

Unravelling the complexities of inequalities in mental healthcare and outcomes for cultural and linguistic minorities

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This is a reappraisal of psychiatric morbidity in North Americans from Indigenous backgrounds, or those from longstanding minority communities. Psychiatric morbidity is often no higher when compared with controls that are similar in other sociodemographic features. Interventions should therefore take into account that disadvantage is rarely from one cause.

In many countries, racial and ethnic minorities are at an increased risk of discrimination across a multitude of settings, including mental healthcare.¹ For instance, minority populations, including immigrants, refugees and ethnic minorities, are less likely to receive out-patient treatment.² By contrast, they are more likely to have had contacts with psychiatric emergency services and experienced a compulsory admission.²

However, disparities in mental health status are not uniform across racial or ethnic groups. For example, there are important differences between minorities with a recent history of migration, and Indigenous peoples or groups with long histories of settlement, where the effects of migration as further complicating factors do not apply.³ In addition, Indigenous peoples have faced unique challenges of dispossession, discrimination and disadvantage. This paper therefore highlights epidemiological work on the experience of people from Indigenous backgrounds, or those from longstanding minority communities, with special reference to North America. In all cases, there were adjusted comparisons with similar controls to understand further the specific contribution of minority status, as opposed to other sociodemographic characteristics.

Indigenous peoples of North America

Although there is considerable literature on rates of psychiatric morbidity, comparisons with the general population that use the same instruments and methodology are more limited. A recent meta-analysis covered 19 studies conducted in the Americas, all but three of which came from North America.⁴ Of these, ten studies were from the United States and six from Canada. For inclusion in the review, studies had to have data on

similar controls. Ways of increasing comparability included checking for similarities in demographic characteristics, stratification by age or gender, and the use of standardisation and/or multivariate analyses. The focus of the review was on common mental disorders but if any of the included papers also reported on alcohol and substance use, these data were included in any meta-analysis.

Rates of alcohol and substance use were consistently higher in all the Indigenous populations surveyed, as was the prevalence of post-traumatic stress disorder (PTSD). By contrast, there were no differences in the rates of other common mental disorders when compared with the general population of similar age or gender, and using the same instruments (Fig. 1). These included the 12-month prevalence of depressive, generalised anxiety and panic disorder. Findings were similar irrespective of geographical region (Fig. 1) In five studies of depression that adjusted for further socioeconomic variables, any effect was to generally lessen the association between Indigenous status and psychiatric morbidity, not increase it.⁴ This applied to both 12-month prevalence and lifetime rates. By contrast, rates of PTSD remained elevated in the three studies that adjusted for similar sociodemographic variables.⁴

There were similar findings in a further meta-analysis of studies from Australia and New Zealand, although the pattern was less clear because of fewer studies.⁵

There may be a number of explanations for these findings. One might be that the instruments or diagnostic criteria used in these studies may not accurately reflect psychiatric morbidity in Indigenous populations. On the other hand, many of the studies used culturally validated forms of standardised assessment measures, and it is unclear why instruments would fail to detect disorders such as major depression, but not others such as PTSD where rates were significantly elevated.^{4,5}

Another is that risk factors for PTSD or alcohol and substance use may differ from those for depression. Possibilities include early removal from families and cultures of origin, as well as subsequent institutional and domestic abuse. In one national survey, nearly a quarter of Indigenous Australians were the victim of physical violence in the previous months, including 8.1% who had

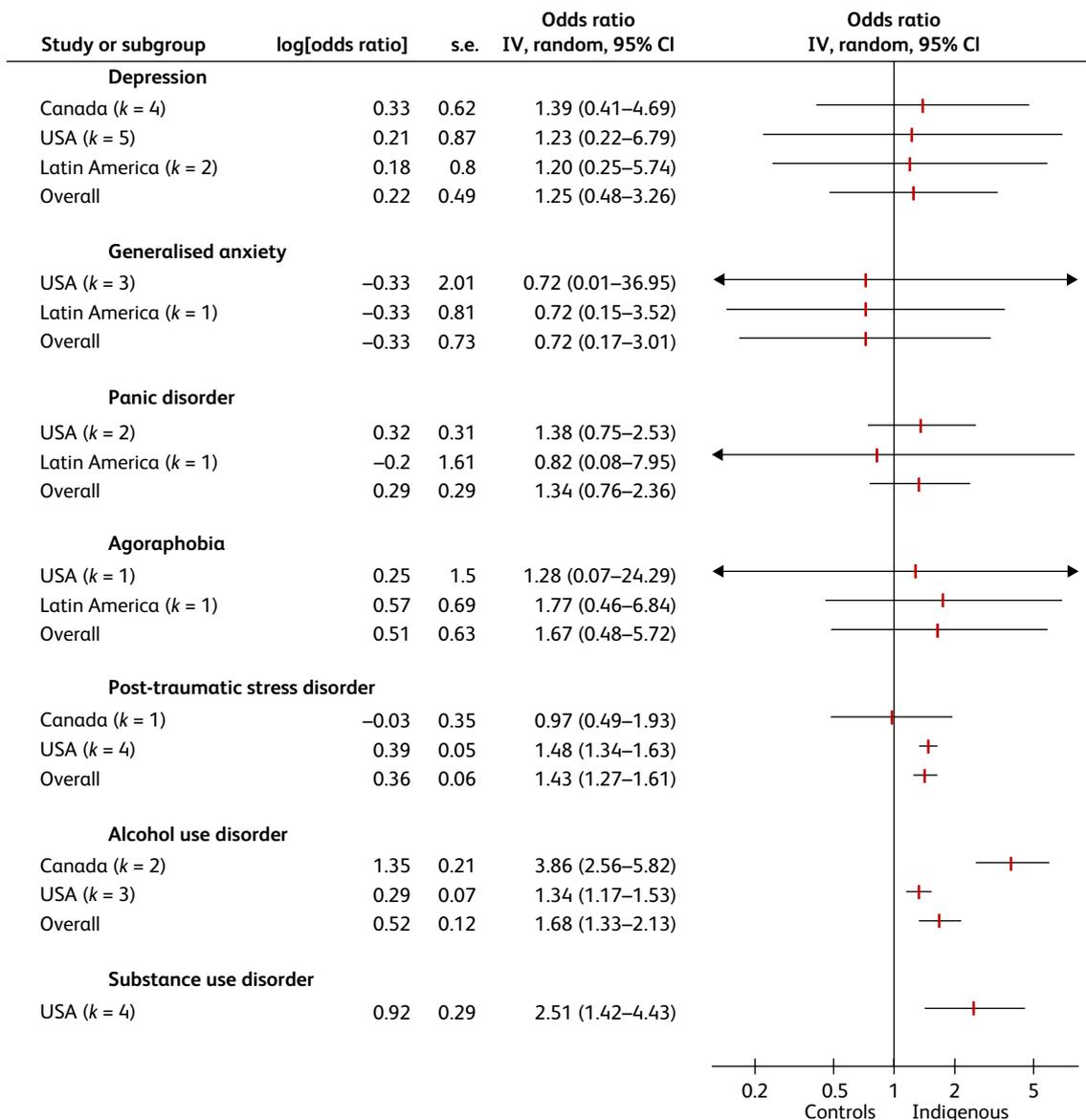


Fig. 1 Comparing the 12-month prevalence of common mental disorders. IV, inverse variance.

experienced physical violence on more than one occasion.⁶ In half of cases, the perpetrator was a family member. Fifty per cent had been the witness to violence and just under 40% reported a recent death of a family member or close friend.⁶ Similar factors apply to the increased rates of suicide reported in Indigenous people worldwide. Common mental health disorders may also be underpinned by different constructs. According to Krueger's three-factor model, generalised anxiety and depression represent distinctly different aspects of internalising when compared with PTSD, whereas externalising patterns are associated with alcohol and substance use disorders.

In other circumstances, Indigenous culture may be protective. For instance, Indigenous Australians and New Zealanders report less psychiatric morbidity when they form a higher proportion of the population despite other markers

of social deprivation, possibly because of connection to culture and traditional lands.^{7,8} Elsewhere, a Canadian survey found that 70% of First Nations adults living on reserves felt in balance physically, emotionally, mentally and spiritually.⁹ Indigenous people may therefore have higher rates of psychological distress because of factors unrelated to ethnicity, but experience lower rates of disorders because of cultural connection or density.

Two unique communities in Nova Scotia

There are also non-Indigenous minority communities with long histories of continued settlement and thus no experience of recent internal or external migration. Two are in Nova Scotia, a province on the eastern seaboard of Canada. Originally occupied by the Mi'kmaq, European settlement dates back to 1605. This rich history

has led to a number of unique communities. One is the African Nova Scotian community of Preston, whose inhabitants are descended largely from refugees from the USA who settled in many areas of the province from 1813 to 1816.¹⁰ Another is the community of Clare, a community whose population is predominantly Acadian (French) who remained in the Province following the large-scale deportation of French settlers by British authorities between 1755 and 1764.¹¹ Given the 200-year history of both communities in the province, immigration would not be a contributing factor to either psychiatric morbidity or health service use. In the case of African Nova Scotians, neither would language.

As in other parts of Canada, all Nova Scotian residents are entitled to in-patient or out-patient care that is free at the point of delivery. Patients are seen at publicly funded facilities, or by private psychiatrists and general practitioners in the community who then bill the provincial health plan. Province-wide data on health service use are therefore available for both primary care and specialist services.

In both cases, treated psychiatric morbidity was compared with other communities matched on other relevant sociodemographic factors, as well as the province as a whole. For instance, Clare is predominantly rural, so comparison Anglophone communities were selected based on similar rurality. Incidence rate ratios relative to Nova Scotia's entire population were calculated for each area and the comparison, using indirect age and gender standardisation.

For both African Nova Scotians and Acadians, there was a low level of contact with psychiatric specialists compared to the province as a whole.^{10,11} By contrast, depending on the comparison group, there were higher rates of family physician visits and hospital admissions. However, this result was attenuated when comparisons were made with groups of similar rurality.¹¹

The findings on Acadians are mirrored by studies of Francophones elsewhere in Canada as well as of international comparisons of different ethnic and language groups.^{12,13} After adjusting for sociodemographic and economic factors, such as age, gender, education, income and place of residence, there was little difference in psychiatric morbidity as measured by community surveys or administrative data.^{12,13} These factors rather than language *per se* appear to explain differences in the prevalence of disorders.¹³ This does not mean that these variables remain static. For instance, the role of Catholicism in defining francophone communities has diminished as they have become more secular.

Conclusions

These examples illustrate the importance of choosing appropriate comparison groups when assessing the influence on psychiatric morbidity

of being from a linguistic or ethnic minority. This applies even in situations where the effects of migration as further complicating factors do not apply. They suggest that risk factors for psychiatric illness are a complex interaction of many educational, economic and sociocultural factors that vary by diagnosis. In some cases, common psychiatric disorders may actually be lower despite greater exposure to discrimination and other adversities. In others, worse mental health outcomes are similar to those among any distressed sample, irrespective of race or ethnicity.

The value of adjusting for sociodemographic factors beyond age and gender is controversial. One view is that adjusting for other sociodemographic factors is inappropriate when sources of disadvantage are clustered and interrelated. This therefore highlights the need to present both unadjusted and adjusted results in any comparison. However, the lack of differences remain even when the controls are only similar in age or gender, as opposed to other sociodemographic factors. Furthermore, identifying the relative strength of factors driving differences may indicate priorities for intervention. Generalisations regarding risk of psychiatric disorders cannot therefore be made for ethnic and linguistic people as whole, as risk varies by disorder type, sociodemographic factors, origin, study method and even comparison group recruited.⁴ Interventions need to take into account that disadvantage is rarely attributable to one cause.

Another influence on outcomes is culture itself. For instance, resilience may increase when Indigenous people live in close proximity with each other. Epidemiological research should therefore examine variations in psychiatric morbidity by region, ethnic density and cultural connection, as well as also ensuring the cross-cultural validity of psychiatric constructs and diagnostic instruments, to avoid misdiagnosis and false negatives.

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Closing the gap between training needs and training provision in addiction medicine

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Substance use disorders pose a significant global social and economic burden. Although effective interventions exist, treatment coverage remains limited. The lack of an adequately trained workforce is one of the prominent reasons. Recent initiatives have been taken worldwide to improve training, but further efforts are required to build curricula that are internationally applicable. We believe that the training needs of professionals in the area have not yet been explored in sufficient detail. We propose that a peer-led survey to assess those needs, using a standardised structured tool, would help to overcome this deficiency. The findings from such a survey could be used to develop a core set of competencies which is sufficiently flexible in its implementation to address the specific needs of the wide range of professionals working in addiction medicine worldwide.

Substance use and substance use disorders (SUDs) are major contributory factors to global morbidity and mortality. According to recent reports, 43% (2.3 billion) of the global adult population have consumed alcohol during past 12 months.¹ A 2016 survey found that more than 5% of people (283 million) had alcohol use

disorders; about 6% (275 million) had used other drugs at least once and about 0.6% (31 million) had drug use disorders.² Annually, about 3 million deaths are attributable to alcohol use and 450 000 deaths are attributable to other forms of drug use. A systematic analysis of the global burden of disease (1990–2016) concluded that 4.2% and 1.3% of all disability-adjusted life years (DALYs) were attributable to alcohol and drug use respectively.³ Such trends have been of increasing concern to public health services. Strengthening the workforce in the field of addiction medicine would contribute to addressing these challenges.

Effective pharmacological and psychosocial strategies exist for treatment of SUDs. Although improving access to treatment requires multifaceted approaches at all levels of the system, increasing the size of an adequately trained workforce can potentially improve treatment outcomes. Despite SUDs being a common public health problem, there seems to be a reluctance among general practitioners, physicians and psychiatrists to treat and manage these conditions.⁴ In addition to cultural, political and legal impediments, stigma and a self-perceived lack of competence in handling SUDs have been cited as important factors that contribute to negative professional attitudes, such as having a low regard for persons with SUDs and a reluctance to work with them.