

AVAILABILITY, ACCESSIBILITY AND ACCEPTABILITY OF ENGLISH-LANGUAGE MENTAL HEALTH SERVICES FOR THE ESTRIE REGION'S ENGLISH-SPEAKING POPULATION: SERVICE USER AND PROVIDER PERSPECTIVES¹

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Abstract

Mental illness affects about 1 in 5 Canadians during their lifetime but only approximately 30% of people needing help actually access mental health services (Gravel, Connolly & Bédard, 2004). This low access rate is worrisome and may not accurately depict the reality as it is lived out by linguistic minorities. The present study documents both the need for and access to English-language mental health services by the Estrie region's English-speaking minority. Intending to record their needs and access experiences against the backdrop of available English-language mental health services, both users and providers of these services were surveyed in tandem. This novel approach to mental health needs assessment research shows the precarious situation of this minority community (high need/low access to language-congruent mental health services) to be further compromised by misperceptions of service availability.

Résumé

Un Canadien sur cinq souffrira d'une maladie mentale au cours de sa vie et seulement 30% des gens ayant besoin d'aide ont réellement accès aux services dispensés en santé mentale (Gravel, Connolly & Bédard, 2004). Ce faible niveau d'accessibilité est préoccupant, d'autant plus qu'il ne reflète pas nécessairement la réalité telle qu'elle est vécue au sein des minorités linguistiques. Cette étude démontre que la minorité linguistique d'expression anglaise de l'Estrie a non seulement besoin de services en santé mentale dispensés en anglais mais également que ceux-ci leur soient accessibles. Afin de bien faire état de leurs besoins et de leurs expériences en termes d'accessibilité, un sondage a été effectué en deux instances, d'une part auprès des usagers, et d'autre part auprès de ceux qui dispensent ces services. Cette

nouvelle approche quant à la recherche sur l'évaluation des besoins en santé mentale démontre la précarité de la situation de cette communauté minoritaire (grand besoin/ faible accessibilité à des services adéquats en santé mentale offerts dans leur langue) d'autant plus compromise par les mauvaises perceptions de la disponibilité des services.

Mental illness affects about one in five Canadians during their lifetime and only approximately 30% of people needing help actually access mental health services (Government of Canada, 2006; Gravel, Connolly & Bédard, 2004; Mouding et al., 2009; Bernèche & Rhéaume, 2010). That so few access these services is worrisome. This low access rate has undoubtedly something to do with the shortage of mental health professionals and services, which is a pattern common to the delivery of health services in general. The stigma associated with mental illness, however, also slows one's pace in seeking help. Mental illness threatens a person's sense of belonging to a community in that, fearing alienation from family, friends and society, an individual will often choose to keep quiet about his or her illness. This is especially true in a geographically or linguistically isolated community where news travels quickly through the social network. It may well be that the 30% access rate reported by Statistics Canada represents an overestimation and does not accurately reflect the reality of minority communities.

The present study was undertaken to document the need for English-language mental health services as reported by the Estrie region's English-speaking minority. Intending to record their needs and access experiences against the backdrop of available English-language mental health services, both users and providers of these services were surveyed in tandem. This novel approach to mental health needs assessment research shows the precarious situation of this minority community (high need/low access to language-congruent mental health services) to be further compromised by misperceptions of service availability.

Perception Matters

A community's perception of the availability of services matters (Deri, 2005; Kasman & Badley, 2004; Chen & Hou, 2002). An example will help to illustrate the point. Let us imagine the case of a dissatisfied customer trying to sort out a problem with a telephone company. If (s)he has to navigate the 'press 1 for this, press 2 for that' protocol, never being able to talk to anyone at the company, is the service claiming "if you have a problem, just call us" really available? The company

would say “yes” because anyone calling will receive a response. Yet, this so-called response, which arrives only after finger-tapping through a maze of recorded instructions, adds frustration to an already troubled consumer. To further complicate the picture, if you are English-speaking and the ‘press 1,2,3 protocol’ is only in French, is the company’s service really available? A building’s structure is the site of service delivery activities. What makes these services ‘serviceable,’ however, are a community’s perceptions and beliefs as these shape the behaviour of potential users. Ronald Andersen’s (1995) model of health service use is helpful in underscoring the importance of health beliefs (attitudes toward health and health services) and enabling resources (i.e. means and know-how for accessing services) in facilitating or impeding health utilization.

While studying health care access among minority groups, Catherine Deri (2005) found that if a social network was highly interactive, the pattern of health service utilization of its members impacted their perceptions of service availability. That is, highly interactive minority communities who frequently access health services show higher than expected perceptions of service availability and subsequent patterns of access. Conversely, similar communities who tend not to access health services show lower than expected perceptions of service availability and subsequent long-term patterns of access. Deri speculated that a minority community’s channels of communication shape perceptions of availability, and, in this way, affect health service utilization patterns.

Deri’s findings suggest that researchers documenting a minority community’s mental health needs and experiences in accessing language-congruent mental health services must be especially mindful of the community’s social cohesiveness and patterns of mental health service utilization. She shows that perceptions of service availability are born of an interaction between the density of a minority community’s social network (high/low social contact) and its patterns of health service utilization (high/low access). Low utilization of health services in a high social contact minority community is associated with perceptions that these services are not available. Of interest in this respect is the Estrie region’s small English-speaking minority group inasmuch as it seems to satisfy both criteria associated with lower than expected patterns of health access. Socially cohesive by the drawing force of shared values, language, cultural life, institutions, as well as volunteer and community work,³ this minority group is culturally different from Quebec and Estrie French speakers in its markedly low reliance on public health and social services when in need, preferring instead to turn to informal support networks.⁴

The Estrie Region's English-speaking community

The Population Health Approach underscores the importance of sociodemographic factors – education, employment, income, as well as social support networks and access to social and health services – in determining the health conditions of individuals (Public Health Agency of Canada, 2008). Income- and education- related determinants have been causally linked to health and mental health inequalities (ministère de la Santé et des Services sociaux, 2005; Orpana et al., 2009). Variations in health determinants lead to social inequalities in the ability to access needed services. Also impeding access is minority language status which may limit citizens' opportunities to obtain culturally appropriate services (Whitehead & Dahlgren, 2007). It bears noting that more than 80% of Quebec's English-speaking communities prioritize accessing health and social services in English (Pocock & Hartwell, 2010). Hence, one might expect that a linguistic minority's difficulties in accessing language-congruent mental health services would thereby intensify the need of such services.

Socio-demographic information pertaining to the Townships and the Estrie region's English-speakers directs us to the distinctive features of this minority group. Quebec's official language minority communities represent 8.2% of the total population. The Estrie region's English-speaking minority constitutes 8% of the area's population and represents close to 24,000 inhabitants (Pocock & Hartwell, 2010; CHSSN, 2009). The 2006 Census data reports a decline of 5% between 1996 and 2006 (Government of Canada, 2006). Charting their distribution across the seven regional county municipalities, the highest concentrations of English-speakers are found in the Memphrémagog, Coaticook and Haut-St-François regions (CRÉ, 2009).⁵

A literature review of previous studies reveals that this linguistic minority community is vulnerable to a host of social and health problems. Notable are the low levels of income, employment and education among those aged 15–44 as well as a vulnerable and mostly unilingual elderly population. Specifically, English speakers in the 65–plus age group constitute 21.6% of the Townships population whereas 13.6% of French speakers fall in this age group.⁶ Only 18.4% of English-speaking seniors are conversationally bilingual. Education-wise, regional comparisons indicate that high school completion is less likely for Townships English-speaking youth aged 15–24 than English speakers in other areas of Quebec, as well as their Townships French-speaking counterparts. They are also less likely to have a trade certificate/diploma (4.9%) than the majority group (11.8%) of the same age. Close to 46% of Townships English speakers aged 15–44 are without a high school certificate compared to 38.3% of French speakers.

While the overall rate of unemployment is higher for Townships English speakers (8.1%) than for the French-speaking majority (6.2%), the most noticeable gap is found in the 15–24 age group. Here, 20.6% of English speakers as compared to 10.9% of their French-speaking counterparts are unemployed (Gouvernement du Québec, 2010; Statistics Canada, 2009; CHSSN, 2009; GRF, 2005; GRF, 2004; Pocock & Hartwell, 2010; Klimp, 2006; Warnke & Bolger, 2006; Pocock, 2006a; Pocock, 2006b; Pocock & Warnke, 2009; Floch, 2005; Kishchuk & Brault, 2005; Kishchuk, 2010; Farley, 2008).

These socioeconomic and educational disparities mark the Estrie region's English speakers as vulnerable to social and health problems. Added to the plight of those struggling with mental health problems is the difficulty of communicating in a second language when unable to access language-congruent services. While focus groups have in the past recognized the problem, no one had yet probed the issue, as the present study has done, by surveying a representative sampling of the Estrie region's English speakers on their need for, and experiences with, English-language mental health services.

Summary and Hypotheses

A number of predictions follow from the previous discussion. Generally speaking, it is expected that the present mental health needs assessment will yield results similar to those uncovered by studies examining health care access among minority groups.

Perceived and actual availability of English-language mental health services

It follows from Deri's (2005) study that a socially cohesive minority group whose members are not frequent users of mental health services will tend to have misperceptions about their availability. As noted above, the Estrie region's English speakers tend to turn to informal support networks rather than have recourse to the formal services of public health and social services institutions when in need. Their patterns of mental health service utilization should consequently be low. Taking both user and service provider responses into account, it is therefore predicted that English speakers' perception of available English-language mental health services will be lower than expected when set against those reported to be available by public health and social services institutions and community organizations.

Need of English-language mental health services

The socioeconomic and educational vulnerabilities of the Estrie region's English speakers place them at risk for health problems. The

15–44 age group shows lower levels of employment, income and education, and the high proportion of senior citizens may entail heavier care-giving duties for family members. When searching for help, this minority group's access to language-congruent mental health services might be difficult, thereby exacerbating an already stressful situation. It is therefore predicted that the percentage of English speakers registering a need of English-language mental health services will fall above national norms (will be greater than 20%).

Access to English-language mental health services

Misconstruals of service availability and low mental health service utilization (stemming from both anticipated linguistic barriers as well as actual cultural differences in help-seeking behaviour) suggest the following three predictions:

1. The number of English speakers attempting to access English-language mental health services will be much lower than those claiming to need them.
2. The number of those actually receiving English-language mental health services will be lower than those who attempted to access them.
3. The percentage of English speakers actually accessing English-language mental health services will fall below national norms (will be less than 30%).

Acceptability of English-language mental health services

Judgments about the acceptability of mental health services should rest on the quality and effectiveness of treatment received. For members of a linguistic minority whose first language is not the one used within the health and social service system, language-congruent communication becomes important and will thereby factor into their judgment bearing on the acceptability of services received. If the use of English is unwelcomed by the mental health service provider or communication-based misunderstandings arise, language can become the lightning rod of complaint and dissatisfaction. It is therefore predicted that English-language mental health services accessed by English speakers will be deemed more acceptable as mental health service providers are more welcoming of the use of English.

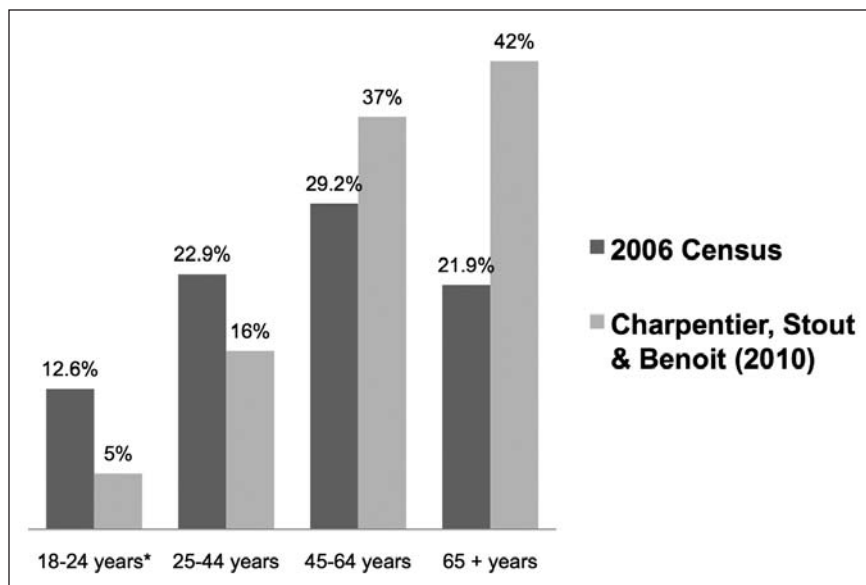
Method

MAIL SURVEY: participants, materials and procedure

A mental health needs assessment questionnaire was developed, pre-tested, and mailed to a stratified random sample of 1500 English

speakers living in the Estrie region's seven regional county municipalities. A data bank of names and addresses was provided by the Régie de l'assurance maladie du Québec (RAMQ) upon the ethical approval of the Commission d'accès à l'information. The only parameters of stratification specified were that the sample of individuals whose language of correspondence was English be representative of both urban and rural realities, that it be proportionally distributed across the Estrie region, and that male and female respondents be 18 years of age and older. Three hundred and four questionnaires were returned, which constitutes a response rate of 20%.

Of the respondents who completed the questionnaire, 42% were men, 58% women, with a mean age of 59. Plotting the sample's age-group distribution against the 2006 Census data for the Estrie region's English-speaking population as a whole, the percentage difference of persons aged 45 and over is noticeable. Using Statistics Canada age categories, Figure 1 shows that a greater percentage of respondents were middle- and senior-aged persons than that found in the general population (79% versus 51.1%).



* In the 2006 Census data, this category included an age range from 15-24.

Figure 1: Comparison of age demographics between our sample and those of the 2006 Census data for Estrie's English-speakers.

A little over half of them (59%) lived in rural areas with the remainder located in urban areas while a clear majority (96%) had been living in the Estrie region for over 10 years. Some two-thirds (67%) earned less than \$50,000 with close to a third (30%) reporting an an-

nual income of less than \$25,000 (11% did not report their income). Education-wise, 47% of respondents had pursued no higher studies than high school. Only 38% of them were employed.⁷ Designed to elucidate the determinants of mental health service utilization, the questionnaire was comprised of fifteen questions asking about respondents' awareness of the availability of local English-language mental health services, their need and use of some forty different adult and youth English-language mental health services, and their satisfaction with services sought. A last section comprised of open questions asked them to relate their experiences in accessing local English-language mental health services while inviting comments as to ways of improving the situation. Socio-demographic variables included gender, age, marital status, urban/rural residence, mother tongue, family income, labour force status, education, and proficiency in French.

PHONE SURVEY: participants, materials and procedure

In tandem with the mail survey, a structured phone survey was conducted of the Estrie region's designated public institutional providers of health and social services, of community organizations offering mental health services, and of private practice mental health professionals.⁸ Public institutions, community organizations and private practice mental health practitioners completed the survey over the phone, except for those public institutions whose complex databases required that the survey be filled out through other means (i.e. electronic attachments). Inclusive of 14 questions, the survey asked about the clientele served, the training and number of mental health service providers (as well as the number of bilingual mental health service providers), their knowledge of available English-language mental health services in the area, the type(s) of English-language mental health services offered within their premises as well as their frequency of use by English-speaking recipients when available, the percentage of English-speaking clientele, the adequacy of the English-language mental health services offered, the difficulties encountered in providing, and the ways of improving, these services. One hundred and forty-six community organizations (inclusive of 880 service providers), 14 public institutions (inclusive of 709 service providers), and 208 private practice mental health professionals agreed to participate in this study.⁹ No previous research had explored the question of English speakers' mental health needs by way of documenting available English-language mental health services in the community, public and private domains. Survey results were pooled so that no single community organization or public institution could be identified. Results drawn from both sets of data (mail and phone surveys) were

juxtaposed in order to show the similarities and discrepancies in responses between those reporting a need for English-language mental health services and those offering them. This comparison points out lacunae while giving directions for improved services.

Results (mail and phone surveys combined)

Perceived and actual availability of adult and youth English-language mental health services

Provided with a list of various types of mental health services, respondents were asked to check all English-language mental health services thought to be available in the area. Presented in Figure 2, in decreasing order of awareness, are the top 11 most frequently mentioned 'adult' English-language mental health services. Public institutions (PI), community organizations (CO), and private practice mental health professionals had also been asked to name the types of English-language mental health services offered within their premises. Juxtaposing mail survey data (respondents' perceptions) and those obtained from PIs and COs (actual English-language mental health services offered)¹⁰ uncovers an interesting finding, as shown in Figure 2. Judging by the noticeable gap between perceived and actual availability, it is evident that English speakers have a fairly dim view of what is available in the way of adult English-language mental health services. In the case of individual therapy, for instance, only 28% of respondents perceive this service to be available in English whereas 75% of PIs report offering it. In fact, in all but two categories (pastoral counseling and career counseling), public mental health service availability exceeds expectations. In contrast, in all but one category (individual therapy), community mental health service availability falls short of expectations. For instance, while 21% of respondents perceive marriage therapy to be available in English in the area, only 6% of COs offer it. A comparison of services offered by COs and PIs, as shown in Figure 2, reveals that the former are not the main providers of adult English-language mental health services in the area.

In a similar vein, respondents' perceptions of available youth English-language mental health services do not accurately represent the situation as reported by PIs and COs. Presented in Figure 3, in decreasing order of awareness, are the top 12 most frequently mentioned youth English-language mental health services. The same gap between perceived and actual availability is apparent. For instance, 21% of respondents believe that individual therapy for youth is available in English whereas only 45% of PIs and 11% of COs offer it.



Figure 2: Awareness of adult English-language mental health services vs public and community availability.

Of all mental health services shown in Figures 2 and 3, few services are available in English by more than half of public institutions. They are: adult individual therapy (75%), adult psychiatric care (55%), and adult medication therapy (65%). For all other types of mental health services, PI and CO offerings fall below, and sometimes far below, 50%. As a community concerned with the health and well-being of all of its members, this situation is troublesome.

Interested in their perception of the adequacy of the situation, we asked PIs and COs to rate their English-language mental health services on availability as well as their ease/difficulty in knowing the extent of other available English-language mental health services in the area. As seen in Table 1, most PIs do not see the availability of English-language mental health services offered within their premises as problematic, giving themselves high ratings on the question (95% rate it as adequate to excellent). While 60% of COs seem content as well, 40% judge the situation to be less than adequate.

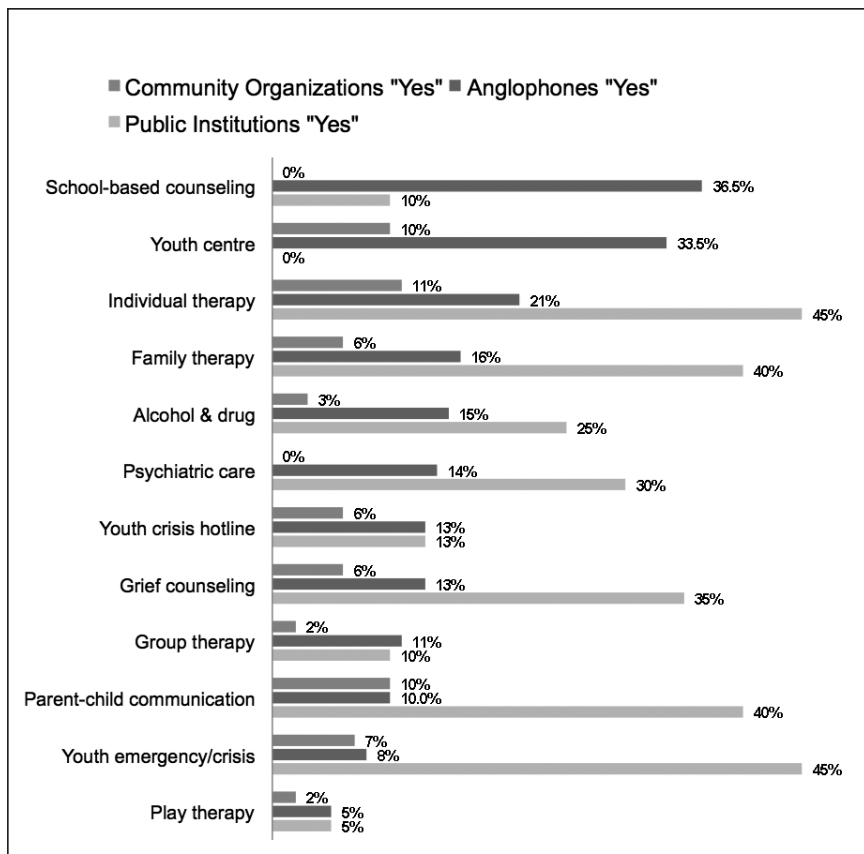


Figure 3: Awareness of youth English-language mental health services vs public and community availability.

When tapping their knowledge of the area’s available English-language mental health services as a whole, Figure 4 shows that 64% of PIs and 52% of COs plead partial ignorance, finding it difficult to come by this knowledge. Such being the case when working within the mental health care system, one can appreciate how much more

Availability of English Services	Less than Adequate	Adequate to Good	Excellent
Public Institutions:	5%	75%	20%
Community Organizations:	40%	39%	21%

Table 1: Availability of English-language mental health services

difficult it might be for those troubled by need trying to find their way to some relief.

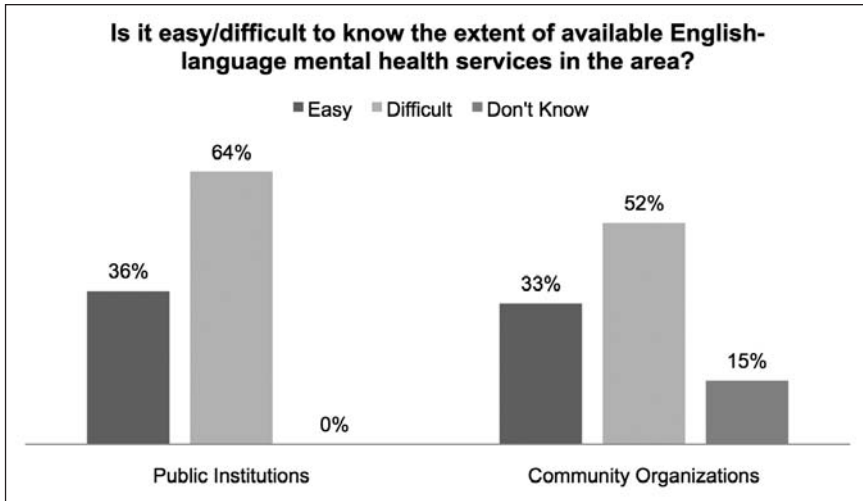


Figure 4: Knowledge of existent English-language mental health services in the area.*

*Of the 20 public institutions surveyed, only 11 answered this question (55%).
Of the 146 community organizations, 135 answered this question (92%).

Advertisement of English-language mental health services

Misconstruals of service availability by the Estrie region's English speakers might also stem from the fact that though available, English-language mental health services are yet invisible to this community. This raises the question of whether English-language mental health services offered by PIs and COs are sufficiently advertised. The fact that close to 90% of respondents answered in the negative does not surprise when understood in light of the self-reported measures taken by PIs and COs to raise awareness of their English-language mental health services among the English-speaking population. Figure 5 shows that aside from the use of bilingual leaflets (used by 75% of PIs and 29% of COs), not much is done in the way of advertising, be it in the form of ads in local English newspapers, bilingual websites, attendance at English-sponsored socio-cultural events, English information sessions, or bilingual newsletters.¹¹

Need of English-language mental health services

The question of need lies at the heart of the present research. As illustrated in Figure 6, respondents in need turn to family, friends, family physician and spouse most frequently when looking for emotional

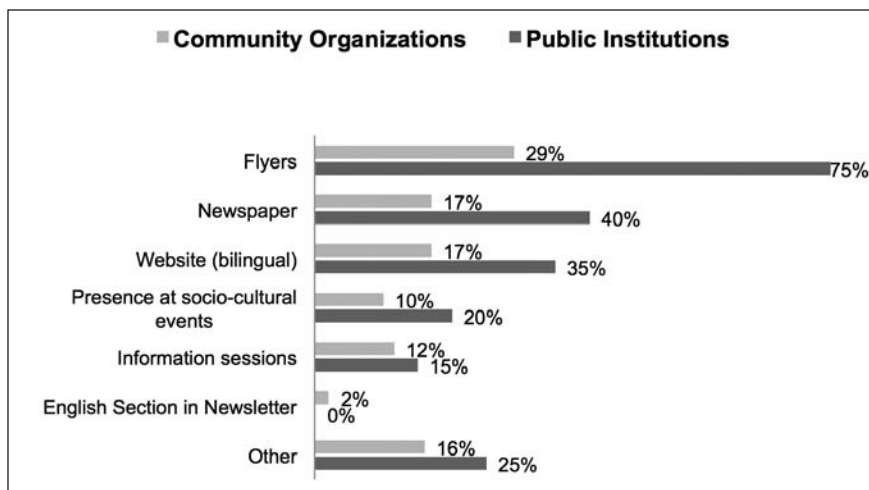


Figure 5: Actions taken to increase visibility of English-language mental health services to the English-speaking community.

support and psychological advice. Turning to a mental health professional such as a psychologist, psychotherapist, or social worker is not their first choice. Fewer turn to psychiatrists.¹²

Asked specifically whether they needed English-language mental health services, 45% of respondents answered in the affirmative. This figure represents more than double the national average (according to Statistics Canada, 20% of people struggling with mental health issues will require help at some point in their life).¹³ An Odds Ratios analysis

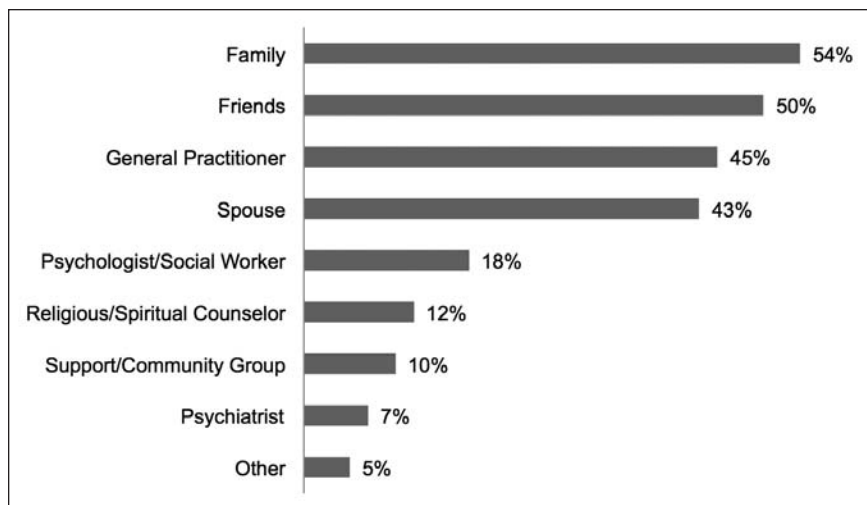


Figure 6: When in need of psychological/emotional support or advice, who do you turn to? [N = 267]

reveals that respondents aged 30–60 were more likely to admit needing English-language mental health services than either those in their 20s or those over the age of 65 (Chi-square = 40.25, $df = 6$, $p < .000$; Cramer's $V = .411$, $p < .000$).

Of those adult English-language mental health services needed by respondents, the top 5 most frequently mentioned, in decreasing order of frequency, were individual therapy, relaxation/stress management, career counseling, medication therapy, and emergency crisis services.¹⁴ Needed youth English-language mental health services most frequently mentioned, in decreasing order of frequency, were individual therapy, parent/child communication, school-based counseling, family therapy, youth centre, and emergency crisis services.

Access to English-language mental health services

While 45% of respondents reported a need of English-language mental health services, only 25% attempted to obtain these services and even fewer received them (20%).¹⁵ That 20% of respondents received mental health services is below national norms. According to Statistics Canada, 30% of those in need of mental health services receive them. Interestingly, slightly more than a third of our survey respondents (35%) deplored the fact that English-language mental health services were not available as often as needed.

Both need and perceptions of service availability impact help-seeking behavior. Respondents who had indicated a need were asked whether their attempts to obtain English-language mental health services had been successful. Figure 7 shows that of the attempts made to receive adult English-language mental health services, a little over two-thirds

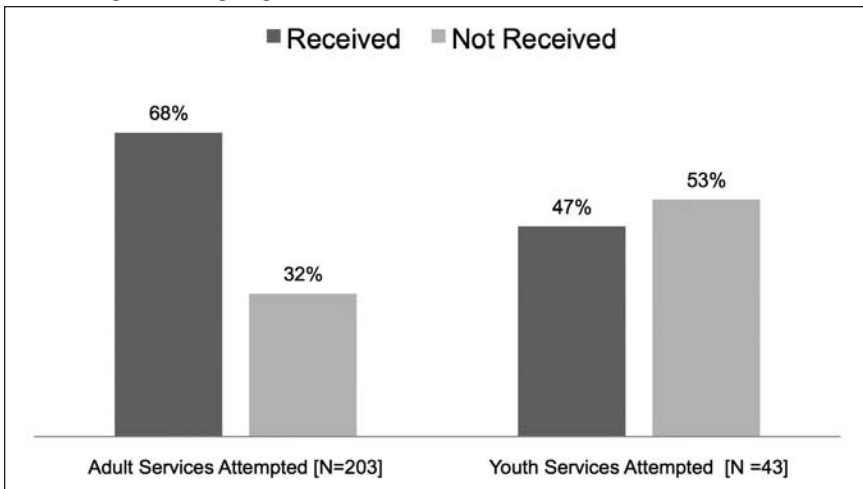


Figure 7: Attempts to receive English-language mental health services

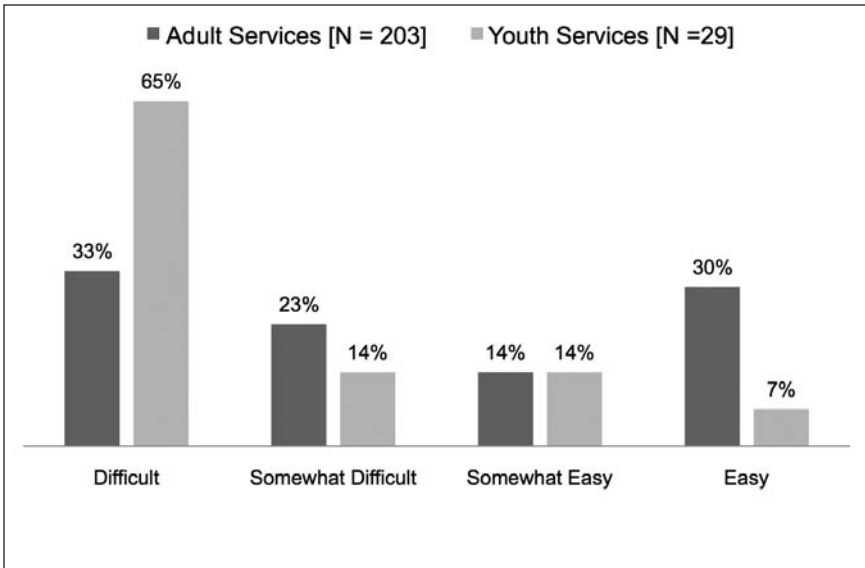


Figure 8: Ease of access – English-language mental health services

were successful (68% received vs 32% not received) while less than half of the attempts made to obtain youth English-language mental health services were successful (47% received vs 53% not received).

Judging by 56% of the ratings (as presented in Figure 8), accessing adult English-language mental health services is a rather difficult experience while the difficulty in obtaining youth English-language mental health services is even more pronounced (79% of ratings fell in the somewhat difficult/difficult category).

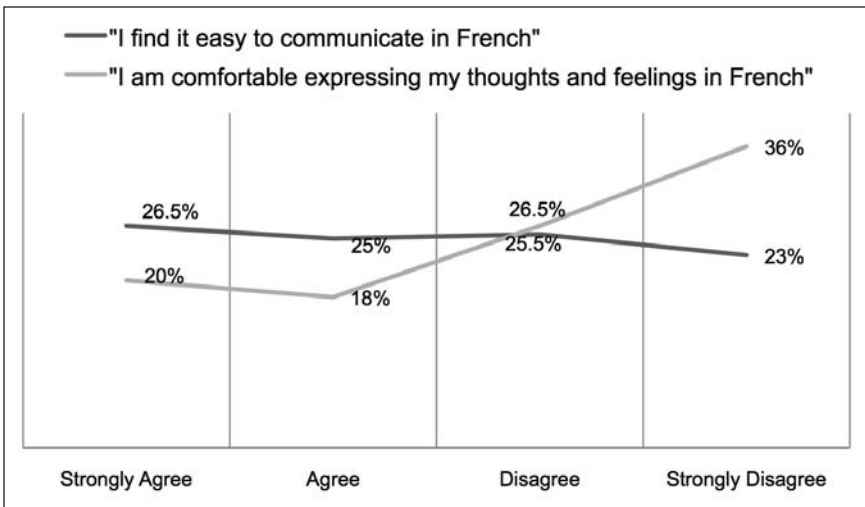


Figure 9: Proficiency in French

Receiving mental health services in one's first language seems particularly important when struggling with emotional/psychological difficulties as the search for words is made harder by the description of painful thoughts and feelings. A good way to illustrate this is by asking respondents to rate both their ease of communication in French and level of comfort in expressing thoughts and feelings in French. While slightly over half (51.5%, as illustrated in Figure 9) find it easy to communicate in French, their discomfort is particularly poignant when having to express thoughts and feelings in French, as evidenced by the significantly greater number (62.5%) who are uncomfortable in doing so ($t(269) = 8.22$ $p < .01$).

When asked, 68% of respondents said that they would not attempt to receive mental health services in French if unavailable in English.¹⁶ This situation seems to have its counterpart in the public sector: few English-speaking clients (less than 10%) accept French-language mental health services, as reported by 63% of PIs and 45% of COs. Overall, 8% of PI's clientele is English-speaking while less than 10% is for a clear majority of COs (85%).¹⁷ Despite the low numbers of English-speaking clients, English-language mental health services are reported to be available 5–7 days/week by 78% of PIs and just under half of COs (48%), though another 33% of the latter group offers no such services. While most PIs (90%) and 59% of COs apparently never turn away clients on the basis of unavailable English-language mental health services, this situation does nevertheless occur a few times a year for 10% of PIs and 41% of COs.

Acceptability of English-language mental health services

The drop in percentage between those in need (45%) who attempt to obtain English-language mental health services (25%) and receive them (20%) points to the existence of obstacles barring access to needed English-language mental health services in the area. For linguistic minorities specifically, questions of accessibility and acceptability of services are intricately connected. The very obstacles impeding access (linguistic barriers) will also influence user judgments bearing on the acceptability of services. Possible impediments may be suggested by pursuing the question of acceptability along one of the dimensions well known to impact it, namely, communication.¹⁸ Respondents who had accessed English-language mental health services were asked to report on their experiences along this dimension.

Clerical staff/service recipient communication

Let us imagine a scenario wherein an English speaker in need of English-language mental health services initiates contact with some

institution/organization. Is the person greeted in English by the clerical staff? While respondents' opinions tended to be slightly more favourable than not when rating the staff's use of English (58% positive, 42% negative),¹⁹ a noted exception was in accessing psychiatric care whereby linguistic barriers created problems for 70% of respondents.

Asked whether the initial contact was bilingual within their premises (see figure 10), 37% of PIs and 62% of COs responded in the negative while another 42% and 25% respectively indicated that it generally or always was. That it depended on who was working was true for 16% of PIs and 13% of COs. While all PIs and three-quarters of COs deemed the situation adequate some dissatisfaction was registered by 22% of organizations for whom staff/client communication difficulties due to linguistic barriers are problematic.²⁰

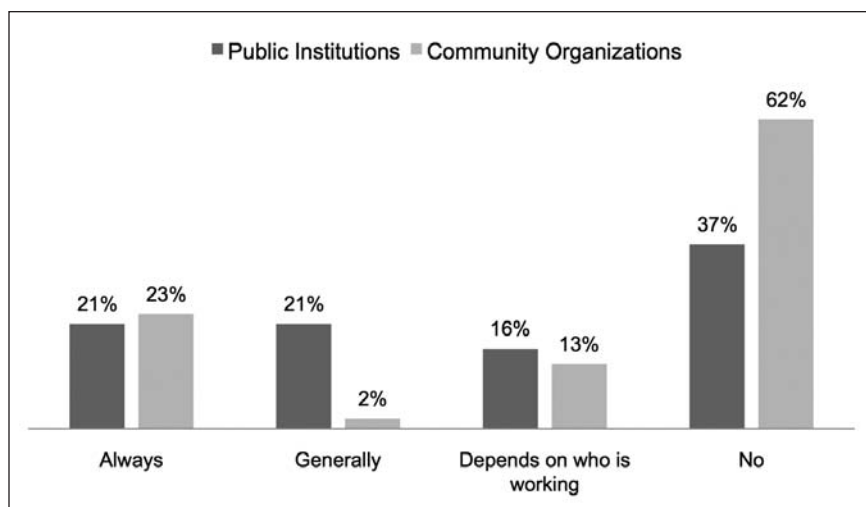


Figure 10: Communication in English – Is the initial contact bilingual?

Service provider/recipient communication

Problems related to the acceptability of services abound when cultural and linguistic barriers prevent the establishment of a good working relationship between service provider and recipient. Within a shared therapeutic environment, ease of communication between service provider/recipient, as well as cultural and linguistic awareness/sensitivity on the professional's part influence user judgments when pronouncing on the acceptability of mental health services (Derose, 2009). Figures 11 and 12 present results related to four questions raised in the mail survey. As shown in Figure 11, the experiences of close to three-quarters of respondents were positive, showing that the English spoken by the service recipient was well understood by the mental health

service provider, and vice-versa. The two types of mental health services breaking this pattern in yielding consistently unfavourable ratings—thereby signaling the presence of linguistic barriers—were adult emergency crisis services and psychiatric care.

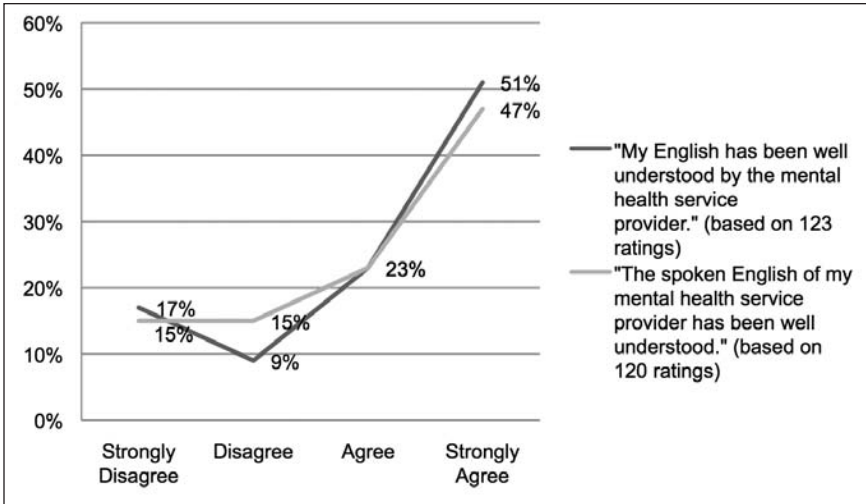


Figure 11: Mental health service provider/recipient communication.

Asked whether the use of English was welcomed, three-quarters of respondents agreed, as Figure 12 shows, though one full third deemed the mental health service provider to be lacking in cultural sensitivity.

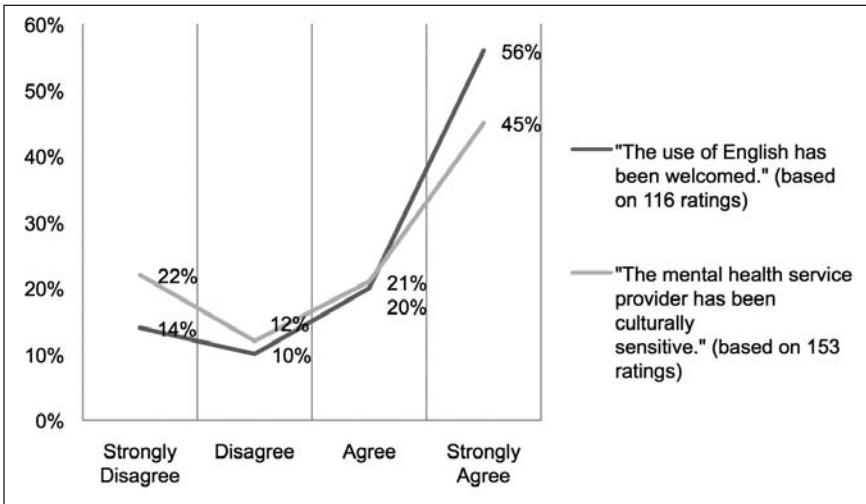


Figure 12: Mental health service provider/recipient communication.

Figure 13 indicates that for some two-thirds of PIs (67%) less than half of their interveners are English-speaking while this is the case for 55% of COs, a third of whom (37%) have no English-speaking interveners on staff.

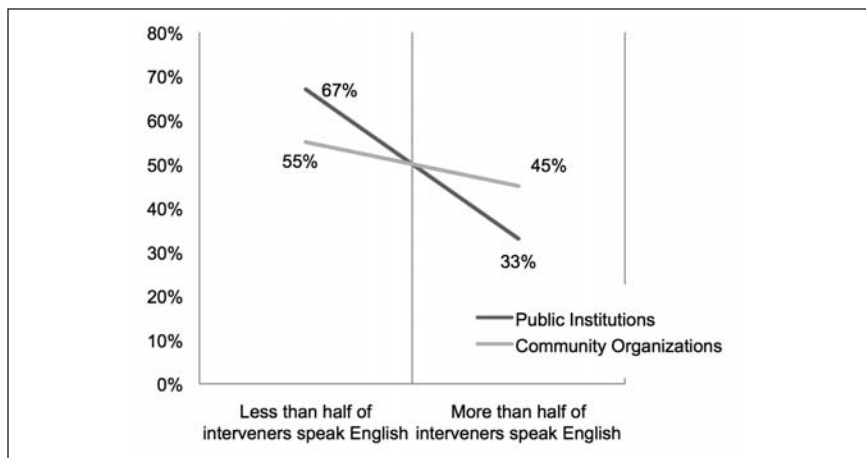


Figure 13: Percentages of English-speaking interveners in Public Institutions and Community Organizations*

*Of the 20 public institutions, 4 (20%) did not know the percentage of English-speaking interveners on staff and therefore could not answer the question. Of the 146 community organizations, 44 (30%) did not reply to this question.

As Figure 14 shows, PI and CO self-ratings indicate that most of them are satisfied with their interveners’ spoken English, though 24% of COs register some discontent in this respect.²¹

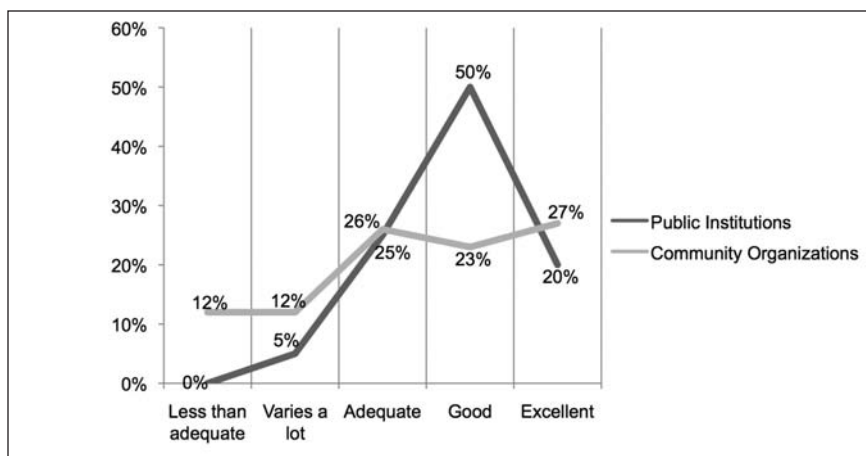


Figure 14: Self-assessed quality of interveners’ English – Public institutions vs community organizations.

Overall assessment

Admittedly, the question of unmet mental health needs is complex because born of various considerations. Unmet needs can be assessed by establishing the ratio of mental health services needed over those attempted, or of mental health services attempted over those received. The question might also be gauged by documenting users' self-reported satisfaction with English-language mental health services received. Asked whether the help received had been effective, a little over half of respondents (59%) answered in the affirmative, 41% in the negative. The types of English-language mental health services for which ratings were most positive were adult individual therapy, pastoral counseling and medication therapy. Close to a third (32%) registered an unwillingness to seek the same service again. PI and CO self-reports reveal that evaluative measures of client satisfaction are absent in 32% and 38% of these settings respectively.²² More than two-thirds of PIs (68%) and just over half of COs (52%) had obtained no feedback (positive and negative) from clients in the previous year.

Probing the relationship between these various dimensions of service acceptability yields an interesting finding (see Table 2 for correlations). English-language mental health services accessed by respondents in the form of individual therapy were deemed more culturally sensitive and effective, and more likely to be sought again, as mental health service providers were more welcoming of the use of English.²³

	Service has been culturally sensitive	Help received has been effective	Would seek the same service again
English has been welcomed	0.472**	0.593**	0.645**
**p < .001			

Table 2. Correlations: English-speaking adults receiving individual therapy (N=31)

In the mail survey's last section, a broader question about general needs asked both respondents who had attempted to obtain and those who had received English-language mental health services to indicate whether their mental health needs were being met. Figure 15 shows that while 41% seemed content in this respect (mental health needs not only well but very well met), just about as many (40%) thought the exact opposite, signaling the presence of unmet mental health needs. Another 19% rated their mental health needs as more or less met.

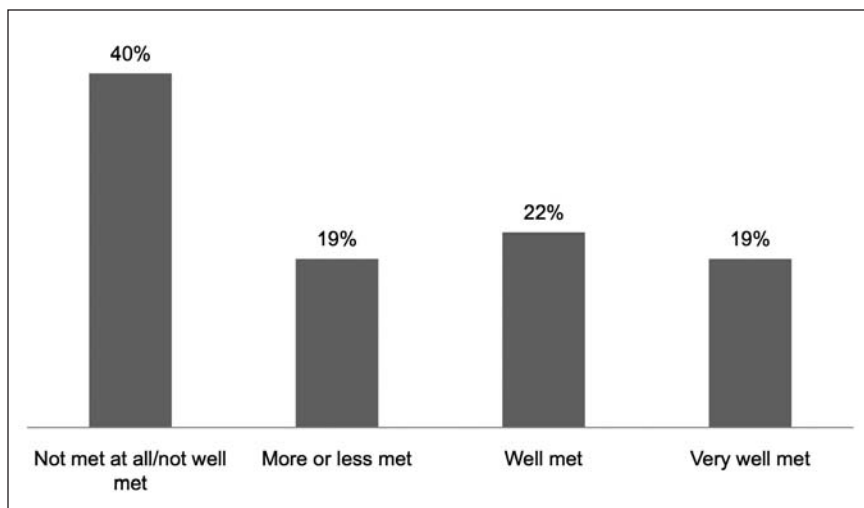


Figure 15: The extent to which mental health needs are being met.

Conclusion

The present health needs assessment was carried out so as to establish the nature and extent of English speakers' mental health needs while documenting their experiences of access to English-language mental health services in the Estrie region. Exploring the question of the availability, accessibility and acceptability of English-language mental health services from both service user and provider perspectives points out lacunae while giving directions for improved services.

All hypotheses laid out in the introductory section were confirmed. We found English speakers' perception of available English-language mental health services to be lower than expected given those actually made available by public institutions. Misconstruals of service availability are undoubtedly reinforced by the fact that there is virtually little to no advertisement of mental health services targeting the English community. By service providers' own admission, knowing how to access English-language mental health services (other than their own, when available) is difficult. More must be done, then, to advertise available English-language mental health services in the area.

Forty-five percent of respondents reported needing English-language mental health services. This high number, more than double the national average, may reflect the eagerness with which our respondents recorded their experiences under the cover of anonymity. Still, it is troubling that only 25% attempted to obtain English-language mental health services while only 20% actually received them. That the English-speaking community as a cohesive social network tends to underuse professional mental health resources may well feed misper-

ceptions of available services and lower subsequent patterns of mental health access, as predicted by Deri's (2005) research. This is substantiated by the Estrie region's English speakers' much lower access rates (20%) than those reported by Statistics Canada (30%). Believing that English-language mental health services are available, within reach, and unimpeded by intervener-client communication barriers might just be the kind of encouragement needed to try to obtain these services, thereby bridging the 45%–25% gap.

Language clearly matters for linguistic minorities when gauging the acceptability of services received. Mental health service providers who are perceived by their English-speaking clients as welcoming the use of English within the therapeutic environment are thereby deemed more culturally sensitive, their treatments more effective, and their services more likely to be used again, if needed.

Medical health needs assessments are fraught with difficulties; those gauging mental health needs are even more troubling. Little stigma is attached to health problems. This is not the case when it comes to mental illness. Regardless of magnitude, a common response to psychological malaise and illness is to keep it to oneself. People with thoughts of suicide often choose not to mention them; if they're depressed, they just leave it alone. They leave it alone, that is, until it is too noisy to silence. They might then just turn to family, friends, as we have shown in the case of our English speakers. If they are so fortunate as to have a family doctor, they might venture there. Only 18% would turn to a mental health professional, such as a psychologist, under the circumstances. Although reaching out to close ones can be beneficial, it puts a strain on these relationships. Untended, these added stressors open pathways to hopelessness, as captured in the words of one respondent.

My husband needs individual therapy but could [only] find free referral through the hospital after waiting in the psychiatric ward for a day and being placed on an 8-week waiting list. His sessions should be starting soon but in the meantime our family is struggling and [his] depression is deepening. I really feel without help he is likely to continue spiraling and I will soon be a single mom.

Arguments against the provision of increased English-language mental health services are sometimes based on statistics showing that the proportion of English-speaking clientele accessing services locally is low, whence the 'there cannot be a need if there is no demand' kind of reasoning. Given that there are some 11.4 Francophones for every English speaker in the Estrie area, one would expect that proportionally speaking, fewer English speakers would access mental health services. The fact, however, that almost half of our sample expressed

a need of English-language mental health services belies a reasoning based on entry and exit statistics. As Whitehead and Dahlgren (2007, p.5) report, equity in access to health services means “creating opportunities and removing barriers to achieving the health potential of all people.”

What can be said of the other 20% who never even attempted to receive English-language mental health services though needing help? “We never try,” one respondent reports, “we figure most things out for ourselves.” Another concludes: “let’s face it, we are on our own.” But they are not on their own. The Estrie region’s English-speaking community’s lack of awareness of available English mental health services is a concern. More services are available than they think. However, that public institutions and community organizations are themselves unaware of the extent and location of available English-language mental health services in the area is also problematic. This suggests that everyone would benefit from concrete measures taken to increase visibility while promoting heightened awareness of existent English-language mental health services.

A broken bone can be set, regardless of language. Setting a broken mind requires sympathy of speech. The lingua franca of mental illness is the sufferer’s mother tongue.

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NOTES

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- 2 Correspondence: Dr. C. Charpentier, Department of Psychology, Bishop's University, 2600 College St., Sherbrooke, QC J1M 1Z7. Tel: (819) 822-9600, ext. 2653, Fax: (819) 822-9661, E-mail: claude.charpentier@ubishops.ca
- 3 Eighty-four percent of Quebec English speakers affirm the importance of ensuring the continuance of English language and culture. They share in common a strong sense of belonging to their own linguistic group (84%) while endorsing a strong Canadian identity (Jedwab, 2008). In the Estrie region, various mediatic forums serve as rallying points around which English speakers come together. They are loyal to the CBC Community Network Radio as well as to local English-language newspapers (*The Sherbrooke Record*, the *Stanstead Journal*, the *Townships Outlet*), venues that are conducive to the expression and sharing of perspectives on local issues and events. Popular cultural events staged at Bishop's University, a local English institution, draws the community together as does their visible support of any number of local seasonal events ranging from Townshippers' Association's Friendship Day, Canada Day celebrations to the very popular Ayer's Cliff, Richmond and Bromont agricultural fairs. All of these afford the possibility of high social contact,—the first of Deri's criteria. To say that a group is socially cohesive is not to say that it is ethnically homogeneous. The Townships English-speaking community is rich in ethnic diversity and this is a source of pride for its members. See Pocock & Hartwell (2010).

- 4 The latter finding is interesting in light of the INSPQ's (2006) report that Quebecers rank ahead of all other Canadians in consulting professionals, such as physicians (3%), psychologists (4%), and psychiatrists (1%), about their mental health. See also Pocock & Hartwell (2010) and Pocock (2006a).
- 5 Source: Statistics Canada, 2006 Census based on First Official Language Spoken (FOLS).
- 6 The reader will note that some stats in the following section refer to the greater geographical area known as the Historical Eastern Townships (thereafter referred to in the text as 'Townships') which includes not only the Estrie administrative region but also parts of Montérégie, Centre-du-Québec, and Chaudière-Appalaches. Unless otherwise specified, the stats refer to the Estrie region.
- 7 This pattern is similar to the one holding for English-speaking communities of Quebec and of the Eastern Townships. See Pocock & Hartwell (2010).
- 8 In compliance with Bill 142 and the Law on Health and Social Services of Quebec, public institutions are the network institutions listed by the Agency for Health and Social Services of the Eastern Townships as the designated providers of health and social services. The Agency which is responsible for the coordination and implementation of health and social services lists 16 such institutions. All but two public institutions completed the survey. Though not compelled by law to offer health and social services, community organizations included in the survey were those who reported offering mental health services. Private practice mental health professionals included psychologists, social workers, psychotherapists, psycho-educators, sexologists, coaches, career counselors and pastoral counselors.
- 9 As data analysis is incomplete, results pertaining to private practice mental health professionals will not be discussed.
- 10 Hereafter referred to as PI (public institutions) and CO (community organizations).
- 11 As reported by PIs and COs, other means of increasing the visibility of their mental health services included working on joint community projects with English-speaking partners (i.e. Townshippers' Association), holding press conferences, and making mental health services known in Anglophone elementary schools.
- 12 As previously noted, Quebec English speakers' tendency to turn to informal networks of support stands in contrast to French speakers who are more likely to turn to public institutions, when in need. See Pocock (2006a) and Pocock & Hartwell (2010).
- 13 Mouding et al. (2009).

- 14 The top ten most frequently cited English-language mental health services, in decreasing order of frequency, were individual therapy, relaxation/stress management, career counseling, medication therapy, emergency crisis services, parent/child communication, support groups, psychiatric care, grief counseling, and family therapy.
- 15 Topping the list of English-language mental health services received were individual therapy followed by psychiatric care, medication therapy, and emergency crisis services.
- 16 Even though many Quebec English speakers are bilingual, access to health and social services in English is a high priority for them. Struggling with physical or mental illness brings its own share of stress which is intensified by the need to communicate in a second language. See Pocock & Hartwell (2010).
- 17 For 49% of community organizations, less than 1% of their clientele is English-speaking.
- 18 See Chen & Hou (2002) and Sibley & Glazier (2009).
- 19 It is important to note that respondents were not asked to rate the quality of the staff's spoken English but to judge the adequacy of the staff's attempts to use English as the shared language of communication.
- 20 In line with Pocock & Hartwell as well as Kishchuk's (2010) discussions, reasons for English speakers' under-representation in health services utilization might be related to their lack of knowledge of services and of ways of navigating the health care system, particularly when access is made difficult by an initial contact that is unwelcoming and in French.
- 21 Pocock & Hartwell (2010) report on the growing number of Townships English-speaking families whose distress is partly due to the low numbers of English-speaking health professionals as well as the inability of many to pay for private services. According to the authors, more support and resources are needed to safeguard the socioeconomic vitality of this community.
- 22 Though these results tell us something about whether measures exist within these institutions and organizations to gauge clients' satisfaction with English-language mental health services received, they reveal nothing as to whether these measures are actually used.
- 23 Individual therapy was chosen because it ranked ahead of all other mental health services as most frequently needed and accessed by respondents, while also being the type of service received for which acceptability ratings were the most positive.