

# Barriers to Access to Mental Health Services for Ethnic Seniors: The Toronto Study

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**Objective:** To identify and describe barriers to access to mental health services encountered by ethnoracial seniors.

**Method:** A multiracial, multicultural, and multidisciplinary team including a community workgroup worked in partnership with seniors, families, and service providers in urban Toronto Chinese and Tamil communities to develop a broad, stratified sample of participants and to guide the study. This participatory, action-research project used qualitative methodology based on grounded theory to generate areas of inquiry. Each of 17 focus groups applied the same semistructured format and sequence of inquiry.

**Results:** Key barriers to adequate care include inadequate numbers of trained and acceptable mental health workers, especially psychiatrists; limited awareness of mental disorders among all participants; limited understanding and capacity to negotiate the current system because of systemic barriers and lack of information; disturbance of family support structures; decline in individual self-worth; reliance on ethnospecific social agencies that are not designed or funded for formal mental health care; lack of services that combine ethnoracial, geriatric, and psychiatric care; inadequacy and unacceptability of interpreter services; reluctance of seniors and families to acknowledge mental health problems for fear of rejection and stigma; lack of appropriate professional responses; and inappropriate referral patterns.

**Conclusions:** There is a clear need for more mental health workers from ethnic backgrounds, especially appropriately trained psychiatrists, and for upgrading the mental health service capacity of frontline agencies through training and core funding. Active community education programs are necessary to counter stigma and improve knowledge of mental disorders and available services. Mainstream services require acceptable and appropriate entry points. Mental health services need to be flexible enough to serve changing populations and to include services specific to ethnic groups, such as providing comprehensive care for seniors. (Can J Psychiatry 2004;49:192–199)

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## Clinical Implications

- The training of psychiatrists and frontline agency workers clearly needs to be redesigned, as does the service system in mainstream institutions.
- Community mental health education programs for ethnic communities and service providers are needed.

## Limitations

- We examined only 2 communities among several possible others in a metropolitan setting, limiting the scope of the data.
- Because of language requirements, some focus groups were led by team members with varying group-work experience.

**Key Words:** geriatric, culture, ethnic, services, service use

Several indicators suggest that members of ethnic communities encounter barriers in access to appropriate mental health services (1,2). Emergency care appears to be overrepresented in this group (3). General mainstream mental health services are used less by ethnic minority communities than by white-dominant communities, and service appears to be less effective because of restrictions imposed by such important factors as language barriers, breakdown in cultural understanding, and failure of mainstream workers to understand the meaning of symptoms (4–6).

There are some data on patterns of use of psychiatric services by ethnic communities and on diagnostic and treatment problems arising from a lack of understanding of cultural, ethnic, and racial differences between patients and caregivers (7,8). This paper describes the results of a qualitative study of specific barriers encountered by ethnic seniors when they need mental health services.

### Goals

The study goals are 1) to identify and describe the barriers to access to care encountered by ethnic seniors when seeking or needing mental health services and 2) to identify and ultimately implement changes in health policies and services to reduce these barriers.

### Setting

The study took place in the metropolitan area of Toronto, Ontario. Forty-three percent of all newcomers to Canada settle in this area, forming 17% of its population. Forty-three percent of the population of Toronto belong to a “visible minority” community (9). Moreover, Toronto is home to large numbers of recent immigrants, well-established ethnic communities, and refugee groups. Over 500 000 new immigrants have settled in Toronto since 1991. Toronto also has well-developed mainstream geriatric psychiatry services in addition to some community-based agencies providing services to specific ethnic communities.

### Methods

Currently, basic data and measures to inform a quantitative study of this area are lacking.

To avoid making premature and perhaps inaccurate assumptions about which questions to pose, grounded-theory methodology was adopted. This methodology involves developing theory that is grounded in systematically gathered and analyzed data. Theory evolves during the research, and it does so through the continuous interplay between analysis and data collection.

A multicultural, multiracial, and multidisciplinary investigative team was constructed. Much time and effort were directed to creating strong links with the communities, so the research

became a task not only of the research team but also of the communities. A community workgroup consisting of seniors, their families, caregiving professionals, and agencies was developed.

After a careful preliminary study of the ethnic and cultural demographics of metropolitan Toronto, 2 contrasting ethnic communities—Chinese and Tamil—were selected for study. The Chinese community is regionally and socioeconomically diverse, is long-standing (since the 1850s), and has a comparatively well-organized service infrastructure. The Tamil community arrived in strength only in the early 1980s. Many are refugees from the violent strife in Sri Lanka. This community is only in the early stages of developing the infrastructure for health and mental health services. The investigators anticipated both similarities and important differences in the needs and problems of the 2 types of community and that these would have an impact on the nature of health policies and service development required.

We used snowball technique to identify key informants. This technique of sociological research allows researchers to penetrate into an unknown community and identify and recruit key informants. It begins by identifying recognized community leaders and building on these contacts by taking their recommendations for other key informants to incorporate into the study interview process. Each informant was interviewed in depth and, together with the community workgroup, helped to determine the sampling framework for constructing the focus groups and for generating areas of inquiry that could then be explored more deeply.

#### *Selection of Focus Groups*

We formed 17 focus groups based on a sampling frame for obtaining representative interview samples from each community. Focus groups were created to obtain a broad sample of opinions from each community (Table 1).

Seniors were defined originally as being over age 65 years. While appropriate for the older Chinese community, this was an inadequate definition for Tamils, since the pensionable age in Sri Lanka is 55 years. Many “old age” issues, such as role redefinition, begin earlier in this generally younger community. Hence, we set 55 as the age of entrance to the study for Tamil seniors, causing the Tamil sample to be younger than the Chinese sample.

The sampling frame for the senior and family groups took into account factors expected by the investigators to influence accessibility of services, attitudes to mental health issues, capacity for self-support, and ability to negotiate the system; these factors were supported by data from other reports (7,10–14). The team strove for adequate representation of language subgroups (for Tamil, English and Tamil; for Chinese, Cantonese and Mandarin); urban geographical subgroups of

**Table 1 Focus groups**

	Chinese		Tamil	
	Number of groups	Number of sessions	Number of groups	Number of sessions
Seniors	3	5	2	4
Family members of seniors	1	1	0	0
Mixed family members and seniors	1	1	3	3
Service providers	3	4	1	1
Physicians	2	2	1	1

seniors, families, and service providers (downtown vs suburban); distressed vs nondistressed subgroups; socioeconomic subgroups (high, middle, and low); country of origin (especially important for the Chinese, who came from Hong Kong, mainland China, Taiwan, or other countries); urban vs rural origins; sex; and age. All focus group members resided at home in the community. Institutionalized elders were not included, since this was a study of community access.

We invited 171 family doctors to participate in physician focus groups. Each was contacted by letter and followed up with at least 1 telephone call. Physicians were selected according to whether they provided significant service to one of the communities. Each was identified by key-informant community members as an important service provider. Only 16 (9%) physicians participated.

A broad cross-section of agencies participated, representing key mainstream agencies, organizations, and institutions, as well as almost all the relevant agencies providing general or specific services to ethnic communities. Agencies were included if they provided health, mental health, social, supportive, or geriatric services to seniors from either of the 2 communities.

#### *Focus Group Format*

Focus groups were conducted at local community sites and at time periods acceptable to the various participants, avoiding mainstream institutional settings, such as hospitals, wherever possible. Focus groups lasted 2 to 4 hours, and some met twice to complete the process. They varied in size from 10 to 18 participants, except for physician groups, which had 2 to 8 participants. Members of the research team led each of the groups, which were conducted in whichever language was appropriate for most participants, with simultaneous interpretation for those needing it. Each group was voice-recorded (using 2 simultaneous recorders), with a scribe concurrently recording written summaries to identify individual speakers. Seniors and families were reimbursed for travel costs and provided with hot meals.

A standard set of clinical vignettes, each describing a DSM-IV syndrome, was created and presented for discussion at each group. The vignettes were validated for diagnostic accuracy by experienced geriatric psychiatrists who were blind to the process. A preliminary pilot study had indicated that the vignettes were necessary to focus discussion on more severe psychiatric disturbances. In their absence, spontaneous foci were predominantly on stressors, such as demoralization, loneliness, adaptation, disappointment, and so on. The vignettes also helped to determine whether these Western-based clinical constructs were familiar to the focus group participants and whether there were cultural variants.

#### *Data Management*

Bilingual transcribers translated and typed English verbatim transcripts from the tapes. Three investigators jointly reviewed 3 sets of transcripts, coded material, and derived themes and categories to create an interpretive framework. The remaining 19 transcripts were divided among the 3 investigators and analyzed manually using the agreed-upon method. The raw analyses were merged and synthesized by 1 investigator and then reanalyzed in detail by the whole team. The investigator team members analyzed their own reactions and responses to the material in group discussions to uncover tendencies toward biased interpretation or emphasis.

## **Results**

#### *Mental Disorders*

Professional caregivers and seniors both revealed limited awareness of the nature and extent of mental disorder in the elderly. While awareness of various forms of stress was high (for example, isolation or family conflict), the understanding of significant mental disorders common to the elderly was rudimentary, except in the physician group. When asked to describe their views of mental health problems of seniors, both consumers and caregivers focused heavily on various life and social stressors. Only when prompted by the vignettes did they address more severe psychiatric disorders, such as dementia, depression, or psychosis.

*Social Stressors*

Various social stressors were identified. Social isolation was most frequently mentioned and ascribed to many factors, including inadequate language ability, living accommodation (such as anonymity in high-rise apartment buildings and danger in urban neighbourhoods), and inadequate knowledge or understanding of how to negotiate the system (such as transportation and health or social services). Participants highlighted socioeconomic distress as the cause of substantial emotional stress based on fears of dependency or infirmity and loss of self-sufficiency and self-esteem. Reactions to loss of prior position and assets were especially evident among Tamil refugees. Participants clearly felt that socioeconomic sources of stress, although a concern of many elders regardless of ethnicity, are exacerbated by the experience of migration. For example, to be eligible for even partial support from the old age security pension from the federal government of Canada, immigrants not only must be over age 65 years but also must have resided in Canada for the previous 10 years.

*Interpersonal Stressors*

In this category, emotional distress produced by family issues predominated. The presence of subtle or overt family conflict emerged repeatedly. Seniors often feel excluded or even extruded from (and by) their families for many reasons. Examples of more subtle emotional reasons included intergenerational conflicts over traditional Chinese and Tamil vs contemporary Western-based values, deep disappointment that children had failed in their traditional duties of filial piety, and humiliation over the loss of power and status in the family. These phenomena occurred within the context of immigration and marginalization within the dominant culture. In the words of one senior, "In Hong Kong I was a tiger, here I am chased by a dog." Immigration-related issues reinforce these phenomena. Overburdened and economically challenged families often lack the time or energy to give seniors the care and respect they expect and require.

Less subtle are the perceptions of both seniors and professionals alike that seniors are often exploited. For example, forced financial and emotional dependency arise secondary to ill health or economic distress and produce situations in which seniors, usually women, feel they must silently acquiesce to spoken or unspoken demands to provide household services such as unpaid housekeeping and childcare or to hand over their assets to other family members.

*Awareness of Services*

All groups demonstrated a surprisingly low level of awareness of the available, appropriate formal mental health services, that is, those funded to provide mental health services as defined by the Ministry of Health. Seniors were most frequently aware of the community-based service organizations

but spoke little about mainstream institutions or services. They had learned about resources largely by word of mouth. Professionals, including agency workers and physicians, revealed only partial and relatively ineffective knowledge of well-established geriatric mental health services in the region. Only in the most severe cases would seniors or agency workers consider turning to hospital emergency departments or mainstream psychiatry. This is in keeping with recent data showing that the use of mental health services by older Chinese Canadians is relatively infrequent. Only 0.4% to 0.6% report consulting a psychiatrist or psychologist, compared with 1% in the general population (15). Similar data emerged for East Asian immigrants in another study (16).

Consumers and caregivers, including physicians, vaguely understood mainstream geriatric mental health services, in particular how to access services. Family doctors reported their preference to send patients with urgent psychiatric problems to individual psychiatrists whom they know personally, despite also perceiving these psychiatrists as hard to access.

*Service Availability*

At the time of study, not a single service existed in the study region that combined ethnic specificity, mental health expertise, and geriatric knowledge and focus. Agency caregivers repeatedly pointed out that their agencies are not funded for mental health services. Frontline workers and administrators in the agencies expressed their frustration at the lack of mental health training for workers. Agency mandates often exclude mental health interventions because of funding-formula restrictions, even though front-line workers are often the first contact and routinely confront mental health problems of varying severity.

We identified many problems with availability, the most serious being a lack of ethnic professionals in mainstream institutions who can provide linguistically and culturally appropriate services. Seniors and families estimated that they were almost always required to bring their own language interpreters, since institutions pay little attention to the need for cultural sensitivity. Hence, mainstream mental health workers usually are blind to the cultural context of an emotional problem. All participants felt that most psychiatric care ideally should be provided on an individual basis, but they recognized the current need for the presence of an interpreter. Participants emphasized that, if they must be used, interpreters should be committed to confidentiality, should understand mental health issues, and should be nonjudgemental and accurate in interpretation.

Seniors feel that relying on family members as interpreters is problematic; for example, seniors may not wish to disclose private information, or family members may be unable or unwilling to accompany seniors. Reluctance to self-disclose

**Table 2 Acceptability of service providers in descending order**

1.	Ethnospecific psychiatrist, full language ability
2.	Ethnospecific mental health worker, full language ability
3.	Ethnospecific mental health worker, limited language ability with interpreter
4.	Western psychiatrist or mental health worker, full language ability
5.	Western psychiatrist or mental health worker with trained interpreter
6.	Western psychiatrist or mental health worker with untrained interpreter
7.	Western psychiatrist or mental health worker with family interpreter
8.	Western psychiatrist or mental health worker with no interpreter (useless)

before an often-young family member (whose language skills are generally better than those of the parent or grandparent) may pose a significant barrier to effective care. Those seniors who are familiar with the English language and Western health care were less hampered by these issues. Chinese physicians and other caregivers are unwilling to initiate a referral if Chinese-speaking staff are unavailable.

All service providers consistently expressed the view that mainstream services and individual psychiatrists are not receptive to or knowledgeable about ethnic senior patients. While relying on prior personal relationships between a psychiatrist and a physician may not be appropriate, this apparently is an important way to ensure effective referral, although waiting lists for preferred therapists pose a prominent barrier to availability.

Access is further impeded by geographical barriers, as seniors often live in the suburbs, while specialized culturally sensitive services are often located downtown. Ethnic seniors frequently cross geographic boundaries within a region to access care, preferring even distant ethnic-focused services to local general mental health services.

#### *Service Accessibility*

The reluctance of both seniors and families to acknowledge and disclose problems is a key barrier to access. Culturally derived beliefs complicate the reactions of seniors and families to emotional distress and probably lead to delays in seeking help. Examples include culturally derived negative perceptions of psychological problems and strong fears of stigma, issues prominent in most communities regardless of ethnicity. Seniors and families believe that such problems will seriously impair the reputation of the family. This factor emerged repeatedly as a key reason for families and seniors to avoid seeking help.

Seniors themselves said their preferred first line of contact or outreach is a close friend, followed by a family member. They expressed fears that family members would not understand or would reject their complaints, while peers already share the experience. Seniors also worry about further burdening an already overburdened family.

After peers and family, “social workers” in community agencies form the next line of support—social workers being regarded nonspecifically as anyone who performs some form of social supportive care, recreational service, or group services. Family doctors are seldom consulted for emotional or psychological problems alone. Seniors and families often believe that there must be a physical or somatic complaint to legitimize a visit to their physician. For reasons of privacy and confidentiality, physicians outside the immediate community may be sought, especially by those who are bilingual and bicultural. This issue of privacy arose repeatedly, especially for the smaller and more closely knit Tamil community.

Table 2 lists the hierarchy of acceptable caregiver characteristics that facilitate or block access to mental health services for ethnoracial seniors. This hierarchy was derived from answers to specific questions posed during each focus group on acceptability of the characteristics of service providers. Seniors, families, and service providers were all very clear and consistent in their responses to these questions. Key service provider attributes as described by focus-group members include trustworthiness, respect, empathy, taking time and expressing a willingness to talk about emotional problems, conveying understanding, and awareness of mental health problems. These are strikingly similar to Valle’s data (17).

#### **Conclusions and Recommendations**

The dearth of appropriate psychiatrists with language and cultural competency is the most clearly identified gap in service provision. Those psychiatrists who are available to the community are perceived to be overworked and pressed for time. The caregivers’ practice of referring to psychiatrists who are personally known to them may contribute to delays or inappropriate access routes. Yet, often referring caregivers believed these individuals would be trusted to respond and follow up on the care. Hence, even if problems are identified by agencies or family doctors, the scarcity of psychiatric personnel means that mental health management often does not continue unless patients are sent to an emergency department. The customary role of the family physician as gatekeeper to the mental health system may be more difficult for ethnic

**Table 3 Key service provider attributes**

Trustworthy
Respectful
Empathetic
Taking enough time
Willing to talk (for example, engage with client)
Understanding
Awareness of mental health issues

communities, given the lack of a broad range of ethnospecific mental health services to which they can refer.

The low numbers of physicians participating in the study was of concern. When initially contacted, many of them expressed interest in and support for the study, perceiving it as relevant and important to their work. Most of those who declined cited overwork and volume of practice as reasons, despite the research team's willingness to meet the physician groups after hours at convenient locations, provide a meal, and offer an accompanying academic program. Clearly, some other strategies may be required to tap into the necessary data from this group. Conducting office interviews may be more acceptable, or attaching discussions to another forum, such as a clinical workshop, may be more convenient.

Our data show that the community-based agencies with ethnospecific workers are perceived as the most accessible and welcoming to ethnic seniors and serve as the point of identification of psychiatric problems and entry to the mental health system. However, they usually have little or no core funding to address intersecting issues of aging, mental health, and ethnic background. This fosters service fragmentation, since clients of these facilities must be referred elsewhere through inadequate channels to service providers who often lack sufficient resources or training. Community agencies are also continuously redefining their priorities in response to the current priorities of funders. This prevents the creation of consistent and reliable programs for seniors. Moreover, restricted funds and mandates prevent adequate or even basic staff mental health training.

The absence of formal mental health services in the agencies combined with the fact that these agencies appear to be the first services sought by ethnic seniors and families creates a significant barrier to service acquisition. These problems are pressing, because mainstream services are not readily accessible to this population. The general mental health delivery system does not seem to recognize the importance of ethnospecific mental health service providers and, hence, requires new hiring policies.

Referral barriers appear to be serious impediments to access. Seniors often are forced to rely on the ability of their family to

recognize or acknowledge their needs and then on their willingness to accompany them to care. Lack of awareness of services, fragmented and uncoordinated services, and inadequate numbers or inconvenient location of key service providers, including psychiatrists, are compounded by instrumental barriers. Because ethnic seniors and their caregivers travel across urban regions for care, it is important for planners either to make provision for flexible boundaries for ethnic communities or to create specific ethnic services in each region.

Consumer characteristics that pose barriers to care include the stigma associated with mental disorder, suspicion or fear of outsiders, and fears of exposure within their own communities. However, it should be stressed that these factors are also frequently found in most communities. Perceived and actual barriers to care differed according to social class. Services specific to ethnic groups are particularly important for non-English-speaking seniors, especially recent immigrants and refugees who are not familiar with the dominant culture. The data suggest that the burden of distress is greater on lower socioeconomic subgroups, members of which often have poor English skills, are less familiar with Western health systems, are less likely to occupy leadership positions within the community, and hence are less able to make use of available resources. The apparent exploitation of some seniors described by some participants does not necessarily suggest that there is intentional or widespread abuse of seniors in these communities. Rather, immigration and settlement issues produce profound family stresses, which may weaken and disrupt traditional family values, structures, and loyalties. Particularly with involuntary migration, emotional isolation is further fostered by impoverished spiritual life, longing for the homeland, and a sense of being in prolonged exile.

Problems of communication impair access and service delivery. Service providers and seniors reiterated the failure of consultants and mainstream institutions to communicate with those who had made the referral. While legal requirements for the release of confidential medical information may underlie some of this miscommunication, it fosters a belief among front-line ethnic service agencies that they are not respected or considered full members of the mental health care team. Service providers tend to refer clients to doctors from specific ethnic backgrounds based on personal relationships and their language capacity, thereby reinforcing an inadequate informal referral pattern. Overall, seniors and agency providers reported that follow-up care is inadequate, a serious impediment to continuity and continuation of care.

Seniors expressed the strong conviction that government seems unaware of the lack of services for minority elders. They advocated that funds be allocated specifically for seniors' services rather than funnelled through general health care organizations, where seniors' issues are often not a

priority. Some service providers advocated that antiracism organizational change be linked to allocation of funding. Seniors recognized the importance of advocating for services, but some Tamil seniors acknowledged that this aggressive form of political lobbying is not in keeping with the traditional values of their culture. In order to address the issues of inequality of funding formulas effectively, the mainstream system needs to confront difficult issues of self-evaluation.

One key outcome of this work is the identification of a clear need to refine our understanding of service delivery provided by the mainstream system. The customary points of entry often are too difficult to access. Clearly, the nonspecific “one-stop shop” approach to service provision advocated by many planners is likely to fail many ethnoracial seniors. Such services need to be ethnically sensitive and flexible to be appropriate.

One model beginning to emerge in mainstream institutions is that of access ports for specific populations. Key components of these access ports include on-site, trained cultural and language interpreters and outreach to community agencies. Similarly, mobile clinical teams, community education services such as public forums or media campaigns, and professional education may be coordinated by the institution in partnership with the communities. The debate over whether services specific to ethnic groups are more desirable and effective than general services that strive for equity is still unresolved. Evolution and change on both fronts is probably necessary (18).

Limitations of this study include the possibility of a cohort effect in the current ethnic groups that will change with different waves of migration. Community demographics and, therefore, service needs change with time. For example, the relatively younger age of the Tamil seniors group probably reduces the current need for dementia services but heightens the need for services to treat psychological trauma, since this is largely a refugee community whose members have been shown to be more vulnerable to posttraumatic stress disorder, anxiety, and depression (19). Hence, periodic reevaluation of the service needs of specific communities should be built into the system. The issues identified must be distinguished from aging, health status, and socioeconomic factors alone (20). Finally, this is a qualitative study with the limitations imposed by that methodology, including the potential for bias in the focus group process and interpretation of data. While every effort was made to limit these factors, the conclusions must be viewed in context and further explored by quantitative studies.

Important research priorities arising from the data include the impact of government policy on stress and mental health; the effectiveness of overburdened immigrant or refugee families

in providing mental health support to senior family members; the most effective interventions for reaching the most disadvantaged ethnic groups; the role and functions of cultural interpreters; and the most useful and effective access point to the mental health system for ethnoracial and other communities, including their physicians.

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### **Résumé : Obstacles à l'accès aux services de santé mentale pour les personnes âgées d'origine ethnique : l'étude de Toronto**

**Objectif :** Déterminer et décrire les obstacles à l'accès aux services de santé mentale que rencontrent les personnes âgées d'origine ethnique.

**Méthode :** Une équipe multiraciale, multiculturelle et multidisciplinaire, comportant un groupe de travail communautaire, a travaillé en collaboration avec les personnes âgées, les familles et les fournisseurs de services aux communautés chinoise et tamoule du Toronto urbain à mettre sur pied un vaste échantillon stratifié de participants et à guider l'étude. Ce projet de participation, d'action et de recherche a utilisé une méthodologie quantitative fondée sur une théorie à base empirique pour produire des zones d'enquête. Chacun des 17 groupes de discussion a appliqué la même formule semi-structurée et la même séquence d'enquête.

**Résultats :** Les principaux obstacles à des soins adéquats incluent le nombre insuffisant de travailleurs de la santé mentale compétents et acceptables, en particulier de psychiatres; la connaissance limitée des troubles mentaux parmi tous les participants; la compréhension et la capacité limitées de naviguer dans le système actuel à cause des barrières systémiques et du manque d'information; la perturbation des structures de soutien familial; le déclin de l'estime de soi individuelle; le recours à des organismes sociaux ethnospécifiques qui ne sont pas prévus ou financés pour des soins de santé mentale officiels; l'absence de services qui combinent des soins ethnoraciaux, gériatriques et psychiatriques; l'incompétence et l'inacceptabilité des services d'interprètes; la réticence des personnes âgées et des familles à reconnaître les problèmes de santé mentale par crainte du rejet et des stigmates; le manque de réponses professionnelles appropriées; et des modèles d'aiguillage inadéquats.

**Conclusions :** Il y a un besoin évident d'un plus grand nombre de travailleurs de la santé mentale d'origine ethnique, surtout de psychiatres compétents. Il faut aussi améliorer la capacité des organismes de première ligne en matière de services de santé mentale par de la formation et du financement de base. Des programmes actifs d'éducation communautaire sont nécessaires pour contrer les stigmates, et améliorer la connaissance des troubles mentaux et des services offerts. Les principaux services ont besoin de points d'entrée acceptables et appropriés. Les services de santé mentale doivent être assez souples pour servir des populations changeantes et pour inclure des services spécifiques aux groupes ethniques, et procurer des soins complets aux personnes âgées.