INCREASING ACCESS AND BUILDING EQUITY INTO MENTAL HEALTH SERVICES: AN EXAMINATION OF THE POTENTIAL FOR CHANGE

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ABSTRACT

This article explores the use of mental health care services by ethnoracial people in Canada and distinguishes between the reasons for underutilization of services by ethnoracial groups and the barriers which prevent ethnoracial groups from accessing services. Research focusing on Canadian race relations is reviewed to reveal how they are paralleled in the functioning of mainstream mental health care organizations. Existing policies and attitudes are then considered in relation to how they support or impede interventions to increase accessibility to services. Finally, frameworks for organizational change based on multiculturalism and anti-racism are presented, and the advantages and disadvantages of both are articulated.

INTRODUCTION

Self-evaluation and planning, under the auspices of mental health reform, seem to be the current focus of Canada's mental health system. Prominent in this discourse is the positioning of consumers of mental health services as stakeholders and decision-makers in the delivery of care (Clarke Institute of Psychiatry, 1997; McKee, 1998). A great deal of progress has been made in establishing standards for such a positioning (Manning, 1999). However, the work to date has neglected the issue of cultural and racial diversity, which is particularly important in the Canadian context.

The literature surrounding consumer involvement and empowerment in mental health services has tended to present a homogenized version of the mental health consumer. Within this literature, there is recognition that the issues faced by clients with severe mental illness are different than those who are otherwise diagnosed (Wilson, 1996a). There is little evidence, however, of recognition of the diversity among mental health consumers. Neither is there evidence of concern for how the experience of mental illness and the mental health system is affected by race, ethnicity, religion, class, sexuality, and other aspects of identity.

Racial and cultural diversity is not experienced equally throughout Canada. Urban centres such as Toronto, for example, receive thousands of immigrants from non-European countries every year (Statistics Canada, 1996) and, consequently, are more racially and culturally diverse than are many other regions of the country. Census projections suggest that ethnoracial[1] people will become the numerical majority in parts of Canada within the next few years; accordingly, the mental

health reform agenda must address the experience of ethnoracial people with the mental health care system.

UNDERUTILIZATION AND ACCESSIBILITY

There is an extensive literature describing the underutilization of mental health services by ethnoracial groups in North America. Presuming that racialized groups experience mental and emotional problems at rates similar to that of mainstream groups, health care providers have expected these groups to be represented proportionately in the number of clients they treat (Leong, 1994; Zhang, Snowden, & Sue, 1998). Although Canada has not generated much research on the issue, the possibility that racialized minorities are not able to access mental health services has been identified as a problem (Ali, 1997; Beiser, Gill, & Edwards, 1993; On-tario Ministry of Health, 1995; Sadavoy & Williams, 1999). This literature sug-gests several reasons why ethnoracial groups may not seek out psychiatric care, or may leave such care before achieving full benefit.

Most researchers conclude that mainstream mental health care is inconsistent with the values, expectations, and patterns of help-seeking used by ethnoracial communities (Coie, Costanzo, & Cox, 1980; Escovar & Kurtines, 1983; Hall & Tucker, 1985; McNicoll & Christensen, 1996; Mokuau & Fong, 1994; Pham, 1986; Rogler, Malgady, Constantino, & Blumenthal, 1987; Ruiz, 1995; Ruiz & Langrod, 1976; Solomon, 1988; Takeuchi & Kim, 2000; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). Clients, or potential clients, are not inclined to make use of services if they do not perceive a need, or if the help offered runs counter to deeply held beliefs about how mental and emotional problems are solved. Because underutilization is attributed to decisions to bypass, avoid, or disconnect from mainstream services, the focus of intervention is often at the individual level—usually with the goal of changing attitudes, knowledge, and, eventually, behaviour.

Underutilization and accessibility of services often are discussed together. There are, however, important distinctions between the two concepts. Under-utilization of mental health services by racialized minorities generally has been conceptualized as resulting from personal choices. Questions of accessibility of services, on the other hand, focus on the specific structures and processes which prevent ethnoracial groups from having the opportunity to receive mental health care.

If underutilization is linked to personal choice, it could be argued that it is not a problem which merits targeted intervention. Certainly, there is ample evidence that people in the mainstream population also underutilize mental health services (Birkel & Repucci, 1983; Horwitz, 1977; Kessler et al., 1994; Parikh, Wasylenki, Goering, & Wong, 1996; Pescosolido, Gardner, & Lubell, 1998). Such an argu-ment is, however, problematic. The attempt to attribute differences in service-use entirely to individual choice is consistent with a pattern of blaming individuals and their behaviour for the lived differences between racial groups in Canada (Reitz & Breton, 1994). This construction of the issue absolves society of blame for racial and cultural inequities; it also absolves society of responsibility for ad-dressing them.

Focusing on accessibility widens the scope of discussion. Barriers to accessibility are created not only by the nature of connections between mainstream organizations and potential service recipients, but also by the staffing of mental health services and the decisions of policymakers who allocate resources for men-tal health care. Among the barriers to ethnoracial people accessing services which have been identified are: (a) culturally insensitive or offensive services (Casimir & Morrison, 1993; McNicoll & Christensen, 1996; Zhang et al., 1998); (b) language barriers between service providers and service recipients (Rogler et al., 1987; Ruiz, 1995; Vega et al., 1999); (c) user fees or insurance requirements which prevent access by lower-income individuals and families (Boyer, Ku, & Shakir, 1997; Takeuchi & Kim, 2000); (d) service locations which are distant from ethnoracial communities, operate during "business" hours only, or have long waiting lists (Casimir & Morrison, 1993; McNicoll & Christensen, 1996; Mokuau & Fong, 1994); and (e) lack of information about services (Hill & Fraser, 1995).

The search for causes of and solutions to accessibility problems must include exploring the opportunities available to and influences of different racial groups in the societal context. Links between accessibility and social problems have been made. Some researchers suggest that underutilization is a natural corollary of the disengagement that racialized groups experience in relating to mainstream society as a whole (Giordano, 1994; Lin, Inui, Kleinman, & Womack, 1982; Van Vooris, 1998). Others suggest that the everyday practices of mainstream institutions are appropriate to the expectations of people from the dominant culture, but are alienating to ethnoracial citizens (Escovar & Kurtines, 1983; Fanon, 1963; Fernando, 1991; Fernando, 1994; Sterlin, 1993; Swartz, 1991; Takeuchi & Kim, 2000; Thielman, 1985; Wade, 1993). Barriers will be defined differently depending on the context and groups involved, and it is difficult to find a common explanation for the difficulties experienced by every racialized group in Canada. However, if Canada's health care system truly is universal, then the ease and comfort with which services can be accessed should be the same for ethnoracial and mainstream citizens.

Evaluating the underuse or overuse of services by ethnoracial and ethnocultural groups is complicated by many factors, including inaccuracies in population counts, socio-demographic differences between ethnoracial and ethnocultural groups which can account for different use patterns, and differential vulnerability to inappropriate or involuntary admission for psychiatric assessment (Halpern, 1993). However, the literature documenting barriers which impede racialized mi-nority access to mental health services is so extensive and consistent that the existence of barriers does not seem to be in question. The issues have been ad-dressed by investigators in several jurisdictions and from the full range of health care disciplines. Notably, these researchers have reached the same conclusions regarding the need for change in clinical practices and service delivery (Reitz, 1995). Curiously, though, the literature documents decades of research pointing to the same solutions but reports no indications either that these solutions have been applied or that ethnoracial groups are receiving better or more appropriate service from the mental health care system. One important exception to this is the report of impressive gains in accessibility of services in an American mental health region described by Sue in 1977 (Sue, 1977) and re-evaluated by O'Sullivan and col-

leagues ten years later after substantial system-level intervention (O'Sullivan, Peterson, Cox, & Kirkeby, 1989).

Health services literature rarely looks beyond the level of interpersonal interactions—perhaps because of the need to meet the immediate needs of ethnoracial clients who are receiving care. Unfortunately, this level of analysis may make it very difficult to understand the lack of increased participation of ethnoracial communities in mental health care. However, by examining the issue at another level and focusing on the social context for organizational functioning, it becomes possible to develop some hypotheses about why different approaches designed to produce equity for ethnoracial communities may result in maintenance of the status quo. An examination of the links between the way Canadian society and organizations function will clarify the need to look beyond the front line of services to understand what supports and impedes meaningful change.

CANADIAN SOCIAL PROCESSES AS A CONTEXT FOR ORGANIZATIONAL CHANGE

There is a perception in Canada that the establishment of multiculturalism as a national policy has contributed to harmonious inter-group relations which are the envy of the rest of the world (Reitz, 1988). However, there is a growing body of evidence which suggests that racial tensions and inequities in Canada are obscured by the infrequency of overt conflict. Levels of social integration for groups of people who are of non-European origin are simply lower than they are for groups of people of European origin. Further, there are both subjective and objective indicators of racialized Canadians facing significant discrimination (Breton, Isajiw, Kalbach, & Reitz, 1990; Henry & Ginzberg, 1985; Henry, Tator, Mattis, & Rees, 1994). The growing dissatisfaction with that discrimination and with outcomes for ethnoracial citizens in schools, the workplace, and other segments of society reflects a shifting consciousness and empowerment of immigrants, and heightened expectations from the growing number of ethnoracial citizens who are born and/or raised in Canada.

Cultural diversity was placed on the mental health agenda by the publication of *After the Door has been Opened: Mental Health Issues Affecting Immigrants and Refugees in Canada* (CTF, 1988). In that document (and in others which have followed), it is noted that racialized groups do not see themselves as having a voice in mental health care, either as internal or external stakeholders. Mainstream mental health services may lament the unavailability of professionals with diverse cultural and linguistic backgrounds (Beiser et al., 1993; Lin & Lin, 1978; Sadavoy & Williams, 1999), but many immigrants with education and work experience as health care professionals enter Canada and have great difficulty securing appropriate employment (Reitz, 1990). Indeed, Canadian health care organizations are listed among the major institutions known to concentrate racial minorities (particularly women) in low-status, poorly paid jobs (Mills & Simmons, 1995).

Clearly, the marginalization of racialized people in the societal context is connected to parallel problems with representation, employment, and service delivery in the mental health care system. Given the essential invisibility of ethnoracial staff and community members in the health care organizations of the nation, it is not

surprising that the needs and rights of potential or current ethnoracial clients are overlooked. If inter-group relations in Canada can be linked to problems in mainstream mental health care service delivery, then perhaps there is potential for the same link to lead to positive reforms which will increase accessibility for ethnoracial groups. This hypothesis can be tested by examining the viability of various accessibility initiatives in Canada.

ORGANIZATIONAL INTERVENTIONS IN CANADA: PROCESS AND OUTCOME

Organizational interventions which are aimed at increasing accessibility to care, employment, and governance of mental health services have been based upon terms such as: (a) anti-racism (Ali, 1997; Mohamed, 1998); (b) cultural competence (Dana, Behn, & Gonwa, 1992; George, Shera, & Tsang, 1998; Hastings-Institute, 1994; Warrier, 1999); (c) valuing diversity (Allotey, Nikles, & Manderson, 1998; Bond, 1999; Wilson, 1996b); and (d) multiculturalism (Jackson & Holvino, 1988; Nagda, Harding, & Holley, 1999; Pernell-Arnold, 1998; Sims et al., 1998). The frameworks for these interventions focus on racial diversity, but are also designed to accommodate other sources of difference (eg., ethnicity, disability, religion, gender, class, and sexuality). Within this wide-ranging discus-sion, most writers distinguish between two types of organizational intervention—multicultural change and anti-racist change (George et al., 1998; Henry et al., 1994; Minors, 1996). A comprehensive review of frameworks for organizational change in mental health services is beyond the scope of this paper; however, there are consistent and critical elements of each type of intervention—multicultural and anti-racist—which can be identified.

Multicultural Organizational Change

Organizational interventions based upon a multicultural perspective (multicultural changes) involve activities which prepare an organization to integrate and accommodate the various cultures encountered in staff and clients. This framework assumes that people from different ethnoracial and ethnocultural groups can identify common goals and interact harmoniously if they are given the opportunity to learn more about one another (Jackson & Holvino, 1988). Therefore, the tools of multicultural change include: (a) recruitment and promotion of staff from diverse ethnoracial groups, (b) community outreach, (c) cultural events, (d) sensitivity training, and (e) developing partnerships which will facilitate improving attitudes between mainstream and ethnoracial groups. Cultivating cultural literacy (i.e., expert knowledge of other cultures which can be applied to practice) can be an important component of education and training (Dyche & Zayas, 1995; Tsang & George, 1998).

Multicultural changes generally are promoted as part of a pragmatic agenda. Their implementation should lead to increased efficiency, an increased capacity to meet community needs, and/or improved employee morale. These activities are, by definition, deliberately isolated from any political or social-justice agenda (Bond, 1999; Wilson, 1996b). By focusing on pragmatic concerns, participants need not feel obligated to address their potential roles as oppressors or as victims of oppression; rather, they can concern themselves with delivering service, meeting

client needs, and increasing the profile and relevance of the organization in the community. The appeal of a multicultural framework is that is focuses on principles of co-operation rather than on conflict or discrimination (Grandy, 1998).

Given Canada's thirty-year commitment to multiculturalism as a national policy, a multicultural approach to organizational interventions would seem to be consistent with existing perceptions of appropriate ethnic and race relations, and would, therefore, seem to be a suitable approach for Canadian health care organizations. According to research, most Canadians believe that current policies are adequately meeting the needs of ethnic and racial groups (Billingsley & Mus-zynski, 1985; Reitz, 1988). In addition, Canadian health care has taken a very active interest in broadened conceptualizations of health and illness which are consistent with non-European methods of intervention (Coburn & Eakin, 1998). The practice of multicultural change, which includes exchanging information about treatment approaches in different cultures, fits with contemporary health care trends. Therefore, multicultural activities have the potential to address some accessibility problems; they could combat issues such as the lack of information, cultural insensitivity, and the lack of connection between ethnoracial communities and mainstream mental health organizations.

The consistency between existing policies and multicultural change is, however, at the heart of the problem with this approach to organizational interventions. The major criticism of multicultural change is its acceptance of existing structures within organizations and within society (Ali, 1997). It is also criticized for its failure to acknowledge or address the racial stratification which favours some groups and disadvantages others in the competition for resources (Connolly, 1992; Ladson-Billings, 1998). Multiculturalism may actually undermine racialized groups by encouraging "in-group" sensibilities to the point that collective political action is impracticable (Dei, 1996). Celebrating cultural diversity and sensitivity training may improve societal attitudes, but these activities are not designed to impact on behaviours such as discrimination or cultural competence.[2] Therefore, in the same way that Canadian multiculturalism has focused on harmony while de-emphasizing inequity and discrimination, this change model only superficially addresses barriers faced by racialized people in the mental health care system.

Another important critique of multiculturalism comes from writers focusing on organizational theory. They charge that multicultural change is an assimilationist model which appears to increase opportunities for ethnoracial groups but, in reality, creates opportunities for racialized staff to advance in exchange for adopt-ing dominant, Eurocentric organizational norms (Mills & Simmons, 1995). These assimilationist expectations may be especially high in health care settings, where pressures to conform to the expectations of the medical power structure are very high, and staff are discouraged from raising controversial issues such as inequity or injustice (Kavanagh, 1991; Margolin, 1997). In the end, they contend, multicultural changes may produce increased participation by ethnoracial groups both as service providers and service recipients; but, for all the reasons cited, they may have minimal impact—the structures and processes of organizations will remain essentially unchanged.

Anti-Racist Organizational Change

Anti-racist change has a different entry point for addressing problems of accessibility. Rather than organizing *for* culture, the model advocates organizing *against* racism, inequity, and injustice. Anti-racism may seem to articulate goals similar to those of multiculturalism (i.e., valuing diversity and more humane interactions between groups); however, unlike multiculturalism, anti-racism assumes that society is resistant to those goals (Jackson & Holvino, 1988).

The expectation of opposition from those who benefit from existing unequal structures necessitates an emphasis on enforcing non-discriminatory behaviour and on dissembling barriers to participation by ethnoracial groups (Nagda et al., 1999). Thus, the tools of anti-racist organizational change include: (a) training to increase competence in specific skills relevant to work with racially or culturally diverse populations, (b) establishing sanctions against discriminatory behaviour, (c) engaging community members as stakeholders in services, (d) promoting social advocacy, and (d) restructuring organization and service policies to increase equity for racialized groups (Ali, 1997; Dominelli, 1988; Mohamed, 1998; Ontario Ministry of Health, 1995).

The language of equity, rather than equality, is particularly important. Anti-racist orientations contend that the goal of equal treatment for all groups should be replaced with the goal of equitable treatment for all groups. Equity would require specific efforts to remedy the limitations and inflexibility of existing practices which currently privilege dominant groups (D'Arcy, 1998; Mhatre & Deber, 1998). Increasing equity is connected quite specifically to redistributing those resources which have been denied to disenfranchised communities. Therefore, equity-based changes in the system would be characterized by the redistribution of professional positions, decision-making roles, and services to presently under-represented sectors—including those occupied by racialized people. Such changes would have the potential to address the systemic, cultural, and interpersonal issues which have impeded access to mental health care.

The anti-racist framework has become part of the policy landscape in Canada. Federally, the Department of Canadian Heritage directs funding at the national, community, and organizational level to actitivities which are specifically anti-racist (Canadian Heritage/Multiculturalism, 1998). In Ontario, anti-racist efforts have included: (a) the establishment of an an Anti-Racism Secretariat (Ontario Anti-Racism Secretariat, 1994)—which, unfortunately, was dissembled when the provincial government changed; and (b) the inclusion of anti-racism as an explicit part of the Ministry of Health's reform agenda (Ontario Ministry of Health, 1995). In the Toronto area, a community agency with an overt anti-racist agenda has been established to provide mental health services to targeted ethnoracial communities (Ali, 1997). As these programs are relatively new, it is too early to evaluate their impact on identified barriers to ethnoracial participation either in Canadian institutions in general or in mental health services in particular. Research is needed to determine whether the organizational changes which have been implemented and the specialized services which have been established have resulted in ethnoracial people receiving the same quality and access to services as do people in mainstream groups. At some point, the impact of government initiatives framed around anti-

racism also should be evaluated to determine whether Canadian attitudes toward discrimination and inequity have shifted.

Advocates of the anti-racist perspective suggest that it creates the type of radical change which is necessary to combat the powerful forces maintaining structured inequity in the health care system. Cynics assert that those in power attempt to defend their own interests by blocking anti-racist approaches to organizational change. This explanation, however, fails to account for apprehensions which are felt by both ethnoracial and mainstream group participants, many of whom fear that anti-racist change, with its focus on oppression and discrimination, will unearth tensions between people in an organization. The disruptions in cohesiveness and morale, which are an expected part of any process of change in an organization, tend to increase anxiety about anti-racist initiatives (Chemers, Oskamp, & Constanzo, 1995; Cox, 1993).

Anti-racist activities are regularly undermined by an underlying belief that racism is a problem of the past that needs no longer be discussed. Additionally, a number of existing tensions further exacerbate the problem:

(1) Staff members of European origin may be wary of discussions of white privilege; at the same time, ethnoracial staff members may feel threatened by interventions in which they risk being further marginalized by discussions of race-based oppression or personal experiences of discrimination (Hyde, 2000; Srivastava, 1993).

(2) Ethnoracial professionals involved in executing anti-racist change may face the particular challenge of being mistrusted by people who believe they are influenced by ideology or vested interest and are, therefore, exaggerating the current impact of racism in Canada (Chigbo, 1997).[3]

(3) Mental health organizations also must deal with growing awareness that psychiatry has reinforced racism by pathologizing ethnoracial groups to legitimize poverty, marginalization, and social control (Deschin, 1971; Escovar & Kurtines, 1983; Fanon, 1963; Fernando, 1991; Fernando, 1994; Swartz, 1991; Takeuchi & Kim, 2000; Wade, 1993).

While these tensions clearly are part of the contemporary landscape, their emergence in the face of anti-racist change can result in that process of change becoming the scapegoat for them. In the current environment of health care cutbacks wherein organizations are focused on their very survival, the perception of an anti-racist methodology as being radical and potentially disruptive makes it risky (Nagda et al., 1999). The anti-racist perspective is controversial: the confidence and commitment needed to sustain interventions long enough to effect change is, in many Canadian organizations, difficult to mobilize. Unfortunately, anti-racism may be abandoned long before change is affected.

IMPLICATIONS FOR SERVING ETHNORACIAL POPULATIONS

Confusion about the expectations of multicultural and anti-racist change are supported by the multiplicity of labels which can be used to describe such initiatives, and the sometimes careless way in which these initiatives are classified.

Yet it would misrepresent both anti-racism and multiculturalism to suggest that there is no overlap in the two approaches. An anti-racist organizational change, for example, certainly can accommodate the social events usually associated with multiculturalism. By the same token, a multicultural organizational change also can accommodate the social-advocacy activities of anti-racism. For the sake of this discussion, these two frameworks for organizational change have been essentialized, as often happens in the discourse surrounding these interventions. Certainly, people who are frustrated by institutions (and systems) which are slow to respond to needs beyond those of white, heterosexual, middle- class society will tend to advocate anti-racism and to disparage multiculturalism. They assert that multiculturalism is far short of the ultimate goal of equity, inclusiveness, and absence of discrimination—to reinforce their stance (Ali, 1997; Dominelli, 1988; George et al., 1998; Jackson & Holvino, 1988; Minors, 1996; Mohamed, 1998).

The sustained commitment to multiculturalism and growing importance of anti-racism in Canada suggest that both approaches will continue to have roles in the future of Canadian mental health care. There are, however, certain aspects of each framework which, in implementation, can be problematic. Both frameworks face particular challenges in the Canadian context and, as has been discussed, the processes involved in both frameworks have the potential to entrench current practices.

As some investigators note, the mental health care system has been aware of barriers to access for decades, but there have been few incentives for change, or consequences for continuing practices that exclude ethnoracial clients and community members (Gottesfeld, 1995). So, before multiculturalism is dismissed as insufficient to increase service accessibility, policy-makers must determine whether multicultural changes actually have been implemented. Although it is assumed that multiculturalism will not transform the system, if it actually is implemented, then the increased involvement of ethnoracial service providers and community members in the organization and delivery of services will have an impact. Increasing the diversity of the organization at all levels can have a deliberate or subversive effect that will translate into more sensitive, appropriate care for ethnoracial groups. There are concrete examples of this already available. The inclusion of health practices from different parts of the world in mental health care is creating a system within which clients from both ethnoracial and mainstream groups can have both more choice and access to a wider range of therapies.

There is, however, still an important role for an anti-racist approach. Sensitivity and the inclusion of alternate treatment modalities do not eliminate inequities or injustice. In fact, one of the dangers of stopping at multicultural interventions is that it supports the exploitation of ethnoracial people. Staff hired to increase diversity, but without any status or decision-making power, will not be able to shift the behaviour of an organization (Pfeffer, 1991). Similarly, inclusion of indigenous methods through appropriation by mainstream service providers, or inclusion of practitioners as poorly paid "paraprofessionals," strengthens mainstream organizations with limited benefit to racialized people. There may be other types of difference which can be addressed through multiculturalism; but, while ethnoracial groups are disenfranchised in Canada and live marginalized lives, anti-racism and the equity agenda will need to be in place to combat the effects of

systemic racism. Models that value anti-racism over multiculturalism may best represent the need to keep moving toward a system in which all Canadians have input and influence. Individual organizations must be prepared to commit fully to any initiative designed to move them along the continuum from exclusionary practices to inclusive practices. There are a growing number of inventories and checklists available to assist organizations in evaluating their progress toward equity; these same checklists can be used to evaluate an organization's readiness to undertake either multicultural or anti-racist organizational change (CMHA, undated; Dana et al., 1992).

Finally, although this discussion has deliberately focused at the level of inter-group relations, all efforts at organizational change need to build on the knowledge provided by the clinical research literature on the importance of interpersonal interactions. Just as society's activities influence organizational functioning, organizations must support an environment in which clients can benefit from the power of intervention: (a) through shared culture and language (Gottesfeld, 1995; Minas, Stuart, & Klimidis, 1994); (b) in culturally compatible contexts (Boyer et al., 1997; McNicoll & Christensen, 1996); and (c) without the threat of race-based discrimination or abuse (Lin, Tardiff, Donetz, & Goresky, 1978; Sassoon & Lindow, 1995; Singleton-Bowie, 1995). These expectations also must inform the evaluation of organizational change initiatives. Evaluations of current norms, values, and practices should be used to set benchmarks to gauge the success of new policies and programs (Jackson & Holvino, 1988; Mokuau & Fong, 1994; Mor Barak, 2000; Pina & Canty-Swapp, 1999). Information should be gathered regularly from staff and clients to better understand subjective perceptions of organizational inclusiveness (George et al., 1998; McNicoll & Christensen, 1996). Additionally, some of the best indicators of progress in eliminating barriers to access for racialized groups will come from intervention studies and data gathering strategies which can link racial status (as well as other variables) to outcomes in mental health care services (Takeuchi & Kim, 2000). Ultimately, we will not know if we have reached the goals of access and equity unless we can demonstrate that race, gender, sexuality, and other sources of difference are not associated with inequities in access to, process of, and outcomes from mental health services.

NOTES

1. I use the terms "ethnoracial," "racialized" and "racialized minority" to refer to people of non-European origin who define themselves in terms of common heritage and see themselves as distinct from, and having less power than, groups defining the dominant culture. The term "mainstream" is used to refer to European-origin groups and influences that dominate North American society.
2. There is no consensual definition for cultural competence but it refers generally to a skill set that equips professionals to work effectively in cross-cultural situations (Tsang & George, 1998).
3. This speaks to problematic assumptions about the competency of racialized people and the foundation of anti-racist work. We need to question why some people believe that an ethnoracial minority person is not a credible source of information about racism (regard-less of his or her theoretical approach). We also need to question the doctrine that suggests there is something called "objective" research that is uncontaminated by researcher ideology and interest.

RÉSUMÉ

Cet article explore l'utilisation des services de santé mentale par les personnes ethnoraciales au Canada. On fait la distinction entre les raisons pour la sous-utilisation des services par les groupes ethnoraciaux et les barrières qui empêchent l'accès aux services par ces groupes. On passe en revue la recherche portant sur les relations interraciales au Canada pour indiquer les parallèles entre ces relations et le fonctionnement des organismes traditionnels de santé mentale. Ensuite on considère les politiques et les attitudes qui existent actuellement au Canada pour voir comment ils supportent ou em-pêchent des interventions pour augmenter l'accès aux services. On présente 2 cadres dans lequel les organisations peuvent changer, l'un basé sur le multi-culturalisme et l'autre sur l'anti-racisme, avec une analyse de leurs avantages et inconvénients.

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