recreational associations, and telephone directories (searching by last name). This exhaustive and time-consuming process produced a list of 25,000 Tamil households from which 1,600 were selected using probability techniques. A research assistant then contacted the selected household, explained the nature and purpose of the study, and conducted a household enumeration. Then, using a table of random numbers, the research assistant selected one adult (older than age 18) as a study subject, and, after obtaining informed consent, proceeded to an interview.

Measures

New research should build upon the experiences and findings of what has gone before. In planning the survey questionnaires, the team reviewed and drew upon previous studies of refugee resettlement, including a decade-long investigation by Dr. Beiser of the resettlement of more than 1,300 South-East Asian "Boat People" (Beiser, 1999). The team decided to incorporate content areas and measures from the Boat People study including such post-migration stressors as unemployment, underemployment, family separations, and experiences with discrimination; psychological resources including time perspective and linguistic fluency; and social resources including intimate relationships and community involvement.

The questionnaire also contains mental health modules derived from the World Health Organization's Composite International Diagnostic Interview (CIDI). The fact that this instrument has been used in a number of international studies helped ensure the opportunity to compare Tamil rates of disorder with those found in other studies, most particularly a mental health survey in the province of Ontario which had also relied on the CIDI. Service utilization measures also overlapped with those used in the Ontario Health Survey. The scale used to assess PTSD was adapted from a 19-item scale previously developed to assess trauma (Kinzie et al., 1986).

Aside from replicating in order to make comparisons, the team developed a number of unique content areas including an assessment of re-traumatization, help-seeking behaviours, the use of complementary health resources, and assessments of the extent to which refugees perceived settlement services as mental health resources.

Engaging the community

The Tamil community leaders took part in the recruitment and selection of staff and interviewers, a process which helped ensure that those hired not only possessed the formal requirements for the job, but were also respected and trusted within the community. They also reviewed English to Tamil questionnaire translations to help ensure quality. The team also developed a number of ways to publicize the study, including the display of posters in prominent Tamil meeting places, placing descriptions of the project in community newspapers, distributing flyers describing the study, and taking part in Tamil-language radio and TV interviews. As an aid to the community and to service agencies, the research team prepared Tamil-language flyers describing various forms of mental disorder and distributed them for use in health care settings and social service agencies.

Preliminary findings have been presented at a province-wide conference for mental health professionals and one national conference for settlement workers sponsored by Citizenship and Immigration Canada.

PRELIMINARY FINDINGS

Socio-demographic characteristics

Table 1 describes a predominantly Hindu, relatively young, well-educated community, with slightly higher numbers of men than women, the majority of whom are married and most of whom came from Northern Sri Lanka, where fighting was the most intense.

Table 2 shows that, despite their relative youth and good education, 12.6 per cent of the sample is unemployed. Unemployment is considerably higher among women than among men (not shown in the table). Canada has been often criticized for failing to take advantage of the job skills immigrants and refugees bring to the country. An unemployment rate of 70 per cent among Tamils with teacher or nursing training provides disquieting evidence in support this criticism. High unemployment rates are often linked to poor command of the language of the host country. This may be a factor in the Toronto Tamil community in which almost one-third of all respondents speak only fair or poor English: the unemployment rate in this group is 75 per cent. Work is no guarantee of satisfaction particularly if – as is often the case for new settlers – there is a disjuncture between qualifications and work level. Almost half the respondents who were working felt they were underemployed. At the time of interview, the median length of stay in Canada was roughly ten years.

TABLE 1

GENERAL DESCRIPTION OF TAMIL MENTAL HEALTH SURVEY SAMPLE (N =1110)

Variables	Frequencies	Percentages
Gender		
Male	625	56.3
Female	485	43.7
Age range*		
18-31	181	16.4
32-45	510	46.0
46-59	263	23.7
60 and older	154	13.9
Background in Sri Lanka*		
Urban	293	26.4
Rural	487	43.9
Semi-urban	329	29.6
Region in Sri Lanka*		
North	975	87.8
East	75	6.8
Central Highlands	5	.5
South	32	2.9
West	17	1.5
Education in Sri Lanka*		
High school	418	37.7
Secondary or university	382	34.5
Technical/nursing/teaching	148	13.3
Marital status		
Married	916	82.5
Unmarried	119	10.7
Spouse deceased	52	4.7
Others	23	2.1
Religion*		
Hindu	929	83.7
Christian	174	15.7

Note: *There are some missing data.

TABLE 2

RESETTLEMENT AND ASSOCIATED FACTORS (N=1110)

Variables	Frequencies	Percentages
Length of stay in Canada		
More than ten years	592	53.3
Less than ten years	518	46.7
Fluency in English*		
Excellent	403	36.3
Good	347	31.3
Limited fluency – fair or poor	357	32.2
Employment		
Employed	693	62.4
Retired	74	6.7
Full-time student	36	3.2
Full-time homemaker	130	11.7
Unemployed	140	12.6
Other	37	3.3
Family income*		
0-10,000	93	8.4
10,001-20,000	182	16.4
20,001-40,000	479	43.2
40,001-50,000	120	10.8
50,001-60,000	60	5.4
60,001-plus	73	6.5

Note: *There are some missing data.

Migration and resettlement experiences

Nearly half (49.8%) of the sample entered Canada as refugee claimants (asylum seekers). Only 6.2 per cent came to Canada as Government-sponsored refugees after being selected abroad. Fewer than 10 per cent came to Canada as independent immigrants, a status which would have required a restrictive and lengthy assessment of qualifications. Having gained landed status in Canada, a person may sponsor a spouse and dependent children, providing the applicant can provide evidence of sufficient resources to support the family. Roughly one-third (32.4%) of the Tamils came to Canada under the latter programme, as “family class” immigrants.

Most Tamils suffered harsh experiences before arriving in Canada. Having lost their homes, 43 per cent of the sample had lived for varying periods of time as

internally displaced people in Sri Lanka, and 17.5 per cent had been interned in refugee camps. About 6 per cent reported physically hazardous conditions during migration, 35 per cent were separated from family during the immigration period, 8 per cent felt they had been harassed during the immigration process, and 7 per cent had been cheated by travel agents. More than one-quarter of the respondents reported that, as a consequence of their immigration travels, they were shouldering large debt loads.

On the plus side, when they first arrived, the majority (87%) of respondents felt they could count on family and close friends who had preceded them to Toronto. However, stereotypes of the supportive Asian family notwithstanding, the presence of family is no guarantee that people will feel supported, either materially or emotionally. This seems to be particularly true for the elderly. Many Tamil seniors (47.4%) were distressed by their enforced dependency on their children, inability to communicate with grandchildren (30.4%), being overburdened by child care responsibilities which had been assigned to them (24.7%), and by loneliness in spite of living with children (21.7%).

Preliminary mental health data

One-third of the respondents reported experiencing traumatic events such as witnessing combat, physical assault, or rape. Rates were higher for women (36.8%) than for men (30.7%).

Among those who had experienced trauma, 36.2 per cent qualified for a diagnosis of PTSD. The overall PTSD prevalence, approximately 12 per cent, is much higher than the rate of 1 per cent found in general population surveys (Davidson et al., 1991; Helzer et al., 1987), but consistent with the burden of distress found in other refugee populations (Beiser, 1999). Only about one in ten persons qualifying for a diagnosis of PTSD has received treatment of any sort.

The fit (often poor) between mental health need and service

Factors that influence the decision to seek help from a health care professional include intrinsic and extrinsic barriers. For the Tamils surveyed, practical barriers to care included language and logistics. Twenty-nine per cent of persons who had visited hospitals reported language problems; seniors and women were particularly likely to encounter linguistic barriers. Physically getting to a place which offered treatment was often a problem: among persons older than age 50, almost half were dependent on their children to take them to see a doctor.

Personal beliefs sometimes created impediments to seeking help for a health problem. Interviewers read the following to survey respondents: “There may be several reasons why a person might decide not to see a health professional for a

problem. How much do each of the following reasons influence you to go or not go for help?" In response, respondents rated the influence of 24 possible reasons, including the following: 38 per cent believed the problem they were experiencing would go away on its own, 27.3 per cent preferred to solve the problem themselves, and 22 per cent felt help would do no good. Twenty-one per cent were interested in getting help but did not know where to go. Although a significant impediment, fear of stigma, was a less often cited deterrent to help-seeking: 17.3 per cent were concerned about what others might think, and 17.7 per cent were ashamed or embarrassed about their condition. For 15.5 per cent of the population with a problem, the decision not to seek health care was influenced by the belief that seeking help at a particular time was astrologically unfavourable.

Preliminary results also demonstrated mistrust of the health care system. Nineteen per cent felt that past experience in seeking help for health problems was unproductive. Many respondents felt that their culture and ethnic background would not be understood, and others were deterred by the lack of health care professionals from their own culture/ethnic group. Some respondents were afraid: 13.5 per cent feared forced hospitalization, and 12.5 per cent feared violation of confidentiality. Eleven per cent of the sample reported experiencing racial discrimination during previous encounters with the health care system.

More than one-half of the population voiced a preference for a Tamil-speaking service provider, while 39 per cent said that a service provider's ethnicity was not important. Multivariate analysis revealed that respondents who were fluent in English, who felt a strong sense of belonging in Canada, and who had been in the country more than ten years were more likely to disregard ethnicity as a criterion for choosing a service provider; those with poor English skills, a weak sense of belonging, and shorter period of residence were more apt to prefer a Tamil provider.

The distinction between "physical" and "psychological" problems influences the propensity to seek help. In response to a hypothetical question about the probability of seeking help for "feeling sad most of the time", "experiencing fear without any reason", and "having suicidal thoughts", 62.7 per cent, 66.6 per cent, and 51.2 per cent, respectively, felt it unlikely that they would seek help. For chest pain, problems with vision and toothache, however, only 1.4 per cent, 1.5 per cent, and 2.1 per cent, respectively, said that it was unlikely they would seek help.

Although nearly 70 per cent of the population had seen a family physician in the 12 months prior to the survey, less than 1 per cent had seen a psychiatrist or other mental health practitioner. For relief of problems they had experienced in the recent past, 30 per cent had used rituals, 15.3 per cent traditional herbal remedies, 9.3 per cent religious stones/bracelets, and 5.5 per cent an astrologer.

Experiments in nature

Unlike laboratory-based research, surveys cannot be tightly controlled. A survey the magnitude of Community in Distress of necessity extends over many months. Sometimes, secular changes occurring during the course of the study can throw findings into doubt, and, at other times, create unanticipated opportunity. The Peace Process in Sri Lanka began in February 2002, at a midway point of the survey. This created an experiment in nature, an opportunity to examine responses to compare responses to a question about where respondents saw their future – in Canada or in Sri Lanka – before the inauguration of the Peace Process and after, when a choice between the two was theoretically more real than before. Contrary to expectation, a higher proportion of respondents interviewed before the initiation of the Peace Process imagined their futures in Sri Lanka than those interviewed afterward. This finding held up even after controlling for possible effects of age, gender, education, and length of time in Canada.

DISCUSSION

The need to seek mental health and social services may be especially acute and difficult for refugees who have experienced hardships, loss, and trauma before migration (Boehnlein and Kinzie, 1995), and who continue to experience difficulties during resettlement (Canadian Task Force, 1988; Watters, 2001). In order to actively seek help, immigrants and refugees must recognize health problems and perceive services to be available, appropriate, and useful. According to one model adapted for analysing immigrant help-seeking behaviours, health service utilization is conditioned not only by existing needs, but also by "predisposing" factors (gender, age, education, language, and cultural beliefs) and "enabling" factors (economic resources, knowledge of facilities, and accessibility) (Anderson and Newman, 1973; adapted by Portes et al., 1992). Other explanations may consider prior experiences, cultural idioms, and patterns of service utilization in the homeland (Ivanov and Buck, 2002), or cultural insensitivity and racism in the mainstream system in the receiving country (Aponte and Barnes, 1995). Among the Tamil population in Toronto we see evidence of many known intrinsic and extrinsic barriers, such as language, as well as fears of mistreatment and beliefs about illness that may hinder help-seeking when needed. On the one hand, we see distressing evidence of special needs that are not being met such as those of women and seniors and, on the other hand, willingness to seek available help that is positively related to length of stay in Canada.

Pathways to help-seeking, influencing factors, and reasons for under-utilization of available services are complex, but challenges to refugee health promotion may be met through education, confidence-building, increasing competence on the part

of service providers, and community-designed interventions (Palinkas et al., 2003). Despite the various multicultural service models that exist, however, none address the major determinants of immigrant health, such as social isolation and socio-economic disadvantage (Kliewer and Jones, 1997). In further analysis, we will use a paradigm of refugee well-being that concerns post-migration conditions that pose a risk to mental health and social and personal resources that help refugees cope, in addition to pre-migration stress factors such as trauma, to emphasize refugee resilience in contrast to pathology (Muecke, 1992: 520; Beiser, 1999).

IMPLICATIONS FOR MENTAL HEALTH POLICY

Today we have a growing appreciation of the social determinants of health and well-being for immigrants and refugees – security, satisfactory shelter and employment, and culturally appropriate and accessible health and social services – factors consistent with conditions required for successful settlement and adaptation (Dunn and Dyck, 2000). In contrast to the broadening of the refugee mental health research agenda, immigrant mental health care remains limited by a static perspective, a narrow view of health care as focused on the point of contact between a patient (often in crisis) and the system, when we presume health needs are met. Studies such as this show, however, that many immigrants may not seek help readily from the health care system. Migration studies that investigate the adaptation process also suggest that needs change over time at the individual and at the population level. An older migrant who might not suffer loss of status and social isolation at home may experience comparatively greater needs and stresses after migration. In general, the health of immigrants seems to decline after migration and worsens with time spent in the receiving country (Perez, 2002).

Research on immigrant and refugee mental health has progressed, but policies and programmes have not kept pace. We still do not yet have a health care system that is able to respond adequately to ethno-racial communities in terms of cultural and linguistically appropriate services, although attempts are made in hospital and community health centres in cities such as Toronto where an increasing proportion of the population is foreign-born. We certainly do not have, especially in mental health, a system that actively promotes health by advocating holistic, supportive policies and programmes that could help immigrants and refugees cope with challenges and achieve a sense of well-being during settlement. The implication for Canadian mental health policy is that more concerted efforts must be made to meet the diverse needs of immigrant and refugee populations, not only as a response to illness, but as a matter of health promotion.

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