Toronto East Quadrant
Local Immigration Partnership
Working Together for a Diverse & Inclusive Community

public good
initiative

Final Report: Identifying and Addressing Barriers to Service-Use

by Newcomers with Disabilities and Complex Health Needs

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I.   Introduction

This report is the final product of a research partnership with Toronto East Quadrant Local Immigrant Partnership (TEQ LIP) with the goal being to better understand the diverse challenges faced by newcomers with disabilities and complex health needs, particularly in the Scarborough area. TEQ LIP collaborates with organizations across Scarborough and embraces diverse stakeholders in the partnership development process, including service provider organizations, different levels of government, school boards, professional associations, ethno-cultural organizations, faith-based organizations, the social services sector and the general community. TEQ LIP is led by a consortium of four organizations, with Catholic Crosscultural Services as the lead agency. It plays a key role in helping to build strong, inclusive and welcoming communities that enable newcomers' settlement success by fostering cooperation, partnerships, and equitable participation of all members.

The objective of this report is to provide TEQ LIP with information regarding the experiences of newcomers with disabilities and complex health needs when accessing support services and navigating the healthcare system, and to offer advice as to how the barriers they encounter can be mitigated. The report draws upon the themes and findings from of review of current literature and incorporates new knowledge about current resources available to newcomers with disabilities and complex health needs, acquired through stakeholder interviews with organizations in the Greater Toronto Area (GTA) that cater to the needs of immigrants and/or people with disabilities. This information provides more nuanced insight into the barriers faced by this group when accessing external support and highlights important promising practice examples of services catering to the needs of immigrants and/or people with disabilities. In addition, the report offers recommendations for service improvement in the hopes of supporting TEQ LIP's mission to create accessible communities with effective resources that are responsive to the unique needs of newcomers and immigrants.

II.   Important Terms

Disability: According to the Accessibility for Ontarians with Disabilities Act (AODA), disability is defined as "(a) any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical coordination, blindness or visual impediment, deafness or hearing impairment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device,

(b) a condition of mental impairment or a developmental disability,

(c) a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,

(d) a mental disorder, or

(e) an injury or disability for which benefits were claimed or received under

the insurance plan established under the Workplace Safety and Insurance Act,

1997; ("handicap")" (AODA Act, 2014).

Complex Health Need: "Patients with complex care needs (PCCNs) often suffer from combinations of multiple chronic conditions, mental health problems, drug interactions and social vulnerability, which can lead to healthcare services overuse, underuse or misuse" (Bujold et al., 2017, p. 1).

Barrier: "Anything that prevents a person with a disability from fully participating in all aspects of society because of his or her disability, including a physical barrier, an architectural barrier, an information or communications barrier, an attitudinal barrier, a technological barrier, a policy or a practice" (AODA Act, 2014).

Access: "Refers not only to the availability of services, but to service characteristics that make it possible or comfortable for persons in need to utilize such services" (Bowen, 2015, p. 11).

(Canadian) Immigrant: Person residing in Canada who was born outside the country, excluding temporary foreign workers, Canadian citizens born outside Canada, and those with student or working visas (Statistics Canada, 2010).

Refugee: The 1951 United Nations (UN) Convention defines a refugee as a person with a "well-founded fear of being persecuted for reasons of race, religion, nationality, or membership of a particular social group or political opinion" and is "outside the country of his or her nationality," unable or unwilling to return to their country of origin due to fear of persecution (UN General Assembly, 1951, p. 3).

III.   Methodology

This report was completed using a combination of peer-reviewed scholarly and grey literature. It involved conducting a literature review on available research on service concerns and barriers to accessing health care among immigrants, and analyzing available services provided by the federal government and agencies in the GTA. Little information could be found related to services available in the GTA and specifically in the Scarborough region to support immigrants with complex health needs and disabilities. Informational interviews were carried out over the phone by Public Good Initiative (PGI) consultants and were based on a set of predetermined questions, with room for elaboration to increase knowledge on available services that target the needs of immigrants with disabilities and complex health needs. The results from the interviews were analyzed and findings were used to support the promising practices section and to develop recommendations for policy makers and service providers to improve existing services.

IV.   Limitations

Although significantly useful information emerged from the literature review and stakeholder interviews, there are some limitations within the findings in this report that must be mentioned. Limitations from the literature review include the inability to find many agencies in the Scarborough area that advertised particular services that could help immigrants with disabilities and complex health needs. Many of the services found were not intersectional and focused either on providing support to individuals with disabilities and complex health needs, or new immigrants. More so, many of the service providers considered youth a primary demographic, but it is not clear whether the majority of these children are first- or second-generation Canadians. Due to the scope and timelines of this study, only a limited number of key informant interviews could be conducted. A greater number of key informants could have added to a more nuanced understanding of support services in the GTA and the challenges faced by immigrants with disabilities. The main limitation is the minimal information found on organizations or programs in the GTA that provide specific services for immigrants with disabilities and complex health needs. This limitation makes it difficult to identify best practice examples for service providers that would like to work with this particular population group.

V.   Key Considerations

Multi-barriered realities

Early research on Canadian poverty has identified certain groups as being more likely to experience persistent poverty, including those with physical/mental disabilities, single-parent families, and immigrants, especially those who are visible minorities (Lammam and MacIntyre, 2016). A 2014 survey conducted by Statistics Canada reinforces the strong correlation between disability and low income, highlighting that "persons with a disability make up 41% of the low‑income population, compared with 18% of the non‑low‑income population" (Wall, 2017). In particular, newcomers with disabilities and complex health needs are among the most socially and economically oppressed in society due to lower education levels, frequent racist and ableist discrimination by employers, as well as language barriers and high fees for medical equipment, treatment, and personal supports (Tiessen, 2016). Their precarious financial situation can cause them to approach the treatment of disability and health concerns differently since the costs associated with certain services, and even the costs of transportation to make appointments, often act as deterrents to healthcare prioritization. As Weiss notes, "what may appear as simple tasks such as attending medical visits and doctor appointments, may become a challenge" (Weiss, 2017, p. 13).

Additional factors that minimize the frequency with which immigrants with disabilities seek aid include an unfamiliarity with support and healthcare systems, a lack of understanding of relevant services, negative perceptions of the roles of service providers, communication challenges stemming from language differences, and service delivery systems that are not culturally sensitive (King et al., 2011). Furthermore, there can be significant mobility concerns for individuals who have a physical disability and cannot easily access healthcare services. These barriers often translate into decreased utilization of these services, as recent refugees have a lower utilization rate for physicians and hospital services compared to other residents

(Gabriel, 2011). This discrepancy between high health needs and low service utilization underscores that limited engagement with healthcare services is a major threat to the well-being of newcomers.

In the Canadian context, a study undertaken by the Ontario Council of Agencies Serving Immigrants (OCASI) and the Ethno-Racial People with Disabilities Coalition of Ontario (ERDCO) discovered that newcomers with disabilities faced barriers to accessing support from settlement services primarily because of difficulties "in the interaction with settlement workers, due to a lack of understanding of disability issues in general and a lack of capacity, and resources to service them" (El-Lahib, 2015, p. 19). This statement was reiterated during an interview with the Learning Disabilities Association of Toronto District (LDATD) in regard to a question about the minimal number of services that specialize in serving immigrants with disabilities. It was suggested that service providers often lack the familiarity, or the capacity, to do such work, as these individuals have a more diverse range of needs which take time to be fully addressed. It is also important to note that, until quite recently, people with disabilities were barred from immigrating to Canada, and thus the small number of services targeted towards newcomers with disabilities could be reflective of their scant representation within the general population. The implications of this policy change are discussed below.

Current trends

Since the passage of the Immigration Act in 1976 and its successor, the 2001 Immigration and Refugee Protection Act, the immigration applications of people with disabilities have been largely rejected by the Government of Canada on the grounds of the medical inadmissibility provision in Section 38. This provision allows for the exclusion of individuals that are likely to place excessive demand upon "health services or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years" (Immigration and Refugee Protection

Regulations Act, 2001, c. 27, s 1.1a). Potential newcomers are expected to undergo physical and mental medical examinations, along with a "review of their past medical history, laboratory test, diagnostic test and medical assessment of records" (Immigration and Refugee Protection Regulations Act, 2001, c. 27, s 29). If a health condition is deemed to be a potential harm or burden to public health, applications to immigrate to Canada are typically rejected.

In 2016, the federal government began seriously discussing with provinces, territories, and stakeholders the validity of the excessive demand clause, and in April of 2018, significant changes were announced. Firstly, the cost threshold for medical inadmissibility was to be increased to three times the previous level (Council of Canadians with Disabilities, 2018). Thus, immigrants who might have been deemed medically inadmissible under the previous policy, may now be accepted with greater likelihood. Secondly, amendments to the definition of social services will be made to align with current Canadian values and policy definitions, which will ultimately benefit applicants with intellectual, hearing, visual, and other disabilities (Immigration, Refugees and Citizenship Canada, Government of Canada, 2018). These changes to the medical inadmissibility policy have already gained support from the Standing Committee on Citizenship and Immigration, and the recommendations have been accepted by the Canadian government.

Given these new developments within the Canadian political landscape, it is clear there will be significant implications for the volume, and type, of demand placed upon settlement agencies. Raising the cost threshold for medical inadmissibility will naturally increase the number of immigrants with disabilities and complex health needs, and has implications for the types of supports they require. El-Lahib suggests that settlement agencies are not "prepared or equipped" to deal with immigrants with disabilities because, under the previous exclusion clause, people with disabilities were not expected to gain entry into Canada and become citizens (El-Lahib, 2016). Therefore, these agencies must now struggle to meet the needs of a new kind of population, and in order to make effective and meaningful progress, it is important

for stakeholders to consider the current barriers that affect immigrant populations today, in particular immigrants with disabilities, in order to develop best practices for the future.

<u>Service-use concerns</u>

Lack of knowledge regarding existing services: Immigrant communities, especially those with disabilities and complex health concerns, consistently struggle to understand available services and how to utilize them. These difficulties of navigation suggest that more accessible information regarding these resources needs to be circulated, and that more services need to be targeted towards specific individual and family-centered needs (Weiss, 2017). The Health Network on Uninsured Clients, based in Toronto, Mississauga, and Scarborough, has attempted to work with other agencies and networks in order to raise awareness about their services. Educational programs have also been proposed as possible bridges to acquiring relevant information, but acquiring information is simply the first step, as processing the details and nuances of the information is crucial to making informed decisions.

A study examining Roma refugees in Canada noted that many experienced substantial barriers in accessing health care due to a lack of understanding of how the healthcare system works, in addition to language and cultural barriers (Walsh et al., 2011). Many participants in the study needed help understanding the correct procedures in accessing care, and many healthcare practitioners noted that providing this care was difficult due to a lack of healthcare documentation and a lack of consistency in visiting the doctor (Walsh et al., 2011). A key informant interviewed for this study also noted that sometimes immigrants do not understand the range of services offered by a particular agency, and the value of these services is not always clear, points that further suggest the importance of providing immigrants with these pieces of information.

For immigrants with complex health needs who struggle with health literacy, understanding the healthcare system and service resources can be particularly challenging.

Health literacy, meaning the knowledge and ability to understand health information, navigate the health care system and make appropriate decisions, plays an important role in determining whether healthcare services are truly accessible and impactful, and its absence is associated with negative outcomes in health, income, and community engagement, all of which are fundamental concerns with which immigrants must already grapple. The evidence supports this intuition; immigrant populations are one of the most affected groups, in addition to seniors and those relying on social benefits. Approximately 60% of recent immigrants have limited health literacy necessary to function in everyday life, a significant difference from the 37% found within the general Canadian-born population (Simich, 2009, p. 4). Most notably, these proportions do not change as time goes on. An important corollary to this information is that immigrants' health literacy does not improve over time, even when time is removed from the equation. Evidently, policy intervention and programming is required to equalize these populations and help immigrants acquire the tools necessary to navigate the Canadian healthcare system with ease.

Language barriers: Language barriers may exacerbate the complexities of accessing and using unfamiliar service delivery systems, have a negative impact on the quality of healthcare immigrants receive, and reduce the frequency of seeking out medical aid (Jacobs, 2004). In his study of immigrant mothers raising children with disabilities in the Greater Toronto Area (GTA), Weiss notes that English is often a second language for these women and that they lack the social connections that had been central to their lives, and this isolation hinders their potential to find important information and effective care (Weiss, 2017).

For individuals who are not fluent in one of the official languages, English or French, the process of verifying relevant services and setting up appointments can be challenging, particularly because internet, telephone, and textual sources are typically offered in either of these two languages. Thus, information that is gleaned from an advertisement in the newspaper or on the radio, is not so easily accessible to immigrant populations. Without access to

interpreter services, assistance is required from family, friends, or untrained employees (Jacobs, 2004). However, LDATD raised the important point that there is often a hesitancy to ask others for help because this increases their workload. Therefore, understanding and addressing language needs is key for service providers to support newcomers. A study conducted by Jacob et al. found that those who accessed interpreter services were more likely to use recommended preventive health services and to receive and fill prescriptions. The test took place in a Massachusetts Health Maintenance Organization (HMO) that involved the implementation of comprehensive interpreter services for Spanish and Portuguese-speaking patients in four of its health centers. They state that these services "were provided by 5 full-time trained interpreters who were available to help patients 24 hours a day either by telephone or during walk-in visits and at all points of contact in the HMO" (Jacobs et al., 2004, p. 866). This sample group of 380 patients was compared to the 4119 patients in the comparison group that did not receive the interpreter services. The group with interpreter services displayed substantial increases per person per year in recommended preventive services received (7.3% vs 2.7%; P=0.033), office visits made (1.74 vs 0.71; P=0.014), and number of prescriptions written (1.70 vs 0.52; P=0.001) and filled (2.38 vs 0.88; P<0.001) (Jacobs et al., 2004, p. 867). The increase in the utilization of healthcare services may additionally result in a reduction in future health complications and therefore lower costs of care in the future (Jacobs, 2004).

Cultural differences: Immigrants are often raised with different understandings of disability and the use of external support systems. As King et al. note, "each ethnic group experiences a unique mix of cultural roles, expectations, and conceptual frameworks that influence how its members view their support systems and communities, as well as their perceptions of services" (King et al., 2011, p. 8). For example, factors such as attitudes towards disability and gender role expectations regarding care, can strongly influence how immigrant populations respond to service options and treatment regimens. In fact, some cultural groups refuse to acknowledge

the presence of a disability due to severe stigma, and as a result, may be hesitant to explore these systems and find meaningful assistance. In particular, many immigrants and refugees may be reluctant to seek or accept mental health support due to the stigma associated with mental illness (Walsh et al., 2011).

Furthermore, it is important to note that most services are grounded in "Euro-Canadian standards of care," and service providers often find it difficult to provide culturally sensitive support (Weiss, 2017, p. 14). Even if healthcare providers and recipients speak the same language, patterns of misinterpretation are still present due to cultural misunderstandings and a lack of knowledge of healthcare services (Dastjerdi, 2011). Outside stressors such as refugee status concerns may further hinder the potential for newcomers to access these services, and can cause refugee parents in particular to be less receptive to the needs of their children who have disabilities (Walsh et al., 2011). Likewise, children may be less likely to receive care if families fail to recognize warning signs, which is concerning because refugee children have higher rates of illnesses, both mental and physical, in comparison to the general population (Walsh et al., 2011). Some immigrants and refugees also report facing discrimination and poor treatment within the healthcare system, barriers that can lead to dissatisfaction and mistrust, thus causing them to distance themselves from external supports (Walsh et al., 2011).

Lack of adequate financial support: The expenses associated with healthcare services, particularly for impoverished immigrants, can be a significant deterrent to the utilization of these services. Immigrant and refugee families are 2.5 times more likely to live in poverty, and approximately 65% of immigrant families experience low income at some point during the first decade of immigrating to Canada (Walsh et al., 2011). This reality prevents these populations from prioritizing their health since, according to the National Population Health Survey, "twice as many lower-income immigrants report unmet health care needs compared to those with higher incomes" (*Health Canada*, 1999, p. 43). LDATD adds that the costs associated with even being

diagnosed can be significant, so their clients often self-identify as having a disability or complex health need. This reality suggests that these individuals do not have the tools or the knowledge to understand the nuances of their health needs and be able to address them. Durham Region Accessibility Awareness Working Group (DRAAW) had also noted that providing specialized services is a challenge due to high costs and a lack of available resources. The Health Network on Uninsured Clients further claims that for immigrants who lack health insurance, even though the agency receives funding from the ministry to provide primary healthcare services and a social worker for their drop-in clinic, it is difficult to address complex health needs, particularly for those with chronic illnesses. Hospital visits, cancer treatments, and numerous doctor appointments are expensive and burdensome for newcomers without Ontario Health Insurance Plan (OHIP). The Health Network on Uninsured Clients notes that specialized care is difficult to access in hospitals among immigrants with complex health needs as registration alone costs $600. Since the Network is primarily volunteer based, a majority of their budget expenses are used for mental health programs, such as crisis management. They explained that mental health services are the most significant need that immigrants are looking to access yet providing adequate services is not a significant priority for government bodies.

In the study conducted by Weiss regarding immigrant mothers with children with autism, mothers emphasized the burdens of the financial costs of services and tests needed for diagnosis and guidance which the government does not cover (Weiss, 2017). Their frustrations are reflected in the following quotes (Weiss, 2017, p. 22):

"[They say] it's not my problem - there are no funds. Can I tell my son there are no funds? I felt disempowered. I had no job. How do you stay positive?"

"Services are being paid for….in order to get into programs you have to be assessed and that costs money and their programming is for the elite, it costs money to get into their programs. People stopped going."

Qualitative research such as this illustrates the practical impact that logistical barriers can have on immigrant populations. It is clear that for effective programming to exist, all levels of government must collaborate with one another, particularly when the fiscal capabilities of the federal government are separated from the jurisdictional authorities of the provinces.

Gaps in care: In 2011, an event called "Welcoming Newcomers with Disabilities to Manitoba" was held in order to provide information about the services and supports available for newcomers with disabilities in the province. However, many of the resources listed reinforce the division in support between either immigrants and refugees, or people with disabilities and complex health needs, as few services offer aid that specifically addresses the needs of both groups. This division suggests that greater communication and collaboration is needed amongst the different organizations. In fact, some of the major gaps in care noted by participants in the event were the lack of partnerships between organizations and a "'spirit of willingness' among some affected organizations" to collaborate and to "stretch their services to include disabilities and/or newcomers" (Government of Manitoba, 2011, p. 3). These networks are key, as there can be challenges in working with newcomers with disabilities which a single organization cannot adequately address, including differing cultural beliefs regarding disability, and so service providers need to work together and learn from one another in order to approach such complex situations.

VI.   Selection Criteria for Interviews

Six key informant interviews were conducted. Main goal of the key informant interviews was to gain a more nuanced and personal understanding of the experiences of newcomers with disabilities and complex health needs through service providers, which is often difficult to access through a scan of current literature on the matter. This understanding is key for offering recommendations that address the issues newcomers are facing when trying to access and use services. Organizations were selected as potential interview candidates by both the Public Good Initiative consultants and TEQ LIP, with preference given to Scarborough-based organizations. Selection criteria required organizations to have either a focus on serving newcomer populations and/or individuals with disabilities or complex health needs. Of the six organizations interviewed for this study, four had programs specifically geared toward newcomers, one had programs focusing on disabilities, and one had programs that focused on newcomers with disabilities.

Durham Region Accessibility Awareness Working Group (DRAAW)

DRAAW is a community collaborative from the Durham Region that works with other service providers "to acquire new skills and knowledge in areas related to service provision, inclusion, and accessibility for people of all abilities and diversities (including newcomers, immigrants and refugees)" (Durham Region Accessibility Awareness Working Group, DRAFT - Terms of Reference, 2018). DRAAW's membership includes two Welcome Centres, funded by Immigration, Refugees and Citizenship Canada (IRCC) to be a one-stop shop for newcomers. The Welcome Centres are open to anyone requiring information about settlement and provide them with access to services and programs during their settlement journey. Although they do not have programs that are specifically tailored to immigrants with disabilities and/or complex health needs, they ensure that their centres are inclusive to serve the needs of all community members.

Health Network on Uninsured Clients (The Network) through Wellesley Institute

The Network is a "collaboration of community members, health care providers, community health centres, immigrant-serving organizations, and policy specialists and researchers who work on issues related to the health of populations who are not medically insured" (Wellesley Institute, 2019). The Network focuses primarily on addressing the needs of individuals without OHIP, refugee claimants, and those lacking a family doctor through a collaborative approach to reducing barriers. The Network strives to address and to reduce any sort of barriers individuals might experience when accessing primary care, focusing on diverse health issues, including those of immigrants with disabilities and complex health needs. Their drop-in clinics have a clinical social worker on site that provides mental health support specifically for immigrants that have depression and adjustment issues. They work largely with elderly populations and children with disabilities and complex health needs and make sure they receive treatment and are referred to professionals in the community that can better serve their needs.

SmileCan

SmileCan is a Canadian organization that provides support for children with disabilities as well as their families. SmileCan works primarily with immigrant families and minority children, particularly from the Muslim community. SmileCan is primarily event-based and holds numerous social events across the GTA, with many located in Mississauga. The organization also has ongoing programs including Buddy Programs, a lecture series, as well as parent education workshops. SmileCan focuses on building social networks and increasing education for families with children with disabilities.

Learning Disabilities Association of Toronto District (LDATD)

The Learning Disabilities Association of Toronto District (LDATD) is a not-for-profit charity and a chapter of the broader Learning Disabilities Association of Ontario. LDATD provides a diverse range of programs and events oriented towards helping community members "achieve the full expression of their intellect and abilities" (The Learning Disabilities Association of Toronto District, 2019). In terms of its newcomer clients, LDATD strives to understand what factors hinder them in their settlement journeys, and offers important services for language support and career preparation. In addition, it helps clients in ways that are often taken for granted, such as conducting follow-ups, reminding clients of appointments, and assisting with payments.

Agincourt Community Services Association (ACSA)

Agincourt Community Services Association (ACSA) is a community organization that has been tackling a wide range of issues in the Scarborough-Agincourt area for over 40 years, including poverty, homelessness, and unemployment. Approximately 90% of visitors accessing ACSA's services are immigrants, and staff at ACSA speak over 10 languages. ACSA provides a variety of different community engagement drop-in programs, with many targeted towards newcomers. The Dorset Park Community Hub provides a one-stop shop for newcomers and immigrants, with the Newcomer Centre, an emergency Food Bank and a family centre. It also serves as their office for neighbourhood action and development projects.

Catholic Crosscultural Services

Catholic Crosscultural Services is a charitable organization with services that help newcomers and immigrants with their settlement and integration journeys. The staff have knowledge of over 30 languages and are equipped with the skills to identify needs of clients and how best to address them. It offers services tailored towards settlement, employment and language support

for newcomers, in addition to refugee sponsorship training. Catholic Crosscultural Services

coordinates with other service agencies in Toronto and Local Immigrant Partnerships.

VII.   Key Interview Findings

From the six stakeholder interviews that were conducted, the most significant take-away was the increasing need among immigrants with disabilities to access services. A large majority of clients with disabilities seen at these organizations were children. Many of the available services are tailored to serve people with visible disabilities rather than invisible ones. Complex health needs were considered to be health conditions that required specialized treatments specifically in hospitals, with examples including diabetes, cancer, or other chronic conditions. The Health Network on Uninsured Clients explained that accessing primary health care was not the main issue; there was sufficient amount of funding and services available, but specialized care, especially for individuals with complex health needs, was difficult to access due to services being very expensive. However, there is an inherent belief that there are little to no organizations that are specifically designed to serve immigrants with disabilities and complex health needs because most immigrants are healthy, and do not require an extensive amount of healthcare service support. All of the agencies believed their services were above a 5 rating for accessibility (with 1 being not accessible and 10 being perfectly accessible). The main reason behind this rating was the ability to benefit from having a strong network to help provide better services for immigrants with disabilities and complex health needs. Yet some of the agencies identified transportation as a major factor affecting accessibility, and LDATD mentioned the importance of being located near a highway or public transit. Since many clients come from throughout the GTA, travel time and costs became large barriers for immigrants in accessing the services of the agencies located in the Scarborough region.

Themes

One of the most prominent themes that emerged from the interviews was that the population of newcomers with disabilities and complex health needs accessing services was mainly comprised of youth. This may be due to the barriers individuals with disabilities or

complex health needs face when immigrating to Canada. It might also be the case that families

with children in this population are more likely to access services than adults, for various

reasons including cultural stigmatization of mental illness. Additionally, the scoring procedures

of health for admittance do not apply to children of economic migrants, but the same health

formula for admittance does apply to refugees (Government of Canada). Trauma is most

frequently represented in the refugee population, and many refugees have experienced

marginalization in their home countries that has suppressed their trauma (ACSA). Invisible

disabilities were not often directly targeted by the programs of the responding organizations

except for mental health, which was the most utilized subject for health awareness and

promotion overall.

VIII. Promising Practice Examples

Several promising practices became evident during the interview process, and these represent key service delivery models and components that are valuable in serving the target population, newcomers with disabilities and complex health needs. In terms of outreach, maintaining strong referral networks were cited by almost every interview respondent. Some, including LDATD, highlighted the importance of partnerships with other organizations in spreading the news of their services. One key informant cited unique outreach strategies as one of their core best practices; directly contacting social workers as well as physicians in the neighbourhood to identify individuals that were not seeking out available services themselves. LDATD also reported that they provide additional supports at all stages of service delivery, including conducting follow-ups with clients, appointment reminders, and helping with payments. These actions are especially important for newcomers who are still unfamiliar with the functioning of the healthcare system and who may be neglecting important appointments and visits due to other stressors.

Almost every organization interviewed reported that their facility was accessible, both by transit and for physically disabled individuals, with staff trained appropriately through Accessibility for Ontarians with Disabilities Act (AODA). DRAAW indicated that they provide transportation cost supports when needed, and also stressed the importance of their policy to not require people to identify their immigration status (DRAAW). This decision has been made with the intention of reducing stigma and barriers that surround mental and physical disabilities, and contributes to an inclusive and welcoming space. SmileCan offers needs-assessment services, buddy programs, as well as online resources such as webinars, which can be extremely valuable for individuals who have difficulty physically accessing services. The accessibility of many services within a single location, the Hub model, was identified by ACSA as incredibly influential in reducing barriers to service utilization for newcomers with disabilities

and complex health needs. Generalizing the space as a community hub rather than a location to specifically receive mental health supports, helped to reduce stigma.

Drop-in services were also referenced when discussing promising practices; they are more flexible and help react to the specific needs of the community being served. Examples of these include an emergency food bank (ACSA) or twice a week drop-in clinics for people without OHIP (The Network). A number of programs were also geared toward empowering and educating newcomers and individuals with disabilities or complex health needs towards greater integration. SmileCan discussed parental workshops, educational lecture series for families with disabled children, as well as scholarships and fun active events for children. ACSA highlighted that English language classes, in particular one-on-one sessions, are giving individuals the tools they need to tell their stories and begin to address their traumas through their assignments.

IX.   Recommendations

Based on the information gathered through a scan of current literature on newcomers with disabilities in Canada, and through the key informant interviews which shed more light on the challenges faced by this group, several recommendations were developed to strengthen access to services and supports for newcomers with disabilities and complex health needs and to ensure that the services provided were meaningful and effective.

Outreach strategies

Several of the organizations interviewed highlighted the importance of improving outreach and education regarding their services. LDATD noted that many clients had heard about them through social media promotion, and discussed the value of cultural apps in spreading the word about their programs. It would be beneficial for services to harness multiple channels (print, Internet and social media) to more broadly circulate information about existing resources. Program descriptions could also be revised with clear, accessible, and culturally sensitive language to mitigate misunderstanding. The Health Network on Uninsured Clients explained that reaching out to shelters in the community and including more information on their website were a few ways through which awareness about their agency could be raised. Additionally, DRAAW explained that networking with other agencies that could provide services that were better able to target the needs of their clients was important. They also noted that their network of referrals was strong and a key factor in their ability to reduce the barriers for immigrants in accessing healthcare services through their drop-in clinics.

With social media, Catholic Crosscultural Services identifies Whatsapp as very popular and promising. Often clients have trouble understanding English over the phone, or cannot access or use email, but Whatsapp allows them to copy what is written in English onto Google and translate it. This organization notes the importance of using multiple languages on social

media, but also states that one should be cognizant of neglecting certain individuals when relying on this channel, such as those without Internet access or those with poor computer literacy skills. It also requires newcomers to search for information online and on social media, and they often do not know what they are looking for. Therefore, other outreach strategies could be considered, such as conferences or community events where service providers come together to inform newcomers/people with disabilities about the diverse range of resources and ways in which they can access them. This will not only help the public to better understand the types of services available, but could also help service providers to better recognize the programs or specializations of other organizations and be able to direct clients to particular resources.

Cultural sensitivity training

Service providers could benefit from cultural competency training to better understand how the stigmatization of disability can act as a significant barrier to assistance, and to be sensitive to the different perceptions of disability. LDATD has noted that disability is often stigmatized within certain groups, and suggests that service providers should be better equipped to identify a disability if there is a reluctance to disclose one, and be able to discuss disability in a more culturally sensitive way. Offering training that is specific to a particular ethnic group and that is cognizant of cultural and spiritual views could help with these goals, and might reduce divisions between service providers and recipients, and build positive relationships based on understanding and trust. Furthermore, this type of specialized training could also allow healthcare services to collaborate with local "ethno-specific agencies" in developing training programs, allowing immigrant populations to benefit from more nuanced and meaningful care (Stanley, 2014, p. 1).

<u>Interpreter resources</u>

It is important that service providers collaborate with translators and are able to connect immigrants and their families with different language service options. A large number of healthcare organizations offer poor interpreter services or do not provide any services at all because of financial burdens, but as a consequence, those with limited English proficiency, particularly immigrants, are less likely to seek out healthcare and are less satisfied with the care that they do receive (Jacobs et al., 2004). DRAAW notes they have a variety of services that focus on overcoming language barriers which include teachers in the clinics that can work with the individuals independently and technological devices that people can use to communicate their needs properly.

While the experiment conducted by Jacobs et al. noted that the group with interpreter services accrued greater costs for medical care provision due to these services, the results ultimately reveal that these patients significantly increased their access to preventive services, physician visits, and prescription drugs. Yet, these costs could be offset by the fact that more frequent visits could reduce the medical complications they experience and therefore lower the costs of future care (Jacobs et al., 2004). It is also important to note that the costs measured in the study are based on the costs of hiring staff interpreters in a large healthcare system, and so the implementation of interpreter services through outside agencies or by telephone may result in lower costs. Overall, it is clear that better means of communication for groups with limited English language skills positively influence consumer attitudes towards healthcare.

<u>Subsidized assessment and medical equipment</u>

Various organizations acknowledged the barriers to assistance created by medical and service costs. The Health Network on Uninsured Clients discussed how successful treatments were difficult to acquire without OHIP, especially for individuals with chronic health concerns that needed consistent treatment. This organization often provides equipment such as

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wheelchairs, since these are additional financial concerns for newcomers with disabilities and complex health needs. LDATD noted the importance of greater financial support for newcomers with disabilities, and suggested the value of subsidized assessment. Often it is expensive simply for an individual to be diagnosed with a disability or complex health need, yet diagnosis is key for monitoring health and improving one's quality of life. It is suggested that policy makers consider the development of subsidized medical assessment programs so that newcomers, including those without health insurance, can at least understand what health concerns they need to track. Subsidized support for medical or disability-related equipment should also be implemented. People with disabilities have been identified as experiencing consistently high poverty rates, but measurements of the poverty gap do not even include the costs of additional health expenditures, including assistive devices (Tiessen, 2016). These necessities are consistent financial burdens which are often forgotten or overlooked, but are crucial for individuals with disabilities, and could be alleviated.

<u>Person-centered/targeted support</u>

Although recipients of care can best identify their needs, rarely are they asked how these needs can be met or how services could be improved. In the immigrant context these types of interactions are key because of differences in belief systems regarding healthcare, which affect how immigrants respond to treatment and professional support. The Community Development Council Durham (CDCD) uses the "Wraparound model" as a preferred method, which involves the recipient of the service, along with an intimate circle of peers (family and friends), in the creation of a plan for settlement success (Clutterbuck et al., 2010, p. 23). This allows the recipient to maintain agency over their goals and allows them to receive support that is tailored to their specific needs.

The Learning Disability Association of Toronto District (LDATD) noted the importance of having specialized services, such as for immigrants who are lower language learners and have

been stuck in the same language level for years. This organization also discussed an interest in helping seniors who struggle with minimal supports. This type of targeted assistance, rather than structured and broad program categories, can benefit individuals whose needs do not fit neatly within these categories, such as immigrants with a unique disability that requires particular care. Service providers might consider creating more flexible programs that can be moulded to address individual client concerns, which might lead to assistance that is more effective and meaningful.

Service collaboration

It is important for services providers and stakeholders to have strong networks within their communities and with other service providers. Through the interviews conducted with stakeholders, it became evident that collaborating with other service providers reduces barriers to accessing health care services among immigrants with disabilities and complex health needs and increased shared knowledge through referrals, resulting in more successful outcomes. For example, DRAAW explained that, although they do not have particular programs specifically for newcomers with disabilities, the value of collaborating with other programs helped agency members to be well equipped to teach immigrants how to live with chronic illnesses and complex health conditions. In addition, LDATD mentioned that their partnership with the Working Women's Center was important in helping them to speak about their own work through the Center's promotion. These types of partnerships have proven valuable in not only improving the quality of care provided, but also in circulating information about the services more widely.

Hubs

It is important to develop a one-stop shop model where people can have access to many different services. Some of the stakeholders that were interviewed explained that they had clinics or hubs onsite which included social workers, a medical practitioner that comes in a few

days a week, mental health supports, workshops, youth services, and supports for children, some of which were volunteer-based or run by employees. The Health Network on Uninsured Clients has a drop-in clinic open 2 days a week that is primarily volunteer-based with a social worker onsite. Service providers such as ACSA and DRAAW discussed having community hubs with services that were accessible and inclusive of the needs of all people. Stakeholders emphasize the need for, and value of, hubs in helping to reduce the challenge for people with complex health needs in having to travel to multiple places to acquire support and pay significant amounts of money for services that are far away. This is also an effective way to help immigrants with disabilities and complex health needs integrate into the community and build trust while also getting the support they need.

X.   Conclusion

Based on the findings of the literature review and the interviews conducted, this report identifies seven recommendations to support the future success of community programs for newcomers with disabilities and complex health needs in Scarborough. In designing interventions to support newcomers with disabilities and complex health needs, the following elements have been identified as beneficial, and therefore should inform the decisions and actions of a) service providers and b) policy makers.

1. **Outreach strategies** should involve clear messaging using multiple information channels and communication platforms to accommodate a range of English literacy skills, and to maximize initial accessibility.

2. Health care and community service providers should receive **cultural competency training** to understand and properly address cultural barriers to service-use such as non-disclosure.

3. Provide health care organizations with **interpreter resources** to decrease language barriers which often prevent newcomers from accessing services, communicating their needs, and following up on health-related issues.

4. Consider **subsidized assessments** for non-insured newcomers with disabilities and complex health needs, as diagnosis represents a costly initial hurdle to accessing other relevant services.

5. Include flexibility in program design to be **person-centered** to provide **targeted support** based on particular needs**,** and incorporate working methods that allow for guidance from the recipient (for example, the "wraparound model").

6. Expand upon and maintain strategies of **service collaboration** to bridge service and knowledge gaps, and leverage networks to connect newcomers with available services in the community that most appropriately reflect their needs.

7. Continue to develop **Hub models** for service delivery to support one-stop-shop service access which reduces barriers to cost, as well as geographic and social accessibility barriers.

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