CONTRIBUTORS/
CONTRIBUTEURS :

Nazilla Khanlou
Laura Simich
Edward Ng
D. Walter Rasugu Omariba
Mengxuan Annie Xu
James Ted McDonald
Biljana Vasilevska
Laura Simich
Morton Beiser
Ruth Marie Wilson
Rabea Murtaza
Yogendra B. Shakya
Alice W. Chen
Charmaine C. Williams
Joanna Ochocka
Elin Moorlag
Sarah Marsh
Karolina Korsak
Baldev Mutta
Laura Simich
Amandeep Kaur
Kwame McKenzie
Emily Hansson
Andrew Tuck
Steve Lurie
Lin Fang
Miu Chung Yan
Shahlo Mustafaeva
Regan Shercliffe
Ginette Lafrenière
Lamine Diallo
Cécile Rousseau
Ghayda Hassan
Nicolas Moreau
Uzma Jamil
Myrna Lashley
Yvonne Lai
Michaela Hynie
Yogendra B. Shakya
Nazilla Khanlou
Tahira Gonsalves
Yuk-Lin Renita Wong
Josephine P. Wong
Kenneth P. Fung
Sepali Guruge
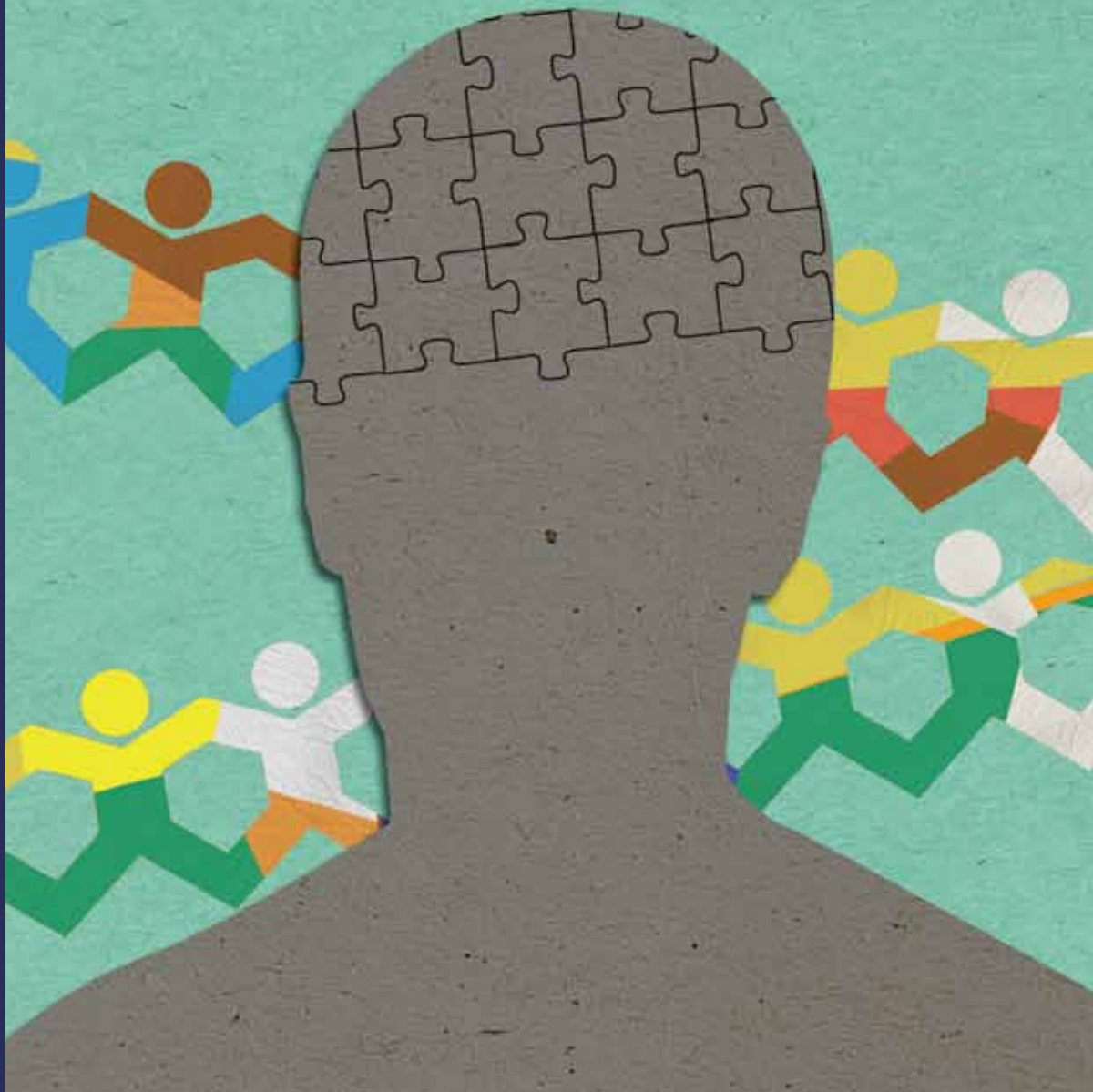**Enid Collins**
Amy Bender

CANADIAN ISSUES
THÈMES CANADIENS

Summer/Été 2010

Immigrant Mental Health
La santé mentale des immigrants

Introduction by/par :

Nazilla Khanlou, RN, PhD, OWHC Chair, Women's Mental Health Research, York University.
Beth Jackson, PhD, Strategic Initiatives and Innovations Directorate, Public Health Agency of Canada.

0 61399 70412 2   04

THE METROPOLIS PROJECT

Bridging Research, Policy and Practice

Immigration and Diversity Issues Gaining Prominence

Canada accepts some 250,000 immigrants and refugees annually

- Are newcomers finding jobs and succeeding economically?
- What impact has diversity had on Canada?
- Do newcomers face barriers?
- Why do immigrants settle primarily in our larger cities?
- Are there social and economic challenges?
  Are we responding appropriately?

Mobilizing the Network

- **Five Centres of Excellence**, located in Vancouver, Edmonton, Toronto, Montréal and Halifax/Moncton generate policy-relevant research on immigration and diversity
- **Metropolis Conferences** attract 700+ participants yearly
- **Metropolis Presents** is a public forum to discuss research and policy findings on emerging issues
- **Metropolis Conversations** are closed-door sessions of experts that contribute to a more informed debate on immigration policy
- **An Interdepartmental Committee of federal partners** meets quarterly for cross-cutting policy discussion
- **Our publications** transfer research knowledge to policy-makers and practitioners
- **Our award-winning suite of websites** provide access to hundreds of articles and working papers
- **Co-chair of the International Metropolis Project**, the largest immigration network of its kind, bringing together more than 30 countries and international organizations

Connecting the Research, Policy and Practice

The Metropolis Project Secretariat is the bridge between research, policy and practice

- Supports and encourages policy-relevant research of interest to the Government of Canada
- Increases the uptake of research findings by policy-makers and practitioners
- Manages the international arm of Metropolis

Our Partnership and Network

Metropolis involves more than 5,500 participants from all over the world

- Social Sciences and Humanities Research Council, Citizenship and Immigration Canada, Canadian Heritage, Human Resources and Skills Development Canada, Public Safety Canada, Public Health Agency of Canada, Royal Canadian Mounted Police, Canada Mortgage and Housing Corporation, Statistics Canada, Atlantic Canada Opportunities Agency, Canada Economic Development for Quebec Regions, Canada Border Services Agency and the Rural Secretariat of Agriculture and Agri-Food Canada
- Project-based partnerships with other government departments, provincial and municipal governments, non-governmental organizations, and service-providing organizations in the sectors of immigration and settlement
- Partnerships with countries in North America, most of Europe and much of the Asia-Pacific region, as well as a number of international organizations
- Centres of Excellence involve several hundred affiliated researchers, graduate students and post-doctoral fellows from more than 20 universities across Canada

LE PROJET METROPOLIS

Un pont entre les recherches, les politiques publiques et les pratiques

L'importance accrue des questions d'immigration et de diversité

Chaque année, le Canada accueille quelque 220 000 immigrants et réfugiés.

- Les nouveaux arrivants ont-ils du succès sur les plans de la recherche d'emploi et économique?
- Quelles sont les répercussions de la diversité sur le Canada?
- Les nouveaux arrivants se butent-ils à des obstacles?
- Pourquoi les nouveaux arrivants s'établissent-ils principalement dans les grandes villes?
- Existe-t-il des défis sociaux et économiques? Y réagissons-nous de façon adéquate?

Mobiliser le réseau

- **Nos cinq centres d'excellence**, situés à Vancouver, Edmonton, Toronto, Montréal et Halifax/Moncton, produisent des recherches pouvant éclairer les politiques publiques sur l'immigration et la diversité
- **Les conférences Metropolis** réunissent plus de 700 participants chaque année
- **Metropolis présente**, une tribune publique où sont étudiés les résultats des recherches et les découvertes stratégiques relativement aux nouveaux enjeux
- **La série de conversations Metropolis**, rencontres d'experts à huis clos servant à éclairer le débat sur les politiques d'immigration
- **Comité interministériel des partenaires fédéraux** : comité dont les réunions trimestrielles donnent lieu à des débats stratégiques à facettes multiples
- **Nos publications** servent à informer les responsables des politiques et les intervenants
- **Nos sites Web primés** comprennent des centaines d'articles et de documents de travail
- **Coprésidence du projet international Metropolis**, le plus important réseau portant sur l'immigration du genre, qui réunit plus de 30 pays et organisations internationales

Un pont entre les recherches, les politiques publiques et les pratiques

Le Secrétariat du projet Metropolis constitue le pont entre les recherches, les politiques publiques et les pratiques.

- Appuie et encourage les recherches qui peuvent informer les politiques publiques et présenter un intérêt pour le gouvernement du Canada
- Favorise la recherche par les responsables des politiques et les intervenants du milieu
- Gère la composante internationale du projet Metropolis

Le réseau et les partenariats du projet Metropolis

Le projet Metropolis compte plus de 6 000 participants provenant du monde entier.

- Partenaires financiers fédéraux, dont le Conseil de recherches en sciences humaines, Citoyenneté et Immigration Canada, Patrimoine canadien, Ressources humaines et Développement des compétences Canada, Sécurité publique Canada, la Gendarmerie royale du Canada, la Société canadienne d'hypothèques et de logement, Statistique Canada, l'Agence de promotion économique du Canada atlantique, le Secrétariat rural d'Agriculture et Agroalimentaire Canada, l'Agence des services frontaliers du Canada, Développement économique Canada pour les régions du Québec, l'Agence de santé publique du Canada
- Partenariats par projets avec d'autres ministères, des gouvernements provinciaux et municipaux, des organisations non gouvernementales et des fournisseurs de services dans les domaines de l'immigration et de l'établissement
- Partenariats avec des pays de l'Amérique du Nord, de la plupart des pays de l'Europe et de nombreux pays de la région de l'Asie-Pacifique ainsi qu'avec plusieurs organisations internationales
- Participation, dans les centres d'excellence, de plusieurs centaines de chercheurs, de diplômés et de boursiers postdoctoraux venant de plus de 20 universités au Canada

METROPOLIS

www.metropolis.net

Canadian Issues
Thèmes Canadiens

Summer / Été 2010

Patrimoine   Canadian
canadien   Heritage

Canadian Studies Program
Programme des études canadiennes

LETTERS/COURRIER

Comments on this edition of Canadian Issues?
We want to hear from you.
Write to Canadian Issues—Letters, ACS, 1822A, rue Sherbrooke Ouest, Montréal (Québec) H3H 1E4. Or e-mail us at <sarah.kooi@acs-aec.ca> Your letters may be edited for length and clarity.

Des commentaires sur ce numéro?
Écrivez-nous à Thèmes canadiens
Courrier, AEC, 1822A, rue Sherbrooke Ouest, Montréal (Québec) H3H 1E4. Ou par courriel au <sarah.kooi@acs-aec.ca> Vos lettres peuvent être modifiées pour des raisons éditoriales.

INTRODUCTION:
IMMIGRANT MENTAL HEALTH IN CANADA

Beth Jackson is the Manager of Research and Knowledge Development in the Strategic Initiatives and Innovations Directorate at the Public Health Agency of Canada (PHAC). She holds a Doctorate in Sociology from York University (Toronto) and completed a Post-doctoral Fellowship with the CHSRF/CIHR Chair in Health Services and Nursing Research in the Institute for Health Research at York University.

Nazilla Khanlou, RN, PhD, is the inaugural Ontario Women's Health Council (OWHC) Chair in Women's Mental Health Research in the Faculty of Health at York University and an Associate Professor in its School of Nursing. Professor Khanlou's clinical background is in psychiatric nursing. Her overall program of research is situated in the interdisciplinary field of community-based mental health promotion in general, and mental health promotion among youth and women in multicultural and immigrant-receiving settings in particular.

It's an exciting time in the mental health field. More people are talking about the crucial role of mental health for the wellbeing of individuals, families, communities, and society. Through the efforts of international, national, and local organizations, recognition of the importance of mental health is gathering momentum. While mental health often continues to be viewed through the lens of mental illness, growing conceptual and empirical work is supporting the need for a broader understanding of the concept. This is clearly seen in the contributions to this special issue on immigrant mental health in Canada.

This collection of articles illustrates a broad spectrum of knowledge on migrant mental health, building and assessing evidence from a variety of sources: clinical practice, community-based research, population surveys and health surveillance. The articles address a range of conceptual, methodological and measurement issues and identify key data and research gaps. Several articles discuss the challenges of defining and operationalizing key concepts and dimensions of mental health and service delivery, including the concept of "mental health" itself (Ochocka et al); "access to care" (Chen); "culture" (Yan); "cultural diversity" (Ochocka et al) and "cultural competence" (Williams). The definition of these terms has important material consequences for immigrants and refugees, shaping how they engage in, and are engaged by, mental health systems and services. Researchers, policymakers, analysts and service providers also face a lack of culturally sensitive diagnostic tools (Vasilevska & Simich; Mustafaeva & Shercliffe) and gaps in: longitudinal data for immigrants and refugees (Beiser, Refugees); data related to women across a range of social locations (Guruge et al); data on older immigrants

(Khanlou); and data related to effects of discrimination on mental health (Khanlou). Furthermore, McKenzie et al note that information on ethnocultural and racialized groups could be enhanced in the Canadian Census, and Chen notes that sub-population analysis would be facilitated by the inclusion of reliable measures of immigration status and ethnicity in health services administrative databases. The research studies described in this issue employ a variety of research methodologies and techniques to fill some of these data gaps, including community-based participatory research strategies (Ochocka et al; Shakya et al; Wilson et al), mixed-methods (qualitative and quantitative) designs (Wong et al), analysis of large-scale population surveys (Beiser, Children; Ng & Omariba), and micro-econometric analysis (Xu & McDonald). Each of these approaches makes an important contribution to knowledge about immigrant and refugee mental health.

The articles in this issue also address an array of subpopulations, substantive issues, and intervention approaches. Subpopulations addressed here include those identified by gender (Beiser, Refugees; Guruge et al), age/life stage—particularly children and youth (Beiser, Children; Wilson et al; Shakya et al), immigration category (Beiser, Refugees; Wilson et al; Vasilevska & Simich), country of origin (Fang; Mustafaeva & Shercliffe; Wilson et al; Wong et al), racialized groups (McKenzie et al; Williams) and survivors of war, torture and organized violence (Lafrenière and Diallo). These subpopulations and the researchers, policymakers, analysts and service providers who work with and for them are confronted with complex challenges and dynamics of racialized discrimination (Chen; Fang; McKenzie; Rousseau et al; Williams), the acknowledgement and attainment of

health literacy (Lai & Hynie; Ng & Omariba; Simich; Wong et al) and cultural competence (Guruge et al; McKenzie et al; Vasilevska & Simich; Yan).

While "challenges and barriers" are often the focus of attention in research, policy and practice, there is increasing consideration of individual and community assets (e.g. resilience), the productive outcomes of community engagement, and the identification and dissemination of promising practices. Lai & Hynie, McKenzie et al, and Khanlou, among others in this issue, emphasize the need to account for the strength and resilience of immigrants and refugees, shifting the focus of the discourse of mental health promotion and interventions from "needy clients" to one that acknowledges the "clients" as resourceful participants in society who have been able to survive and thrive in very challenging circumstances. Community engagement in research, policy and program development and service delivery is one way to build on individuals' and community wisdom and strengths. Lai & Hynie and McKenzie et al focus on the positive impact of community engagement on mental health, and Wong et al demonstrate the successes of program development and delivery that integrate principles of social inclusion, access and equity. Promising practices such as those described by Wong et al (and others in this issue) may be undertaken at different, sometimes multiple and concurrent, levels of intervention (from the social determinants of mental health, to mental health promotion, to clinical treatment). Khanlou proposes a "systems approach" to mental health in migrant populations, and corresponding micro-, meso- and macro-levels of analysis are demonstrated in the articles that follow (e.g. Ng & Omariba; Vasilevska & Simich). Building on this systemic approach, several articles in this issue identify key principles or 'success factors' for promising practices. Fang recommends multi-faceted, multi-level interventions that engage individuals, practitioners, families, and communities. Even micro-level clinical treatment interventions can adopt a community-based focus (Lafreniere & Diallo). Reaffirming the potential transformative effect of community engagement, Wong et al identify collective empowerment and capacity building (via peer leadership training and outreach) as key to building a sustainable mental health promotion program.

This special issue will push forward our understanding of the complex dynamics involved in promoting the mental wellbeing of diverse groups of immigrants in Canada. The articles collectively add to our knowledge of the social, economic, cultural, and multi-systems context of immigrant mental health. Of significant importance are the intersections of the resettlement context and immigrant status with mental health and well being that are considered throughout the articles.

The pan-Canadian contributions successfully draw from cross-disciplinary collaborations and consider diverse dimensions of mental health.

Upon reflecting on the articles included in this important compilation of research on immigrant and refugee mental health, we find there are important questions for future research to consider. Some of the questions are larger in scope (requiring longitudinal approaches) and others are more specific (and can be localized to the particular settings in which immigrants and refugees resettle in Canada):

- How do gender, lifestage, migrant status, and social position influence mental health during the early years of resettlement and over time?
- What are the systems pathways to resilience versus vulnerability across groups?
- What are the best practices for individualized mental health service delivery across settings (for example, large urban settings with significant numbers of immigrants compared to smaller urban setting with smaller representations of immigrants)?
- What are the mental health needs of individuals and families without legal immigration status?
- What are the access barriers to mental health services for refugee claimants?
- How does the pre-migration context for Government Assisted Refugees influence their post-migration mental health?
- What community educational strategies are effective in reducing stigma around mental health challenges and promoting early access to mental health care?
- How can advocacy strategies related to mental health and well being be integrated across sectors to enhance the resettlement experience of immigrant populations?

We believe this special issue of research will contribute to the momentum in mental health promotion and open up opportunities for collaborative and cross-sectoral work in mental health practice, public policy, pedagogy and research among those working with and for immigrant and refugee populations in Canada.

LA SANTÉ MENTALE DES IMMIGRANTS AU CANADA : UNE INTRODUCTION

Beth Jackson est gestionnaire de Recherche et développement des connaissances à la Direction des politiques stratégiques et de l'innovation de l'Agence de la santé publique du Canada (ASPC). Elle est titulaire d'un doctorat en sociologie de l'Université York (Toronto) et elle a complété à titre de boursière une recherche postdoctorale auprès de la chaire FCRSS/IRSC de recherche en services de santé et en soins infirmiers de l'Institute for Health Research de l'Université York.

Nazilla Khanlou, IA, Ph. D., est la première titulaire de la chaire du Conseil ontarien des services de santé pour les femmes (COSSF) en recherche sur la santé mentale des femmes de la Faculté des sciences de la santé de l'Université York et elle est aussi professeure agrégée à son École de sciences infirmières. L'expérience clinique de la professeure Khanlou est en soins infirmiers psychiatriques. Ses recherches portent sur le domaine interdisciplinaire de la promotion de la santé mentale dans la collectivité en général, et sur la promotion de la santé mentale auprès des jeunes et des femmes dans les milieux qui accueillent des immigrants en particulier.

Il s'agit d'une période palpitante pour le domaine de la santé mentale. Davantage de gens discutent du rôle crucial de la santé mentale au regard du bien-être des personnes, des familles, des collectivités et de la société. Grâce aux efforts d'organisations internationales, nationales et locales, la reconnaissance de l'importance de la santé mentale prend de l'ampleur. Même si la santé mentale continue d'être abordée sous l'angle de la maladie mentale, des travaux conceptuels et empiriques sont de plus en plus nombreux à souligner le besoin de comprendre le concept d'une façon plus large. Cela se reflète clairement dans les articles de ce numéro spécial sur la santé mentale des immigrants au Canada.

Les articles mettent en évidence un large spectre de connaissances au sujet de la santé mentale des immigrants, accumulant et évaluant des éléments de preuve tirés de sources diverses : pratique clinique, recherche au sein des collectivités, sondages menés auprès de la population et surveillance médicale. Les articles abordent une gamme de questions conceptuelles, méthodologiques et de mesures, et cernent les lacunes clés au regard des données et de la recherche. Plusieurs articles portent sur les difficultés rencontrées au moment de définir et d'opérationnaliser les dimensions et les concepts clés de la santé mentale et de la prestation de services, y compris le concept de « santé mentale » lui-même (Ochocka et coll.); « d'accès aux soins » (Chen); de « culture » (Yan); de « diversité culturelle » (Ochocka et coll.) et de « compétence culturelle » (Williams). La définition de ces termes a des conséquences concrètes importantes pour les immigrants et les réfugiés en façonnant comment ils abordent les systèmes et les services de santé mentale et comment ils sont reçus par ceux-ci. Des outils diagnostiques tenant compte des différences culturelles font aussi défaut aux chercheurs, aux décideurs, aux analystes et aux fournisseurs de services (Vasilevska et Simich; Mustafaeva et Shercliffe) qui connaissent également des lacunes en ce qui concerne : les données longitudinales sur les immigrants et les réfugiés (Beiser, Refugees); les données relatives aux femmes selon diverses origines sociales (Guruge et coll.); les données sur les immigrants plus âgés (Khanlou); et les données relatives aux effets de la discrimination sur la santé mentale (Khanlou). En outre, McKenzie et coll. soulignent que l'information sur les groupes ethno-culturels et raciaux pourrait être améliorée dans le Recensement du Canada. Par ailleurs, Chen mentionne que l'analyse des sous-populations serait facilitée par l'ajout de mesures fiables du statut d'immigrant et de l'appartenance ethnique dans les bases de données administratives des services de santé. Les recherches présentées dans le présent numéro utilisent diverses méthodes et techniques de recherche pour pallier certaines de ces lacunes relatives aux données; y compris des stratégies de recherche participative au sein de la collectivité (Ochocka et coll.; Shakya et coll.; Wilson et coll.), des méthodes mixtes (qualitative et quantitative) (Wong et coll.), des analyses de sondages à grande échelle de la population (Beiser, Children; Ng et Omariba) et des analyses microéconométriques (Xu et McDonald). Chacune de ces approches contribue de façon importante à l'enrichissement des connaissances concernant la santé mentale des immigrants et des réfugiés.

Les articles de ce numéro touchent également à une série de sous-populations, de questions de fond et d'approches d'intervention. Les sous-populations abordées ici comprennent celles classées selon le sexe

(Beiser, Refugees ; Guruge et coll.), l'âge/l'étape du cycle de vie – en particulier les enfants et les jeunes (Beiser, Children ; Wilson et coll. ; Shakya et coll.), la catégorie d'immigration (Beiser, Refugees ; Wilson et coll. ; Vasilevska et Simich), le pays d'origine (Fang ; Mustafaeva et Shercliffe ; Wilson et coll. ; Wong et coll.), les groupes raciaux (McKenzie et coll. ; Williams) et les survivants de la guerre, de la torture et de la violence organisée (Lafrenière et Diallo). Ces sous populations et les chercheurs, décideurs, analystes et fournisseurs de services qui travaillent avec eux ou pour eux sont confrontés à des difficultés complexes et aux dynamiques de la discrimination raciale (Chen ; Fang ; McKenzie ; Rousseau et coll. ; Williams), à la reconnaissance et à l'acquisition des connaissances générales en santé (Lai et Hynie ; Ng et Omariba ; Simich ; Wong et coll.) et à la compétence culturelle (Guruge et coll. ; McKenzie et coll. ; Vasilevska et Simich ; Yan).

Même si les « difficultés et les obstacles » sont souvent au cœur de l'attention de la recherche, des politiques et de la pratique, on considère de plus en plus les atouts individuels et collectifs (la résilience, par exemple), les résultats positifs des engagements communautaires et l'identification et la dissémination des pratiques prometteuses. À ce sujet, Lai et Hynie, McKenzie et coll., et Khanlou, entre autres, insistent sur la nécessité de rendre compte de la résilience des immigrants et des réfugiés, changeant l'accent du discours sur l'intervention et la promotion de la santé mentale — de « clients nécessiteux » on en vient à reconnaître que les « clients » sont des participants ingénieux dans la société qui ont été en mesure de survivre et de réussir dans des circonstances très difficiles. L'engagement communautaire dans la recherche, l'élaboration de politiques et de programmes et dans la prestation de services constitue une façon de bâtir sur les forces et la sagesse des personnes et des collectivités. Lai et Hynie, McKenzie et coll. mettent l'accent sur les conséquences positives de l'engagement communautaire sur la santé mentale. Wong et coll. démontrent, quant à eux, les succès de l'élaboration et de la prestation de programmes qui intègrent les principes de l'inclusion sociale, de l'accès et de l'équité. Les pratiques prometteuses, comme celles décrites par Wong et coll. (et par d'autres chercheurs ayant contribué au présent numéro) peuvent être appliquées à divers niveaux d'intervention (déterminants sociaux de la santé mentale, promotion de la santé mentale, traitement clinique) ; et parfois à plusieurs niveaux simultanément. Khanlou adopte une « approche par systèmes » au regard de la santé mentale dans les populations migrantes et les niveaux d'analyse (micro-, méso- et macro) sont mis en évidence dans les articles qui suivent (p. ex. Ng et Omariba ; Vasilevska et Simich). En s'appuyant sur cette approche systémique, plusieurs articles du présent numéro cernent des principes

clés, ou des « facteurs de réussite », des pratiques prometteuses. Fang recommande des interventions aux niveaux et aux facettes multiples qui font appel aux personnes, aux praticiens, aux familles et aux collectivités. Les interventions de traitement clinique de microniveau peuvent adopter une approche fondée sur la collectivité (Lafrenière et Diallo). En réaffirmant l'effet transformateur potentiel de l'engagement communautaire, Wong et coll. identifient l'autonomisation et le renforcement des capacités des collectivités (au moyen du la formation en leadership entre pairs et relations communautaires) comme étant essentiels à la création d'un programme durable de promotion de la santé mentale.

Ce numéro spécial poussera plus loin notre compréhension des dynamiques complexes en jeu dans la promotion du bien-être mental des divers groupes d'immigrants au Canada. Collectivement, les articles ajoutent à notre connaissance du contexte social, économique, culturel et multisystémique au regard de la santé mentale des immigrants. Les intersections entre le contexte de réétablissement, le statut d'immigrant et la santé mentale et le bien-être qui sont examinées tout au long des articles sont d'une importance significative. Les contributions pancanadiennes tirent profit avec succès de collaborations interdisciplinaires et examinent diverses dimensions de la santé mentale.

Après avoir réfléchi au sujet des articles de cette importante compilation de recherches sur la santé mentale des immigrants et des réfugiés, nous constatons qu'il existe des questions importantes que des recherches futures devront examiner. Certaines de ces questions sont de portée plus vaste (nécessitant des approches longitudinales) et d'autres sont plus précises (et peuvent être situées dans les milieux particuliers où les immigrants et les réfugiés se réétablissent au Canada) :

• Comment le sexe, l'étape du cycle de vie, le statut d'immigrant et la position sociale influencent-ils la santé mentale au cours des premières années de la réinstallation et au fil du temps ?

• Quelles sont les voies systémiques vers la résilience, plutôt que vers la vulnérabilité, chez les divers groupes ?

• Quelles sont les pratiques exemplaires pour la prestation de services individualisés en matière de santé mentale selon le milieu (par exemple, les grandes villes comptant un nombre élevé d'immigrants comparativement aux petites villes où les immigrants sont moins nombreux) ?

• Quels sont les besoins en matière de santé mentale des personnes et des familles sans statut d'immigrant légal ?

• Quels sont les obstacles à l'accès aux services en matière de santé mentale pour les demandeurs d'asile ?

• Chez les réfugiés pris en charge par le gouvernement, comment le contexte avant la migration influe-t-il sur la santé mentale après la migration ?

• Quelles stratégies éducatives communautaires sont efficaces pour réduire les préjugés entourant les difficultés en matière de santé mentale et pour promouvoir un accès rapide aux soins ?
• Comment des stratégies relatives à la santé mentale et le bien-être peuvent-elles être intégrées entre les secteurs pour améliorer l'expérience de réinstallation des populations immigrantes ?

Nous croyons que ce numéro spécial contribuera à soutenir l'élan dans le domaine de la promotion de la santé mentale et qu'il ouvrira des possibilités de travaux intersectoriels menés en collaboration au sujet des pratiques, des politiques publiques, de la pédagogie et de la recherche en matière de santé mentale pour les personnes travaillant avec et pour les immigrants et les réfugiés au Canada.

Le Pont

Le Pont est un bulletin d'information publié toutes les six semaines par le Secrétariat du projet Metropolis. Ce bulletin électronique fait état des récentes activités dans chacun des six domaines prioritaires de recherche et comprend aussi des renseignements sur les événements à venir et les publications.

Pour avoir accès au bulletin électronique *Le Pont*, rendez-vous à l'adresse <http://canada.metropolis.net/thebridge/thebridge_f.html> ou à <http://canada.metropolis.net/thebridge/pdfs/thebridge_f_vol2_1.pdf>.

The Bridge

The Bridge is an information bulletin broadcast and published, every six weeks, by the Metropolis Project Secretariat. The e-bulletin will include recent activity in each of the six research priority areas and will also contain information on events and publications.

To access the e-bulletin:
<http:/ /canada.metropolis.net/thebridge/thebridge_e.html> or
<http://canada.metropolis.net/thebridge/pdfs/thebridge_e_vol2_1.pdf>

MIGRANT MENTAL HEALTH IN CANADA[1]

Nazilla Khanlou, RN, PhD. OWHC Chair in Women's Mental Health Research. Associate Professor, Faculty of Health, York University

DEFINING MENTAL HEALTH, SOCIAL DETERMINANTS OF MENTAL HEALTH, AND MENTAL HEALTH PROMOTION

Our mental health is a vital component of our wellbeing. The World Health Organization (WHO) defines mental health as "a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2007). According to WHO (2007) without mental health there is no health. This state of wellbeing arises from interactions between the individual and his or her environment (Khanlou, 2003).

The health and mental wellbeing of migrant populations is influenced by complex and interrelated factors. According to Ornstein (2002), the social determinants of health, which are the socio-economic conditions that influence the health of individuals, communities and jurisdictions, affect both physical health and mental health. While the health of migrant populations can be influenced by similar dimensions of social determinants as that of mainstream Canadians, additional determinants due to their migrant status (e.g. social and economic integration barriers, access barriers to relevant social and health services due to language and cultural differences, lack of social networks) also may exert significant influences. Some argue that the migration and settlement process itself is a significant social determinant of health (Meadows, Thurston, & Melton, 2001).

Pre-migration contexts also affect subsequent post-migration health outcomes. In cases of war-torn home countries, for instance, post-traumatic stress disorder may be a potential health risk that needs addressing in the post-migration context. In the case of family separations, mental health risk factors may be exacerbated. Those who have migrated to Canada as the only economic hope for a larger family in the country of origin, bear a tremendous burden to be economically successful (Preliminary findings, Khanlou, Shakya, and Muntaner, CHEO, 2007-2009; Eiden, 2008).

There is growing attention towards both the conceptual and practical aspects of mental health promotion (Khanlou, 2003). Mental Health Promotion (MHP) is,

> …the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. [MHP] uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections and personal dignity (Centre for Health Promotion, 1997).

MHP models and approaches grounded in majority-culture based research, however, may be limited in that they do not necessarily take into account multiple cultural, linguistic, and systemic barriers to maintaining and promoting mental health in the post-migration and resettlement context. Understanding, developing, and implementing specific MHP principles and strategies offer important opportunities for enhancing the mental wellbeing of diverse segments of society.

This policy brief addresses the mental health of migrant populations in Canada. Several caveats are brought to the reader's attention. First, the focus of this policy brief is on mental wellbeing with a particular emphasis on the social determinants of migrant mental health. The policy brief applies a mental health promotion perspective, rather than a psychiatric or biomedical approach in considering the mental wellbeing of migrant populations. Psychiatric and biomedical perspectives provide invaluable information in relation to mental illness of individuals. And, support for practice and policy are needed, which address accurate diagnosis, effective treatment, follow-up, and rehabilitation for migrants who have acute or chronic mental illness. These, however, are not the focus of the literature review for this policy brief.

Second, our notion of immigrant/migrant is not a monolithic one. We have attempted to distinguish between the categories of immigrants, refugees, and those with no legal status (or precarious status). However, within each of these categories are many diversities. In order to recognize the intersections of gender, cultural background, racialized status, lifestage, and other influences, we have applied a systems approach to organizing the findings from the literature review and considered the micro, meso, and macro level factors influencing migrant mental health.

MENTAL HEALTH OF MIGRANT POPULATIONS

In health research, the impact of migration on the health and well-being of migrants has been described through three dominant approaches. In the first approach, the hypothesis is that newly arrived immigrants have

worse health than the general population. This approach is referred to as the "morbidity-mortality" hypothesis. A second approach, referred to as the "healthy immigrant effect," proposes that immigrants tend to have better health than the general population (Hyman, 2004; Alati et al. 2003). The final approach, referred to as the "transitional effect," suggests that the health advantage that immigrants demonstrate upon arrival decreases the longer they live in the country (Alati et al., 2003).

While these conceptualizations of immigrant health have greatly influenced current research in this area, they have been predominantly based on the health and well-being of immigrants and refugees arriving through mainstream migration channels. In addition, due to the distinct pre-migration experiences of immigrants and refugees, their health and wellbeing can be significantly different in the post-migration settlement context, requiring recognition of the differences between the two groups of migrants (Khanlou, 2008b). A third group, migrants with no legal status, face additional systemic challenges in the post-migration context. For these individuals, their non-status gives them and their families limited or no access to health care, education, social services and legal rights required to promote and protect their health (Omidvar & Richmond, 2003; Mulvihill, Mailloux, & Atkin, 2001). Recognizing the above differences, we use the term migrant as an inclusive one, which includes immigrants, newcomers, refugees, refugee claimants and/or individuals with precarious immigration status.

In order to examine the research evidence on migrant mental health and implications for policy, a systems approach has been applied here. A systems approach fits well with the underlying premises of MHP. The approach allows for a multi-layered examination of factors influencing the mental wellbeing of migrants. The findings of the review have been organized along individual, intermediate, and systems levels of influences and experiences, in line with previous findings on migrant mental health (Khanlou, 2008b; Khanlou et al, 2002).

Individual (micro level) influences address individual attributes such as age, gender, and cultural background. Intermediate (meso level) influences are those that link individuals to their social context such as family and social support networks, and acculturation. Systems (macro level) influences are in relation to the broader social and resettlement context such as economic barriers, appropriate services, access to healthcare, and experiences of discrimination and racism. Micro, meso, and macro level influences intersect and interact, influencing migrant mental health.

INDIVIDUAL INFLUENCES

AGE

The age at which people migrate can have an important impact on their subsequent health status. Limited research has been conducted on the impact of migration on mental wellbeing from a lifestage perspective.

Children who migrate at a very young age (or may even have been born here), may not experience great differences in their health status in comparison to their Canadian-born counterparts. However, studies show that structural or macro factors such as barriers to education and employment (such as their parents faced) (Portes & Rumbaut, 2005) may continue to be potential mental health stressors. More research is still required in this area.

Adolescents have both specific challenges as well as resiliencies in the post-migration context (Khanlou et al., 2002; Khanlou & Crawford, 2006). Caught between their own identity development and having to mediate the new culture for their parents, youth often take on roles far beyond the capacity of their actual age (Preliminary findings, Khanlou, Shakya, and Muntaner, CHEO, 2007-2009). Female refugee youth in particular, face settlement and migration challenges that may put them at added risk for negative mental health outcomes, given the often traumatic pre-migration contexts they are coming from and the post-migration identity development they have to contend with (Khanlou & Guruge, 2008).

The immigrant elderly face their own set of challenges, specifically around isolation and abuse, language, culture, and mobility (Hasset and George, 2002; Guruge, Kanthasamy, and Santos, 2008). Further research is also required in this area.

GENDER

Gender is a significant influence on health status and intersects with other influences. Because women often migrate as dependents of their male relatives, their unique migration trajectories and specific health needs are often not incorporated into policy formulation, the focus being on male migrants (Guruge & Collins, 2008; Mawani, 2008) thereby undermining their access to healthcare services (Oxman-Martinez et al., 2005).

Gender and age as intersecting variables create an added layer of complexity for post-migration contexts, where adolescent women face different barriers than their male counterparts, and younger migrants also have different challenges than older ones. Women with precarious status are also at risk of being exploited and subject to unsafe or unclean working environments. Women with no legal status may have family members who depend on their income and are therefore unwilling

and unable to report exploitative work practices (Guruge & Collins, 2008).

CULTURAL BACKGROUND, SPIRITUALITY AND RELIGIOUS IDENTITY

Mental health services that attempt to fit migrants into categories of western clinical knowledge, do not capture the cultural and spiritual or religious factors that may be involved in migrant mental health (James & Prilleltensky, 2002; Collins, 2008). Research in ethnically diverse cities has shown that spirituality and cultural context often construct mental health and mental illness in very different ways (Fernando, 2003; Collins, 2008; Across Boundaries). Keeping this in mind, western models of mental health promotion can be supplemented by culturally-specific programs (Khanlou, 2003; Khanlou et al., 2002).[2]

Religion in particular plays an important role in the lives of different groups of immigrants, and their religious affiliations may even be strengthened post-migration, whether for reasons of renewed religious belief in the context of marginalization of religious identities, or because religious institutions become locations of community support (Preliminary findings, Khanlou, Shakya, and Muntaner, CHEO, 2007-2009; for the importance of religious education, see: Zine, 2007).

Many of the studies reiterate the importance of understanding these individual factors within an intersecting or systems framework. Other factors that also require attention within the policy and practice context are migrants who face barriers due to their differing abilities/ disabilities, and those who experience marginalization both from mainstream society and in-group ethnocultural communities due to their different sexual orientation(s). Little or no Canadian research has examined the impact of othering and discrimination on the mental health of these migrants.

INTERMEDIATE INFLUENCES

FAMILY AND SOCIAL SUPPORT NETWORKS

The family and social networks of migrants can be an important source of support in the resettlement context and promote mental wellbeing. Research findings reveal that immigrants tend to rely first and foremost on extended family members (especially those who have been in the country longer) for settlement related needs and also for a social support network (Preliminary findings, Khanlou, Shakya, and Muntaner, CHEO, 2007-2009). While Canadian immigration policy previously encouraged family reunification (Government of Canada, Immigration Act, 1978), in reality, this is difficult for refugees or those with precarious status. The ways in which family is defined in legislation, may not always

accord with the reality of immigrant families' lives. The specific needs of a potential immigrant, and the importance of extended family members needs also to be taken into consideration (Canadian Association for Community Living, 2005).

Social support networks outside of the family tend to revolve around the ethnic community, and religious organizations that cater specifically to that ethnic community. Some mosques for instance, while not formally connected to settlement programs, provide informal assistance to newcomers from legal advice, to employment skills, to explanations of cultural difference (Preliminary findings, Khanlou, Shakya, and Muntaner, CHEO, 2007-2009).

While social support can mean different things to different people within communities, Simich et al., (2005) reported common forms of social support as identified by policy makers and service providers, which include: informational, instrumental, and emotional supports (Simich et al., 2005: 262). In order to provide different levels and types of support, there must be an attempt made towards holistic coordination of services (Simich et al., 2005). The perceived impact of social support on the wellbeing of immigrant communities is also significant (Simich et al., 2005) and must be connected to the broader social determinants of health, discussed below.

ACCULTURATION

Acculturation is a process whereby contact between different cultural groups results in changes in both groups (Berry, 2001). Acculturation is premised on the existence of ethnic, cultural, and or national identities. Studies have shown that, being able to balance a sense of ethnic identity with adaptation into the new society can lead to positive mental health outcomes (Berry, 2008). In other words, ethnic identification with a particular group, in the context of a multiethnic society, can become a protective factor leading to well being. In some cases, strength of ethnic identification may lead to higher risk of psychological distress, as when the community of identification is negatively stereotyped within the broader society. Beiser and Hou (2006), in their study of Southeast Asian "Boat People", found that if a particular group experiences discrimination or perceives discrimination they may be at higher risk for psychological distress. This is because experiences of discrimination will serve as reminders of marginalized status for ethnic minorities. There are other variables, such as language, which produce different results in terms of mental health and well being (Beiser & Hou, 2006). Overall, however, cultural, ethnic, and spiritual identifications, as well as community belonging are considered to be important factors in fostering positive mental health (Canadian Institute for Health Information, 2009).

SYSTEMS INFLUENCES

ECONOMIC BARRIERS

Economic hardship is a significant determinant of health and linked to health disparities. One of the most significant stressors for mental health identified by immigrants is the underemployment or unemployment that they must deal with upon arrival. Economic barriers to integration became significant sources of stress in immigrants' lives, affecting their families. Immigrant youth often internalize the frustration of their parents and this in turn affects their own performance in school (Khanlou, Shakya, & Muntaner, CHEO, 2007-2009). On the other hand, some research also indicates that even though foreign-born immigrant children are more than twice as likely to live in poor families, they show lower levels of emotional and behavioural problems (Beiser et al., 2002). This may in part be due to the fact that hardship is expected by immigrants when they first come to the receiving country and the hope is that their situation will improve over time (Beiser et al., 2002; CHEO *op cit)*. However, if poverty persists, this can have negative effects on a child's IQ, school performance and lead to behavioural problems (Beiser et al., 2002).

APPROPRIATE SERVICES

At the larger societal level, culturally sensitive and specific mental health services prove to be the best approaches towards positive mental health outcomes. Despite the best intentions, services remain underused when formulated without a contextual understanding of the clients they are intended for (Whitley et al., 2006; Hasset & George, 2002; DesMeules et al., 2004; Newbold, 2005). Services must also account for the fact that immigrants are not a monolithic or homogeneous group and their heterogeneities are significant enough to warrant new delivery models, based on the age, gender, cultural differences and immigration status of clients.

Service agencies and organizations tend to be oriented towards giving information on paper or through the Internet, however, a verbal exchange is often the most effective way to provide information about services to newcomers (Khanlou, Shakya, & Muntaner, CHEO, 2007-2009). Research suggests that ethnic media may also be a better way to reach specific populations (Simich et al., 2005), given language barriers.

Organizations and agencies (governmental and non-governmental) need to continue their coordination efforts and avoid working in silos (CHEO, *op cit.*) and research needs to continue on the long-term health outcomes of immigrants. In addition, research is required into examining the effectiveness and efficiency of different mental health service delivery models (for example, ethno-specific service delivery models vs. culturally sensitive mainstream service delivery models).

MIGRATION STATUS AND ACCESS TO HEALTHCARE

Migration status influences access to healthcare. Immigrants and refugees have various challenges, but may at least in theory be able to access healthcare services. Those with precarious status however (Oxman-Martinez et al., 2005) are often caught in 'liminal' spaces of incertitude (McGuire & Georges, 2003), which leave them particularly vulnerable to negative mental health outcomes. Those with no legal status are at even greater risk, as they simply may have no recourse to health services (Khanlou et al., manuscript in progress).

The pre-migration experiences of refugees can also have lasting impact on their mental health status after migration. In general, newcomers may have different health status than their Canadian born counterparts and over time this can deteriorate (Alati et al., 2003; Beiser, 2005). Ali (2002) found that newer immigrants exhibit fewer mental health problems, when compared to their Canadian-born peers, but it is not clear whether this is the result of a greater resiliency in the immigrants or a difference in how they understand and conceptualize mental health problems (Ali, 2002: 6). Further longitudinal research needs to be conducted to see to what extent health status remains unaltered.

PREJUDICE, DISCRIMINATION AND RACISM

While it may be difficult to measure racism, perceptions of racism have been found to have an effect on mental health (McKenzie, 2006), and subsequent service utilization by immigrants (Whitley et al., 2006). Racialized immigrants face barriers of discrimination, prejudice and racism, based on their skin colour, accents, and sometimes cultural differences (Simich et al., 2005). Experiences of prejudice and discrimination affect immigrant youth's sense of belonging and psychosocial integration to Canada (see Khanlou, Koh, & Mill, 2008). Research continually shows connections between systemic discrimination, underemployment or unemployment and mental health outcomes (McKenzie, 2006; Raphael, Curry-Stevens, & Bryant, 2008; Mawani, 2008).

In summary, migrant mental health is influenced by a multitude of factors, and requires an understanding in the context of their intersections (Khanlou et al., 2002; Oxman-Martinez et al., 2005), which has policy implications.

POLICY RECOMMENDATIONS

Beiser (2005) observes that prevailing paradigms towards immigrants affect health policy. Conceptual approaches to studying immigrant health also need to

account for not just multiple factors as variables, but also how and under what circumstances different influencing factors may be "activated" (Bergin, Wells, & Owen, 2008). Traditional paradigms that have been used to explain immigrant health (such as the healthy immigrant effect or the morbidity-mortality paradigm) need to be re-examined (Dunn & Dyck, 2000) in light of longer term outcomes and the heterogeneity of immigrants along the lines of gender, age, immigrant status, and the historical pre-migration context from which they come (Alati et al., 2003; Beiser, 2005; Salant, 2003).

While subgroups of migrants such as refugees or those with precarious status are at greater risk of mental health problems (Khanlou & Guruge, 2008; McGuire & Georges, 2003; DesMeules et al., 2005; Oxman-Martinez et al., 2005; Simich, Wu, & Nerad, 2007), the resilience and resourcefulness of immigrants also needs to be factored into the analysis (Simich et al., 2005; Khanlou, 2008a; Waller, 2001). This has specific policy implications, as the discourse needs to also shift from the focus on immigrants as "needy service recipients" (Simich et al., 2005: 265), to a recognition of their capacity to survive in the face of tremendous challenges. This shift in attitudinal focus has practical consequences for the ways in which employers will see potential newcomer employees. If newcomers are looked upon as adaptable and resilient, rather than being the cause of social problems (Simich et al., 2005), then their opportunities in the workforce may increase.

The following policy recommendations arise out of a mental health promotion approach and recognize the inter-relations between micro, meso and macro levels of influence on migrant mental wellbeing:

RECOMMENDATION:

Support intersectoral approaches to promoting migrant wellbeing across systems (including health, social services, resettlement, education, etc) through developing, enhancing, and coordinating partnerships between sectors.

RECOMMENDATION:

Support integrated community-based mental health services that:
- address the social determinants of migrant mental health;
- are gender and lifestage sensitive; and
- recognize both the challenges and resiliencies of diverse groups of migrants (newcomers, immigrants, refugees, precarious status).

RECOMMENDATION:

Support education and training towards providing the following:

- provide public education campaigns directed at diverse groups of migrants on the mental health system (acute and community based) and how to access appropriate services;
- provide standardized and quality monitored education to cultural interpreters; and
- provide education to health and social service providers and students on culturally competent mental health promotion.

RECOMMENDATION:

Support policies that remove barriers to economic and social integration of newcomers (for example through recognition of previous training and education).

RECOMMENDATION:

Support longitudinal and comparative research on migrant mental wellbeing that considers the multiple determinants of migrant mental wellbeing through interdisciplinary approaches and community-academia alliances.

CONCLUSION

Over two decades have passed since the publication of the report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada (Beiser, 1988). Community-based and govern-mental initiatives attest to the progress we have made, though more intersectoral work needs to occur.

While Canada has built a reputation as a leader in health promotion, it is the only G8 country that does not yet have a mental health strategy. It is estimated that $23 billion is spent annually in medical bills, disability, and sick leaves in Canada (Globe and Mail, July 25th page A4). Mental health, a crucial part of overall health, must become a policy priority in Canada. There are positive steps already being taken in this direction. In a 2006 report to the Standing Senate Committee, the honour-able Michael Kirby recommended that a mental health commission be set up in Canada. In 2007, the federal government committed $10 million for two years and $15 million per year for two subsequent years (up to 2010) towards the establishment of the Mental Health Commission of Canada (Office of the Prime Minister, http://pm.gc.ca/eng/media.asp?id=1807). The Govern-ment has also confirmed an amount of $130 million over 10 years to the Canadian Mental Health Commission (Health Canada, 2008).

In January 2009 the Commission released its "Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada" as a draft summary for public discussion. In 2009 the Canadian Institute for Health Information also released its document entitled

"Improving the Health of Canadians 2009: Exploring Positive Mental Health." On 12 February 2009 the Pan-Canadian Planning Committee for the National Think Tank on Mental Health Promotion released its document, "Toward Flourishing for All… National Mental Health Promotion and Mental Illness Prevention Policy for Canadians." Media features and conferences are also addressing the gaps around the public discussion of mental health and mental illness in Canada. The Globe and Mail featured a series on "Canada's Mental Health Crisis," (http://www.theglobeandmail.com/breakdown). A conference (held in Toronto, 4-6 March 2009) in conjunction with the Mental Health Commission of Canada focused on mainstreaming mental health and wellness promotion (http://www.clifordbeersfoundation.co.uk/toronto.htm).

Such initiatives are very timely and are contributing to mental health promotion efforts. Attention is also needed on specific sub-groups of the population, such as migrants. In light of the stigma around mental illness, and barriers to accessing mental health services for migrants, mental health promotion efforts need to consider how best to reach diverse audiences. We hope that this policy brief will be a timely contribution to the broader movement towards the creation of a national mental health strategy, an educational tool to create awareness of mental health promotion for migrant communities, and an impetus for specific policy initiatives promoting the mental wellbeing of migrant populations in Canada. We believe that such initiatives will have benefits both for the specific populations they are targeted at as well as communities and Canadian society at large.

REFERENCES

Access Alliance Multicultural Health and Community Services. Available URL: http://www.accessalliance.ca.

Across Boundaries. Available URL: http://www.acrossboundaries.ca/.

Alati, R., Najman, J.M., Shuttlewood, G.J., Williams, G.M., & Bor, W. (2003). Changes in mental health status amongst children of migrants to Australia: a longitudinal study. *Sociology of Health and Illness*, 25(7), 866-888.

Ali. J. (2002). Mental Health of Canada's Immigrants. Supplement to Health Reports, volume 13, Statistics Canada, Catalogue 82-003, 1-11.

Beiser, M. (2005). The health of immigrants and refugees in Canada. *Canadian Journal of Public Health*, 96(Supplement 2), S30-S44.

Beiser, M. (1988). After the door has been opened: Mental health issues affecting immigrants and refugees in Canada. Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. Minister of Supply and Services Canada.

Beiser, M., and Hou, F. (2006). Ethnic identity, resettlement stress and depressive affect among Southeast Asian refugees in Canada. *Social Science and Medicine*, 63, 137-150.

Beiser, M., Hou, F., Hyman, I., & Tousignant, M. (2002). Poverty, family process, and the mental health of immigrant children in Canada. *American Journal of Public Health*, 92(2), 220-227.

Bergin, M., Wells, J.S.G., and Owen, S. (2008). Critical realism: a philosophical framework for the study of gender and mental health. *Nursing Philosophy*, 9, 169-179.

Berry, J.W. (2008). Acculturation and adaptation of immigrant youth. *Canadian Diversity*. Vol. 6. No. 2, 50-53.

Berry, J.W. (2001). A Psychology of Immigration. *Journal of Social Issues*, Vol. 57, No. 3, 615-631.

Canadian Association for Community Living. (2005). Immigration and Disability – submission to the Standing Committee on Citizenship and Immigration, April, 2005.

Canadian Institute for Health Information. (2009). Improving the Health of Canadians: Exploring Positive Mental Health. Ottawa: Canadian Institute for Health Information.

Centre for Health Promotion. (1997). Proceedings *from the International Workshop on Mental Health Promotion*. University of Toronto. In C. Willinsky, and B. Pape. (1997). Mental *health promotion*. Social Action Series. Toronto: Canadian Mental Health Association National Office.

Collins, E. (2008). Recognizing Spirituality as a Vital Component in Mental Health Care. In, Guruge, S. and Collins, E. (Eds). (2008). Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Canada: Centre for Addiction and Mental Health.

DesMeules, M., Gold, J., Kazanjian, A., Manuel, D., Payne, J., Vissandjée, B., McDermott, S., and Mao, Y. (2004). New approaches to immigrant health assessment. *Canadian Journal of Public Health*, 95 (3), I-22 to I-26.

DesMeules, M., Gold, J., McDermott, S., Cao, Z., Payne, J. Lafrance, B., Vissandjée, B., Kliewer, E., and Mao, Y. (2005). Disparities in Mortality Patterns Among Canadian Immigrants and Refugees, 1980-1998: Results of a National Cohort Study. *Journal of Immigrant Health*, Vol. 7, No. 4, 221-232.

Dunn, J., & Dyck, I. (2000). Social determinants of health in Canada's immigrant population: Results from the National Population Health Survey. *Social Science & Medicine*, 51, 1573-1593.

Eiden, J. (2008). Family Separation: Impacts on Children. *INSCAN: International Settlement Canada*, Vol. 22 (1), 19.

Expanding Our Horizons: Moving Mental Health and Wellness Promotion into the Mainstream. March 4-6, 2009. International Conference organized by the Clifford Beers Foundation and in conjunction with the Mental Health Commission of Canada. Metro Toronto Convention Centre.

Fernando, S. (2003). Cultural Diversity, Mental Health and Psychiatry: The Struggle Against Racism. New York: Brunner-Routledge Taylor and Francis Group.

Globe and Mail. Section A4. July 25th, 2008.

Government of Canada, Immigration Act (1978). Regulations Amending the Immigration Regulations, 1978. Available online: http://canadagazette.gc.ca/partII/2001/20011219/html/sor525-e. html.

Guruge, S., and Collins, E. (2008). Emerging Trends in Canadian Immigration and Challenges for Newcomers. In: Guruge, S. and Collins, E. (Eds). (2008). Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Canada: Centre for Addiction and Mental Health.

Guruge, S., Kanthasamy, P., and Santos, E.J. (2008). Addressing older women's health: A pressing need. In: Guruge, S. and Collins, E. (Eds). (2008). Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Canada: Centre for Addiction and Mental Health.

Hasset, A., and George, K. (2002). Access to a community aged psychiatry service by elderly from non-English-speaking backgrounds. *International Journal of Geriatric Psychiatry*, 17, 623-628.

Health Canada. (2008). *Government of Canada Confirms Funding for Canadian Mental Health Commission.* News Release, Health Canada. Online: http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2008/2008_134-eng.php.

Hyman, I. (2004). Setting the stage: reviewing current knowledge on the health of Canadian immigrants. *Canadian Journal of Public Health*, 95(3), I1-I18.

James, S., and Prilleltensky, I. (2002). Cultural diversity and mental health: towards integrative practice. *Clinical Psychology Review.* 22, pp. 1133-1154.

Khanlou, N. (2008a). Migration and Mental Health. Canadian School of Public Service Presentation, Ottawa. Available URL: http://canada.metropolis.net/mediacentre/mediacentre_e.htm.

Khanlou, N. (2008b). Young and new to Canada: Promoting the mental wellbeing of immigrant and refugee female youth. *International Journal of Mental Health & Addiction*. 6(3), 514-516.

Khanlou, N. (2003). Mental health promotion education in multicultural settings. *Nurse Education Today*, 23(2), 96-103.

Khanlou, N. et al., Manuscript in Progress. Social determinants of non-status migrant women's health.

Khanlou, N., & Guruge, S. (2008). Chapter 10: Refugee youth, gender and identity: On the margins of mental health promotion. In: Hajdukowski-Ahmed M, Khanlou N, & Moussa H (Editors) Not born a refugee woman: Contesting identities, rethinking practices. Oxford/New York: Berghahn Books (Forced Migration Series).

Khanlou, N., Koh, J., & Mill, C. (2008). Cultural identity and experiences of prejudice and discrimination of Afghan and Iranian immigrant youth. *International Journal of Mental Health & Addiction.* 6(3), 494-513.

Khanlou, N., Shakya, Y., and Muntaner, C. (2007-2009). Mental health services for newcomer youth: Exploring needs and enhancing access. Funded by Provincial Centre of Excellence for Child and Youth Mental Health at CHEO.

Khanlou, N., & Crawford, C. (2006). Post-migratory experiences of newcomer female youth: Self-esteem and identity development. *Journal of Immigrant and Minority Health*, 8(1), 45-56.

Khanlou, N., Beiser, M., Cole, E., Freire, M., Hyman, I., and Kilbride, K.M. (2002). *Mental health promotion among newcomer female youth: Post-migration experiences and self-esteem.* Ottawa: Status of Women Canada.

Mawani, F.N. (2008). Social Determinants of Depression among Immigrant and Refugee Women. In, Guruge, S. and Collins, E. (Eds). (2008). Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Canada: Centre for Addiction and Mental Health.

McGuire, S., & Georges, J. (2003). Undocumentedness and liminality as health variables. *Advances in Nursing Sciences*, 26(3), 185-195.

McKenzie, Kwame. (2006). Racial discrimination and mental health. *Psychiatry* 5:11, 383-387.

Meadows, L., Thurston, W., & Melton, C. (2001). Immigrant women's health. *Social Science and Medicine*, 52, 1451-1458.

Mental Health Commission of Canada. Available URL: http://www.mentalhealthcommission.ca/mhcc-en.php

Mental Health Commission of Canada. (2009). Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada. Available online: http://www.mentalhealth-commission.ca/SiteCollectionDocuments/Key_Documents/en/2009/Mental_Health_ENG.pdf.

Mulvihill, M.A, Mailloux, L., & Atkin, W. (2001). Advancing policy and research responses to immigrant and refugee women's health in Canada. Prepared for the Centres of Excellence in Women's Health. Ottawa: Women's Health Bureau, Health Canada.

Newbold, B. (2005). Health status and health care of immigrants in Canada: A longitudinal analysis. *Journal of Health Services Research and Policy*, Vol 10, No. 2, 77-83.

Office of the Prime Minister. (2007). Mental Health Commission of Canada – Media Backgrounder. Available URL: http://pm.gc.ca/eng/media.asp?id=1807

Omidvar, R., & Richmond, T. (2003). Immigrant settlement and social inclusion in Canada. Toronto, Canada: Laidlaw Foundation.

Ornstein, M (2002). Ethno-Racial Inequality in the City of Toronto: An Analysis of the 1996 Census. Retrieved 6th October 2006 from URL: www.city.toronto.on.ca/diversity/pdf/ornstein_fullreport.pdf

Oxman-Martinez, J, Hanely, J, Lucida, L, Khanlou, N, Weerasinghe, S, & Agnew, V. (2005). Intersection of Canadian policy parameters affecting women with precarious immigration status: a baseline for understanding barriers to health. *Journal of Immigrant Health*, 7(4), 247-258.

Pan-Canadian Planning Committee for the National Think Tank on Mental Health Promotion. (2009). Toward Flourishing for All…National Mental Health Promotion and Mental Illness Prevention Policy for Canadians. Available online: http://www.utoronto.ca/chp/mentalhealthpdf/National%20Mental%2Health%20Promotion%20and%20Mental%20Illness%20Prevention%20-%20Best%20Adviceon%20a%20Policy%20for%20Canadians.pdf

Portes, A., and Rumbaut, R.G. (2005). Introduction: The Second Generation and the Children of Immigrants Longitudinal Study. *Ethnic and Racial Studies*, Vol. 28, No. 6, 983-999.

Raphael, D., Curry-Stevens, A., and Bryant, T. (2008). Barriers to addressing the social determinants of health: insights from the Canadian experience. *Health Policy In Print*, doi:10.1016/j.healthpol.2008.03.015.

Salant, T., and Lauderdale, D.S. (2003). Measuring culture: a critical review of acculturation and health in Asian immigrant populations. *Social Science and Medicine*. 57, pp. 71-90.

Simich, L., Beiser, M., Stewart, M., and Mwakarimba, E. (2005). Providing social support for immigrants and refugees in Canada: Challenges and directions. *Journal of Immigrant Health*. Vol. 7. No. 4, 259-268.

Simich, L., Wu, F., and Nerad, S. (2007). Status and health security: an exploratory study of irregular immigrants in Toronto. *Canadian Journal of Public Health*. (98) 5, pp. 369-373.

Waller, M.A. (2001). Resilience in ecosystemic context: Evolution of the concept. *American Journal of Orthopsychiatry*, 71(3), 290-297.

Whitley, R., Kirmayer, L., and Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: a qualitative study from Montreal. *Canadian Journal of Psychiatry*. (51) 4, pp. 205-209.

World Health Organization (WHO). (2007). *Mental health: Strengthening mental health promotion.* Fact Sheet # 220. Available URL: http://www.who.int/mediacentre/factsheets/fs220/en.

Zine, J. (2007). Safe havens or religious 'ghettos'? Narratives of Islamic schooling in Canada. *Race, Ethnicity and Education*, Vol. 10, No. 1, 71-92.

FOOTNOTES

[1] This article presents a shortened version of a policy brief written for the Public Health Agency of Canada and the Metropolis Project. The policy brief was commissioned and funded by the Strategic Initiatives and Innovations Directorate (SIID) of the Public Health Agency of Canada. Support for its development was provided both by SIID and the Metropolis Project. The opinions expressed in this publication are those of the author's and do not necessarily reflect the views of the Public Health Agency of Canada or Metropolis. The full policy brief can be found at: http://canada.metropolis.net/events/health/health_seminar.html.

[2] Being aware of and addressing the unique cultural needs of different groups is at times referred to as cultural competence. Some argue that cultural competence can in fact further marginalize and separate culturally different "others," and that a more appropriate framework is one based on anti-racism and anti-oppression. While debates continue around this issue, most agree that diverse individual needs must be addressed in mental health service delivery, as Canada's population is not homogeneous.

HEALTH LITERACY, IMMIGRANTS AND MENTAL HEALTH[1]

Laura Simich, Ph.D. is Scientist in Social Equity and Health Research at the Centre for Addiction and Mental Health, Toronto; Assistant Professor in the Department of Psychiatry and the Department of Anthropology, University of Toronto; and Health and Wellbeing Domain Leader at the Ontario Metropolis Centre. An anthropologist with expertise in qualitative methods and community-based research, her research focuses on sociocultural determinants of mental health among immigrants and refugees and aims to inform policy and promote community mental health.

ABSTRACT

This article defines health literacy and its implications for immigrants in Canada. Existing evidence about health literacy, health outcomes, language proficiency, gender and social and cultural barriers that affect immigrants' health literacy is noted. Mental health literacy, stigma and culture are discussed. The article concludes with suggested health literacy interventions.

ACKNOWLEDGEMENTS:

Good mental and physical health, defined simply as feeling good and functioning well in daily life, is a key outcome of successful immigrant settlement and integration. Newcomers to Canada must obtain new information about health issues and services while experiencing resettlement stress and often new health needs. "Health literacy" describes the ability to obtain, process, understand *and use* health information to make appropriate decisions about health (Ad Hoc Committee 1999). There are many definitions of health literacy, but the most clear and comprehensive definition includes the ability to seek information, learn, appraise, make decisions, communicate information, prevent diseases and promote individual, family and community health (Rootman, Frankish, and Kaszap 2007). Current definitions of health literacy encompass a critical understanding of health issues and knowledge of how to use the health care system (Nutbeam 2000), and emphasize the responsibility of health and educational institutions to smooth the two-way communication process and help people obtain needed health care (Nielsen-Bohlman, Panzer and Kindig 2004). According to the Canadian Public Health Association, attention should be paid to health literacy among immigrants because these are areas in which immigrants are especially disadvantaged (Rootman and Gordon-El-Bihbety 2008).

International literacy surveys, such as the *International Adult Literacy and Skills Survey* (IALSS), have assessed individual and collective health literacy skills in the areas of health promotion, health protection, disease prevention, healthcare maintenance and system navigation (Canadian Council on Learning 2007, 2008). Three basic levels of health literacy skills have been identified: the first, involving reading and numeracy, the second, interactive skills, i.e., knowing how to converse with a busy health professional about symptoms and concerns and a third, *critical* health literacy, describing the ability to analyze and use health information to exert greater control over life situations. From this perspective, health literacy is seen as a right and an issue of equity and citizenship (Nutbeam 2000; Kickbusch, Wait and Maag 2005).

The basic idea behind health literacy appears straightforward: the greater a person's ability to learn about health, the better that person's health. But health literacy is not just a personal ability or a one-way process that depends upon the individual's linguistic proficiency or comprehension of written information such as a doctor's prescription. Rather, it is a complex, multidimensional communication process that also involves health-care providers' competencies, the "legibility" of the health care system for diverse groups and appropriate

policy and programs to achieve effective communication (Kickbusch et al. 2005). Health literacy is a complex inter-action that goes beyond reading; it is affected by education, culture, and language (Nielsen-Bohlman et al. 2004). Immigrants arrive in Canada having had different health and health care experiences and knowledge of health issues in their homelands. The resettlement experience involves cultural adaptation, which produces new health challenges as well as new opportunities for knowledge exchange about health in family life, schools, neighbourhoods and the workplace. Enhancing health literacy therefore applies not only to medical settings, but also to a variety of settings across one's life span and throughout settlement and integration.

HEALTH LITERACY AND IMMIGRANTS IN CANADA

Results of the IALSS, which surveyed 23,0000 Canadians, showed that 60% of adults in Canada lack the capacity to obtain, understand and act upon health infor-mation and services and to make appropriate health decisions (Canadian Council on Learning 2007). Health literacy is a strong predictor of overall health status and self-reported health status is, in turn, a reliable indicator of health outcomes. Canadians with the lowest health literacy scores are 2.5 times as likely to perceive them-selves as being in fair or poor health compared to those with higher health literacy scores. This statistical relation-ship holds even after removing the impact of age, gender, education, mother tongue, immigration and Aboriginal status (Canadian Council on Learning 2008).

There is cause for concern because low health literacy may have a long-term impact on population health. Those individuals with lower literacy skill levels are 1.5 to 3 times more likely to experience negative health outcomes and difficulties managing chronic diseases, although it is difficult to disentangle the effects of poor literacy and poor access to health care (DeWalt, Berkman, Sheridan, Lohr and Pignone 2004). Other outcomes of low literacy and health literacy include lower income and less community engagement--outcomes that are also associated with poorer health and quality of life. These outcomes may affect disproportionately recent immigrants who are not well established. Recent immi-grants, those with lower levels of education and with low French or English proficiency, seniors and people receiving social assistance tend to have lower levels of literacy and health literacy (Rootman and Gordon-El-Bihbety 2008, 21).

Barriers to health literacy, such as lack of meaningful multilingual information about health issues, knowledge of where to find the right health care or how to access preventive services contribute to the deterioration in health status of immigrants in Canada over time

(Zanchetta and Poureslami 2006). While existing evidence demonstrates that immigrants experience many linguistic and cultural barriers in accessing health care in Canada (Bowen 2001; Gagnon 2002), we still do not know enough about how social and cultural barriers actually affect health literacy or health outcomes. Although more research is needed, there is sufficient evidence to suggest practical ways to enhance immigrants' health literacy skills, including using clear and multiple forms of communication, community-based development and delivery methods and increasing cultural competence in providers of health and social services.

LANGUAGE PROFICIENCY, GENDER AND HEALTH LITERACY

Despite the high educational levels of many immi-grants and refugees, it is not surprising that health literacy levels are low in the early years of settlement. As the 2003 IALSS results show, about 60% of immigrants fell below Level 3 in prose literacy (considered the minimum level for coping with the demands of everyday life and work in a knowledge economy) compared to 37% for the Canadian-born population (Canadian Public health Association 2006, 27). The IALSS estimated that 32% of foreign-born women have extreme difficulty with, and only limited use of printed materials compared to 24% of foreign-born men and approximately 10% of Canadian-born women and men (Rootman and Gordon-El-Bihbety 2008,17). Immigrant women's lower levels of health literacy can have a wide impact on information exchange about health and help-seeking for immigrant communities because women often play a central care giving role in families and other social networks. Longitu-dinal research with Southeast Asian immigrants in Canada identified English fluency as a significant determi-nant of both depression and employment, particularly for immigrant women (Beiser and Hou 2001), and found that when women participate in formal language training they benefit more than men.

Analysis of the Longitudinal Survey of Immigrants to Canada (LSIC) has shown that self-reported poor health was significantly related to lack of improvement in language proficiency over time for both immigrant men and women (Pottie, Ng, Spitzer, Mohammed and Glazier 2008). This finding has implications for increasing the availability of language training as well as improving health care for immigrants. A lack of affordable English or French as a Subsequent Language (ESL or EFL) programs for adults is a barrier for newcomers to Canada who wish to improve their literacy and health literacy skills, which in turn promote social integration and wellbeing. Without basic literacy skills, new immi-grants have difficulty becoming health literate enough to

manage health-relevant information within the context of the Canadian health system (Rootman and Gordon-El-Bihbety 2008, 26).

STRUCTURAL AND CULTURAL BARRIERS TO HEALTH LITERACY

Common sense suggests that providing written information alone is not enough to ensure good health. The social and cultural context in which information is exchanged, ways of communicating and the timing of health information also matter. Information about employment, housing and other immediate needs are often priorities in the early years in Canada; however, information about health is one of the top needs of longer established immigrants (Caidi 2007). Immigrants report more barriers to health care than non-immigrants and perceive that existing health services and information are not sensitive to the cultural, faith, language or literacy needs of diverse communities. Barriers identified by immigrants include fear of speaking English; suspicion of authority; isolation and sense of being an outsider; reliance on children (who may have inadequate experience and language proficiency themselves) to find accurate information; lack of familiarity with Canadian information sources; cultural differences; and absence of knowledge of how to ask for services (Caidi 2007). Factors that affect health literacy for immigrants may include, but are not limited to, language proficiency, prior education about health issues in the country of origin, cultural beliefs about illness, familiarity with the health care system in Canada and perceptions of cultural awareness among health service providers and institutions. When service providers think of health literacy only in narrow terms of verbal skills during their interactions with immigrants, the social and cultural context of communication is neglected and the meanings of important messages are lost.

Consideration of cultural diversity in health literacy has to extend beyond language to a broader appreciation of cultural values, help-seeking beliefs and community engagement. Most health care providers have a very limited understanding of immigrants and refugees' experiences and special health needs. Often the first need is not primarily "medical," but the need to improve trust, comfort and communication, which highlights the two-way nature of health literacy as a social process and an agent to help break down structural and cultural barriers (Anderson Scrimshaw, Fullilove, Fielding, Normand and the Task Force on Community Preventive Services 2003; Vissandjee and Dupere 2000; Weerasinghe 2001). Some mental health care practitioners in Canada are also raising awareness and developing professional training about how to work with immigrants and cultur-

ally diverse groups (Fung, Andermann, Zaretsky, A. and Lo 2008; Guruge and Collins 2008). There is also growing recognition that safe and effective mental health care requires the provision of trained cultural or community interpreters (Abraham and Rahman 2008).

MENTAL HEALTH LITERACY, STIGMA AND CULTURE

Mental health literacy poses particular challenges. Lack of public awareness about mental health and stigma against people suffering from mental illness are widespread problems in Canada (Bourget and Chenier 2007); new policies and program initiatives are required to meet these challenges (Standing Senate Committee 2006). Mental health literacy may be defined as knowledge and beliefs about mental disorders which aid their recognition, management or prevention (Jorm 2000). It entails knowledge and beliefs about mental health disorders that emerge from general pre-existing belief systems. Lack of mental health literacy results in delays in seeking appropriate treatment and creates difficulties communicating with health professionals. Lay people generally have a poor understanding of mental illness. They are unable to identify mental disorders, do not understand what causes them, are fearful of those who are perceived as mentally ill, have incorrect beliefs about treatment, are often reluctant to seek help for mental disorders and are not sure how to help others (Canadian Alliance on Mental Illness and Mental Health 2008).

The Canadian Alliance on Mental Illness and Mental Health has identified immigrants as a priority group for mental health literacy interventions. New Canadians tended to identify life stress, such as the challenges of cultural adaptation, as the primary cause of mental health problems (Canadian Alliance on Mental Illness and Mental Health 2008, 21). Although immigrants in general tend to suffer from depression and alcoholism in lower proportions than Canadian-born citizens (Ali 2002), the early years after resettlement are especially stressful. For many immigrants, resettlement stresses such as discrimination and underemployment experienced after arrival in Canada add substantially to the risks of experiencing psychological distress (Beiser 2005). Moreover, many refugees have acute unmet needs for mental health care because of traumatic pre-migration experiences. The problem comes not from the health of newcomers, but from the fact that immigrants and refugees have less access to mental health information and services when they need them. Newcomers may not be familiar with formal mental health services, not only due to a lack of mental health care in some countries of origin, but also due to linguistic barriers and lack of culturally appropriate mental health promotion and services in Canada (Beiser, Simich and Pandalangat 2003; James and

Prilleltensky 2003). In some languages, there are no specific equivalent terms for mental illnesses (Littlewood 1998), and talking about them may be considered *taboo*. To overcome the negative impact of stigma in immigrant communities, it is necessary as a first step to talk more openly about mental health in collaboration with communities and to increase mental health literacy through community-based education (Simich, Maiter, Moorlag and Ochocka 2009).

Culture is of particular interest with regard to mental health literacy because there are significant cultural variations in how people recognize, explain, experience and respond to mental disorders. People in all cultural groups experience depression, but they may talk about it differently (Jadhav, Weiss and Littlewood 2001). Their mental health experiences are often closely connected to social support, expectations about how others will respond and to fear of shame and social isolation, which can delay help-seeking (Lauber, Nordt, Falcato and Rossler 2004). Current research on mental health with ethnocultural and immigrant groups in Canada, however, suggests that they would like greater access to mental health information that is community-based and culturally responsive (Simich et al., 2009).

HEALTH LITERACY INTERVENTIONS FOR IMMIGRANTS

Health literacy interventions appear to help counteract factors such as poverty, unequal access to quality health services, lack of preventive health care and culturally and linguistically relevant health services. In general, using participatory educational methods for learners to identify and learn about health issues results in an improvement to most aspects of health literacy (King 2007). Shohet and Renaud (2006) distinguish three domains of good health literacy practices: first, clear writing; second, oral communication (between patients and health care professionals, and training for health professionals targeting low-literate groups), and third, visual tools such as video and other non-written means of communication. The most promising practices combine multitasking approaches and direct inter-personal communication, usually by an educator who is linguistically competent and culturally acceptable to the community involved. In addition, relying on a variety of public outreach sites is important for immigrant communities for whom language classes, community health centres, ethnic associations, places of worship and shopping malls are often points of contact. Some health literacy initiatives in Canada are using a broad range of approaches including communication, education, community development, organizational and network development. For example, one Canadian project

developed a photonovella about nutrition as a health literacy tool with ESL-speaking immigrant women (Nimmon 2007). The British Columbia Health Literacy Research Team has carried out projects focusing on Farsi-speakers (Poureslami, Murphy, Nicol, Balka and Rootman 2007) and is currently looking at ways to help Spanish-speaking immigrants develop health literacy skills.

Health literacy initiatives targeting mental health and immigrants are still rare, but one popular resource produced by the Centre for Addiction and Mental Health with funding from Citizenship and Immigration Canada in Ontario is the booklet, *Alone in Canada: 21 Ways to Make it Better*. This booklet has been used widely in ESL language classes in Ontario since 2002. The content for *Alone in Canada*, which focuses on ways for newcomers to adapt and to reduce mental distress during settlement, was developed in each target language by focus groups of immigrants and refugees who shared their personal experiences and coping strategies. The content was written in plain language, translated and edited by ethnolinguistic community experts and again verified by community focus groups (Simich, Scott and Agic 2005). *Alone in Canada* is available in 18 languages in print and on line at www.camh.net and at www.settlement.org. Also available online from CAMH are a number of other resources: multilingual educational fact sheets about mental health and addictions problems, including the types of problems and what contributes to them, information on asking for help when things are not right and on coping with stress.

CAMH fact sheets can be found at: http://www.camh.net/About_Addiction_Mental_Health/Multilingual_Resources/index.html.

REFERENCES

Abraham, D. & Rahman, S. 2008. "The community interpreter: a critical link between clients and service providers." In S. Guruge and E. Collins (eds.), *Working with Immigrant Women: Issues and Strategies for Mental Health Professionals*. Toronto: Centre for Addiction and Mental Health. 103-118.

Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association 1999. Health literacy: report of the council on scientific affairs. *Journal of the American Medical Association* 281: 552-7.

Ali, J. 2002. "Mental health of Canada's immigrants." *Health Reports* 13 (Supplement):1-11.

Anderson, L., Scrimshaw S., Fullilove, M., Fielding, J., Normand, J. & the Task Force on Community Preventive Services 2003. "Culturally competent health care systems: a systematic review." *American Journal of Preventive Medicine* 24(3S), 68-79.

Beiser, M. 2005. "The health of immigrants and refugees in Canada." *Canadian Journal of Public Health* 96, (Supplement 2):S30-S44.

Beiser, M. & Hou, F. 2000. "Gender Differences in Language Acquisition by Southeast Asian Refugees." *Canadian Social Policy,* 26 (3): 311-330.

Beiser, M., Simich, L. & Pandalangat, N. 2003. "Community in distress: mental health needs and help-seeking in the Tamil community in Toronto." *International Migration* 41(5): 233-245.

Besier, M. & Hou, F. 2001. "Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: a 10-year study." *Social Science & Medicine* 53(10):1321-1334.

Bourget, B. & Chenier, R. 2007. *Mental Health Literacy in Canada: Phase One Report Mental Health Literacy Project* Ottawa, ON: Canadian Alliance on Mental Illness and Mental Health.

Bowen, S. 2001. *Language Barriers in Access to Health Care.* Ottawa: Health Canada. Avaialble at www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-lang-acces/index_e.html.

Caidi, N. 2008. *Information Practices of Ethnocultural Communities: Final report to CERIS*, Ontario Metropolis Centre, Toronto. Available online at www.ceris.metropolis.net/Virtual%20Library/RFPReports/CaidiAllard2005.pdf.

Canadian Alliance on Mental Illness and Mental Health. 2008. *National Integrated Framework for Enhancing Mental Health Literacy in Canada: Final Report.* Ottawa, ON: Canadian Alliance on Mental Illness and Mental Health.

Canadian Council on Learning 2007. *Health Literacy in Canada: Initial results from the International Adult Literacy and Skills Survey*, Ottawa: Canadian Council on Learning.

Canadian Council on Learning 2008. *Health Literacy in Canada: A healthy understanding*, Ottawa: Canadian Council on Learning.

Canadian Public Health Association 2006. *Increasing Understanding of the Impact of Low Health Literacy on Chronic Disease Prevention and Control: Final Report.* Ottawa: Canadian Public Health Association.

DeWalt, D.A., Berkman, N., Sheridan, S., Lohr, K. & Pignone, M. 2004. "Literacy and health outcomes: a systematic review of the literature." *Journal of General Internal Medicine* 19(12):1228-39.

Fung, K., Andermann, L., Zaretsky, A. & Lo, H-T. 2008. "An integrative approach to cultural competence in the psychiatric curriculum." *Academic Psychiatry* 32(4):1-11.

Gagnon, A.J. 2002. *The Responsiveness of the Canadian Health Care System towards Newcomers.* Paper #40. Ottawa: Royal Commission on the Future of Health Care in Canada (Romanow Commission). November.

Guruge, S. & Collins, E., (Eds.) 2008. *Working with Immigrant Women: Issues and Strategies for Mental Health Professionals.* Toronto: Centre for Addiction and Mental Health.

Jahdav, S., Weiss, M.G. & Littlewood, R. 2001. "Cultural experience of depression among white Britons in London." *Anthropology and Medicine* 8(1):47-69.

James, S. & Prilleltensky, I. 2003. "Cultural diversity and mental health: towards integrative practice." *Clinical Psychology Review* 22:1133-1154.

Jorm, A. 2000. "Mental health literacy: Public knowledge and beliefs about mental disorders." *British Journal of Psychiatry* 177:396-401.

Kickbusch, I., Wait, S. & Maag, D. 2005. *Navigating Health: The role of health literacy.* London: Alliance for Health and the Future, International Longevity Centre-UK, 2006. www.ilcuk.org.uk/record.jsp?ID=1&type=publication.

King, J. 2007. *Environmental Scan of Interventions to Improve Health Literacy: Final Report*, National Collaborating Centre for Determinants of Health, St. Francis Xavier University, Antigonish, Nova Scotia.

Lauber, C., Nordt, C., Falcato, L. & Rossler, W. 2004. "Factors influencing social distance towards people with mental illness." *Community Mental Health Journal* 40(3):265-274.

Littlewood, R. 1998. "Cultural variation in the stigmatization of mental illness." *The Lancet* 352:1056-1057.

Nielsen-Bohlman, L., Panzer, A.M. & Kindig, D.A. (eds.) 2004. *Health Literacy: A Prescription to End Confusion.* Institute of Medicine of the National Academies of Sciences, Washington, D.C.: National Academies Press.

Nimmon, L.E. 2007. "Within the eyes of the people: using a photonovel as a consciousness-raising health literacy tool with ESL-speaking immigrant women." *Canadian Journal of Public Health* 98(4): 337-340.

Nutbeam, D. 2000. "Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century." *Health Promotion International*, 15, 259–267.

Pottie, K., Ng, E., Spitzer. D., Mohammed, A. & Glazier, R. 2008. "Language proficiency, gender and self-reported health: a an analysis of the first two waves of the Longitudinal Survey of Immigrants to Canada." *Canadian Journal of Public Health* 99(6):505-510.

Poureslami, I., Murphy, D., Nicol, A., Balka, E. & Rootman, I. 2007. "Assessing the effectiveness of informational video clips on Iranian immigrants' attitudes toward and intention to use the B.C. Health Guide program in the Greater Vancouver Area." *MEDSCAPE General Medicine* 9(1):12.

Rootman, I. & Gordon-El-Bihbety, D. 2008. *A Vision for a Health Literate Canada Report of the Expert Panel on Health Literacy.* Ottawa, ON: Canadian Public Health Association. Available online at http://www.cpha.ca/uploads/portals/h-l/report_e.pdf.

Rootman, I. Frankish, J. and Kaszap, M. 2007. Health Literacy: A New Frontier, in *Health Promotion in Canada*, M. O'Neill, A. Pederson, and S. Dupere (Eds.) Canadian Scholars' Press.

Shohet, L. & Renaud, L. 2006. "Critical analysis on best practices in health literacy." *Canadian Journal of Public Health* 97: Supplement 10-S13.

Simich, L., Scott, J. & Agic, B. 2005. "Alone in Canada: a case study of multilingual health promotion." *International Journal of Mental Health Promotion* 7(2): 14-22.

Simich, L., Maiter, S., Moorlag, E. & Ochocka, J. 2009. "Ethno-cultural community perspectives on mental health." *Psychiatric Rehabilitation Journal* 32(3):208-214.

Standing Senate Committee on Social Affairs, Science and Technology 2006. *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada.* Ottawa: The Senate of Canada. Available online at http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/pdf/rep02may06part1-e.pdf.

Vissandjee, B. & Dupere, S. 2000. "Intercultural communication in the clinical context: a question of partnership." *Canadian Journal of Nursing Research* 32(1):99-113.

Weerasinghe, S. 2001. Language barriers in access to health care. Health Canada, Ottawa.

Zanchetta, M.S. & Poureslami, I.M. 2006. "Health literacy within the reality of immigrants' culture and language." *Canadian Journal of Public Health* 97, (Supplement 2):S26-30.

FOOTNOTES

[1] Longer versions of this article were published in 2009 as a Policy Brief by the Public Health Agency of Canada and in Contact, the journal of TESL Ontario.

IS THERE A HEALTHY IMMIGRANT EFFECT IN MENTAL HEALTH? EVIDENCES FROM POPULATION-BASED HEALTH SURVEYS IN CANADA

Edward Ng is a senior analyst with the Health Analysis Division at Statistics Canada. He obtained his Ph.D. in Social Demography (the University of Western Ontario), and has since worked in various research areas at Statistics Canada. His recent research interests are on micro-simulation of cancers, diabetes hospitalization risk, as well as on immigrant health.

Walter Omariba holds a Ph.D. in Sociology (University of Western Ontario) and completed two years of post-doctoral training in socio-economic determinants of population health at McMaster University. He is currently a Social Science Researcher at Statistics Canada. His research interests are population health and social demography, and the application of advanced statistical techniques to understand health inequalities and contextual and structural influences on health.

ABSTRACT

This article presents a review of recent studies based on Statistics Canada's health surveys to examine the mental health of immigrants and its changes over time, and documents factors found to influence mental health. The article concludes with a discussion on recent developments in data collection at Statistics Canada and how the data can shed light on immigrant mental health.

INTRODUCTION

Immigration has increased the diversity in Canada over the past 40 years. According to the 2006 census, recent immigrants (those arriving within the last five years) mainly came from Asia (58%), followed by Europe (16%) (Chui et al. 2007). The corresponding figures were drastically different in 1971 at 11% and 61% respectively. Immigrants, especially those from the non-traditional sources such as Asia and Africa, may face adjustment challenges because many of these are visible minorities who come from countries with cultures and languages very different from those of Canada. The difficulties associated with settling in a new country are likely to affect the mental health of immigrants.

Past studies on immigrant health mostly found a health advantage among immigrants to Canada, possibly a result of strong selection factors.[1] However, these studies also found a loss in this advantage over time in several standard health measures including self-reported health (Chen et al. 1996a; Newbold and Danforth 2003; Ng et al. 2005), self-reported chronic disease (Pérez 2002; McDonald and Kenndy 2004), self-reported disability (Chen et al. 1996a; Chen et al. 1996b), and mortality (Wilkins et al. 2008).[2] Previous research on immigrant mental health in Canada, however, has found that immigrants experienced high level of psychiatric disorders, depression or substance abuse. These studies have typically focused on specific sub-groups of immigrants such as refugees or recent immigrants from various war-torn parts of the world (Ali 2002). Because mental health of immigrants is emerging as an important issue in Canada (Khanlou 2009), there is a need to have an overall picture of it at a population level.

This article has three objectives. First, it reviews selected studies based on population-based health surveys from Statistics Canada to establish whether the healthy immigrant effect at arrival and its loss over time extends to the mental health.[3] Second, we report on important factors found to influence mental health for the overall and/or immigrant populations. Lastly, we highlight recent developments in data collection within Statistics Canada that can potentially shed light on various aspects of immigrant mental health.

INSIGHTS ON IMMIGRANT MENTAL HEALTH FROM STATISTICS CANADA'S HEALTH SURVEYS

With the implementation of the various cycles of large population-based health surveys such as the National Population Health Survey (NPHS from 1994 to present) and the Canadian Community Health Survey (CCHS from 2000 to present), Statistics Canada has provided health practitioners, researchers and policy

makers the information to understand immigrant mental health at the population level.[4] In this short article, we review selected research work on the healthy immigrant effect in the area of mental health, based on a systems approach used by Khanlou (2009) which allows for multi-layered analysis. Specifically, we look at how each of the studies reviewed considers the influences at the individual, intermediate and systemic levels. Table 1 shows the three levels used to organize the factors influencing mental health. First, individual factors include age (including the age at immigration), gender, cultural background and religious identity. Second, intermediate factors include family, social support networks, and acculturation. Third, the systemic level includes economic barriers, appropriate services, healthcare access, prejudice, discrimination and racism.

Our search of literature yielded four articles on immigrant mental health studies based on Statistics Canada Health Survey data with a focus on healthy immigrant mental health effect. Table 2 summarizes the comparison of the four research works reviewed. First we review the work by Ali (2002) published by Statistics Canada on mental health of immigrants, followed by other studies conducted by researchers who used Statistics Canada health surveys to examine explicitly the healthy immigrant effect in terms of mental health (Lou and Beaujot 2005; Wu and Schimmele 2005; Bergeron, Auger and Hamel, 2009).

1. Using the Canadian Community Health Survey (2000 CCHS cycle 1.1),[5] Ali (2002) examined mental health in terms of depression and alcohol dependence, and found that 8% of Canadians aged 12 or older reported symptoms suggesting that they had at least one major depressive episode within the 12 month before the survey interview. For those born in Canada, the rate was 8%, while the corresponding rate for immigrants was statistically lower, at 6%. In fact, immigrants were found to have lower rates in both depression and alcohol dependence than the Canadian-born population, with this healthy immigrant effect being strongest among recent immigrants. On the other hand, long-term immigrants had similar depression rates as the

Canadian-born. This study also found a country of origin effect whereby the rates of depression and alcohol dependence were both lower among those from Africa and Asia. The country of origin effect is highly related to the recency of arrival effect, as those from Africa and Asia were most likely to be recent immigrants.

Even after taking into consideration the differences in individual influences such as age, sex, marital status, income and education, and by other factors at the intermediate or systemic levels such as language barriers, sense of belonging or employment status, recent immigrants were still found to have the lowest risk for both depression and alcohol dependence. These results are consistent with the healthy immigrant effect at arrival and the convergence toward the Canadian norm over time.

This article also provided insights into factors that influence mental health for the overall population which includes immigrants. At the individual level, compared to females, males were less likely to have a depressive episode, but were much more likely to have alcohol dependence. The study also shows, for both sexes, a gradient by household income and educational level for both depression and alcohol dependence, that is, the higher the socioeconomic status, the lower the risk of having mental health issues. At the intermediate level, those with a sense of belonging to local community also had a lower risk of both depression and alcohol dependence. Finally, at the systemic level, those who held a job were less likely than those who did not to have depression.

2. Lou and Beaujot (2005) used the cycle 1.2 of the Canadian Community Health Survey (2002)[6], which had as its focus mental health. Their analysis confirmed a healthy immigrant effect and the decline in health for longer term immigrants. Mental health was measured in this study through a self-reported measure, where 'fair' and 'poor' are defined as 'poor' mental health, in response to the question: 'In general, would you say your mental health is Excellent/Very good/Good/Fair/Poor?' The proportion of poor mental health of the Canadian-born and foreign-born populations were 7% and 6% respectively. Recent immigrants have a statistically significant

TABLE 1: Systems Approach Framework on Factors Influencing Mental Health of Migrants*

LEVEL	FACTORS (EXAMPLES)	DETAILS
Individual (micro)	age, sex/gender, cultural background, religious identity	Children (including the age at immigration), adolescents, the elderly
Intermediate (Meso)	family, social support networks, acculturation	• Informational, instrumental and emotional • Cultural, ethnic and spiritual
Systemic level (Macro)	economic barriers, appropriate services, healthcare access by migration status, prejudice, discrimination and racism.	• Unemployment and underemployment • Based on age, gender, cultural differences and immigration status • Immigrants, refugees and those with precarious status

* based on Khanlou (2009)

TABLE 2: Summary Table of Review of Recent Articles using Statistics Canada Dataset to Study the Healthy Immigrant Effect in terms of Mental Health.

	ALI (2002)	LOU AND BEAUJOT (2005)	WU AND SCHIMMELE (2005)		BERGERON ET AL. (2009)
Nature of the study	Statistics Canada Health Report article	Research report funded by Health Canada	Research published in academic journal		Research published in public health journal
Dataset used	CCHS 1.1	CCHS 1.2	NPHS cycle 2		CCHS 3.1
Mental health outcome(s) examined	1. Depression 2. Alcohol dependence	Self-rated poor mental health	1. Depressive symptoms 2. Experience of major depressive episode		Self-rated mental health
Target population	Overall population	Over population	Overall population	Immigrant population	Overall population
	Selected key factors found to be statistically significant based on the systems approach framework on factors influencing mental health of migrants (Khanlou, 2009)				
Individual level	• age • sex • marital status • income • education • country of origin	• age • sex • marital status • income • education • self-reported poor (physical) health • life dissatisfaction • self-reported underweight • self-reported ability to handle demand	• age • sex • marital status • income • education • health • chronic conditions • race/ethnicity • children under 6 • rural residence	• age at immigration (under 18) • other results not presented	Results not presented
Intermediate level	• language barriers • sense of belonging	• social support • sense of belonging to local community • number of friends and relatives	• social support • social contact	• results not presented	None
Systemic level	• employment status	• lack of fit between occupation and education	None		None
Healthy immigrant mental effect and its loss over time (confirmed or not)	Yes	Yes	Yes		Yes for visible minority recent immigrants only

advantage of 4% compared to 7% for those who had arrived more than five years before the survey. They argued that the variation in immigrant mental health may be explained by selection factors as well as the structural strain theory at the macro level or stress theory in the micro level.[7] Although various demographic and socio-economic, stress and coping factors were significantly associated to self-reported poor mental health, immigrants still maintained a mental health advantage over non-immigrants even after taking the structural strain and stress factors into consideration.

The selected factors from all levels were found to be significantly related to poor mental health. These include young age, female gender, being previously married (widowed, separated or divorced), low education or income, poor self-reported health, life dissatisfaction, being underweight, self-reported poor ability to handle demand at the individual level; lack of social support, weak sense of belonging to local community, fewer close friends and relatives at the intermediate level; and the lack of fit between occupation and education at the systemic level. Specifically, compared with people having higher education, but working in less professional occupations, those working in occupations that match their high education level have lower risk of reporting poor mental health.

3. Using cycle 2 of the National Population Health Survey (NPHS 1996/97), Wu and Schimmele (2005) examined changes in depression among immigrants over time.[8] They measured depression as the number of depressive symptoms and experience of major depressive episode (MDE). Their analysis confirmed the healthy immigrant effect and loss in health advantage over time: visible minority immigrants were especially mentally healthy, and that depression among immigrants was found to increase soon after arrival.

This study also found individual factors such as being female, low family income, lower education, having children under 6, marital status (separated/divorced, widowed, never married compared to married/cohabitation) to be significantly related with depression. At the intermediate level, the study found social support and social contact to be protective factors against depression, while at the systemic level whether one was employed or not did not seem to matter.

An interesting finding here is the age of migration effect; people who immigrated young (less than age 18) had a higher risk of depression. The authors reasoned that the pressures for young immigrants to 'fit' in at school and in the new social environment can create potentially stressful conflicts between the values and norms present in their homes and those learned in school and social life. Others may explain this by way of various structural or macro factors such as barriers to education and employment (as faced by their parents), when immigration took place at young age (Pores and Rumbaut 2005; as cited by Khanlou 2009).

4. Using the CCHS cycle 3.1, Bergeron et al. (2009) examined the relationship among time since immigration, visible minority status, and knowledge of an official language with self-rated health, self-rated mental health and body mass index for immigrants residing in Montréal, Toronto and Vancouver, Canada's largest metropolitan and gateway cities.[9] Concerning mental health, the study found that recent visible minority immigrants were less likely to report poor mental health relative to the non-immigrant population. Although this study supports the healthy immigrant effect, the effect is only present in certain subgroups of immigrants. Specifically, non-visible minority recent immigrants did not report better mental health than the non-immigrant population, contrary to what the healthy immigrant effect would suggest.

Although the study controlled for individual level characteristics such as age, sex, education, income, marital status and region, the results were not reported. A limitation of the study is that it did not take into consideration intermediate or systemic levels.

DISCUSSION

The consensus from this review is that these studies in general provide support for the healthy immigrant mental health effect and its loss overtime. However, there are some exceptions to this overall conclusion. For example, Wu and Schimmele (2005) noted that the Chinese ethnic group has better overall mental health than those from Northern and Western Europe. As well, Bergeron et al. (2009) also observed that the healthy immigrant mental health effect is only present in certain

visible minority recent immigrants. Further research would be needed to affirm these observations.

A few common limitations of all these studies can be observed. First, since these studies used surveys that are collected at one point in time, the examination of the healthy immigrant effect is not ideal. Although the study by Wu and Schimmele was based on the NPHS which has a longitudinal component, it used only data at one time point. Longitudinal surveys that follow a cohort of individuals over time can better handle the transition from good to poor health (e.g. Ng et al. 2005). Second, previous immigrant mental health research tends to focus on refugees or immigrants from various war-torn parts of the world based on sub-group specific survey (e.g. Noh et al. 1999). In contrast, none of the studies based on Statistics Canada's health surveys we reviewed focused on refugees or conducted the analysis by immigration class. This is mainly because immigrant respondents were not asked for information about their immigration class at the time of entry.[10] Thirdly, most of these studies combined immigrant population with non-immigrant population in the analysis, and provide rich information on the factors that influence the overall mental health of the overall population. However, it is not known whether the factors that affect non-immigrant mental health are the same as those for immigrant population. There is therefore a need for studies in this area. Fourthly, some of the authors acknowledged that there are limits associated with the measurement of mental health, and that self-reported mental health can be prone to reporting errors due to non-objectivity or cultural differences, such as variation of social acceptability of the reporting of poor mental health. Individual interpretation and construction of what 'healthy' means may also change with time spent in Canada, as well as with age. Lastly, while age was included to control for the age effect in all the studies reviewed, it is also important to examine age effects *per se* on mental health in the context of life course transitions (Khanlou 2009).

CONCLUDING REMARKS AND FUTURE PROSPECTS

The health survey program at Statistics Canada has provided information to health practitioners, researchers and policy makers to understand immigrant mental health. All CCHS cycles gathered several dimensions of mental health, and can be used by researchers to examine various aspects of immigrant mental health, other than the healthy immigrant effect. For example, Smith et al. (2007) used CCHS 1.1 to examine the effects of income and gender on depression among immigrants and found a differential income effect on depression for male and female recent immigrants. Researchers have also used other Statistics Canada surveys such as National Longitudinal Survey on Children and Youth to study topics such

as behaviours and outcome of immigrant children (e.g. Beiser et al. 2002; Georgiades Boyle and Duku 2007).

Mental health has come out of the shadows in Canada as evidenced by the formation of the Mental Health Commission of Canada in 2007. The Commission, created by the Federal Government to focus national attention on mental health issues, has highlighted immigrant and refugee, ethno-cultural and racialized groups as one of the priority areas for investigation in terms of mental health services appropriateness. One recent data development at Statistics Canada that attempts to link health records with Statistics Canada surveys can potentially enable researchers to examine the health care utilization patterns for groups with different health conditions (Canadian Institute for Health Information 2008). For example, one can examine from the linked datasets whether immigrants experienced more or less mental health related hospitalization than the local-born population. Also, the 2012 Canadian Community Health Survey which has a mental health focus may also be an appropriate population-based survey for researchers to gain more recent insights on mental health issues of immigrant and ethno-cultural groups.

Finally, health literacy, defined as the ability to access and use health information to make appropriate health decisions and maintain basic health (Canadian Council on Learning 2007), has been identified as an important health-related tool to improve the population health (Canadian Council on Learning 2007 and 2008). However, the role of health literacy on mental health has not been well studied (Simich, 2009). The International Adult Literacy and Skills Survey (IALSS) is a unique survey that allows researchers to examine the mental condition of immigrants and refugees compared to non-immigrants, as well as to understand the role of health literacy on mental health.

REFERENCES

Ali, J. 2002. "Mental Health of Canada's Immigrants," *Health Reports*, 13 (Suppl.), 1-11. Ottawa: Statistics Canada.

Bergeron P., N. Auger and D. Hamel. 2009. "Weight, General Health and Mental Health: Status of Diverse Subgroups of Immigrants in Canada." *Canadian Journal of Public Health*. Vol. 100(3): 215-20.

Beiser, M., F. Hou, I. Hyman, and M. Tousignant. 2002. "Poverty, Family Process, and the Mental Health of Immigrant Children in Canada." *American Journal of Public Health*; 92:220-27.

Canadian Institute for Health Information. 2008. A Framework for Health Outcomes Analysis: Diabetes and Depression Case Studies. Ottawa: CIHI.

Canadian Council on Learning. 2007. *Health literacy in Canada: initial results from the International Adult Literacy and Skills Survey 2007*. Ottawa: Canadian Council on Learning.

Canadian Council on Learning. 2008. *Health literacy in Canada: a healthy understanding*. Ottawa: Canadian Council on Learning.

Chen, J., E. Ng and R. Wilkins. 1996a. "The Health of Canada's Immigrants in 1994-95." *Health Reports*, 7(4):33-45.

Chen, J., R. Wilkins and E. Ng. 1996b. "Health Expectancy by Immigrant Status." Health Reports, 8(3):29-37.

Chui, T., H. Maheux. and K. Tran. 2007. *Immigration in Canada: A Portrait of the Foreign-born Population, 2006 Census.* Catalogue no. 97-557-XIE. Ottawa: Statistics Canada.

Georgiades K., M.H. Boyle and E. Duku. 2007. "Contextual Influences on Children's Mental Health and School Performance: The moderating Effects of Family Immigrant Status." *Child Development*, 78(5) Pp1572-1591.

Khanlou, N. 2009. *Immigration mental health* policy brief prepared at the request of the Public Health Agency of Canada and Metropolis Canada, Ottawa. March 30, 2009.

Lou, Y. and R. Beaujot. 2005. *What happens to the 'healthy immigrant effect: the mental health of immigrants to Canada.* Discussion paper no. 05-15. London, Ontario: Population Studies Centre, University of Western Ontario.

McDonald, J. T. and S. Kennedy. 2004. "Insights into the 'Healthy Immigrant Effect': Health Status and Health Service Use of Immigrants to Canada." *Social Science and Medicine*, 59, 1613-1627.

Newbold, K. B. and J. Danforth. 2003. "Health Status and Canada's Immigrant Population." *Social Science and Medicine*, 57, 1881-1995.

Ng E, R. Wilkins, F. Gendron and J.M. Berthelot. 2005. "Dynamics of Immigrants' Health in Canada: Evidence from the National Population Health Survey." In *Healthy Today, Healthy Survey* (Statistics Canada, Catalogue 82-618). Ottawa: Statistics Canada.

Noh S, M. Beiser, V. Kaspar, F. Hou, J. Rummens. 1999. "Perceived Racial Discrimination, Depression, and Coping: A Study of Southeast Asian Refugees in Canada." *Journal of Health and Social Behaviour*, 40: 193-207.

Perez, C.F. 2002. "Health Status and Health Behaviour among Immigrants." *Health Reports*, 13(Suppl.): 89-100.

Portes, A. and R.G. Rumbaut. 2005. "Introduction: The Second Generation and the Children of Immigrants Longitudinal Study." *Ethnic and Racial Studies*, Vol. 28 (6), 983-999.

Simich L. 2009. *Health literacy and immigrant populations:* policy brief prepared at the request of the Public Health Agency of Canada and Metropolis Canada, Ottawa. March 30, 2009.

Simth K.L.W., F.U. Matheson, R. Moineddin, R.H.Glazier. 2007. "Gender, Income and Immigration Differences in Depression in Canadian Urban Centres. "*Canadian Journal of Public Health*; 98(2):149-153.

Wilkins R, M. Tjepkema, C. Mustard, and R. Choinére. 2008. "The Canadian Census Mortality Follow-up Study, 1991 through 2001." *Health Reports*, 19(3). Pp. 25-43.

Wu Z. and C. Schimmele. 2005. "The Healthy Migrant Effect on Depression: Variation Over Time?" *Canadian Studies in Population*, 32(2). Pp 271-298.
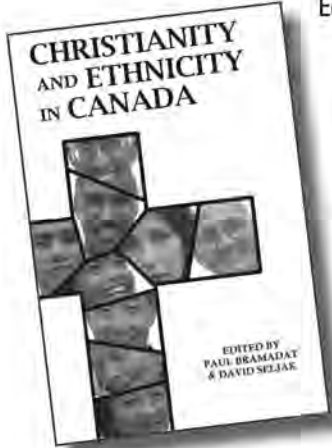
FOOTNOTES

[1] For various reasons, good health is associated with the immigration process. For example, healthier people tend to be more likely than those in poor health to emigrate (self-selection effect). As well, immigration screening rules in Canada also ensure that mostly healthy immigrants are selected in at entry.

[2] Many reasons have been put forth to explain this apparent loss of health with the increase of time spent in Canada. For example, immigrants may encounter stress and barriers in the settlement period leading to health problems. Alternatively, immigrants may adopt negative health behaviours and sedentary lifestyle that lead to gradual health decline.

[3] Other evidences on mental health of immigrants can be found in Hyman (2007), which reviewed recent work on mental health of seniors, children and youth, women, and refugees (adults and youth) and in Khanlou (2009), which also summarized finding of review of mental health of migrant populations.

[4] The reviews reported here are summary findings. Readers are encouraged to examine for themselves the respective articles and reports reviewed.

[5] The CCHS 1.1 survey collected information on health status and health care utilization from over 131,000 respondents aged 12 and over in all provinces and territories.

[6] The CCHS cycle 1.2 was a survey conducted in 2002 with a sample of 36,984 respondents.

[7] The structural strain theory relates to the lack of sustained economic growth following the large numbers of arrivals that influence immigrant mental health through fewer opportunities and increased competition. The stress theory refers to the impact of acculturative stress results from uprooting, relocation and adaptation, and the interaction between certain risk factors such as alienation and discrimination and the strength of coping factors such as psychological resources and sense of belonging to community.

[8] This study used the NPHS cycle 2, conducted in 1996-97, had a sample of about 70,000, after excluding children under 12 for whom no mental health condition was collected and cases where any dependent mental health measure was missing.

[9] The CCHS cycle 3.1 was conducted in with a sample of 132,947 respondents. This study focused on the 22,694 respondents residing in Montreal, Toronto and Vancouver.

[10] Though not a health survey, the Longitudinal Survey of Immigrants to Canada is a good exception, as it contains both immigrant class information and on mental and physical health condition of recent immigrants (including incidence of emotional problems and stress levels).

THE MENTAL HEALTH OF IMMIGRANTS AND MINORITIES IN CANADA: THE SOCIAL AND ECONOMIC EFFECTS[1]

Mengxuan Annie Xu was born and raised in Northern China. In 2001 she came to Canada for her graduate studies. She completed a master's degree in Economics, and a second master's in Applied Health Services Research, both at the University of New Brunswick. After school she worked for Nova Scotia Department of Health as an epidemiologist for five years. She is currently working as an Evaluation Officer at Human Resources and Skills Development Canada.

James Ted McDonald completed his Ph.D. in Economics at the University of Melbourne in 1996 and after 5 years at the University of Tasmania, began his current appointment in the Department of Economics at the University of New Brunswick, Canada in 2001. His current research focuses mainly on the relationships between socio-economic status, ethnicity and cancer.

ABSTRACT

This article provides a comprehensive analysis of immigrant mental health from a population health perspective. The result of the research conducted by the articles' authors confirms that there is a "healthy immigrant effect" in terms of mental health outcomes. It also offers evidence of the significant role that local ethnic networks play in influencing immigrant mental health.

INTRODUCTION

Resulting from centuries of immigration, Canada is a multicultural nation comprised of people from a wide range of ethnic and cultural heritages. Immigrants have always made and will continue to make significant contributions to the development of Canada's economy, society, and culture. However, migration to a new country is a potentially disruptive and stressful experience. It can produce profound distress even among the best prepared. Difficulties in connecting with and adapting to the economic and social institutions of the host country may result in poor mental health outcomes. This in turn can hinder longer-term economic and social adjustment such as labor market performance, linguistic and cultural adjustment, etc.

Our understanding of the determinants of the mental health of immigrants in Canada and how their mental health changes over time is limited. In previous research, considerable attention has been paid to the variation in mental health among ethnic groups and the underlying causes, but the findings have been inconsistent. This article provides an examination of our study which aims to address some of the serious gaps in the general understanding of the mental health of immigrants and minorities in Canada by estimating statistical models involving a range of mental health measures and socio-economic, demographic, and immigration-related factors. By analyzing the extent of differences in mental health

between immigrants and native-born individuals of comparable socio-economic and demographic characteristics, our study contributes to the literature on immigrant mental health in the following two ways. First, it provides evidence on how the observed difference varies by year of arrival in Canada, by years since migration, by age at arrival, and by ethnicity. Second, it offers additional evidence on the influence of local ethnic communities on immigrants' mental health. Analyses of these focal points will yield important insights into the extent to which immigrants acculturate into the Canadian society in terms of mental health, and whether the process of acculturation is on balance a positive or negative effect.

A better understanding of the dynamics and determinants of mental health for potentially 'at risk' groups is vital both to the prosperity and success of new immigrants to Canada and, more broadly, to the success of Canada's ambitious immigration program. Results of this study can be used to identify these at-risk groups and the factors that contribute to their poorer mental health. This information in turn can be used to guide particular policy development that addresses those factors and improves the health, quality of life and prosperity of immigrant and native-born Canadians.

METHODS

Following the approach of McDonald and Kennedy (2004), our study analyzes various dimensions of

immigrant and minority mental health using micro-econometric techniques. The main approach is to estimate a series of regression models in which mental health is expressed as a function of socio-economic and demographic conditions. In these models, mental health is defined by an aggregated index constructed using a number of most commonly used mental health indicators including stress, depression, alcoholism and suicidal ideation. A higher index score indicates a higher incidence of various mental health conditions. The socio-economic and demographic factors included are gender, age, marital status, education, home ownership (as a proxy for income), social support, physical health, and ethnicity. Controlling for observable socio-economic and demographic differences in the regression allows the extent to which mental health varies between immigrants and otherwise comparable non-immigrants to be identified. Further, given the wide variation in immigrant inflows by source country, by age at arrival and by year of arrival, it is of interest to compare across different immigrant groups defined by these measures after controlling for differences in observable characteristics such as age and education level. For example, it will be instructive to compare the mental health of recent adult immigrants of a particular ethnicity with that of otherwise similar native-born Canadians of the same ethnicity, or with immigrants of the same ethnicity who arrived as children, as well as with immigrants and native-born Canadians of other ethnicities.

Using this framework, the study examines two important aspects of immigrant mental health that have been identified in the literature on immigrant physical health. The first is the existence of a 'healthy immigrant effect' in terms of mental health; that is, the extent to which recent arrivals are in better mental health than otherwise comparable non-immigrants. Related to this, it is also of interest to determine whether any health advantage enjoyed by recent immigrants is lost with additional years in Canada, as has been found to be the case for physical health. Second, the study also attempts to measure the relationship between an immigrant's mental health and characteristics of his or her local neighborhood, such as local ethnic concentration. This variable captures the individual's proximity to and interaction with people of the same language, background and customs. Local ethnic concentration is measured as the proportion of population belonging to a particular ethnic group in the neighborhood, relative to that ethnic group's population proportion at the national level. The approached used in measuring this relationship follows Bertrand et al. (2000).

This study uses 2001-2005 data from the confidential files of the Canadian Community Health Survey (CCHS).

The CCHS is a series of national health surveys conducted by Statistics Canada. It contains rich information on health determinants, health status, and health system utilization for over 130 health regions across the country. For the purpose of this study, only working age individuals aged 20 to 65 are included since individuals from this age group are likely to face similar mental health stressors such as those related to employment and family responsibilities. The 2001 Canadian Census data file is used to calculate population sizes of local ethnic groups.

RESULTS

Our study compares the incidence of mental health conditions between immigrants and native-born Canadians to examine the evidence of a "healthy immigrant effect". The results show that, overall, immigrants enjoy a significantly better mental health than their comparable native-born peers. When comparing the status of mental health among various ethnicity groups, it is found that people who belong to "Asian" and "Black" minority groups are less likely to have mental health problems than their white counterparts. Latin American men are also found to have a better mental health status compared to their white counterparts, but no such relationship is found for women.

To determine how immigrants' mental health changes over time, this study examines the relationship between the mental health of immigrants and their length of residence in Canada. It provides strong evidence that, for both male and female immigrants, their mental health deteriorates with increased years of residence in Canada. Moreover, both period of arrival and age at arrival are important determinants of immigrants' mental health. Immigrants who arrived during 1961 to 1965 are found to have a poorer mental health than others. The implied negative impact on mental health for those arrived within the time frame could be a reflection of Canada's large intake of immigrants and refugees during the early 1960s for humanity reasons (The Applied History Research Group, University of Calgary, 1997).[2] It is also found that men who have arrived in Canada after age 50 enjoy a significantly better mental health than those who arrived at an earlier age, while men who have arrived in Canada as children (before age 12) have a disadvantage in mental health compared to those who arrived at a later age. Again, no such evidence is found for women.

In terms of the different findings between male and female immigrants, one possible explanation is that men are more likely to be the principal applicants for immigration while women are more likely to immigrant to Canada as spouses. For example, between 2000 and 2001, 77% of the principal applicants in the economic class were men, while immigrant women who were admitted under this

category were more likely to be admitted as a spouse or a dependent. The principal immigration applicants are the ones who initiate the immigration process and therefore are those who might be most affected by the nature of the immigration process. Spouses or dependents might be more likely to experience an accommodated process, particularly if there is a time lag between the arrival of the principal migrant and his or her spouse and family.

Mental health is also found to be closely related to local ethnic and neighborhood factors. Evidence suggests that it is beneficial for immigrants' mental health if they reside in a neighborhood with a higher density of individuals who are from the same ethnicity. There is also a positive relationship between an individual's mental health status and the average mental health status of the ethnic group from the same neighborhood.

In terms of the relationships between mental health and socio-economic, demographic factors, this study reveals similar findings as in the existing literature. For both men and women, the incidence of mental health conditions increases with being divorced or separated, living in a metro area, having poor or fair physical health, etc, and decreases with receiving social support, having very good or excellent physical health, etc. The relationship between mental health and age is U-shaped over the life cycle—that is, mental health is the best among youth and old age while mental health problems are the most common among men and women in their middle age. Persons who have post-secondary education are more likely to experience mental health conditions compared to secondary school graduates (more so for women than for men). House ownership and house type are also predictors of mental health. Those who own their own houses are estimated to have less mental health conditions than those who do not, and those who live in single houses also have less mental health conditions than those who live in other accommodation types (apartment, mobile home etc). As house ownership can be considered as an indicator of one's long-term wealth, these results suggest a positive relationship between mental health and wealth.

CONCLUSIONS

Issues related to immigrant mental health are fundamental to Canada's immigration policy development. First, the mental health of immigrants is an important determinant of general measures of population health, and therefore is directly related to issues of the cost and adequacy of Canada's healthcare system. Second, the mental health of Canada's immigrant population is one important determinant of the costs and benefits of Canada's immigration policy, and relates to questions such as whether Canada is maximizing the returns of its large-scale immigration program.

The findings of this study contribute to our knowledge that mental health is closely related to demographic and socio-economic factors. It is also found that a wide range of mental health disparities exists across different ethnic groups. By examining the extent to which differences in mental health status are explained by immigration status, this study presents some tentative evidence on a "health immigrant effect" on mental health—most visible minority groups enjoy a better mental health status than their white counterparts, however the mental health of immigrants deteriorates over time.

This study also contributes to the existing literature by offering additional evidence on the influence of local ethnic networks on mental health. It reveals that local ethnic networks have significant effects on the mental health of immigrants and minorities. It is found that residing in a neighborhood with a high ethnic density is beneficial for an individual's mental health. This may be attributed to the potential protective effects offered by a high ethnic density such as strong ethnic networks, accessible and available social support, as well as sense of familiarity and belongingness.

REFERENCES

Bertrand, M., E. Luttmer, and S. Mullainathan. 2000. "Network Effects and Welfare Cultures." *The Quarterly Journal of Economics*, 115: 1019-1055.

McDonald, J.T. and S. Kennedy. 2004. "Insights into the healthy immigrant effect: health incidence and health service use of immigrants to Canada." *Social Science and Medicine*, 59(8): 1613-1627.

The Applied History Research Group, University of Calgary. "The Peopling of Canada: 1946-1976". University of Calgary. 1997. http://www.ucalgary.ca/applied_history/tutor canada1946/index.html (November 19, 2008).

FOOTNOTES

[1] The opinions expressed in this article are those of the authors' and do not necessarily reflect the views of the Department of Human Resources and Skills Development Canada or the Government of Canada.

[2] Due to high unemployment rates in Canada and global humanitarian actions in the first years of the 1960s, Canada revised its immigration policy to accommodate more immigrants and refugees, including those who would not normally have qualified for admission (The Applied History Research Group, University of Calgary, 1997).

Ryerson University M.A. in Immigration Studies

Canada's first graduate program devoted to advanced study of immigration policy, services and experience was launched in September 2004 at Ryerson University. The Master of Arts in Immigration and Settlement Studies is an innovative new program that will explore immigration trends, policies and programs in Canada from multi-disciplinary perspectives. Available in both full-time and part-time study, this program is designed to:

- Enhance in-depth knowledge, through four core courses, of the key historical, theoretical, methodological, policy and program literature and issues in the field of immigration and settlement studies in Canada;

- Explore and critically assess, through a selection of courses and seminars, some of the social, economic, political, cultural, spatial, policy, service-delivery and human rights aspects of immigration and settlement;

- Compare the experience of migration and settlement in Canada with that of other countries, through the incorporation of international perspectives in the curriculum;

- Provide focused discussions of the theoretical, conceptual, methodological issues/concepts practitioners need to know (and think) about when using related information;

- Develop a critical understanding of the methodological and practical issues facing research in the field;

- Generate, through a practicum, an understanding of the ways in which information in the field is utilized, in both practice and policy-making contexts;

- Demonstrate an ability to contribute to knowledge in the field through the preparation of a research paper or demonstration project paper.

<www.ryerson.ca/gradstudies/immigration>

A REVIEW OF THE INTERNATIONAL LITERATURE ON REFUGEE MENTAL HEALTH PRACTICES

Biljana Vasilevska is the research coordinator of the Refugee Mental Health Practices study.

Laura Simich is the principal investigator of the Refugee Mental Health Practices study.

ABSTRACT

This article is a summary of the literature review for the Refugee Mental Health Practices study. The goal of the study is to fill the gap in empirical research on services that are available for refugees to Canada which supports their mental health, emotional wellbeing, resiliency and recovery. The review is organized according to themes relating to three levels: the individual (refugees); the level of social systems (medical care and service provision), and policy-level decision-making.

ACKNOWLEDGEMENTS:

Since 2000, Canada has supported the resettlement of approximately 7,500 refugees annually. With the introduction of the Immigrant and Refugee Protection Act, *IRPA*, in 2002, the criteria for eligibility for government-assisted resettlement softened to give greater consideration of refugees' needs. With less emphasis being placed on their ability to integrate quickly, "many refugees now have different settlement needs that include special requirements arising from years of trauma or torture followed by years in camps" (Pressé & Thomson, 2007).

The mental health of refugees has received more attention in the academic literature than have studies of refugee economic integration, social identity or adaptation (Ryan, Dooley, & Benson, 2008). While there is some existing data on the mental health concerns and needs of refugees, there is a greater gap in empirical research on mental health services for refugees in Canada (Yu, Ouellet, & Warmington, 2007). This article is a brief summary of a literature review from the Refugee Mental Health Practices study, a project which seeks to fill this gap in empirical research[i]. The review is organized according to themes relating to three levels: the individual (refugees); the level of social systems (medical care and service provision), and policy-level decision-making.

REFUGEE-LEVEL THEMES

EXPLANATORY MODELS

Recent work has sought to understand how refugees and other ethno-minority groups conceptualize and express emotional distress and how these cultural conceptions may differ from the Western medical perspective or vocabulary. Studies have sought to understand the gaps between clients and mental health services, and how differences may be bridged. Arthur Kleinman's concept of *explanatory models* [EMs] is heavily invoked in this literature. Explanatory models are "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process. ...The study of the interaction between practitioner EMs and patient EMs offers a more precise analysis of problems in clinical communication" (Kleinman, 1980). Mental health professionals who work with refugee clients must be aware of differences in explanatory models, that is, notions of cause, course and treatment for mental distress.

CONCEPTUAL MODELS OF HEALTH AND CARE

The Western or *biomedical* model of health care is understood to be one where the client, as an individual, seeks professional care. The professional may have no other relationship with the client than that of diagnosis and treatment, and the relationship is unidirectional: the patient changes, while the medical practitioner goes about her or

his work. It is important to bear in mind that the biomedical explanation of health and illness, which is common to Canadian and many other medical professionals in the Western tradition, is itself an explanatory model, one which may not be comprehensible to all clients, particularly refugees who are also ethno-cultural minorities (Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006).

In many traditional cultures, the model of care emphasizes the connection of self and one's community, with a preference for social forms of intervention when mental health support is needed. The interconnectedness of self and society is taken to be axiomatic; therefore, responsibility for care of the individual rests with the family or community. *Psycho-social* or *social-ecological* models of health care are conceptual frameworks for understanding the health of individuals within society and include social determinants of mental health, such as income, social support, employment, housing, and education (Public Health Agency of Canada, 2005; World Health Organisation, 2001).

Among Southeast Asian refugees, the most important factors contributing to positive mental health in the post-migration period were being in a stable, significant personal relationship, and having stable employment (Beiser, 1999). Having ethnic or ethnic-like community supported mental wellbeing initially, but was not necessarily supportive in the long term. An interactional model is put forth to explain the more complex relationships between an individual and social resources that contribute to mental health (Beiser, 1999).

TRAUMA DISCOURSE

Many refugee mental health studies have sought to determine the prevalence of Post Traumatic Stress Disorder (PTSD) and other mental illnesses. Meta analyses of research findings on the extent of trauma and emotional distress and associated social factors in specific refugee populations is presented in Table 1.

Concern has been expressed about the lack of culturally sensitive diagnostic tools used in academic studies (Keyes, 2000). Moreover, the application of the concept of PTSD to refugees and other marginalized communities has been challenged for pathologizing individual responses to events which often have a social and political origin (Bracken, Giller, & Summerfield, 1995; Burstow, 2005; Friedman & Jaranson, 1994).

While medical care for acute mental disorders should be available upon resettlement, refugees' psycho-social needs must also be addressed. As Porter and Haslam (2005) suggest, humanitarian efforts to improve the post-migration social and material experiences of refugees would likely have a positive influence on mental health outcomes.

SOCIAL SUPPORT

Support networks are known to protect refugee mental health, and resettled refugees in Canada may engage in seemingly counter-intuitive secondary migration in order to be nearer to family and their own ethno-cultural community (Simich, 2003; Simich, Beiser, & Mawani, 2003). Qualitative data show that the affirmation of shared experiences through community-level support is a strong determinant of refugee wellbeing (Beiser, Simich, & Pandalangat, 2003; Simich et al., 2003). These findings corroborate epidemiological data showing that post-migration conditions matter to refugee mental health (Fazel et al., 2005; Porter & Haslam, 2005).

Refugee or ethno-cultural communities may not have the capacity to address acute mental illnesses

TABLE 1: Results of Meta-Analyses

REFERENCE	TOTAL ARTICLES	TOTAL REFUGEES	KEY FINDINGS AND CONCLUSIONS
Mental Health Status in Refugees: An Integrative Review of Current Research (Keyes, 2000)	n = 12	n =2,065	• At least one negative mental health state present in populations studied • Only one-third of studies used culturally sensitive measurement instruments • Psychological concerns *and* physical complaints present in all the studies that used culturally sensitive diagnostic tools
Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis (Porter & Haslam, 2005)	n= 56	n = 22,221 refugees and 45,073 non refugees	• Post-migration economic, social and housing conditions influenced mental health. • Worse outcomes experienced by refugees living in institutional accommodation and experiencing restricted economic opportunity. • Refugees who were older, more educated, female, had higher pre-displacement socioeconomic status and rural residence also had worse outcomes.
Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review (Fazel, Wheeler, & Danesh, 2005)	n=20	n= 6,743	• 9% to 11% of refugees resettled in Western countries were diagnosed with post-traumatic stress disorder (PTSD). • 4 % of resettled refugees experienced a generalized anxiety disorder, and about 5% suffered from major depression.

without the help of medical professionals, yet they may be well-equipped to support mental wellbeing and prevent emotional distress. Programs in Canada (Li, Koch, & Angelow, 2008) and in the United States (Weine et al., 2003) have sought to formally encourage social support through multi-family group-therapy types of programs. Some agencies match clients with volunteers in a befriending program or foster mutual supports groups with a goal of breaking down isolation (Canadian Centre for Victims of Torture, 2009). Many formal programs are offered through settlement and social service agencies, which do not often have the capacity to engage in evaluation and reporting of their activities. Therefore there is a need for more empirical research.

SYSTEMS-LEVEL THEMES

PROGRAM ACCESSIBILITY AND BARRIERS

Refugees face many barriers to accessing mental health services, both in Canada and internationally. In Canada, the challenge is in part due to the difficulty of finding culturally appropriate care and the lack of interpretation services in the health care system in general (Gagnon, 2002; Scheppers et al., 2006; White, 2008). Similar under-usage of health services has been found by ethnic minorities in other industrialized Western nations (Chow, Jaffee, & Snowden, 2003; Guerin, Abdi, & Geurin, 2003; Scheppers et al., 2006; Ten Have & Bijl, 1999). While mental health service providers in Canada are working to eliminate systems level barriers, perceptions of barriers may persist. Perceived accessibility of a service influences attitudes towards seeking help. If the perception of access to mental health services is improved through outreach programs, then more refugees and ethno-cultural minorities may be encouraged to use services (Fung & Wong, 2007).

Ingleby (2009) puts forth three components to accessing services: entitlement to care (a question of legality and status), ease of accessibility, and the level of trust one has in a service and expectation of positive results (Ingleby, 2009). Scheppers and colleagues categorize barriers to services according to a three-level model of interaction: patient level, provider level, and system level (Scheppers et al., 2006). While differently directed, both models emphasize a dynamic and systemic understanding of access and barrier, rather than focusing on the individual in need of care.

MODELS OF SERVICE DELIVERY

A number of approaches and models of service delivery have been described. These include inductive models based on the qualitative input of clients and service providers, a model of a specific service or program being piloted, and broad approaches or schools of thought which influence service provision. Ingleby and Watters (2005) use the following groupings: mainstream health care approaches; multicultural health care approaches; sociological health care approaches; managed care, and service provision which has been influenced by the users' movement.

Currently in Canada, there is a focus on client-centred care, which should include refugees and ethno-cultural minorities. Ryan, Dooley and Benson (Ryan et al., 2008) advocate a *resource-based model*, in which resources are personal, material or social. Services premised on such a model would acknowledge that refugees are not passive victims of trauma; they are active survivors in a new environment which affects their mental health and adaptation as well (Birman et al., 2008; Birman & Tran, 2008) Services that capitalize on refugees' resources should be considered in future policy and programming decisions.

BRIDGING PRIMARY CARE AND MENTAL HEALTH

The importance of bridging primary care and mental health systems is underscored often by the World Health Organization (World Health Organisation and World Organization of Family Doctors (Wonca), 2008; World Health Organization, 2009). Upon arrival in Canada, refugees' primary health care needs often have not been met for many years, and it is through primary care that most refugees experience their first contact with the Canadian medical system. Mental health concerns are often raised in primary care settings, in the context of dealing with physical problems. Headaches, fatigue, difficulty sleeping, and difficulty breathing are physical complaints that may be expressions of psychological disturbances (Patel, 2002; Summerfield, 2005).

To increase capacity in primary care settings to better work with clients from diverse cultures, holistic, anthropological perspectives may aid in medical training and practice (Gozdziak, 2004; Kleinman, 1980). Some practitioners have promoted the need for recognizing the roles of spirituality (Collins, 2008; Mollica, Cui, McInnes, & Massagli, 2002) and the family (Stepakoff et al., 2006) in refugee mental health care. Given the barriers refugees and ethno-cultural minority groups face when accessing mental health services, some initiatives have sought to bridge services from multiple sectors, including mental health and social services, and to foster informal, community supports. Success has been demonstrated in programs that bridge gaps among services and build the internal capacity of agencies to better work with cultural minority clients (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003; Yeung et al., 2004).

POLICY-LEVEL THEMES

LACK OF POLICY

The World Health Organization's 2001 Annual Report, "Mental Health: New Understanding, New Hope," states that most countries do not have a national mental health policy. This statement applies to Canada, with different levels and breadth of service coverage across the country, compounded by a lack of policy to address the needs of low English/French proficiency clients (Abraham & Rahman, 2008). There has been movement towards filling this gap in recent years. The consultation activities of the new Mental Health Commission of Canada and publication of a discussion paper on Ontario's mental health care strategy (Ontario Ministry of Health and Long Term Care, 2009) are examples.

While mental health is a concern for all Canadians, refugees are especially vulnerable. They have experienced significant pre-migration stress and likely need services immediately upon entering Canada, yet they cannot be expected to know how to access those services. However, it is the post-migration conditions that potentially have the greatest moderating effect on refugee mental health and which the Canadian policy environment is most able to address. Current pre-settlement health screening practices in refugee camps are narrowly focused, and leave insufficient opportunity for mental health promotion and prevention (Gushulak & Williams, 2004).

MULTI-LEVEL GOVERNANCE

The Canadian context of health policy and programming is affected by the constitutional division of power of the federal and provincial governments. Health—including mental health—falls within the domains of the provinces and territories, and the transfer of federal health funds to the provinces and territories occurs when the latter have met the conditions of the federal Health Act. Thus, any discussion of pan-Canadian mental health policies is also a discussion of multi-level governance. In case studies of settlement programming and administration, the most successful cases are those in which all levels of government meaningfully work with local service providers, and where the later participate in the design and implementation of the programs (Leo & August, 2009; Leo & Enns, 2009). As noted above, economic opportunity and quality of housing are important predictors of emotional wellbeing in refugees. This is a strong argument for coordinating supports and services across traditionally separate sectors—in this case, housing, the labour market and health—when designing refugee resettlement policy and programming.

CONCLUSION

Current resettlement programs do not meet the mental health and wellbeing needs of Canada's newcomers, in particular refugees. Displaced people who have sought refuge in Canada face real challenges in obtaining culturally appropriate services for mental health problems that may not be understood well by medical practitioners. Given Canada's humanitarian commitment to refugee resettlement and the more acute needs of today's refugees, there is a need for culturally inclusive and appropriate mental health care practices for refugees. In particular, practices should be based on models which are more likely to be understood and accepted by clients from diverse cultural backgrounds, and which do not take the individual as the sole unit of care, but which included the family, the community, or the broader population. At the program or service level, more culturally competent care is needed. Programs may have no obvious institutional barriers, but because there has been little outreach to refugee and ethnic minority communities, the perception of accessibility needs to improve, as well as the quality of care. While some mental health service and settlement service providers are working to provide more comprehensive care at the local level, the lack of integration of sectors and services is most appropriately addressed at the provincial and national policy or systems level.

REFERENCES

Abraham, D., & Rahman, S. (2008). The community Interpreter: A critical link between clients and service providers. In S. Guruge & E. Collins (Eds.), *Working with immigrant women: Issues and strategies for mental health professionals* (pp. 103-118). Toronto: Centre for Addiction and Mental Health.

Beiser, M. (1999). *Strangers At The Gate: The 'Boat People's' First Ten Years in Canada*. Toronto: University of Toronto Press.

Beiser, M., Simich, L., & Pandalangat, N. (2003). Community in distress: mental health needs and help-seeking in the Tamil community in Toronto. *International Migration*, 41(5), 233-245.

Birman, D., Beehler, S., Harris, E. M., Everson, M. L., Batia, K., Liautaud, J., et al. (2008). International Family, Adult, and Child Enhancement Services (FACES): A community-based comprehensive services model for refugee children in resettlement. American Journal of Orthopsychiatry, 78(1), 121-132.

Birman, D., & Tran, N. (2008). Psychological Distress and Adjustment of Vietnamese Refugees in the United States: Association With Pre- and Postmigration Factors. *American Journal of Orthopsychiatry*, 78(1), 109-120.

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological Responses to War and Atrocity: The Limitations of Current Concepts. *Social Science & Medicine*, 40(8), 1073-1082.

Burstow, B. (2005). A critique of posttraumatic stress disorder and the *DSM. Journal of Humanistic Psychology*, 45(4), 429--445.

Canadian Centre for Victims of Torture. (2009). Programs and Services. Retrieved 30 November, 2009, 2009, from http://www.ccvt.org/programs.html

Chow, J. C.-C., Jaffee, K., & Snowden, L. (2003). Racial/Ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health*, 93(5), 792-797.

Collins, E. (2008). Recognizing spirituality as a vital component in mental health care. In S. Guruge & E. Collins (Eds.), *Working with immigrant women: Issues and strategies for mental health professionals* (pp. 89-102). Toronto: Ontario: Centre for Addiction and Mental Health.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet, 365*, 1309-1314.

Friedman, M., & Jaranson, J. (1994). The applicability of the post-traumatic stress disroder concept to refugees In A. J. Marsella, T. Bornemann, S. Eklad & J. Orley (Eds.), *Amidst peril & pain: The mental health and well-being of the world's refugees* (pp. 207-227). Washington DC American Psychological Association.

Fung, K., & Wong, Y.-L. R. (2007). Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women. *International Journal of Social Psychiatry*, 53(3), 216-216.

Gagnon, A. (2002). *Responsiveness of the Canadian Health Care System Towards Newcomers: Discussion Paper No. 40.* Retrieved. from http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/40_Gagnon_E.pdf.

Gozdziak, E. M. (2004). Training refugee mental health providers: Ethnography as a bridge to multicultural practice. *Human Organization*, 63(2), 203-210.

Guerin, B., Abdi, A., & Geurin, P. (2003). Experiences with the medical and health systems for Somali refugees living in Hamilton. *New Zealand Journal of Psychology*, 32(1), 27-32.

Gushulak, B. D., & Williams, L. S. (2004). National Immigration Health Policy: Existing Policy, Changing Needs, and Future Directions. *Canadian Journal of Public Health*, 95(3), I27-I29.

Ingleby, D. (2009). *Issues in mental health service delivery for migrant and ethnic minority communities.* Paper presented at the International Metropolis Conference.

Keyes, E. F. (2000). Mental Health Status In Refugees: An Integrative Review of Current Research. *Issues in Mental Health Nursing*, 21(4), 397-410.

Kirmayer, L. J., Groleau, D., Guzder, J., Blake, C., & Jarvis, E. (2003). Cultural Consultation: A Model of Mental Health Service for Multicultural Societies. *Canadian Journal of Psychiatry*, 48(3), 145-153.

Kleinman, A. (1980). *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry.* Berkeley and Los Angeles: University of California Press, Ltd.

Leo, C., & August, M. (2009). The Multilevel Governance of Immigration and Settlement: Making Deep Federalism Work. *Canadian Journal of Political Science*, 42(2), 491.

Leo, C., & Enns, J. (2009). Multi-Level Governance and Ideological Rigidity: The Failure of Deep Federalism. Retrieved July 29, 2009, 2009, from http://blog.uwinnipeg.ca/ChristopherLeo/ISV07-11-26.pdf.

Li, J., Koch, A., & Angelow, L. (2008). Lapathee and Family Support Group (LAFS) Pilot Program Evaluation. Unpublished Report. Access Alliance Multicultural Community Health Centre.

Mollica, R. F., Cui, X., McInnes, K., & Massagli, M. P. (2002). Science-based policy for psychosocial interventions in refugee camps: A Cambodian example. *Journal of Nervous and Mental Disease*, 190(3), 158-158.

Ontario Ministry of Health and Long Term Care. (2009). *Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy. A discussion paper.* Retrieved July 14, 2009. from http://www.health.gov.on.ca/english/public/program/mentalhealth/minister_advisgroup/pdf/discussion_paper.pdf.

Patel, V. (2002). *Where There is No Psychiatrist: A mental health care manual.* Glasgow: Gaskell.

Porter, M., & Haslam, N. (2005). Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis. *JAMA*, 294(5), 602-612.

Pressé, D., & Thomson, J. (2007). The Resettlement Challenge: Integration of Refugees from Protracted *Refugee Situations. Refuge: Canada's periodical on Refugees*, 24(2), 48-53.

Public Health Agency of Canada. (2005). Population Health. Retrieved 16 October 2009, from http://www.phac-aspc.gc.ca/ph-sp/index-eng.php

Ryan, D., Dooley, B., & Benson, C. (2008). Theoretical Perspectives on Post-Migration Adaptation and Psychological Well-Being among Refugees: Towards a Resource-Based Model. *Journal of Refugee Studies*, 21(1), 1-18.

Scheppers, E., van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: a review. *Family Practice*, 23, 325-348.

Simich, L. (2003). Negotiating Boundaries of Refugee Resettlement: A Study of Settlement Patterns and Social Support. *The Canadian Review of Sociology and Anthropology*, 40(5), 575-591.

Simich, L., Beiser, M., & Mawani, F. N. (2003). Social support and the significance of shared experience in refugee migration and resettlement. *Western journal of nursing research*, 25(7), 872-891.

Stepakoff, S., Hubbard, J., Katoh, M., Falk, E., Mikulu, J.-B., Nkhoma, P., et al. (2006). Trauma healing in refugee camps in guinea: A psychosocial program for Liberian and Sierra Leonean survivors of torture and war. *APA Annual Convention, Aug 2006, New Orleans, LA, US*, 61(8), 921-921.

Summerfield, D. (2005). "My whole body is sick… my life is not good": A Rwandan asylum seeker attends a psychiatric clinic in London. In D. Ingleby (Ed.), *Forced migration and mental health: rethinking the care of refugees and displaced persons* (pp. 97-114). New York: Springer.

Ten Have, M. L., & Bijl, R. V. (1999). Inequalities in mental health care and social services utilisation by immigrant women. *The European Journal of Public Health*, 9(1), 45-51.

Weine, S. M., Raina, D., Zhubi, M., Delesi, M., Huseni, D., Feetham, S., et al. (2003). The TAFES Multi-Family Group Intervention for Kosovar Refugee: A Feasiblity Study. *Journal of Nervous & Mental Disease*, 191(2), 100-107.

White, J. A. (2008). *Enhancing and developing policies, models and practices to address the mental health needs of immigrant and refugee women in Saskatchewan*. Unpublished Dissertation/Thesis, Univeristy of Manitoba, Winnipeg.

World Health Organisation. (2001). The World Health Report 2001: Mental Health: New Understanding, New Hope.

World Health Organisation and World Organization of Family Doctors (Wonca). (2008). *Integrating mental health into primary care: a global perspective.* Retrieved July 13, 2009. from http://www.who.int/mental_health/policy/Integratingmhintoprimarycare2008_lastversion.pdf.

World Health Organization. (2009). Mental Health of Refugees, Internally displaced persons and other populations affected by conflict. Retrieved Feb 13th, 2009, from http://www.who.int/en/

Yeung, A., Kung, W. W., Chung, H., Rubenstein, G., Roffi, P., Mischoulon, D., et al. (2004). Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans. *General Hospital Psychiatry*, 26, 256-260.

Yu, S., Ouellet, E., & Warmington, A. (2007). Refugee Integration in Canada: A Survey of Empirical Evidence and Existing Services. *Refuge: Canada's Periodical on Refugees*, 24(2), 17-34.

FOOTNOTES

[1] The full review will be available with the final report, in spring of 2010.

Canadian Diversity / Diversité canadienne
Immigration Futures

The summer 2008 issue of *Canadian Diversity / Diversité canadienne* looks at the future of immigration with articles that focus on migration trends and patterns, and on new migration phenomena. This edition stems from a Metropolis inter-conference seminar on Immigration Futures hosted by the Monash Institute for the Study of Global Movements and held in Prato, Italy, in May 2006. Articles are drawn from this event, as well as from the 12th International Metropolis Conference in Melbourne, Australia. Contributions to this issue thus examine future immigration flows, the trend toward circular and return migration, the increased feminization of migration, the growth of Asia as a migration competitor, migration and the environment, and the ethics of migration. With an introduction by Demetrios Papademetriou of the Migration Policy Institute, this issue of *Canadian Diversity / Diversité canadienne* provides researchers, policy-makers and practitioners with a wide range of perspectives on what the future of immigration may look like.

Summer 2008
Guest Editor: Demetrios Papademetriou (Migration Policy Institute)

To obtain a copy: <www.canada.metropolis.net/publications/publication_form.htm>

COMPASSIONATE ADMISSION AND SELF-DEFEATING NEGLECT: THE MENTAL HEALTH OF REFUGEES IN CANADA

Morton Beiser is Professor of Distinction and Program Director Culture, Immigration and Mental Health, Dept of Psychology, Ryerson University; Crombie Professor Emeritus of Cultural Pluralism and Health, University of Toronto; and Founding Director and Senior Scientist, Ontario Metropolis Centre of Excellence for Research on Immigration and Settlement (CERIS). Past academic appointments include Associate Professor of Behavioral Sciences, Harvard School of Public Health (1965-1975); Professor and Head, Division of Cultural Psychiatry, Department of Psychiatry University of British Columbia (1975-1991), David Crombie Professor of Cultural Pluralism and Health, and Head, Culture, Community and Health Studies, University of Toronto (1975-2002).

ABSTRACT

The Ryerson University Refugee Resettlement Project, a decade-long investigation of the admission and resettlement of 1348 Southeast Asian "Boat People," is the largest and longest-lived investigation of refugee resettlement and mental health ever attempted. Findings are summarized in the form of four propositions: i) considerations of refugee mental health must take into account not only vulnerabilities but also resilience and its sources ii) resettlement is a long, perhaps even a life-long process iii) men and women experience resettlement differently and iv) mental health is human capital. Each of these propositions is illustrated by research findings.

ACKNOWLEDGEMENTS:

Canada is one of 147 countries who have signed the UN Convention on refugees, pledging to provide asylum for the persecuted and the stateless. Canada is also one of a much smaller group of Convention signatories—about 20—who offer not just temporary protection, but the option of permanent resettlement. Although protecting the oppressed is consistent with our national values, critics question the wisdom of this country's relatively generous refugee policies. They ask how much it costs to admit and resettle refugees, and whether the demand for mental health and social services is a drain on the country's resources.

The Ryerson University Refugee Resettlement Project, a decade-long investigation of the admission and resettlement of 1348 Southeast Asian "Boat People," provides some answers. It also points to ways in which policy and practice could be improved in order to better safeguard the mental health and human capital of refugees coming to Canada.

THE REFUGEE RESETTLEMENT PROJECT

The admission of a large complement of Southeast Asian "Boat People" between 1979 and 1981 was a singular and important event in Canadian immigration history. Prior to 1979, Canada's response to asylum seekers had ranged from tight-fisted to shameful. In a dramatic about-face, this country responded to the Southeast Asian refugee crisis by admitting more people on a per capita basis than any other country. In the years since, Canada has become a world leader in refugee and immigrant affairs, and the citizens of Canada have gained an enviable reputation as people who care.

The history of the Boat People crisis begins with the fall of Saigon in 1975, an event that precipitated a large-scale exodus from Southeast Asia. Shortly after their victory over the combined forces of the US and the South Vietnamese military, the new North Vietnamese communist government sealed the country's borders. A few years later, angered by China's incursions along its northern border, Hanoi expelled all ethnic Chinese living in Vietnam. Ethnic Vietnamese, unhappy about living under the communist regime, took advantage of the confusion surrounding the massive expulsions to escape along with the Chinese. At roughly the same time, Vietnam began conducting raids on neighbouring Southeast Asian countries. The ensuing instability created

an opportunity for Cambodians to escape the tyranny of Pol Pot, and for Laotians who feared retaliation because of previous alliances with the west to flee their homeland.

Canada's 1976 Immigration Act contained a provision for private sponsorship of refugees. To encourage individuals as well as organizations such as church groups to become private sponsors, the government of the day pledged to match every refugee admitted under private auspices with another to be sponsored by government. The final tally of refugee admissions between 1979 and 1981 was 60,000, among whom 5,000 were resettled in and around Vancouver, British Columbia. With funding from Canada's National Health Research and Development Program (NHRDP) in 1981, two University of British Columbia (UBC) colleagues, Dr. Phyllis Johnson and Dr. Richard Nann, and I initiated the Refugee Resettlement Project (RRP). We conducted an initial mental health survey on a community sample of 1348 adult refugees in 1981, and two follow-up surveys, the first in 1983, the last in 1991. When I left UBC in 1991, the administrative base for the project shifted to the University of Toronto, and from there to Ryerson, the first university in Canada to declare a major focus on immigration studies. RRP products include one book (Strangers at the Gate, University of Toronto Press, 1999) and approximately 50 scientific publications. This article recaps some important lessons learned from the study in the form of propositions: i) there is a need to shift from a single-minded focus on risk factors that jeopardize mental health to a broader framework that includes not only risk, but an understanding of resilience and its determinant, ii) resettlement is a long, perhaps even a life-long process; iii) men and women experience resettlement differently; and iv) mental health is human capital.

Proposition 1: Challenge and Resilience: By definition, refugees have suffered trauma and persecution, experiences that jeopardize mental health. On top of that, coming to Canada entails challenges—cultural disruption, separation from family and community, and the need to learn a new language and new ways of doing things—all of which threaten well-being. Since all refugees suffer these psychological assaults, the rate of mental disorder among refugees could potentially be very high. However, most refugees never become mental health casualties. Despite all the pre- and post-migration challenges they face, most refugees manage to attain some degree of inner peace, to work, and to find a way to integrate into Canadian society. In other words, risk does not necessarily translate into damaged mental health. Human resilience helps convert risk into challenges, most of which refugees apparently manage to overcome. Finding ways to support the personal and social resources that promote resilience is at least as important as identifying pre- and post-migration miseries.

According to the RRP results, the availability of a like-ethnic community is one of the most powerful forces promoting resilience, at least in the short and medium term. In 1981, when the refugees arrived in Vancouver, that city could boast one of the largest Chinese communities anywhere in North America. There were, however, no Vietnamese, Laotian or Cambodian communities in place. In 1981, the rate of depression among non-Chinese refugees was three times higher than it was for the Chinese. The mental health advantage did not last long. By 1983, non-Chinese rates of depression dropped to the point where they equalled Chinese rates. During that time, the non-Chinese were establishing their own ethnic-based communities thereby linking an uncertain present to the past, and affirming the worthiness of their shared history and culture within the largely uncomprehending European-dominated Canadian society of that era.

Newcomers do not always have ready-made like-ethnic communities waiting for them. Someone has to be the first to arrive. Canada's decision to admit the Southeast Asian refugees under either private or government sponsorship created an "experiment in nature" that the RRP investigators used to test the idea that private sponsors might potentially provide the support refugees typically look for in like-ethnic communities.

Like all citizens and permanent residents of Canada, the refugees were entitled to provincially administered insured health care. Many received language training in federally funded programs, and their children attended schools supported by provincial tax dollars. Privately sponsored refugees got a little extra. Sponsors were obliged to provide financial support for the person or family they sponsored for a period of one year, or until the person or family had achieved financial stability, whichever came first. Moved by the horrors of the Southeast Asian experience, most private sponsors did much more: they helped refugees find jobs, schools for their children, doctors and dentists.

Assuming that the level of welcome the privately sponsored group received would give them an advantage over the government sponsored whose only official guide to the new society was a usually overworked civil servant, we predicted that privately sponsored refugees would enjoy better mental health than the government sponsored refugee. In the short run, the prediction proved wrong. There were no mental health differences between the two groups in 1981 or in 1983. In retrospect, government and academics were more impressed with the virtues of private

sponsorship than the refugees themselves. Half of all privately sponsored Southeast Asian refugees and almost all the government sponsored refugees said that government sponsorship was preferable. One reason was that private sponsors sometimes confused kindliness with intrusiveness, calling the refugees at all hours and insisting on taking them to various activities. They forgot that refugee families, like all other families, need and value privacy. Sponsors were sometimes insensitive to the refugees' needs. For example, they often found housing that the refugees could no longer afford after the sponsorship period terminated. Inequality was another source of discontent. Government sponsored refugees all got the same treatment, whereas, in the words of one refugee, "With private sponsorship, sometimes it depended on luck whether you met a nice group or not."

A sub-group of privately sponsored refugees in the RRP was, in fact, at greater risk for depression than the government sponsored. These were refugees whose religions did not match their sponsors. Most of the sponsors were Christian or non-denominational, most of the refugees were either Christian, Buddhist or members of one of the smaller Southeast Asian religious groups. Non-Christian refugees sponsored by Christian groups developed very high rates of depression.

Although some overt attempts to proselytize the refugees probably contributed to the burden of depression among the religiously-mismatched privately sponsored refugees, other, more wide-spread psychological pressures operated at a more subtle level. The refugees had difficulty understanding the concept of voluntary sponsorship. Since the sponsors were not family, but strangers, many refugees reasoned that something was required in return. Virtually all the sponsoring groups had been organized through a network of multi-faith religious institutions. Since religious institutions provided the context for sponsorship, the refugees came to believe that they were expected to adopt their sponsors' religions. Some did and regretted it. Others did not, but felt they were being ungrateful. Both circumstances increased the risk of depression.

Proposition 2: Resettlement is a long, perhaps even a life-long process. Factors that jeopardize or protect mental health early on can recede in importance over time, to be replaced by others that are more important for the later stages of resettlement.

Without language one can never really enter a new society. Two years after their arrival in Vancouver, 17 per cent of the refugees in the RRP sample spoke English well, 67 per cent had moderate command of the language, and 16 per cent spoke no English. Ten years later, 32 per cent had good language skills, 60 per cent moderate skills, and

8 per cent still spoke no English. It is troubling that, as long as a decade after arriving in Canada, a small, but significant number of newcomers had not acquired one of the most basic tools for integration.

During the initial period of resettlement, English-speaking ability had no effect on depression or on employment. By the end of the first decade in Canada, however, English language fluency was a significant predictor of depression and employment, particularly among refugee women and among people who did not become engaged in the labor market during the earliest years of resettlement.

Young, well educated male refugees were the most likely to learn English during the first year or two in Canada. In comparison with their young male counterparts, females and elderly refugees tended to be less well educated and less likely to have had any prior exposure to English, and their level of language fluency was correspondingly lower. The initial linguistic disadvantages of women and the elderly were compounded by lack of opportunity. For example, because English as a Second Language (ESL) classes were primarily directed to persons deemed likely to enter the labour force, women and the elderly were less likely to receive such instruction. More recent developments such as Canada's Language Instruction for Newcomers to Canada programmes have been adapted in order to reach previously neglected groups, but women are still underserviced. Lack of language compromises employability and access to services; it also limits options to participate in other important domains such as civic life and mainstream entertainment. It is particularly troubling that precisely those persons most likely to be isolated by circumstance—women, the poorly educated and the elderly—are those least likely to learn English, and thus to risk further isolation.

According to evaluation reports from Citizenship and Immigration Canada (CIC) (2004), most new immigrants participate in ESL training (or other second-language training). However, the average length of exposure is less than six months, and most people attend as part-time students during that period. Research from other countries demonstrates that the longer the period of language training, the greater the linguistic benefit. Immigrant ESL students in Canada have complained that teaching methods and materials are often inappropriate, that classes are too large, and that instruction is compromised by an inappropriate mix of students with differing levels of English ability. Addressing these problems should have an impact on both mental health and integration.

Sponsorship offers an example of the way in which time affects mental health salience. As already pointed

out, privately sponsored refugees had no material or mental health advantages over their government-sponsored counterparts during the early years of resettlement. By the time 10 years had passed, that changed. In 1991, the refugees who had been admitted under private sponsorship were more likely than their government-sponsored counterparts to be employed, to be speaking English and to have made friends outside their like-ethnic community. These RRP findings are consistent with an evaluation report from CIC (2007) which found that privately sponsored refugees entered the labour force more quickly than government sponsored, and enjoyed better incomes. The CIC report also pointed out that the number of applications by potential sponsors consistently exceeded the numbers of refugees admitted to the country each year.

Canada's private sponsorship program could support the country's humanitarian goals by making it possible to admit more refugees. Suggested improvements to help prevent the development of mental health risks and to promote integration include the provision of expert back-up for sponsors to help the latter effect an appropriate balance between helping and respecting the need for privacy and dignity, and to promote awareness of how vulnerable refugees are to outside influence, well-intentioned or not.

Proposition 3: Gender makes a difference.

In 1981, shortly after the refugees arrived, men had higher rates of depression than women. This finding runs counter to almost every other community study of depression in the literature. During the years thereafter, male rates of depression dropped more rapidly than female rates. By the end of the first decade of resettlement, sex ratios for depression among the Southeast Asian refugees resembled those in most community studies.

There is, and probably always will be, disagreement concerning the relative importance of nature versus nurture in the genesis of depression. The RRP gender analyses introduced an intriguing commentary on the debate. Among women, depression scores in 1981 predicted depression scores in 1983 more strongly than the 1983 scores predicted depression levels in 1991. The reverse was true for men. Persistent or recurrent depression suggests genetic or physiological predisposition, whereas depression which disappears over time is more likely to be associated with external factors. Shortly after the refugees arrived, men were more likely than women to be subjected to acculturative stress because they were more likely to be in the labour force. Men tended to be charged with the burden not only of providing for family who accompanied them to Canada, but for those remaining at home or in refugee camps abroad. During this same period, women were more sheltered from

stressors. With the passage of time and the resolution of initial resettlement stresses, depression rates for men declined. Perhaps, as the risk factors for depression gradually lessened, predisposition began to play a stronger role in predicting future depression. In other words, men with a constitutional predisposition tended to stay depressed, whereas others improved when external pressures began to recede.

The opposite may have happened among women. Predisposition may have played a strong role in accounting for the relatively strong relationship between depression levels in 1981 and 1983, periods when, compared to their male counterparts, the female refugees were relatively protected from acculturative stresses. However, the longer they remained in Canada, the more likely refugee women were to be exposed to the structural inequities and inequalities in North American society that help account for elevated rates of depression among women in general. The increasing importance of external factors in the genesis of depression may have diluted the role of predisposition, thereby reducing the strength of association between the 1983 and 1991 levels of depression.

Proposition 4: Mental health is human capital. Paying attention to mental health needs during resettlement will promote integration and could have long-term economic benefits for Canada.

At the time of the final RRP survey in 1991, Greater Vancouver's former Boat People were more likely than their native-born counterparts to be working. For people between 25 and 44, the age of most of the refugees, the national unemployment rate was 9.6 percent and, in Vancouver, it was 9.1 percent. In comparison, the unemployment rate for the refugees was 8 percent. The refugees were making a disproportionate contribution to the economy. At the same time, they were taking less out of it than their fellow Canadians. (Most refugees visited a doctor two to three times per year, just about the national average, and, compared to their majority culture counterparts, they were less likely to use social assistance.)

Although many of the refugees in the RRP eventually achieved economic success, it came neither quickly nor easily. Studies by economists such as Don deVoretz and Jeffrey Reitz have shown that it takes seven to ten years for newcomers—immigrants and refugees alike—to achieve economic stability. In the interim, unemployment rates are apt to be high, and incomes to be low. About one third of all immigrant and refugee families in Canada live in officially defined poverty during the first ten years of resettlement. Recent trends are even more troubling. Compared with refugees who came to Canada in the early 1980s, more recent arrivals are at even greater risk of living in poverty during the initial years of resettlement. When they do find employment, visible minority immi-

grants (the majority of today's immigrants and refugees) earn less than their native-born counterparts, even when working at the same jobs.

Many community-based studies have shown that job loss is associated with a high risk for depression. Because the RRP was longitudinal, we were able to examine sequencing—in other words, does unemployment precede, and possibly cause depression, or are depressed people more likely than the non-depressed to lose their jobs? Both proved to be correct—unemployment is followed by depression, but depression also raises the risk of losing a job. One implication is that mental health should be added to education, training, and ability to speak English or French, the attributes that come to mind more usually in discussions about human capital.

Although mental health should be of concern to policy makers, it rarely is. More attention needs to be paid to both the stresses of resettlement that create risk and to the determinants of resilience.

Unemployment has already been discussed as a risk factor. Discrimination is another important force. One in five of the refugees reported experiences with discrimination in the year prior to each of our surveys. Discrimination was associated with a high risk for depression. Once again, the RRP's longitudinal design made it possible to address a question that has plagued research. Does the experience of discrimination tend to make people depressed, or are depressed people more likely to perceive discrimination in situations that other people would likely disregard? The data show that the first proposition is true, the second is not. People who reported an experience with discrimination were more likely to be depressed on a subsequent interview than people who had not experienced discrimination, but people who were depressed at a particular point in time were no more likely than anyone else to subsequently perceive discrimination.

Turning to the resilience side of the equation, it is important to acknowledge the important role of personal factors, such as linguistic fluency. The ability to speak English or French is another of those variables that affects both mental health and integration.

Regionalizing is an example of a situation in which resettlement policy would benefit from considering mental health. In accordance with the policy of regionalization, government-sponsored refugees are spread across the country, preferably to small towns and rural areas. However, within the first year after coming to Canada, 50 percent of government-sponsored refugees leave, and migrate elsewhere in Canada, mostly to southern Ontario. Refugees do not identify jobs as the number one reason for their behaviour, but instead, the wish to be close to a like-ethnic community. Debate about regionalization tends to focus on whether or not the policy is consistent

with safeguarding human rights. This is a serious issue. There is, however, little if any debate about the equally serious issue of the role of the like-ethnic community in safeguarding mental health, or about the feasibility of creating communities of welcome that are not necessarily ethnically based, but that might help provide the mental health support new settlers want and need.

Personal Reflections: National policy has been too exclusively preoccupied with adjudicating the legitimacy of refugee claims, and with developing selection procedures to ensure that Canada admits healthy people. Too little policy and practice are directed to ensuring that refugees stay healthy. This neglect is wrong-headed: ensuring that new settlers not only are healthy when they get here, but that they stay that way is just, humane, and consistent with achieving long-term national benefit.

REFERENCES

Books:

Beiser, M. *Strangers At the Gate: The 'Boat People's' first ten years in Canada.* Toronto: University of Toronto Press, 1999.

Book Chapters:

DeVoretz D, Beiser M, Pivenko S, "The Economic Experiences of Refugees in Canada', in Peter Waxman and Val Colic-Peisker (eds.), *Homeland wanted: Interdisciplinary perspectives on the refugee resettlement in the West.* New York: Nova Science Publishers, 2005, 1-21.

Beiser M. "Resettlement," in Parrillo, Vincent N (ed) *Encyclopedia of Social Problems*, Thousand Oaks, Sage Publications, 2008.

Refereed Journal Articles:

Beiser, M. and Hou, F. "Gender Differences in Language Acquisition by Southeast Asian Refugees." *Canadian Social Policy.* 2000, 26 (3):311-330.

Beiser, M., and Hou, F "Language Acquisition, unemployment and depressive disorder among Southeast Asian Refugees: a 10-year study" *Social Science & Medicine* 2001, 53:1321-1334.

Beiser M, Johnson P, "Sponsorship and Resettlement Success," *Journal of International Migration and Integration,* 2003, 4, 2, 203-216.

Beiser M., "Resettling Refugees and Safeguarding Their Mental Health: Lessons Learned from the Refugee Resettlement Project, *Transcultural Psychiatry*, 2009 (in press).

Hou F, Beiser M, "Learning the Language of a New Country: A Ten-Year Study of English Acquisition by Southeast Asian Refugees in Canada, *International Migration* Volume: 44, Issue: 1, March 2006, pp. 135-165.

Simich, L. Beiser, M. and Mawani, F., Issues and Commentaries, "Paved with good Intentions: Canada's Refugee Destining Policy and Paths of Secondary Migration", *Canadian Public Policy*, 2002, 28, (4): 597-607.

Simich L, Beiser M, Mawani FN. "Social Support and the Significance of Shared Experience in Refugee Migration and Settlement," *Western Journal of Nursing Research*, 2003, 25, 7, 872-891.

Reports:

Citizenship and Immigration Canada Evaluation of the Language Instruction for Newcomers to Canada (LINC) Program. 2004, ww.cic.gc.ca/english/resources/evaluation/linc/findings.asp.

Citizenship and Immigration Canada: Summative evaluation of Canada's Refugee Sponsorship Program. 2007, *cic.gc.ca*

PRE-MIGRATION AND POST-MIGRATION DETERMINANTS OF MENTAL HEALTH FOR NEWLY ARRIVED REFUGEES IN TORONTO

Ruth Marie Wilson, MSW, is a graduate of the University of Toronto. In her current role as research coordinator at Access Alliance Multicultural Health and Community Services, Ruth coordinates two qualitative, community-based research projects looking at racialized health disparities, particularly the relationship between income security, race and health in the lives of racialized families living in low-income neighborhoods.

Rabea Murtaza coordinates the Determinants of Newcomer Mental Health research agenda at Access Alliance. She is a feminist, anti-racist and queer-positive community worker, researcher, writer and facilitator. She studied Social and Political Thought at York, focusing on situated, relational, praxis-based feminist pedagogies and epistemologies, and Physics and Political Science with a minor in Globalization Studies at McMaster University.

Yogendra B. Shakya is the Director of Research at Access Alliance Multicultural Health and Community Services. His research interests include social determinants of newcomer health, racialized health disparities, and globalization and community based research.

ABSTRACT

Drawing on two community-based research projects, this article discusses pre-migration and post-migration determinants of mental health for newly arrived refugees in Toronto. The article examines the argument that settlement policies and services need to be more reflective of the unique challenges and needs faced by refugee groups.

INTRODUCTION

There is small but growing body of Canadian literature on refugee mental health. To add to this evidence, Access Alliance Multicultural Health and Community Services (Access Alliance) conducted two community-based research (CBR) projects focused on newly arrived refugee communities in Toronto from Afghan, Karen and Sudanese backgrounds. Both projects investigated determinants of refugee mental health with one project focusing on adult refugees (specifically Government Assisted Refugees) and the other one on refugee youth between the ages of 16 to 24.[1] Drawing on these two CBR projects, this article discusses pre-migration and post-migration determinants of mental health for newly arrived refugees. Findings from the two studies suggest that newly arrived refugees face unique and acute forms of pre-migration and post-migration stressors to their mental health.

REFUGEES RESETTLEMENT TREND IN CANADA

Once recognized as a world leader in global peace keeping efforts, humanitarian work, and for providing resettlement and other support for refugees around the world, Canada has granted protection to over 700,000 refugees since World War II. In 1976, the Canadian Immigration Act formally distinguished between refugees and immigrants. The Act laid out both a claim determination system for refugees landing in Canada as well as introducing a humanitarian category for government sponsored refugee resettlement. The introduction of the Immigration and Refugee Protection Act (IRPA) in June 2002 consolidated the commitment for Canada to proactively sponsor refugees primarily on humanitarian grounds and protection needs. This Act not only removed additional restrictions on "admissibility" based on medical or economic criteria for refugees but also strengthened the basis for resettling refugees who are particularly at high risk.

Since 1999, Canada has been welcoming between 25,000 to 35,000 refugees every year; this represents about 10-12% of the roughly 250,000 permanent residents (immigrants and refugees) that settle in Canada annually (CIC 2008). Refugee resettlement trend in Canada since 1999 is presented in Figure 1. On average, about 11,000 refugees come as "sponsored" refugees under the Refugee and Humanitarian Resettlement stream: 7,500 as

FIGURE 1: Permanent Resident Arrivals in Canada, Ages 15-24, by Category, 1999-2008
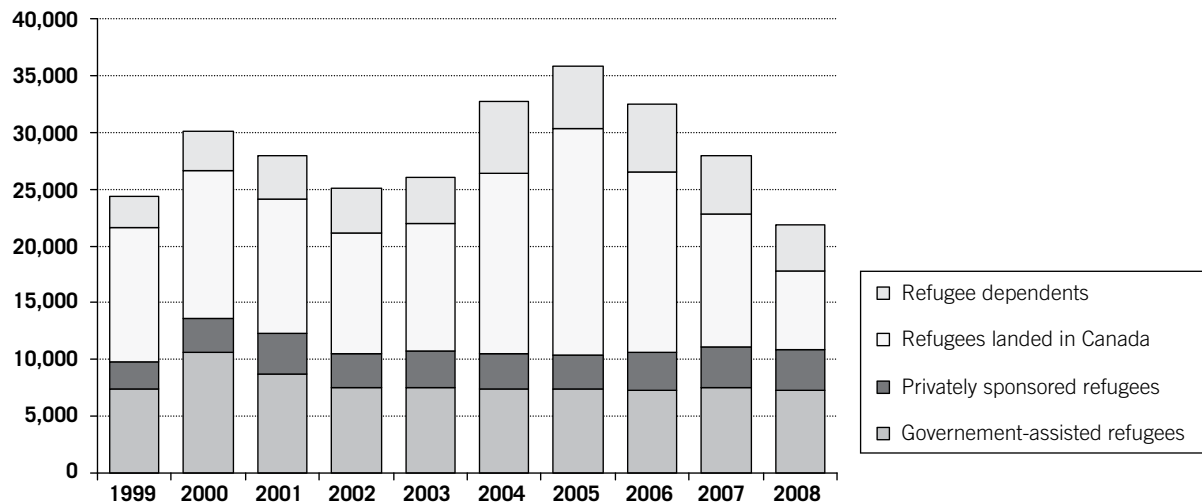
Source: Citizenship and immigration Canada. Developed by Access Alliance.

Government-Assisted Refugees (GARs) and 3,500 as Privately Sponsored Refugees (PSRs). Roughly 12,000 to 19,000 come to Canada through the "In-Canada Asylum" stream in which people apply as refugee claimants upon entering Canada and then become "permanent residents" once their claim process is approved by a quasi-judiciary body called IRB. The remaining 5,000 settle in Canada as family dependents of people who have come as refugees (CIC 2008).

PRE-MIGRATION FACTORS INFLUENCING MENTAL HEALTH

Responses from participants in both studies indicate that many of the newly arrived refugees in Toronto have undergone difficult and traumatic pre-migration experiences that constitute salient risks and stressors to their mental health. Many adult and youth refugees shared personal stories of having experienced or witnessed war, torture, violence, targeted persecution, forced labor, forced migration and family separation. One Afghan refugee summed the immense impact of thirty years of war in Afghanistan in the following way:

> Of course there was war in Afghanistan for almost thirty two years and people lost family, people lost their homes and they experienced a lot of difficulties. That is one of the most challenge of their life.

Participants discussed numerous mental health impacts of these pre-migration stressors including worry, sadness, depression, and going 'crazy.' According to one participant:

> The country situation was not good and we had to worry all the time. The bad news, the torture, the oppression did not only affect our physical being but also our mental being.

Refugees (adults and youth) from all three communities also pointed out that experiences of living for protracted periods in under-serviced refugee camps in 'transition countries' as 'stateless' individuals resulted in diminished rights and opportunities, increased exposure to discrimination and abuse, and undermined mental health. An Afghan refugee mentioned how:

> In Pakistan they don't treat Afghani [sic] people the right way. They tell them why you are here? You destroy your country, now you want to destroy ours? They don't like Afghani people

Another participant likened the confined life in refugee camp to living in a pig's pen:

> But, life in refugee camp was like the pig's pen. {Idioms ~ strictly confined in a place where you have no way out}. It was very difficult to travel and work. ..This was the greatest oppression. We had to live in confined refugee camps

One refugee youth recalled how he had to do difficult manual labor (without anything to eat) that exceeded his capacity:

> In [the refugee camp], you go and work outside, you get nothing to eat, but you have to handle heavy work, and thus you do you grow well...In [the refugee camp],

*people sometimes help you out. But, the
point is, you have to carry too heavy
things that you can't carry.*

Beiser, Simich, and Pandalangat (2003) research on Tamil refugees in Canada also identified similar pre-migration determinants of mental health including war, displacement (within and outside of country of origin), living as IDPs or in refugee camps, harassment from authorities, family separation, and economic hardship.

Existing studies on refugee mental health have found strong correlation between traumatic pre-migra-tion experiences and PTSD. For example, a study of Tamil refugees in Canada found that during pre-migra-tion, 1/3 of participants had directly witnessed a traumatic event such as rape or combat, and 12% of the study group suffered from PTSD (compared with a general population prevalence rate of 1%) (Beiser, Simich, and Pandalangat 2003). Rummens (2007) found that 50% of refugee children who have witnessed violence are likely to experience PTSD. In fact, in the United States the rates of PTSD range from 25% to 50% among refugee children and youth (Kinzie, Jaranson, & Kroupin). Torture was found to be the strongest pre-migration predictor of PTSD (Lidencrona, Ekblad, and Hauff 2008) and is unfortunately a common refugee experience: 20% of all refugees are believed to be primary or secondary victims of torture (International Rehabilitation Council for Torture Victims 2008).

In both studies, refugees also highlighted some positive aspects of their lives before arriving in Canada. In particular, they talked about the strong family and community bonds and supports that they develop in refugee camps. To this extent, leaving family and community behind to come to Canada appear to have serious emotional impacts on refugees.

Service providers highlighted that the bulk of pre-migration mental health issues go undetected and unaddressed. This is primarily due the limited understanding and capacity of settlement and healthcare providers to address mental health issues faced by refugee groups.

POST-MIGRATION FACTORS INFLUENCING MENTAL HEALTH OF REFUGEES

Existing literature on refugee health suggests that post-migration factors impacting refugees may compound mental health issues faced by this group (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada 1998, Gifford, Bakopanos, Kaplan & Correa-Velez 2007). Further, in the context of resettle-ment, experiences of poverty, interracial conflict, family instability, parental psychosocial distress, youth unem-ployment and intergenerational conflict were all found to

be sources of poor mental health among refugee youth (Hymen et al., 1996). Findings from our two studies add to this body of evidence. In referring to the compounding pre-migration and post-migration challenges that she faces, one refugee participant summed up her sense of despair in the following way:

*Whenever I think about my problems and
what is going on right now, I almost get
crazy. Not only getting crazy, I don't even
want to live anymore.*

While being selected for resettlement in Canada is viewed positively by most government assisted refugees (GARs), particular policy anomalies and process chal-lenges related to refugee resettlement in Canada themselves appear to worsen rather than alleviate mental health issues that refugees face. Stressors related to refugee resettlement process include delays in processing applica-tions, errors in the paper work, delays in family reunification, lack of information, and having little or no input into which province or city GARs get settled in Canada. Our study on GARs mental health also found that the transportation loan (covering airfare and initial settle-ment costs for the family) that GAR families are required to repay was a major source of worry, anxiety and stress.

Several participants from this study recall that the contractual obligation to take and repay the transporta-tion loan was signed more out of vulnerability and desperation rather than through informed choice.

*There are a number of documents that
need to be signed when you are in the
process to come to Canada. You because
you are so desperate to come to Canada
they make you sign some documents in
Egypt. You just sign any document
[including the loan document] just to
come to Canada.*

Findings from both research projects indicate that the critical post-migration mental health stressors that newly arrived refugees in Canada face include labor market challenges (difficulties finding decent jobs, non-recognition of foreign credentials, having to make do with precarious jobs), poverty, linguistic barriers, difficulties in learning (particularly learning English), adaptation to new culture/context, isolation and discrimination. While non-refugee groups may also face these barriers and chal-lenges, our findings reveal that refugee groups experience these determinants in acute and unique ways. The acute impact on refugees result from traumatic experiences that refugees may have faced and/or due to gaps in educa-tional, economic and political opportunities before coming to Canada

For example, while non-refugee newcomers may also face linguistic barriers, refugees face this barrier in acute

ways because many of refugees arrive with limited education, low literacy and low English language fluency. The following quote illustrates the intense difficulties that refugees face in learning English even though they are trying their best and their teachers are giving their best:

> *The language barrier is the most difficult circumstance for me in Canada. It becomes a big worry and concern for me and some times I get mad at myself…I try my best, I don't seem to improve my language skills… the teachers try their best in class, but we just don't understand them and lost concentration*

A service provider working closely with refugee groups highlighted the impact of trauma on learning capacity for refugees:

> *In general we know that trauma has an effect on people's concentration and memory and ability to learn language. So in my experience with working with refugees, people who experienced trauma, I did work with people who were highly educated, they were professionals in their countries. They came to Canada and were unable to move from level one to level two, and that contributed to their depression because some of them put lots of effort into learning new language, but because of trauma, still they didn't know it was because of trauma, they were not able to learn language, new information, concentrate, you know memorize new things. And it just contributed to their depression*

Others researchers have shed light on the relationship between trauma and learning (Freire 1990; Mojab and McDonald 2008; Stone, 1995). They emphasize that language training and other training programs geared at refugees need to be grounded on pedagogical framework that incorporates potential histories of trauma, interrupted schooling, multiple language backgrounds, gaps in literacy platforms, disassociation, and difficulty in concentrating.

Due to limited literacy and English language fluency combined with gaps in educational and career experiences before coming to Canada, refugee groups are more likely to face additional barriers in the labor market and experience unemployment and poverty levels that are much higher than for non-refugee groups. An internal client survey conducted by Access Alliance in 2008 found that over 70% of refugee clients remain unemployed even after 3 years of arrival in Canada.

Findings from both studies indicate that discrimination is a salient stressor that both adult and youth refugees face. An Afghan refugee mentioned that:

> *Since September 11, most people are even afraid to go to the mosque to pray. They are in fear of being accused of terrorism.*

Based on one's social position, marginalized people may face multiple layers of discrimination and disadvantage. The label of 'refugee' itself can become an added layer of discrimination that refugee groups face. For example, a female refugee youth from Sudan characterized the multiple discrimination and disadvantage she faces in the following way:

> *That is what I am saying double disadvantage. First you are refugee second you are black and third you are female. Have so many things pushing you down.*

Many refugee youth pointed out that education and 'studying hard' were their strategy for achieving happiness in Canada and going beyond past experiences of hardships. However, multiple barriers including financial pressure and discrimination hinder their academic aspirations.

A Sudanese refugee youth pointed out how teachers sometimes perpetuate racism instead of helping to fight it:

> *Teachers assume that you are stupid when you are black.*

The following quote by a Sudanese female youth exemplify how acute income insecurity and lack of supportive systems can force newly arrived youth into having to choose between 'shelter, food or school':

> *Financial way school wise you have to buy books and you can't buy certain books because you are thinking of okay, if I spend this amount of money. Because OSAP they didn't tend to give out enough money and to buy books and laptop and here you are and working limited job and don't have enough money and trying differentiate which one come first: shelter, food or school. So in that cases you buy certain books and the rest, library, photocopy, all this. So it is really a lot of pressure. Sometimes you just tend to drop out and take a semester off and think okay, if I work I might be able to help.*

RECOMMENDATIONS

Findings from the two research projects on refugee mental health indicate that (1) newly arrived refugees in Toronto have faced critical pre-migration stressors including war, violence, torture, persecution, precarious migration and protracted stay in underserviced refugee camps; and (2) pre-migration determinants, particularly gaps in educational and economic opportunities, exacer-

bate post-migration stressors that refugees face.

To this extent, we recommend the following:

a. Implement innovative refugee-centred mental health services and community empowerment strategies that can enable refugee families overcome pre-migration mental health issues (particularly PTSD and other trauma)

b. Enhance resettlement policies and process in ways that minimize risk for refugee families, including getting rid of the transportation loan repayment requirement.

c. Make settlement services including English/French language training and employment preparation services more sensitive to the unique needs of refugee population

d. Recognize that settlement is a health issue and promote active collaboration between health and settlement sector.

e. Implement anti-racism/anti-oppression process for proactively overcoming the multiple layers of discrimination that refugee groups face.

f. Design services within rights-based, equity framework in ways that enable refugee groups to overcome perceptions of dependency and helplessness that they might be feeling.

g. Engage marginalized refugee groups in 'critical pathways' (including research, policy development planning, decision making, etc) to promote social inclusion.

REFERENCES

Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada. 1988. *After the door has been opened: mental health issues affecting immigrants and refugees in Canada*. Health and Welfare Canada.

Beiser, M., Simich, L., and Pandalangat, N. "Community in distress: mental health needs and help-seeking in the Tamil community in Toronto." *International Migration* 41.5 (2003): 233 – 245.

Freire, M. "Refugees: ESL and Literacy Trying to Reinvent the Self in a New Language". *Refuge* 10.2 (December 1990): 3-6.

Gifford, S., Bakopanos, C., Kaplan, I., and Correa-Velez, I. "Meaning or Measurement? Researching the Social Contexts of Health and Settlement among Newly-arrived Refugee Youth in Melbourne, Australia". *Journal of Refugee Studie*s 20.3 (2007): 414-440.

Hyman, I., Beiser, M., & Vu, N. (1996). "The Mental Health of Refugee Children in Canada." *Refuge* 15.5 (1996): 4-8.

International Rehabilitation Council for Torture Victims. "Remember tortured refugees." 2009. http://www.irct.org/Default.aspx?ID=159&M=News&PID=549&NewsID=1405. (19 June 2009).

Kinzie, J.D., Jaranson, J., and Kroupin, G.V. 2007. "Diagnosis and Treatment of Mental Illness." In P. Walker & E. Barnett (eds.), Immigrant medicine. Philadelphia: Saunders. 639-651.

Lidencrona, F., Ekblad S., and Hauff E. "Mental health of recently resettled refugees from the Middle East in Sweden: the impact of pre-settlement trauma, resettlement stress and capacity to handle stress." *Social Psychiatry and Psychiatric Epidemiology* 43 (2008):121-131.

Mojab, S. and McDonald, S. 2008 (in press) "Women, Violence and Informal Learning", in K. Church, N.Bascia, and E. Shragge (Eds.) *Learning through Community: Exploring Participatory Practices*. Springer Press

Rummens, J. A. 2007. "Research on immigrant and refugee health in Canada." [Powerpoint Slides] presented at the McMaster Refugee Child Health Conference, Settlement and Integration Services Organization (SISO), Hamilton, Ontario, May 23, 2007.

Stone, N. 1995. Teaching ESL survivors of trauma. *Prospect*. 10, 3. (The Journal of the National Centrefor English Language Teaching and Research, Macquarie University)

FOOTNOTES

[1] Both CBR projects employed qualitative methods comprising of focus groups and interviews; the research on refugee youth included a short survey. The research on adult refugees (Co-Principal Investigators: Dr Carles Muntaner and Dr Yogendra Shakya) was funded by the Centre for Addiction and Mental Health and completed in 2008. The research on refugee youth was initiated in 2008 (Co-Principal Investigators: Dr Sepali Guruge, Dr Michaela Hynie, Rabea Murtaza and Dr Yogendra Shakya) with funding from Laidlaw Foundation and Citizenship and Immigration Canada and is expected to be completed by March 2009.

Our Diverse Cities

Our Diverse Cities / Nos diverses cités is a special Metropolis series that examines issues related to diversity, integration and immigration in cities. It has also been assigned as course reading in university classes across the country.

Volume 4, Fall 2007 – Ontario

- Margaret Walton-Roberts (Wilfrid Laurier University) "Immigration Regionalization in Ontario: Policies, Practices and Realities
- Brian K. Ray (University of Ottawa) and Jean Bergeron (Citizenship and Immigration Canada) "Geographies of Ethnocultural Diversity in a Second-tier City: Moving Beyond Where People Sleep"
- Sandeep Kumar Agrawal (Ryerson university), Mohammad Qadeer (Queen's University), and Arvin Prasad (Regional municipality of Peel) "Immigrants' Needs and Public Service Provisions in Peel Region"
- Myer Siemiatycki (Ryerson University) "Invisible City: Immigrants Without Voting Rights in Urban Ontario"

Volume 5, Spring 2008 – Atlantic Region

- Bridget Foster (Association for New Canadians, Newfoundland and Labrador) "Perspectives of an Atlantic Settlement Service Provider"
- Nicole Gallant (Université de Moncton, Institut national de la recherche scientifique) "How Social Networks Help to Attract, Integrate and Retain Immigrants: A Multidimensional Research Initiative"
- Alexandra Dobrowosky and Evangelia Tastsoglou (Saint Mary's University) "Women, Gender and Networks"
- Ather H. Akbari (Saint Mary's University) "The Role of Networks in Economic Integration of New Arrivals"

Volume 6, Spring 2009 – Prairies Region

- The Honourable Nancy Allan (Government of Manitoba) "Foreign Worker Recruitment and Protection: The Role of Manitoba's *Worker Recruitment and Protection Act*"
- Jim Frideres (University of Calgary) "The New Ethnic Identity? Young People on the Prairies
- Rick Enns (University of Calgary) and Tom Carter (University of Winnipeg) "Refugee Housing Trajectories in Edmonton"
- Joseph Garcea (University of Saskatchewan) and Smita Garg (City of Saskatoon) "Cultural Diversity, Race Relations, Immigration and Integration in Saskatoon: The Process of Developing Institutional Arrangements"
- Marc Arnal (University of Alberta, Campus Saint-Jean) "Rethinking Canada: Canadian Values as a New Framework for Development"

To obtain a copy, in English or French, please contact <canada@metropolis.net>

IMMIGRANT ACCESS TO MENTAL HEALTH SERVICES: CONCEPTUAL AND RESEARCH ISSUES

Alice W. Chen is currently adjunct professor and university research associate in the Faculty of Health Sciences at Simon Fraser University. She received her doctoral degree in healthcare and epidemiology from the University of British Columbia. Her research activities have included healthcare utilization by immigrants, indicators of children's mental health and linkage of secondary databases.

ABSTRACT

The concept of access to mental health services includes cultural responsiveness and effectiveness as well as mental health promotion and prevention. Research on immigrant access must consider cultural factors which affect the next generation and must examine mental health outcomes. Improving immigrant access will ultimately benefit all Canadians.

Under the Canada Health Act, Canadians have come to expect "reasonable access to health services without financial or other barriers" (Canada Health Act 2009). However, achieving that goal remains a challenge. In 2000/01, 12% of Canadians aged 12 and over reported unmet health care needs. This rate is almost triple that when the indicator was first measured in 1994/95 (Sanmartin, Houle, Tremblay and Berthelot 2002). The reasons identified for the needs being unmet were predominantly access issues, including long waiting times and services being unavailable, inaccessible or inadequate (Sanmartin, Houle, Berthelot and White 2002).

Access to mental health care is even more disappointing. In a related survey, 21% of Canadians with symptoms of mental disorders or substance dependencies reported unmet needs for their problems (The Daily 2003, Statistics Canada). In this context of overall challenges in accessing mental health services, are immigrants' difficulties to access unique? Generally, immigrants' access is treated separately in research and policy literature because of evidence that the difficulties are more acute and imply different response strategies.

Data in Canada have shown that immigrants and ethnic minorities are underrepresented in the mental health care system or are less likely to use mental health services. Even among those who experienced a major depressive episode, it was found that Chinese immigrants, for example, were less likely to consult health professionals (Chen, Kazanjian and Wong 2009; Tiwari and Wang 2008). Numerous other studies have examined the barriers that deter immigrants from benefiting from mental health services, including language, health beliefs, family dynamics and indirect financial costs.

Extant knowledge has spurred various initiatives by health service providers and policy-makers to reduce the identified barriers and increase the use of mental health services. However, these responses may be inadequate because of the restricted interpretation of access to mental health services and the related shortfall in research evidence. This article will advocate for broadened concepts of access and mental health services and will recommend some directions for future research to fill the gaps in knowledge. It will conclude that the research and policy agenda for immigrant access to mental health services is ultimately the agenda for all Canadians.

CONCEPTUAL UNDERSTANDING OF ACCESS

At present, the discourse on immigrant access to mental health care is largely focussed on individual deficits, such as language and cultural barriers. The response strategy, accordingly, is to help immigrants overcome these deficits through programs such as language/cultural interpretation or community outreach. The goal of this approach is to connect immigrants with available mental health services and access is measured in terms of the use of existing services. However, a popular model of health service use suggests that access is more than the "output" of the healthcare system in that the number of clients served is not equivalent to the level of access.

According to this model proposed by Andersen and Davidson, access to healthcare involves both individual and contextual components (Andersen and Davidson 2001). While individual characteristics (such as age, gender, health beliefs, financial means) predispose and enable a person to seek healthcare, contextual characteristics

(including the delivery and organization of healthcare) strongly influence the use of healthcare as well. Andersen and Davidson also define access as:

> "actual use of personal health services and everything that facilitates or impedes their use…..Access means not only getting to service but also getting to the right services at the right time to promote improved health outcomes" (p.3).

This definition espouses several quality indicators of health system performance proposed by the Canadian Institute of Health Information—*availability, accessibility, appropriateness, acceptability, competence, safety and effectiveness*—as essential components of access (Canadian Institute of Health Information 1999). Taking this broad view of access and considering the criteria involved, current approaches to improve immigrants' access are profoundly inadequate.

Despite the fact that all health services offered in Canada are *available* to landed immigrants, their use of mental health services consistently lags behind that of the general population. While the goal of the current approach is to make existing services more *accessible*, the fundamental question is whether the *right* services are available, that is, whether the services offered are *appropriate* and *acceptable*. Immigrants from certain cultural backgrounds tend to express their psychological distress as somatic symptoms. They may resist the medical approach to psychological problems or the stigma of psychiatric treatment. At the same time, their psychological distress often stems from real social stressors. Under these complex circumstances, making the right diagnosis and providing the right intervention may require multifaceted efforts. Existing mental health services, which are built around the medical model, are often not appropriate or acceptable. Appropriate and acceptable therapies, including traditional and alternative treatment and psychosocial interventions, are usually not covered by health plans. Moreover, many health practitioners in Canada called to care for immigrants and refugees are not trained in cross-cultural service provision or in the specialized areas pertinent to this vulnerable group, e.g. post-traumatic stress disorder. Despite the best intentions, care provided may not be *competent* or *safe*. Taking into account these nuances of access, it is fair to conclude that access to the *right* mental health services for immigrants is limited at best. Finally, Andersen and Davidson state that access is ultimately evaluated by the improved outcome of the service. Increasing immigrant's use of existing services does not necessarily mean they have access to *effective* services. In fact, current statistics on immigrants' use of mental health services may overestimate their true access to services that meet all the criteria implied in the broad definition.

CONCEPTUAL UNDERSTANDING OF MENTAL HEALTH SERVICES

The expansion in scope of the concept of mental health to include mental wellbeing opens up another area in which the unique needs of immigrants must be understood and addressed. The World Health Organization defines mental health as:

> "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization 2007).

The Public Health Agency of Canada defines mental health as:

> "the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity" (Public Health Agency of Canada 2006).

The discourse on immigrant access to mental health service has to date largely focussed on remedial services for those who experience mental health difficulties. To ensure that immigrants achieve optimal mental health and live to their full potential in Canada, attention must be paid to their "access" to mental health promotion and prevention initiatives.

The strategies for promoting mental health typically targets the determinants of health, such as employment, housing, education, social support. These are also issues of particular salience to immigrants who are in transition in all these spheres. Many of the hurdles immigrants face during this vulnerable phase—recognition of credentials, finding full employment, affordable housing, language training, building social networks, integration with the local community, acculturation, discrimination—are in fact critical points of intervention to achieve the goals of mental health promotion and prevention. Successful immigrant settlement, in addition to benefiting the socio-economic future of Canada, contributes also to the health of the population. Current research suggests that immigrants' mental health worsens over time. Although there is no direct evidence that attributes the decline to their settlement experience, concerted efforts to facilitate this transition may help immigrants maintain their health advantage.

RESEARCH ON FACTORS THAT INFLUENCE ACCESS

Much about immigrants' access to mental health services or lack thereof is still unknown. Two areas of research are particularly needed to inform the development of appropriate strategies for improving access: specifying the role of factors that influence access and measuring the outcome of intervention.

Although there is general agreement that immigrants are disadvantaged in terms of access to mental health services and many barriers to access have been identified, there is still no clear understanding of the role that these factors play or the factors most responsible for lack of access. The complexity of health service use and access is one obvious reason why the pathway to access has not been articulated. For responsive strategies to be developed, it is important for researchers to begin to tease out the many influences on access. Clarifying the contribution of two general categories of influences is helpful as a start: migration and culture.

The majority of recent immigrants to Canada come from non-European origins and are ethnically and culturally different from the (majority) resident Canadian population, for whom the health system is designed. As a result, the issues of migration and cultural diversity are intertwined in the discourse on access to care. Owing to constraints in research design or data availability, current research on access to care often fails to separate the effects of the two, even though there is evidence that not all immigrants experience lower levels of access. White immigrants, for instance, are statistically indistinguishable from the Canadian-born White population in mental health service use. Even among visible minorities, Chinese immigrants have lower rates of use than South Asian and Southeast Asian immigrants (Tiwari and Wang 2008). If, as the earlier discussion on conceptual understanding of access highlights, challenges to access arise from cultural discordance as much as factors associated with the migration experience (e.g. language fluency, knowledge of health system), different strategies will have to be implemented to counter the challenges. For instance, while language barriers are regarded as deterrents to using mental health services, having primary care doctors who speak one's native language has been shown to decrease the use of mental health services, likely as a result of the doctors' cultural orientation and practice (Chen and Kazanjian 2009). Such paradoxical findings illustrate the need to take apart the many influences on access to care.

Conversely, challenges to access are not unique to the immigrant population. Other than the overall high level of unmet mental health needs in the general population, there is evidence that underuse of existing mental health services persists in the second generation of Chinese immigrants (Chen, Kazanjian and Wong 2009).

Cultural orientation, which is transmitted to the next generation, may be the major barrier not only in the first generation of immigrants, but also in the Canadian-born ethnic minority population. By focussing only on immigrants, the mental health needs of the next generation of Canadians may be overlooked, and the effort to improve access to mental health care for all Canadians is unnecessarily hampered. Currently, the cultural aspect of mental health service provision is discussed only in relation to aboriginal Canadians and immigrants. As Canada becomes increasingly diverse, culture will have to be on the agenda for access to mental health service for all. Research on immigrant mental health has much to contribute to this agenda and the potential to lead the effort to improve the mental health system.

RESEARCH ON MENTAL HEALTH OUTCOMES

Another area where research is needed is in evaluating the outcomes of the mental health system. As mentioned before, the ultimate test for access is in improved mental health outcomes. This outcome evaluation refers not only to assessing the effectiveness of specific programs and interventions. While such evaluations are important to ensure that the health system invests in services supported by strong evidence in the immigrant population, the mental health outcome of the immigrant population must also be tracked to ascertain the overall level of access, both to clinical services and to promotion and prevention policies and strategies. Findings on the use of specific services and programs will have to be interpreted in a larger body of research examining the mental health outcome of patterns of such service use. Underrepresentation in formal mental health care does not necessarily indicate lack of access if the immigrant population demonstrates improvement in mental health outcomes overall. In fact, decreased use of professional mental health care is expected if strategies to promote mental health and prevent disorders are successful.

To achieve the purpose of identifying the factors that contribute to use of mental health services and monitoring the mental health outcome of the immigrant population, there must be relevant data. The challenges of acquiring data on minority populations have hindered many research endeavours. This effort can be much more efficient if stakeholders in multiple sectors can collaborate to collect relevant data at a population level. For instance, many national immigrant and health surveys by Statistics Canada already collect detailed information on ethnic background and immigration status. More emphasis can be given to mental health in these surveys to help reveal the mental health outcomes of current health policies and system.

Conversely, reliable measures of immigrant status and ethnic identity can be introduced to administrative databases on healthcare to facilitate understanding of the patterns of healthcare use. While there must be safeguards against the misinterpretation and misuse of such information, the lack of such information can be more detrimental to the wellbeing of the minority populations.

CONCLUSION

This article has outlined a broader concept of access to mental health services to be applied to the discussion regarding the immigrant population and access to mental health care. Improving immigrant access to mental health services should not be confined to increasing the number of immigrants who contact existing mental health services. It must also assess the responsiveness of services and the effectiveness in improving the mental health outcomes of the immigrants. Similarly, current emphasis on promoting mental wellbeing in the population should also dovetail with immigration settlement, in order to address many of the determinants of mental health that uniquely affect the immigrant population.

Research will have to support health service providers and policy-makers by elucidating the relative contribution of different influences on access to mental health services. The research agenda on barriers to mental health services should include not only immigrants but eventually the culturally diverse Canadian population. Research must also focus on the mental health outcomes of the immigrant population, in addition to the barriers to existing mental health services and the effectiveness of specific interventions. Policy-makers in turn can assist research efforts by facilitating the collection of relevant data.

The framework for a mental health strategy in Canada recently released by the Mental Health Commission of Canada endorses this broad view of access and the scope of the population (Mental Health Commission 2009). Individuals and groups experience mental health in different ways. Migration-related stresses pose particular risks to immigrants and refugees. Mental health systems, therefore, must be responsive to the diverse needs of all Canadians, including immigrants, the second and third generations, aboriginals and other individuals whose needs differ from the mainstream. Under this framework, it is hoped that innovative strategies to improve access will be found and the mental health outcomes of all Canadians will be improved.

BIBLIOGRAPHY

Canada Health Act Chapter C-6. Minister of Justice. November 11, 2009. http://laws-lois.justice.gc.ca (9 Dec. 2009).

Canadian Community Health Survey: Mental Health and Well-being. *The Daily* (Statistics Canada), September 3, 2003, p. 2-4.

Andersen, R.M., and P.L. Davidson. 2001. Improving Access to Care in America: Individual and Contextual Indicators. In T.H. Rice and G.F. Kominski (eds.), *Changing the US Health Care System.* San Francisco: Jossey-Bass. 3-30.

Canadian Institute of Health Information. 1999. *National Consensus Conference on Health Indicators: Final Report.* Ottawa: CIHI.

Chen, A.W., and A. Kazanjian. Do Primary Care Providers Who Speak Chinese Improve Access to Mental Health Care of Chinese Immigrants? *Open Medicine* 3.1 (2009): E1-9.

Chen, A.W., A. Kazanjian, and H. Wong. Why do Chinese-Canadians not Consult Mental Health Services: Health Status, Language or Culture? *Transcultural Psychiatry* 46.4 (December 2009): 623-641.

Mental Health Commission of Canada. 2009. Toward Recovery and Well-being: A Framework for a Mental Health Strategy for Canada.

Public Health Agency of Canada. 2006. The Human Face of Mental Health and Mental Illness in Canada. Ottawa: Government of Canada.

Sanmartin, C., C. Houle, J. Berthelot, and K. White. 2002. Access to Health Care Services, 2001. Ottawa: Statistics Canada.

Sanmartin, C., C. Houle, S. Tremblay, and J. Berthelot. Changes in Unmet Health Care Needs. *Health Reports* 13.3 (March 2002): 15-21.

Tiwari, S.K., and J. Wang. Ethnic Differences in Mental Health Service Use Among White, Chinese, South Asian and South East Asian Populations Living in Canada. *Social Psychiatry and Psychiatric Epidemiology* 43 (2008): 866-871.

World Health Organization. Mental Health: Strengthening Mental Health Promotion. Fact sheet No. 220. September 2007. http://www.who.int/mediacentre/factsheets/fs220/en/print.html (9 Dec. 2009).

CULTURAL COMPETENCE IN MENTAL HEALTH SERVICES: NEW DIRECTIONS

Charmaine C. Williams, PhD is an Associate Professor and Associate Dean Academic at the Factor-Inwentash Faculty of Social Work, University of Toronto. She conducts and publishes research in the areas of mental illness, cultural competence, HIV prevention in Black communities, and access to health care for racial and ethnic minority populations.

ABSTRACT

This article describes existing problems with cultural competence definitions and examines new developments in cultural competence theory and practices that have the capacity to increase the mental health care system's proficiency in serving racial and ethnic minority clients.

CULTURAL COMPETENCE: THE FIRST 20 YEARS

Shifts in Canadian immigration policy have increased the number of newcomers arriving from non-Western nations and nations identified as part of the global south, greatly increasing the racial, ethnic and linguistic diversity of this nation. Accordingly, the health care system is working to respond to meet the needs of our diverse population. Moreover, there is recognition of a particular need to be equipped to address mental health concerns in newcomer populations. Immigrants and refugees are often coming from situations in which they have survived tremendous environmental stress, political persecution and other types of hardship, and the immigration process itself and stressors associated with settlement in a new environment can increase vulnerability to mental health problems (Perez Foster 2001).

The mental health care system has responded to these challenges by articulating the need for cultural competence at all levels of service delivery. The now classic definition of cultural competence identifies it as a set of integrated behaviours, attitudes and policies that enable a system, agency, and professionals to work effectively in cross-cultural situations (Cross, Bazron et al. 1989). This definition has been adopted by many North American health care systems and is evoked regularly in discussions surrounding the delivery of mental health care in multicultural environments. Yet, many have struggled with how to translate these guidelines into hands-on strategies that would alter mental health services to make them more effective for ethnic and racial minority populations. Many of the efforts to operationalize cultural competence have resulted in the development of programs to equip service providers with cultural knowledge about various groups, with the hope that increasing cultural literacy at the service frontline will improve the level of understanding that mental health professionals bring to their work with clients from different cultures (Husband 2000). This approach, however, has proven inadequate for several reasons.

First, the cultural content that has been used to educate service providers is often based on static representations of culture that either reinforce stereotypes or dominant group experiences, not taking into account within-group diversity or dynamic transformations in culture that accompany changes in environment (Williams 2006). Second, this version of cultural competence has not addressed the power dynamics that are associated with identification of cultural 'difference' and how these dynamics of racialization and marginalization are associated with oppressive experiences within and beyond the mental health care system (Williams 2002). Third, this discourse has done little to address the question of effectiveness in service delivery. Although there is some understanding that retaining racial and ethnic minority clients in services is a minimal indicator of culturally competent service delivery(Williams 2001), research is revealing that these clients do not consistently receive equal benefits from service as those individuals who are identified with the racial/ethnic majority (Bhui and Morgan 2007). This is especially troubling as effectiveness is becoming a major focus of mental health care service design, reinforced by the growing availability of evidence-based practices that we know are highly effective in alleviating mental distress and illness (Muñoz and Mendelson 2005). Unfortunately, efforts at increasing the cultural competence of the system seem to run parallel to efforts to increase the effectiveness of services in the system with little thought to how these agendas can be merged to increase equity in the mental health care system. Therefore, although the mental health care system has greatly increased its awareness of the need to evolve to meet the demands of

an increasingly diverse population, the efforts to date have done little to address Cross's (1989) assertion that cultural competence involves attention to both the cultural context of treatment and its effectiveness. The most common iteration of cultural competence falls short of equipping the system to adequately serve many member of our growing Canadian population.

NEW CONTRIBUTIONS TO THE CULTURAL COMPETENCE AGENDA

Twenty years after Cross defined cultural competence, new developments in theory, research and practice are converging to enrich the cultural competence agenda and address the concerns noted above. Notable new contributions in this area include evolving definitions of how culture should be understood as part of the practice context, indigenous additions to defining the scope of competence for practice with racial/ethnic minority populations, and research-based efforts to increase the accessibility of evidence-based practices by culturally adapting some of our most effective interventions.

DYNAMIC, MULTIDIMENSIONAL DEFINITIONS OF CULTURE

There needs to be attention to specific cultural practices that affect the experience of mental health problems, culture-bound syndromes that may appear in practice settings, and cultural dynamics that affect the helping relationship, as defined via cultural formulation (Lewis-Fernández and Díaz 2002). However, theoretical developments articulating how culture is experienced through intersectionality and in varying epistemological frames are broadening our understanding of what it means to engage with someone at a cultural level.

The intersectionality discourse is critical of the culture in cultural competence being identified primarily with racial and ethnic difference signaled by accent, physical appearance, etc. and urges practitioners to recognize culture more inclusively, in the attitudes, behaviours, characteristics and shared experiences of groups defined by other social markers like sexuality, age, class, religion, etc. (Kelly 2009). Layers of cultural experience intersect so that the lived experience of any one is affected by the simultaneous experience of the others. This understanding directs practitioners away from accepting essentialized, stereotyped definitions of cultural experience and toward raising questions about how gender, class, sexuality, religion and other social categorizations affect the way in which individuals access and adhere to cultural experience. This dynamic view of culture effects mental health practices by discouraging the delivery of services in 'one-size-fits-all' packages that cannot address the diversity of needs within a cultural group. This line of theorizing converges with epistemolog-

ical contributions that can aid practitioners to recognize culture being lived and created in multiple forms. Although culture can be defined in a specific body of knowledge, it also manifests and changes based on consensus within and across groups, it is defined intersubjectively within specific interactions, it develops in response to dominance and oppression in different contexts, and it can be as unique as the individual we are trying to know (Williams 2006). All these ways of knowing culture are relevant to mental health care practice because of the importance of finding ways to gain knowledge of clients that will aid in understanding how illness and health is defined in the context of intrapersonal, interpersonal, intragroup, and intergroup environments. Both intersectionality theory and the epistemological lens on culture re-define cultural competence as multiple competencies that can support a range of responses to a range of cultural expressions and experiences. Although such contributions undoubtedly make cultural competence more complex, they also have the potential to make it more precise in its efforts to incorporate culture into practice.

THE EMERGENCE OF CULTURAL SAFETY

Another important development has been the iterations of standards for cross-cultural practices from indigenous populations, most completely articulated by Maori health practitioners in New Zealand who have developed standards for what they term 'cultural safety' (Kearns and Dyck 1996). Cultural safety acknowledges the importance of work already underway to recognize the points of disconnection between mainstream mental health care and health paradigms used by many racial and ethnic minority groups. It asserts, however, that these efforts must also recognize the power dynamics inherent in service delivery systems that are primarily organized and executed by racially, ethnically and political dominant groups who bring their higher social status into interactions with members of racial and ethnic minority groups. The consequences of this power and status manifest in the poor record that the mental health care system has had with such groups, as demonstrated in research documenting their mistreatment, misdiagnosis and poorer prognosis in Western mental health care systems (Williams 2002). The work of these Maori practitioners identifies negotiating this power dynamic as a skill that must be prioritized in training for service providers, as inattention to it easily leads to misuse of power, prejudice and discrimination that can alienate racial and ethnic minority clients from seeking services and/or completing treatment (Polaschek 1998). Cultural safety holds practitioners of all racial and ethnic backgrounds responsible for examining the power dynamics in practice

and recognizing their potential to contribute to systemic and interpersonal racism that can disengage and harm clients (Baker 2007).

CULTURAL ADAPTATION OF EVIDENCE-BASED PRACTICES

Finally, there is work underway to increase access to evidence-based practices by culturally adapting existing treatment models so they are more culturally appropriate. Cultural adaptation involves strategies like building on culture-specific models of health, integrating culturally-relevant rituals into treatment, using culturally syntonic examples for psychoeducation, and developing intervention strategies to address population-specific stressors in the current environment (Muñoz and Mendelson 2005). Evidence-based practices require cultural adaptation because they have usually been developed in mainstream settings and tested with clients who identify with the dominant culture. The assumptions, examples, goals and expectations for treatment embedded in these models do not necessarily translate effectively to racial and ethnic minority clients. Close examination of such work, for example, the prevention and treatment manuals developed for Latino populations at the San Francisco General Hospital (Muñoz and Mendelson 2005) suggests that effective cultural adaptation proficiency in making use of cultural knowledge as it is transformed in a specific environment, recognizing service practitioners as cultural bridges between immigrants and mainstream service institutions, and taking deliberate steps to modify practices so they are feasible, acceptable and culturally appropriate. Adaptations of our best practices is an important component of increasing cultural competence in the mental health care system, as it increases the likelihood that racial and ethnic minority clients will receive the same benefits from treatment as other clients.

These developments potentially form the foundation of the next generation of cultural competence. The standards set by the Cross definition continue to be relevant and useful, and theory and research are moving move us toward increasing our proficiency in attaining them.

CONCLUSIONS

Cultural competence has already been established as an ongoing process of identifying the cultural competencies necessary for practice in their environments and evaluating individual, service and system strengths and challenges in achieving those competencies (Williams 2005). These described new contributions give further shape to the definition of those competencies by suggesting that practitioners, in particular, need to understand the dynamic and multidimensional nature of culture, the impact of power dynamics in their practice,

and the steps that must be taken to make evidence-based practices culturally appropriate and responsive. Service settings and systems can support practitioners in these efforts by prioritizing training for cultural competence and building relationships with newcomer and citizen communities that will support them in remaining responsive to mental health needs in racial and ethnic minority populations. Improving cultural competence at service and system levels is an ongoing process that will require regularly reevaluating the competence standards we have in place and the strategies we are using to achieve them. Diversity and equity have been named as priorities in health care planning at the provincial and federal levels, therefore a space has been created in which new contributions to cultural competence can be brought to attention. This should strengthen our resolve and our optimism about improving services available to immigrants and other racial and ethnic minority groups in the mental health care system.

REFERENCES

Baker, C. (2007). "Globalization and the cultural safety of an immigrant Muslim community." *Journal of Advanced Nursing* 57.3: 296-305.

Bhui, K. and N. Morgan (2007). "Effective psychotherapy in a racially and culturally diverse society." *Advances in Psychiatric Treatment* 13: 187-193.

Cross, T., B. J. Bazron, et al. (1989). *Towards a Culturally Competent System of Care.* Washington, Howard University Press.

Husband, C. (2000). "Recognising diversity and developing skills: The proper role of transcultural communication." *European Journal of Social Work* 3.3: 225-234.

Kearns, R. and I. Dyck (1996). "Cultural safety, biculturalism and nursing education in Aotearoa/New Zealand. ." *Health and Social Care in the Community* 4.6: 371-380.

Kelly, U. A. (2009). "Integrating intersectionality and biomedicine in health disparities research." *Advances in Nursing Science* 32.2: E42-E56.

Lewis-Fernández, R. and N. Díaz (2002). "The cultural formulation: A method for assessing cultural factors affecting the clinical encounter." *Psychiatric Quarterly* 73.4: 271-295.

Muñoz, R. F. and T. Mendelson (2005). "Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals." *Journal of Consulting and Clinical Psychology* 73.5: 790-799.

Perez Foster, R. M. (2001). "When immigration is trauma: Guidelines for the individual and family clinician." *American Journal of Orthopsychiatry* 71: 153-170.

Polaschek, N. R. (1998). "Cultural safety: A new concept in nursing people of different ethnicities." *Journal of Advanced Nursing* 27: 452-457.

Williams, C. C. (2001). "Increasing access and building equity into mental health services: An examination of the potential for change." *Canadian Journal of Community Mental Health* 20.1: 37-51.

Williams, C. C. (2002). "A rationale for an anti-racist entry point to anti-oppressive social work in mental health services." *Critical Social Work* 2.2: 20-31.

Williams, C. C. (2005). "Training for cultural competence: Individual and group processes." *Journal of Ethnic & Cultural Diversity in Social Work* 14.1/2: 111-143.

Williams, C. C. (2006). "The epistemology of cultural competence." *Families in Society: The Journal of Contemporary Social Services* 87.2: 1-12.

TAKING CULTURE SERIOUSLY IN COMMUNITY MENTAL HEALTH: A FIVE-YEAR STUDY BRIDGING RESEARCH AND ACTION

Joanna Ochocka is Executive Director of the *Centre for Community Based Research*. Joanna was the Principle Investigator of the *Taking Culture Seriously in Community Mental Health* project and is a Canadian leader in participatory action research using research as a tool for social change, particularly in the fields of mental health, cultural diversity, and supports for marginalized populations.

Elin Moorlag is a Senior Researcher at the *Centre for Community Based Research*. Elin was involved in the CURA project as a graduate student research from 2005-2009. As a mixed-methods sociologist, her research interests include the sociology of community, policy analysis, Canadian multiculturalism, immigrant integration and settlement, mental health and diversity, and community-based and participatory action research.

Sarah Marsh is a Researcher at the *Centre for Community Based Research*. Sarah was responsible for coordinating the *Taking Culture Seriously in Community Mental Health* project from 2007-2009. She has also led a number of other projects at the Centre, including a two-year evaluation of a Bridge Training program for internationally trained Social Workers.

Karolina Korsak worked on the CURA from 2006-2008 collecting data and assisting with analysis. She is currently involved in two of the CURA demonstration projects, being a navigator for "Strengthening Mental Health in Cultural-Linguistic Communities," and a support group facilitator for the "Men's and Women's support groups" (run by the Multicultural Centre) project. Karolina is the recipient of a SSHRC award, and as such will be pursuing a Master's degree in the social sciences beginning January 2010.

Baldev Mutta has been in the field of social work for over 30 years. He is the Founder and Executive Director of the Punjabi Community Health Services (PCHS). For the last 20 years, he has developed an integrated holistic model to address substance abuse, mental health and family violence in the South Asian community. PCHS was a integral community collaborator on the CURA project.

Laura Simich was a co-investigator on the *Taking Culture Seriously in Community Mental Health* project. She is a Cultural and Medical Anthropologist with the Social, Equity and Health Section in the Social, Prevention and Health Policy Research Department, CAMH. Dr. Simich's research focuses on community resources for mental health, social determinants of immigrant health, social support in refugee resettlement, and mental health promotion for culturally diverse communities.

Amandeep Kaur, Manager, Punjabi Community Health Services. Amandeep has been a key contributor to the operations and growth of Punjabi Community Health Services (PCHS) for more than 15 years. She has taken on several roles at PCHS, including designing and delivering direct services, and managing programs.

ABSTRACT

Taking Culture Seriously in Community Mental Health (2005-2010) is a collaborative interdisciplinary project with over 40 partners conducted in two Ontario sites. With the project now coming to an end, this article presents a synopsis of empirical findings, emergent theoretical implications, and recommendations for research, policy and practice within mental health services in Canada.

RESULTS

DEVELOPMENT OF THE FRAMEWORK

Through analysis of the data compiled from the study, we proceeded to develop a framework to guide future mental health policy and practice. Our intent was to develop a framework that was principle-driven, action-oriented and that could inspire future innovation ("scaffolding for demonstration projects" was how one partner put it). This theory-building process was highly collaborative and is described in detail in one of our CURA publications (Westhues, Ochocka, Jacobson, Simich, Maiter, Janzen & Fleras, 2008).

Figure 1 graphically shows the *Taking Culture Seriously in Community Mental Health* framework. This framework adequately addresses combined ideals of both the culture-oriented and the power-oriented theories (Janzen, Ochocka, et al., 2007). It includes three main components: *values* that guide concrete *action* that in turn produces desired *outcomes* that serve to reinforce the stated values. Central to the framework is the active involvement of mental health policy-makers/system planners, mental health organizations/practitioners and

cultural-linguistic communities. Their collaboration in innovating mental health policy and practice is characterized by reciprocity in which the benefits and responsibilities of collaboration are shared (Maiter, Simich, Jacobson & Wise, 2008). This type of reciprocal collaboration is the transformational process by which the present context of disconnections is rectified and through which the values, actions and outcomes of the emerging framework are achieved (for details see Janzen, Ochocka et al., 2009, *in press*).

The *Taking Culture Seriously in Community Mental Health* study participants affirmed what our earlier literature revealed: the need to develop a conceptual framework that synthesizes notions of culture and power if improvements to mental health policy and practice are to be made. Such a position resonates with recent mental health discourse that, on the one hand, points out the detrimental effects of abuses of power in the mental health system and the need for critical voices to keep that power in-check and to remain consumer-centered (Bassman, 2001). On the other hand are growing calls to take culture seriously and develop competencies towards more effective mental health policy and practice in

FIGURE 1: "Taking Culture Seriously in Community Mental Health" Framework

Values
- Individual and community self determination
- Dynamic inclusion
- Relational synergy

Reciprocal collaboration
- Mental health policy-makers/planners
- Mental health organizations/practitioners
- Cultural-linguistic communities

Outcomes
- Improved acceptability and accessibility of services
- Better mental health promotion and illness prevention
- Increased evidence that culture is taken seriously

Actions
- Enhancing communities
- Reconstructing the mental health system
- Building reciprocal relationships

Reinforce

Guide

Produce

increasingly cross-cultural settings (CAMH, Report by the Mental Health Commission of Canada Task Group on Diversity, 2009). By synthesizing both culture and power our framework stresses that the mental health system's responsiveness to diversity rests as much in naming and addressing privilege and socio-economic inequalities, as it does in understanding and managing cultural differences (Maitra, 2008). The emerging theoretical framework lays out how mental health policy and practice can change to become more responsive to people from diverse cultural-linguistic backgrounds.

DEMONSTRATION PROJECT IMPLEMENTATION AND EVALUATION

After building a theoretical framework and discussing its practical implications at community forums and a CURA conference, our CURA partners developed demonstration projects. People clustered into sub-groups to develop a series of demonstration project proposals. Each project was a collaborative effort that sought to examine both power and culture in practice, while committing to actions that advance reciprocal relationship building between the mental health system and cultural linguistic communities. While no one project illustrated the complete emerging theoretical framework, collectively they aspired to promote innovation at multiple levels of intervention.

In total, twelve demonstration project proposals emerged through collaborative efforts among CURA partners and additional collaborators and were submitted to funders. Some projects were initiated by cultural communities, some by settlement and mental health service organizations. Of the twelve demonstration projects that were developed, six were funded and are currently active beyond the end date of the CURA study. Contained in Figure 2 is a representation of each of the demonstration projects on the continuum of mental health service delivery, from primary to tertiary intervention.

The CURA evaluation committee developed a common evaluation design to test and refine the project's emerging theoretical framework. The evaluation aimed to 1) gain insights about the process of implementing the

FIGURE 2: The 12 CURA Demonstration Projects on the continuum of mental health service delivery
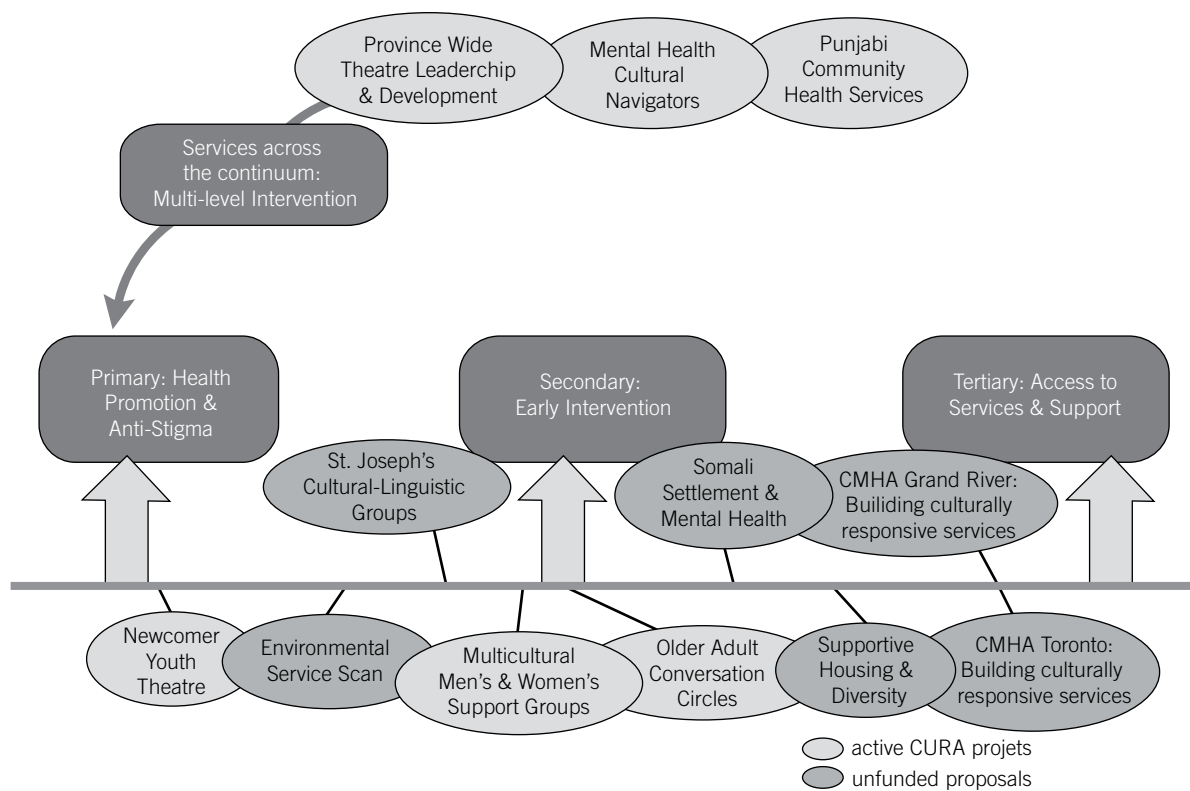
emerging framework, 2) assess the degree to which study findings guided or influenced the demonstration projects, and 3) assess the degree to which the study findings have enhanced the ability of demonstration projects to have an impact on the mental health system and cultural linguistic communities. Preliminary evaluation results were shared at a conference concluding the CURA project on December 4th, 2009, deepening our collective understanding of the framework's "theory of change"—of the logical link between its values, actions and desired outcomes. Evaluation findings will be further described in future presentations and publications.

CONCLUSIONS

While the deeply ingrained current policies cannot be expected to change overnight to make the mental health services effective for multicultural Canada, one important thing that this CURA study did was foster a broad, cross-sectoral collaboration of a large number of people in Ontario, without which any relevant changes may not be possible at all. It also equipped and inspired people for change due to the collaborative research production and knowledge mobilization efforts. In keeping with the core values of the emerging theoretical framework, throughout the project there were ample opportunities for reciprocal relationship building, dynamic inclusion of community members, mental health providers and academics alike, as well as a necessary space for developing the self-determination that is crucial within cultural communities for change to occur. This CURA initiative demonstrated how community based research using participatory and action oriented approaches can inspire innovative practice to address gaps and barriers in policy and in practice.

MAIN MESSAGES OF THE CURA STUDY

The *Taking Culture Seriously in Community Mental Health* study results indicate the importance of a reciprocal relationship between the mental health system and diverse communities. It points out that all stakeholders involved need to work together differently, so that collaborators are mutually responsible for ensuring power is shared to optimize mutual benefits. We acknowledge this goal is not easily accomplished, but it becomes more attainable when:
- Time, space and resources are devoted to collaboration
- The mental health system is open to change
- Policies & procedures within the mental health system support innovation
- The problem to be addressed is clearly defined
- There is a long term vision and commitment
- Diverse cultural groups, policy makers, & practitioners take leadership in different parts of the solution

Our study results have implications specific to each stakeholder group: policy makers, service providers and cultural communities. Out of the data collected throughout this project, it is suggested that policy makers need to facilitate changes at the structural level while simultaneously working toward better processes. This would involve developing flexible funding structures to accommodate innovative, collaborative culturally-appropriate practice. For instance, positive change would result if funding requirements for organizations were to include benchmarks based on collaboration and power-sharing for cultural-linguistic communities in decision-making. Furthermore, the area of mental health and diversity does not neatly fall into one policy portfolio, so collaboration is paramount to develop effective policy that intersects across the health, education, immigration, and employment arenas.

Two recommendations for service providers are to engage in ongoing reciprocal outreach and collaboration with cultural-linguistic groups, and to challenge power and racism within and outside the organization. Increased mutuality can be achieved through cross-cultural consultations, sustained partnerships and the development of a diverse work force. Key elements of challenging power imbalances and racism include a recognition that "cultural competency" involves reciprocal collaboration, an emphasis on building community awareness around mental health and service use, and promotion of holistic understandings of wellness/illness.

According to our data, cultural communities must also take responsibility for increasing the effectiveness of the mental health system. Positive change results when communities are mobilized through increased dialogue aimed at de-stigmatizing mental illness and through active exchange with mental health services to increase knowledge & skills for both sides. Cultural communities optimize their strengths when they develop ongoing collaboration strategies, validate and encourage mental health practitioners from within the cultural community itself, and recognize that individuals and organizations that bridge across cultures and services contribute to solutions.

The *Taking Culture Seriously in Community Mental Health* results indicate the importance of prevention in mental health. Stigma-busting health promotion, early interventions and population specific interventions were strongly suggested. The importance of ongoing learning and exposure to cultural diversity by all players in the mental health system is needed along with sustainable funding for innovative practice and accountability by using PAR evaluation research.

For more information about the CURA study, see www.takingcultureseriouslyCURA.ca

REFERENCES

Bassman, R (2001). Who's reality is it anyway? Consumers/survivors/ex-patients can speak for themselves. *Journal of Humanistic Psychology*, 41(4): 11-35.

Beiser, M. (2003). Community in distress: mental health needs and help-seeking in the Tamil community in Toronto. *International Migration*, 41: 233-245.

Burman E., Gowrisunkur, J. & Walker, (2003). Sanje Rang/Shared colours, shared lives: a multicultural approach to mental health practice. *Journal of Social Work Practice*, 17(1), pp. 63-76.

Chiu, Lyren, Ganesan, Soma & Morrow, Marina (2005). Spirituality and treatment choices by South and East Asian women with serious mental illness. *Transcultural psychiatry*, 42(4): 630-656.

Clarke, D. E., Colantonio, A., Rhodes, A. E., & Escobar, M. (2008). Pathways to suicidality across ethnic groups in Canadian adults: the possible role of social stress. *Psychological Medicine*, 38(3): 419-431

Health and Welfare Canada and Multiculturalism and Citizenship Canada. (1988) *After the door has been opened: Mental health issues affecting immigrants and refugees in Canada—Report to the Canadian Task Force on Mental Health Issues affecting immigrants and Refugees.* Ottawa: Health and Welfare Canada And Multiculturalism and Citizenship Canada.

Hosley, C., Gensheimer, L., Yang, M., (2003). Building effective working relationships across culturally and ethnically diverse communication. *Child Welfare*, 82(2), pp.157-168.

Hsu, L. & Alden, L. E. (2008). Cultural influences on willingness to seek treatment for social anxiety in Chinese- and European-heritage students. *Cultural Diversity and Ethnic Minority Psychology*, 14: 215-223.

Hyde, C., Hopkins, K., (2004). Diversity climates in human service agencies: An exploratory assessment. *Journal of Ethnic & Cultural Diversity in Social Work*, 13(2), pp. 25-43.

Jacobson, N., Ochocka, J., Wise J., Janzen, R. & the Taking Culture Seriously Partners (2007). Inspiring knowledge mobilization through a communications policy: The case of a Community University Research Alliance. Progress in Community Health Partnerships: Research, Education and Action. 1(1), 99-104.

Janzen, R., Ochocka, J., Jacobson, N., Maiter, S., Simich, L., Westhues, A., Fleras, A. and the "Taking Culture Seriously" Partners (in press). Synthesizing Culture and Power in Community Mental Health: An Emerging Framework. *Canadian Journal of Community Mental Health.*

Kemmis, S. & McTaggart, R. (2005). Participatory action research: Communicative action in the public sphere. In Norman K. Denzin and Yvonna S. Lincoln (Eds.). *Handbook of qualitative research, 3rd edition* (pp. 559-603). Thousand Oaks, CA: Sage Publications.

Li, Han Z. & Browne, Annette J. (2000). Defining mental illness and accessing mental health services: Perspectives of Asian Canadians. *Canadian Journal of Community Mental Health*, 19(1): 143-159.

Maitra, B. (2008). Postcolonial psychiatry: the Empire strikes back? or, the untapped promise of multiculturalism. In Cohen, C. & Timimi, S. (Eds.) *Liberatory psychiatry, philosophy, politics and mental health* (pp.183-204). New York, NY: Cambridge University Press.

Mental Health Commission of Canada, Task Group on Diversity. (2009). *Understanding the issues, best practice and options for service development to meet the needs of ethnocultural groups, immigrants, refugees, and racialized groups.*

Mental health consumer/survivor researchers working together in participatory action research project. *Psychiatric Rehabilitation Journal*, 25, 379-387.

Ochocka, J. (2008). Working with Diverse Communities Towards Social Change: A Community University Partnership in Canada Using a Participatory Action Research Approach. In A. Bokszczanin (Ed). *Social Change in Solidarity: Community Psychology Perspectives and Approaches* (pp.76-83). Opole: University of Opole Press, Poland.

Ochocka, J., Janzen, R., & Nelson, G. (2002). Sharing power and knowledge:Professional and mental health consumer/survivor researchers working together in participatory action research project. *Psychiatric Rehabilitation Journal*, 25, 379-387.

Simich, L., Maiter, S., Moorlag, E. & Ochocka, J. (2009). 'Taking Culture Seriously': Ethno linguistic community perspectives on mental health. *Psychiatric Rehabilitation Journal*, 32 (3), 208-214.

Tiwari, S. K. & Wang, J. (2008). Ethnic differences in mental health service use among White, Chinese, South Asian and South East Asian populations living in Canada. *Social Psychiatry and Psychiatric Epidemiology*, 43(11): 866-871.

Westhues, A., Ochocka, J., Jacobson, N., Simich, L., Maiter, S., Janzen, R. & Fleras, A. (2008). Developing theory from complexity: Reflections on a collaborative mixed method Participatory Action Research study. *Qualitative Health Research*. 18(5), 701-717.

Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: a qualitative study from Montréal. *Canadian Journal of Psychiatry*, 51: 205-209.

Wu, I.H., & Windle, C., (1980). Ethnic specificity in the relative minority use and staffing of community mental health centres. *Community Mental Health*, 16(2),pp. 156-168.

Wu, Z., Noh, S., Kaspar, V., & Schimmele, C. M. (2003). Race, ethnicity, and depression in Canadian society. *Journal of Health and Social Behavior. Special Issue: Race, Ethnicity and Mental Health* 44(3): 426-441.

IMPROVING MENTAL HEALTH SERVICES FOR IMMIGRANT, REFUGEE, ETHNO-CULTURAL AND RACIALIZED GROUPS

Kwame McKenzie is a Professor of Psychiatry at the University of Toronto and he is the Medical Director of Health Equity at the Centre for Addiction and Mental Health. He is a psychiatrist, researcher and policy adviser. Dr. McKenzie has authored four books and over 100 academic papers. His policy interests are improving services for immigrant, refugee, ethno-cultural and as a researcher he is the Director of the Canadian Institutes of Health Research (CIHR) Strategic Training Centre in the social causes of mental illness (SAMI) and is an expert on cross cultural psychiatry and social capital.

Emily Hansson is a research coordinator at the Centre for Addiction and Mental Health (CAMH). With a M.Sc. in Medical Anthropology. Her research interests include both international and cultural mental health; in particular, exploring cultural understandings of mental health and illness. Ms. Hansson has spent time in Southern Africa working in global health and contributed to the Global Health Watch publication.

Andrew Tuck is a research assistant at the Centre for Addictions and Mental Health. He has an MA in Sociology. His research interests include self-harm and suicide, victim's rights and criminology, and the social determinants of health in relation to IRER groups and mental health.

Steve Lurie is currently the Executive Director of the Canadian Mental Health Association Toronto Branch, a post he has held since 1979. Has been a Board member and Vice President of the Ontario Federation of Community Mental Health and Addiction Programs and represented community health employers on the Board of the Health Sector Training and Adjustment Program, where he served as Treasurer. He served as a trustee on the Board of the Centre for Addiction and Mental Health, (CAMH) from 1998 until 2007. Steve is adjunct faculty at the University of Toronto Faculty's of Social Work and currently chairs the Service Systems Advisory Committee of the Mental Health Commission of Canada.

ABSTRACT

Canada is one of the most diverse countries in the world but its mental health policy and services do not embrace that diversity. People from immigrant, refugee, ethno-cultural and racialized (IRER) groups often have poorer access to care and poorer treatment. The size of the population and specific issues may differ in each province or territory but all jurisdictions will have to provide mental health services to their multi-cultural population, and develop health promotion strategies that improve the health status of IRER groups. With this in mind, the Service Systems Advisory Committee of the Mental Health Commission of Canada established a project to consider the issues and options for service improvement for IRER groups in Canada. The emergent issues and options will help the Commission to develop an equitable Mental Health Strategy for Canada.

ACKNOWLEDGEMENTS:

INTRODUCTION

Improving services and outcomes for immigrant, refugee, ethno-cultural and racialized groups (IRER), is now a common issue for mental health systems in high income countries (Hansson et al, 2009). Worldwide there are 20 major cities with over half a million residents that were born in a different country. The Canadian Senate investigated the response of health systems in selected countries, (Australia, New Zealand, the UK and USA) to the needs of their diverse populations (Standing Senate Committee, 2004). They concluded that there was often poorer access to mental health care and this was associated with: increased use of crisis and emergency care, increased use of the police and prison justice system, increased hospitalization (involuntary), poorer outcomes, and an increased community burden of mental illness. The picture is however complex and dependent on context. For instance, the reasons for migration in different groups, the reception of the host population, the socio-economic position of a group, differences in culture and language, and the structure of the health system are just a few of an intersecting array of variables which may be important and make importing ideas and practices from other countries difficult.

Canada is becoming more diverse each year because immigration is the driver of population growth. The size of the population, the rate of increase, and specific issues may differ in each province or territory but all jurisdictions will have to provide mental health services to their multi-cultural population, and develop health promotion strategies that improve the health status of IRER groups.

With this in mind, the Service Systems Advisory Committee of the Mental Health Commission of Canada established a project to consider the issues and options for service improvement for IRER groups in Canada.

WHO WAS CONSIDERED BY THE PROJECT?

Canada is one of the most diverse countries in the world. The study did not attempt to deal with all diverse groups. It was limited to assessing the mental health needs and services for those who are from an immigrant, refugee, ethno-cultural, or racialized group (IRER).

It quickly became apparent that there was no one term that encompasses all of these categories so the acronym was coined. Canada's IRER groups are comprised of different populations with different histories, cultures, social realities and needs. There are some common experiences such as issues of status in society and difficulties with access and use of services but there is substantial and significant diversity. Diversity within groups includes different national heritages and cultures as well as social location due to gender, sexual orientation and physical ability. For every statement where a group is considered as a collective there will be particular sub-groups and individuals to whom the statement does not apply. However, one thing that all IRER groups have in common is that they are on average younger than other population groups in Canada.

The challenges faced by refugees are different from the challenges for new immigrants and these in some measure are different from those faced by ethno-cultural and racialized groups who have been in Canada for some time.

The study did not specifically investigate the diversity within diverse populations because it was considered that separate targeted studies were needed to do justice to the issues of service development for IRER Lesbian, Gay, Bisexual, Transgender, Transsexual, Two-spirited, Inter-sexed, Queer, and Questioning (LGBTTTIQQ) population and age or gender groups. Some of these groups are marginalized within already marginalized groups and analysis may indicate significant increased risk for the development of mental health problems and illnesses and a need for service improvement.

METHODS

The study used a number of different lines of investigation and consultation.

An analysis of the data from the 2006 Census supplemented by available data from different provinces was used to produce a statistical picture of Canada's IRER groups. A literature review of published papers was then performed with the guidance of a specialized mental health librarian. These two sources of information and the experience and knowledge of a steering group of experts in multicultural health from across Canada was used to help develop a paper outlining the issues and some potential options for service improvement for IRER groups. Consultation on this paper took a number of forms. The paper was posted on the Mental Health Commission of Canada website and on the Centre for Addiction and Mental Health's website. A "survey monkey" tool was developed so that the public could give their opinions on the paper and more specifically the options for service improvement. The electronic postings were widely advertised at face-to-face presentations, through professional networks and through community networks. The paper was sent to bodies that govern health in provinces, territories and cities, to Federal Government offices involved in health in general, and in settlement and welfare services for immigrants and refugees. Face-to-face focus groups of professionals, service providers, community organizations, and settlement and education services were undertaken in seven centres across Canada from Vancouver to St. John's.

Feedback from the face to face and electronic consultations was incorporated in the paper.

Because people with lived experience of mental health problems and illnesses were under-represented in the focus groups, extra focus groups specifically for this sector of the population were undertaken to ensure that the recommendations were in line with the aspirations of people who use current services. Finally, there was a national consensus meeting to review the findings and recommendations which was attended by a diverse group including people with lived experience, clinicians, academics, policy makers and members of the Mental Health Commission of Canada.

RESULTS

Census data: The analysis of the Census data offered a snapshot of Canada's diversity. Every province, territory and region has an IRER population; the populations are all growing but at different rates. The demographic changes vary with some areas having substantial existing IRER populations that need to be served and others having small populations that are growing quickly. Within IRER groups there is significant diversity and intersecting issues such as older age, youth, sexual preference or gender issues which add a further level of complexity of need when considering service development. Over 200 different languages are spoken in Canada and 20% of Canadians have a non-official language as their mother tongue (Statistics Canada, 2006).

Canadian literature: There is growing Canadian academic and grey literature investigating IRER mental health. It focuses on three areas: social determinants, the rate of mental illness, and barriers to and facilitators of care. There have been a few national studies but these are not detailed enough to form the basis of service development. The research has mainly been undertaken in British Columbia, Ontario and Quebec (Hansson et al., 2009). Most provinces, territories and regions do not have a local evidence base to use for developing services.

Social determinants: The literature reports that IRER groups are more exposed to the known social factors that promote mental health problems and illnesses as well as other social factors such as migration, discrimination and language difficulties (Hansson et al., 2009). Those from IRER groups in general are more likely to live in poverty, to be unemployed or underemployed, to be socially isolated and to live in neighbourhoods that are disadvantaged (Clarke et al., 2008). In addition, pre-migration factors (such as war and torture), post migration factors (such as acculturation and uncertainty because of the immigration system), exposure to racial discrimination and difficulties due to language are significant issues in the generation of mental health problems and illnesses

and in the receipt of services (Hansson et al., 2009). Other studies report that a positive ethnic identity (Fenta et al., 2004), employment (Beiser et al., 2004) and social networks (Dyck, 2004) decrease the risk of mental illness.

The balance of influence of these issues is different for different groups, for instance: refugee groups are more likely to be exposed to pre-migration problems, whereas poverty and under-employment may be more important in recent immigrants (Hansson et al., 2009). Information on existing ethno-cultural and racialized groups is not well captured in the census.

Rates of mental health problems and illnesses: National studies report lower rates of anxiety and depression in immigrant groups (Ali, 2002). This may reflect true lower levels of illness which is expected because immigration practices may screen out entry for people with existing physical or mental illness. However, it could also be due to concern about getting permanent residency, could be inaccuracy in the disclosure of mental health problems and illnesses in official surveys. Studies report that over time the lower rates of common mental disorders rise to the level of the general population (Ali, 2002).

There are significant differences between groups as well with specific groups in particular areas reporting high rates of mental health problems and others reporting lower rates (Hansson et al., 2009).

Barriers to care: Access to care is a major issue. Where particular IRER groups have higher or lower rates of illness is a moot point given they all have difficulty getting care. Equity of service provision is a particular concern. Canadian literature cites barriers to care such as stigma, awareness of services, language difficulties, transportation costs, socio-economic factors and differences in illness models between services and clients as factors that delay treatment (Hansson et al., 2009). There are a number of studies which also list factors that have been demonstrated to facilitate service use. These include literacy, trust in services, cultural competence, targeted health promotion, an increased diversity of services, and links between different types of services.

Policy analysis: National responses to these issues have been rare. There has been some consideration of the needs of new immigrants and refugees but this has not led to significant service development. There has not been a similar consideration of the mental health needs of existing ethno-cultural and racialized groups.

ISSUES AND OPTIONS: A STRATEGY FOR SERVICE DEVELOPMENT

The service improvement recommendations that were developed from the data and the consultation have a firm foundation in the goals of the Mental Health Strategy

for Canada. The Strategy will be based on the principle that everyone can benefit from improved mental health and well-being, while also acknowledging that people living with mental health problems and illnesses will need special services and supports. This includes helping adults recover, children and youth to maximize their mental wellness as they pass through different developmental stages, seniors to maximize their quality of life and dignity as they age, and for all people living in Canada to achieve greater well-being.

The Commission is firmly convinced that a focus on recovery, including hope, empowerment, choice, and responsibility, needs to occupy a central place in the transformation of the mental health system in Canada. The objective will be to ensure that people living with mental health problems and illnesses of all ages are treated with the same dignity and respect as their fellow citizens and have the opportunity to lead full and meaningful lives in the community, free from discrimination.

However, in order to be comprehensive, the strategy will also need to look at ways of keeping people from becoming mentally ill in the first place and at how to improve the mental health of the whole population. The challenges in this regard are many, but the potential benefits are enormous. Mental health promotion and illness prevention can both enhance overall mental health and well-being of the population and also contribute to reducing the individual, social and economic impact of mental health problems and illnesses.

The study outcomes took the position that the challenges faced by IRER populations need a mainstream service response. All services will need to be capable of offering equitable care to Canada's diverse population. Such a response would need to recognise the extensive diversity that exists within these groups. It will also need to recognise that the direction of travel is towards a position where service providers are working alongside groups and communities to improve mental health and where services that are capable of offering equitable treatment to Canada's diverse population are a fundamental building block of the health system. In line with the Mental Health Strategy for Canada, mental health promotion and illness prevention are considered as important as service improvement.

The plan for moving towards the vision of improved services for IRER groups has three intertwined actions:
1. Better co-ordination of policy, knowledge and accountability;
2. The involvement of communities, families, and people with lived experience; and,
3. More appropriate and improved services.

Better coordination of policy, knowledge and accountability recognises the need for there to be specific written plans to improve the mental health of IRER groups and services for mental health problems and illnesses. If these are coordinated at the various levels of government and across different sectors then they will be more effective. Plans will need data streams and initiatives will need to be evaluated. One approach which brings many of these actions together would be to develop population-based, flexible services. Provinces, territories and regions would produce a plan to tailor service development to their demographic imperatives. The plan would focus on policy improvement and public health interventions aimed at health promotion and illness prevention as well as interventions targeted at service improvement. The exact extent of the plan would depend on the needs of the population and, of course the resources available.

The involvement of communities, families and people with lived experience is key. Engaging local IRER population groups in the planning process helps in the development of more appropriate services and also allows for linkage to community based services, decreasing duplication and increasing the diversity. The planning process will also have a community engagement and knowledge exchange function that may build capacity and networks, improve awareness and access to care.

With a plan in place, a data stream and an engaged community, services can forge a path of collaboration and internal development. There are five groups of actions required to improve mental health services for IRER groups:
1. Changed focus—an increased emphasis on prevention and promotion
2. Improvement within services—organizational and individual cultural competence
3. Improved diversity of treatment—diversity of providers, evaluation of treatment options
4. Linguistic competence—improved communication plans and actions to meet Canada's diverse needs
5. Needs linked to expertise—plans to offer support by people and services with expertise to areas with lower IRER populations so they can offer high quality care

The study included 16 recommendations for service improvement as well as some examples of how these ideas are being implemented in various parts of Canada. Neither is exhaustive nor prescriptive. They offer an outline of the issues that planners will have to face when moving forwards. Across Canada pockets of good practice exist but to date there is no area whose respondents say their services are meeting the mental health needs of their IRER populations.

CONCLUSIONS

The strategies for service improvement outlined in the final report are an attempt to fuse the data, the views

of a diverse group of people with interest in the issues and those of governance bodies across Canada. It is not a protocol for service development but an outline of the issues that policy makers, health planners, and service providers may find beneficial to consider when embarking on improving mental health services for IRER groups.

REFERENCES

Ali, J. (2002). *Mental Health of Canada's Immigrants.* Supplement to Health Reports, volume 13. Statistics Canada, Catalogue no. 82-003.

Beiser, M. & Wickrama, K. A. (2004). Trauma, time and mental health: a study of temporal reintegration and Depressive Disorder among Southeast Asian refugees. *Psychol.Med.*, 34, 899-910.

Clarke, D. E., Colantonio, A., Rhodes, A. E., & Escobar, M. (2008). Pathways to suicidality across ethnic groups in Canadian adults: the possible role of social stress. *Psychol.Med.*, 38, 419-431.

Dyck, I. (2004). *Immigration, place and health: South Asian women's accounts of health, illness, and everyday life.* Research on Immigration and Integration in the Metropolis, No. 04-05.

Fenta, H., Hyman, I., & Noh, S. (2004). Determinants of depression among Ethiopian immigrants and refugees in Toronto. *J Nerv.Ment.Dis.*, 192, 363-372.

Hansson, E., Tuck, A., Lo, T., Lurie, S., Pendakur, S., and McKenzie, K. (2009). Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups: Issues and options for service improvement. *Mental Health Commission of Canada Diversity Task Group.*

Standing Senate Committee on Social Affairs, Science and Technology (2004). *Mental Health Policies and Programs in Selected Countries*. 38th Parliament—1st Session.

Statistics Canada (2006). The Evolving Linguistic Portrait. http://www12.statcan.gc.ca/english/census06/analysis/language/pdf/97-555-XIE2006001.pdf. Accessed August 01, 2009, Catalogue no. 97-555-XIE.

MENTAL HEALTH SERVICE UTILIZATION BY CHINESE IMMIGRANTS: BARRIERS AND OPPORTUNITIES

Lin Fang is an Assistant Professor at Factor-Inwentash Faculty of Social Work, University of Toronto. Her research interests include acculturation, psychosocial adjustment of immigrant families, culturally appropriate mental health assessments and treatments, and prevention of substance abuse among adolescents.

ABSTRACT

Mental health service underutilization by Chinese immigrants is a critical health and equality issue. This article reviews factors that contribute to low mental health service use across individual, family, cultural and system domains, and discusses ways to improve the responsiveness and equality of mental health care in Canada for Chinese immigrants.

Immigrants often experience an elevated levels of psychological distress in the period soon after immigration (Beiser and Edwards 1994). Job insecurity, altered family dynamics, economic hardships, and cultural differences between the country of origin and the host country all contribute to heightened psychological stress during the first years following immigration (Ritsner and Ponizovsky 1999; Tang, Oatley and Toner 2007). Paradoxically, studies in North America have repeatedly confirmed the underutilization of formal mental health services by Chinese immigrants (Bui and Takeuchi 1992; Chen and Kazanjian 2002; Sue and Sue 1999; Tsai, Teng and Sue 1981; Matsuoka, Breaux and Ryujin 1997; Kung 2003). Studies have documented that by the time Chinese immigrants finally receive formal mental health treatment, they tend to present more severe symptoms compared to non-immigrant users (Snowden and Cheung 1990; Chen et al. 2003), are harder to treat, and frequently require lengthy inpatient hospitalization.

What may contribute to gaps between mental health needs and service utilization among Chinese immigrants? Literature has shown that factors explaining service underutilization are multifaceted, extending across individual, family, cultural and system domains. The first of these is the *cultural explanation of mental illness.* Cultural beliefs regarding the cause of mental disorders greatly affect service utilization. The aetiology of mental illness includes moral, religious or cosmological, physiological, psychological, social and genetic factors. From a moral perspective, mental illness is deemed to be a punishment for "misconduct" against Confucian norms, the principles defining interpersonal relations and personal behaviours (Kramer et al. 2002; Lin and Lin 1981). As implicated in the religious or cosmological perspective, mental illness has also been seen as representing the wrath of supernatural spirits (Gaw 1993; Kramer et al. 2002; Koss-Chioino 2000) or ancestors (Barnes 1998; Lin and Lin 1981) induced by patients or other family members. In a Toronto study, Chinese immigrants who subscribe to supernatural beliefs tend to hold a negative attitude toward seeking professional help (Fung and Wong 2007). Traditional medical theory also plays an important role, in which all illnesses, both physiological and mental, are considered as imbalances of *yin* and *yang* (Lin and Lin 1981; Chung 2002; Ergil, Kramer and Ng 2002; Ma 1999). Psychosocial factors, such as major life events, are also considered to contribute to the onset of mental illness (Kramer et al. 2002; Lin and Lin 1981). Lastly, genetic transmission and the inheritance of the consequences of familial misconduct may be considered as causes of mental illness (Lin and Lin 1981). Each component described above is weighted differently, depending on the individual and context.

The second factor affecting Chinese immigrant's lack of treatment for mental illness is the experience of *shame and stigma.* Stigma attached to mental illness may prevent Chinese immigrants and their families from seeking mental health services (Chung 2002; Gaw 1993). Although psychiatric stigma is a well recognized issue across cultures, it may have more severe and decisive consequences among the Chinese (Sue and Sue 1987). The negative effect of stigma among the Chinese is often reflected in a low rate of mental health service utilization, excessive concern about confidentiality, reluctance in using insurance coverage, and absolute refusal to use professional help in the face of obvious psychiatric symptoms (Gaw 1993).

Literature suggests that given the collective and family-centered cultural orientation in Chinese society, an

individual's mental illness taints family grace, and naming and shaming extends to ancestors (Kramer et al. 2002; Lin 1981). Furthermore, seeking mental health services is not only considered to bring shame to the individual, but also to his family members, their ancestors and their offspring (Gaw 1993; Leong and Lau 2001). Fear of "losing face" and being derided is common among Chinese families with mentally ill members. This, in turn, leads to a denial of the existence of mental illness, or attempts to mask the problem with a socially acceptable label. Clearly, family-oriented stigma prevents individuals with mental health needs from receiving timely and appropriate assessment and treatment (Gaw 1993; Lin 1981).

Symptom presentation also influences the use of mental health services. Chinese people tend to perceive mental disorders as organic disorders (Lin and Cheung 1999; Uba 1994). Often, Chinese patients express their psychological problems in a psychosomatic form, which can explain why *somatisation* and *neurasthenia* are commonly observed in Chinese communities. Somatisation is "the presentation of personal and interpersonal distress in an idiom of physical complaints together with a coping pattern of medical help-seeking" (Kleinman et al. 1986, 51). Consistent with the Chinese cultural context, somatisation allows one to suppress the expression of potentially disruptive and ego-centered experiences in order to maintain the harmony of social relations. Transferring the mental disorder to a physical complaint also meshes with the desire to avoid the strong stigma attached to mental illness. Additionally, soma-tisation is consistent with the perceived legitimacy of seeking help for bodily complaints rather than psychological issues (Kleinman 1981).

Somatisation also contributes to the popular use of *neurasthenia.* Originating in the U.S. in the 1860's, neur-asthenia was introduced into China in the early 1900s and has been widely accepted and recognized in Chinese communities (Kleinman et al. 1986; Lee 1998; Flaskerud 2007). Neurasthenia is a complaint of increased physical or mental fatigue that often reduces individual perfor-mance and functioning (World Health Organization 1993). It often is accompanied by diverse somatic and psychological symptoms, ranging from headaches, dizziness, fatigue, insomnia, chest discomfort, and gastro-intestinal problems, to depression, anxiety, irritability, and anorexia. Often, psychological issues are secondary to physical problems (Schwartz 2002). Although neuras-thenia was eliminated from the U.S. *Diagnostic and Statistical Manual* as of 1980 due to its indiscriminate features, laymen and clinicians in mainland China, Hong Kong and Taiwan continue to apply this term (Flaskerud 2007; Schwartz 2002).

Help-seeking preference is also influenced by Chinese culture. Often, family, rather than the individual with mental illness, makes the treatment decisions (Lin and

Lin 1981; Lin and Cheung 1999). Lin and Lin (1978) studied help-seeking patterns among Chinese Canadian families having a member with psychotic disorders and identified a hierarchical pattern that has five phases.[1] Notably, the first three phases, seen as a protracted "intra-familial" and "pre-psychiatric" stage, can last from several to over 20 years. When the family and other informal networks have failed to provide effective assistance, the formal institution is the last resort for a person with severe mental illness (e.g. psychotic disorders). Individuals with other types of mental illness, such as depression, neuroses or psychosomatic diseases, hardly ever approach mental health professionals, since these conditions are not regarded as mental health problems (Lin and Cheung 1999). Kung (2003) studied Chinese adults in the Los Angeles and discovered that 75% of respondents who had emotional needs did not seek help from any resource. Out of the 25% who ever sought help, family and friends appeared to be the major source (20%). Moreover, among respondents who had a diagnosable mental disorder, only 15% had used mental health services.

Effect of discrimination. Facets of social context that are ever present in the lives of visible minorities are racism and discrimination. The perceptions of being treated unfairly or with disrespect due to one's race or ethnic background can play a role in the development of mistrust of service providers and subsequent reduced service use among minority populations (Spencer and Chen 2004; van Ryn and Fu 2003). Spencer and Chen (2004) have found that discrimination is associated with greater use of informal services and more assistance sought from friends or relatives, but not with use of formal services among Chinese Americans. Moreover, discrimination due to speaking a different language or having an accent was a significant contributor to the types of service one may use—Chinese Americans who have experienced language discrimination were 2.2 times more likely to use informal services and 2.4 times more likely to seek help from friends or relatives compared to those who did not experience such a treatment.

The lack of recognition by general practitioners. Somatisation or focusing on somatic symptoms of mental health issues naturally leads Chinese patients to consult their general practitioners, rather than seeking help from mental health professionals (Hsu and Folstein 1997). However, Chung and colleagues (2003) has indicated general practitioners, including those who speak the same language and share the culture, often fail to recognize and address treat their patients' mental health issues. Moreover, the provider stigma—which refers to physi-cians' fear of embarrassing their patients—further exacerbates negative feelings and inaccurate myths about mental illnesses, and delays proper referrals and treatment for patients who are in need (Chung 2002).

The use of complementary and alternative medicine also influences access to conventional mental heath services. Literature suggests that along with traditional Chinese health beliefs, indigenous medical practices exert important effects on the manifestation of symptoms and health behaviours among Chinese patients (Barnes, 1998; Kleinman et al., 1975, 1978). First, Chinese patients may rely on traditional Chinese medical practitioners, such as herbalists or acupuncturists for relief from emotional difficulties (Barnes 1998; Lin and Cheung 1999). In addition, as indicated earlier, the folk concept that mental illness is caused by supernatural forces and ancestral deeds is widely accepted in Chinese society. Therefore, folk healers such as shamans, physiognomers, geomancers, bonesetters and fortune-tellers are also commonly used in helping the Chinese manage daily stresses and treat illnesses (Gaw 1993). In Kung's study (2003), 8% of Chinese respondents with emotional problems reported that they had sought help from herbalists, acupuncturists, religious leaders or fortune-tellers. Compared to obtaining assistance from mental health clinicians or medical doctors, these alternative approaches are more likely to be solicited.

A lack of accessibility to linguistically and culturally appropriate mental health services has been proposed as one of the major reasons for service underutilization in this population. Perceived access to services was the most significant factor predicting negative attitudes towards seeking professional help among Canadian immigrants from mainland China and Taiwan (Fung and Wong 2007). Lin (1994) studied the length of treatment and dropout rate of 145 Chinese Americans treated by ethnic- and language- matched clinicians in an outpatient clinic and concluded that providing well-trained and culturally matched providers promotes the acceptance of mental health treatments among Chinese Americans and helps to ensure equal access and treatment opportunities.

OVERCOMING BARRIERS

As is true for other ethnic groups, mental health service utilization among Chinese immigrants is multidimensional and complex. Efforts ranging from micro- to macro- levels are needed to address the under-utilization issue:

Assessment. Understanding the interconnections between mind, body, and spirit is essential for service providers and it will allow practitioners to provide more relevant, effective and efficient services. When assessing and treating Chinese immigrants, practitioners should be watchful for clients' somatic complaints. As studies have repeatedly demonstrated, unexplained somatic symptoms among Chinese patients may be a manifestation of mental health issues (Lin and Cheung 1999; Chung 2002; Kleinman et al. 1986). Distresses of physical

health are likely to exacerbate the Chinese client's mental health condition.

Provider education. General practitioners are the gatekeepers to specialists and other medical services. To enhance practitioners' capacity to detect mental health problems early and to ensure adequate service provision, education and training are necessary to improve practitioners' skills and knowledge in identifying and treating mental health problems commonly seen in general practice settings. In addition, providers should learn how to communicate with patients about using culturally appropriate and familiar wordings, describe the biopsychosocial basis for mental illness, and discuss possible treatment plans.

Workforce development. Increasing the representation of bilingual and bicultural staff is critical in addressing the service utilization issue. Efforts should be made to attract and recruit bilingual and bicultural individuals to disciplines that are related to mental health service, such as nursing, medicine, psychology, and social work. Moreover, interpreter services should be made accessible at practices where bilingual service is not available. Providing culturally and linguistically appropriate services not only tackles the availability and accessibility issue, but also can address the negative effect of language discrimination on service utilization among Chinese immigrants.

Community outreach and education. Community outreach and education are necessary means to raise the awareness of mental health issues and to overcome the stereotypes of mental health problems among Chinese immigrants. Linguistically and culturally appropriate information related to mental health can be disseminated to members of the Chinese community through the use of educational brochures, mass media, health fairs, or community workshops.

Working with families. Family can exert a strong influence on a Chinese patient's healthcare decisions. Practitioners should not underestimate the pronounced influence of family on the lives of individuals with mental health problems (Kung, 2001; Uba, 1994), and should seek to understand the help-seeking patterns from the family-oriented perspective in addition to individual-focused assessment. Furthermore, practitioners should strive to engage the family members into help-seeking processes through harnessing the potential barriers resulting from a poor communication between providers and patient system. As each family has its idiosyncratic help-seeking and decision-making patterns; the trusting and respectful relationship among patient, family members and providers are likely to foster and maximize the treatment outcome.

Program development. Mental health needs and service use are influenced by socio-cultural determi-

nants. Policy and program makers should provide funding and technical support geared at encouraging the development of culturally appropriate and innovative mental health programs that maximize the service capacity in accordance with population needs. A pioneer program that integrates mental health and primary care in the Chinese community in New York City, NY has shown promising outcomes in delivering mental health services through culturally sensitive and creative approaches (Chen et al. 2005; Fang and Chen 2004). The program aims to enhance service access by providing mental health services in primary care; to enhancing the skills of general practitioners by training them to better identify and treat mental health problems commonly seen in general practice; and to raise community awareness by providing public education on mental health and mental illness. The program has been successfully operated for over a decade, proving that such a collaborate model can create new opportunities for improving access to mental health care, and ultimately enhance wellbeing for Chinese immigrants.

Premising that neither biomedicine nor the traditional healing paradigm can claim sole ownership of interpreting health and disease, and healing processes, integrative care that combines both traditional healing approaches and conventional medical treatments is increasingly available in Canada (Boon et al. 2004; Francoeur et al. 2006). Initial evaluation has shown that integrative care assists to increase patients' health status, including mental health functioning (e.g., Mulkins et al. 2003). The success of integrative care, although still preliminary, provides a new direction for effective models of mental health service provision. The philosophical underpinnings of integrative care are perhaps more congruent with beliefs of mental health among Chinese immigrants, and such a treatment approach has vast potential in effectively addressing patients' needs.

CONCLUSION

Due to cultural explanations of mental illness, stigma, discrimination, help-seeking preferences, and inadequate service, Chinese immigrants with mental health needs often become invisible to service providers. However, these issues are not unsolvable. Collective efforts can facilitate a responsive service environment that is accessible to, and culturally appropriate for, Chinese immigrants.

REFERENCES

Barnes, L.L. "The Psychologizing of Chinese Healing Practices in the United States," *Culture, Medicine and Psychiatry,* 22(1998): 413-443.

Beiser, M., and R. Edwards. "Mental Health of Immigrants and Refugees," *New Directions for Mental Health Services*, 61(1994): 73-86.

Boon, H., M. Verhoef, D. O'Hara, and B. Findlay. "From Parallel Practice to Integrative Health Care: A Conceptual Framework," *BMC Health Services Research,* 4(2004): 15.

Bui, K.-V.T., and D.T. Takeuchi. "Ethnic Minority Adolescents and the Use of Community Mental Health Care Services," *American Journal of Community Psychology*, 20(1992): 403-417.

Chen, A., and A. Kazanjian. "Rate of Mental Health Service Utilization by Chinese Immigrants in British Columbia," *Canadian Journal of Public Health*, 41(2002): 75-82.

Chen, H., E. Kramer, T. Chen, J. Chen, and H. Chung. "The Bridge Program: A Model for Delivering Mental Health Services to Asian Americans through Primary Care," *AAPI Nexus: Asian Americans & Pacific Islanders Policy, Practice and Community*, 3(2005): 13-29.

Chen, S., N. Sullivan, Y. Lu, and T. Shibusawa. "Asian Americans and Mental Health Services: A Study of Utilization Patterns in the 1990s," *Journal of Ethnic and Cultural Diversity in Social Work*, 12(2003): 19-42.

Chung, H. "The Challenges of Providing Behavioral Treatment to Asian Americans: Identifying the Challenges Is the First Step in Overcoming Them," *Western Journal of Medicine*, 176(2002): 222-223.

Chung, H., J. Teresi, P. Guarnaccia, B.S. Meyers, D. Holmes, T. Bobrowitz, J.P. Eimicke, and E. Ferran. "Depressive Symptoms and Psychiatric Distress in Low Income Asian and Latino Primary Care Patients: Prevalence and Recognition," *Community Mental Health Journal,* 39(2003): 33-46.

Ergil, K., E. Kramer, and A. Ng. "Chinese Herbal Medicines," *Western Journal of Medicine*, 176(2002): 275-279.

Fang, L., and T. Chen. 2004. "Community Outreach and Education to Deal with Cultural Resistance to Mental Health Services," in N. Webb (ed.), *Mass Trauma and Violence: Helping Families and Children Cope.* city: Guilford Press., 234-255.

Flaskerud, J.H. "Neurasthenia: Here and There, Now and Then," *Issues in Mental Health Nursing,* 28(2007): 657-659.

Francoeur, C., C. Patterson, H.M. Arthur, C. Noesgaard, and M. Swinton. "Considerations for Adolescent Integrative Health Care in Canada," *Journal of Holistic Nursing*, 24(2006): 212-219.

Fung, K., and Y.-L.R. Wong. "Factors Influencing Attitudes Towards Seeking Professional Help among East and Southeast Asian Immigrant and Refugee Women," *International Journal of Social Psychiatry,* 53(2007): 216-231.

Gaw, A.C. 1993. "Psychiatric Care of Chinese Americans," in A.C. Gaw (ed.), *Culture, Ethnicity, and Mental Illness.* city: American Psychiatric Association, 245-280.

Hsu, G., and M. Folstein. "Somatoform Disorders in Caucasian and Chinese Americans," *The Journal of Nervous and Mental Disease*, 185(1997): 382-387.

Kleinman, A. 1981. *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*, Berkely, CA: University of California Press.

Kleinman, A., J.M. Anderson, K. Finkler, R.J. Frankenberg, and A. Young. "Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China," Current Anthropology, 24(1986): 499-509.

Koss-Chioino, J.D. 2000. "Traditional and Folk Approaches among Ethnic Minorities," in, *Psychological Intervention and Cultural Diversity (2ⁿᵈ Ed.)*. city: Needham Heights, MA, US: Allyn & Bacon, 149-166.

Kramer, E., K. Kwong, E. Lee, and H. Chung. "Cultural Factors Influencing the Mental Health of Asian Americans," *Western Journal of Medicine,* 176(2002): 227.

Kung, W.W. "Chinese Americans' Help Seeking for Emotional Distress," *Social Service Review,* 77(2003): 110-134.

Lee, S. "Estranged Bodies, Simulated Harmony, and Misplaced Cultures: Neurasthenia in Contemporary Chinese Society," *Psychosomatic Medicine*, 60(1998): 448-457.

Leong, F.T.L., and A.S.L. Lau. "Barriers to Providing Effective Mental Health Services to Asian Americans," *Mental Health Services Research*, 3(2001): 201-214.

Lin, K.-M. 1981. "Traditional Chinese Medical Belief and Their Relevance for Mental Illness and Psychiatry," in A. Kleiman and T.Y. Lin (eds.), *Normal and Abnormal Behavior in Chinese Culture*. city, 95.

Lin, K.-M., and F. Cheung. "Mental Health Issues for Asian Americans," *Psychiatric Services*, 50(1999): 774-780.

Lin, T., and M. Lin. "Service Delivery Issues in Asian-North American Communities," *American Journal of Psychiatry*, 135(1978): 454-456.

---. 1981. "Love, Denial and Rejection: Responses of Chinese Families to Mental Illness," in A. Kleiman and T.Y. Lin (eds.), *Normal and Abnormal Behavior in Chinese Culture.* city: D. Reidel, 387-401.

Ma, G.X. "Between Two Worlds: The Use of Traditional and Western Health Services by Chinese Immigrants," *Journal of Community Health*, 24(1999): 421-437.

Matsuoka, J.K., C. Breaux, and D.H. Ryujin. "National Utilization of Mental Health Services by Asian Americans/Pacific Islanders," *Journal of Community Psychology*, 25(1997): 141-145.

Mulkins, A., M. Verhoef, J. Eng, B. Findlay, and D. Ramsum. "Evaluation of the Tzu Chi Institute for Complementary and Alternative Medicine's Integrative Care Program," *The Journal of Alternative and Complementary Medicine*, 9(2003): 585-592.

Ritsner, M., and A. Ponizovsky. "Psychological Distress through Immigration: The Two-Phase Temporal Pattern?," *International Journal of Social Psychiatry*, 45(1999): 125-139.

Schwartz, P. "Why Is Neurasthenia Important in Asian Cultures?," *Western Journal of Medicine*, 176(2002): 257-258.

Snowden, L.R., and F.K. Cheung. "Use of Inpatient Mental Health Services by Members of Ethnic Minority Groups," *American Psychologist*, 45(1990): 347-355.

Spencer, M.S., and J. Chen. "Effect of Discrimination on Mental Health Service Utilization among Chinese Americans," *American Journal of Public Health,* 94(2004): 809-814.

Sue, D., and D. Sue. "Counseling the Culturally Different: Theory and Practice,"in Wiley, New York, 1999.

Sue, D., and S. Sue. "Cultural Factors in the Clinical Assessment of Asian Americans," *Journal of Consulting and Clinical Psychology,* 55(1987): 479-487.

Tang, T., K. Oatley, and B. Toner. "Impact of Life Events and Difficulties on the Mental Health of Chinese Immigrant Women," *Journal of Immigrant and Minority Health*, 9(2007): 281-290.

Tsai, M., L. Teng, and S. Sue. "Mental Health Status of Chinese in the United States," *Normal and abnormal behavior in Chinese culture*, 1981): 291-310.

Uba, L. 1994. "Underuse of Mental Health Services," in, *Asian Americans: Personality Patterns, Identity, and Mental Health.* city: Guilford Press, 196-213.

van Ryn, M., and S.S. Fu. "Paved with Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health?," *American Journal of Public Health*, 93(2003): 248-255.

World Health Organization. 1993. *The Icd-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*, Switzerland: WHO.

FOOTNOTES

[1] Phase 1. Exclusive intrafamilial coping. At this stage, all possible remedial resources and means within the family are used by the family to influence the abnormal behaviour of the sick member to its limit of tolerance.

Phase 2. Inclusion of certain trusted outsiders in the intrafamilial attempt at coping, such as friends and elders in the community.

Phase 3. Consultation with outside helpers, such as herbalists, religious healers, physicians and finally a psychiatrist while keeping the patient at home.

Phase 4. Labelling of mental illness and seeking the psychiatric service first on an outpatient basis, and then hospitalization.

Phase 5. Scapegoating and rejection, while the sick family member is kept in a distant mental hospital.

HOW CULTURAL AWARENESS WORKS

Miu Chung Yan is an associate professor of the School of Social Work, the University of British Columbia, the Acting Co-Director and a Domain Leader of Metropolis British Columbia. His research interests include youth from immigrant family, immigrant settlement and integration at the neighbourhood-level, and critical social work practice with multicultural/racial groups.

ABSTRACT

Working with multicultural groups poses routine challenges for many mental health professionals in Canada. This article reports on a study of 30 frontline social workers and how they reflect on their own cultures when working cross-culturally. The strategies used are identified and analyzed.

INTRODUCTION

Working with a culturally diverse population is an everyday reality for many helping professionals in the Canadian mental health field. To negotiate the ingrained effect of their own culture and to respect their clients' cultural differences, culturally competent helping professionals are expected to maintain a high level of cultural awareness, which means a *self-awareness* of their own cultural background. In the literature related to many helping professions, the discussion on cultural awareness tends to simplify the relationship between the helping professionals and their own cultures to a mere filtering process through which the influence of their cultures can be controlled, or even blocked, from affecting their engagement with clients from different cultures. Through pre- and post-intervention self-reflection, helping professionals are assumed to have the ability to sustain their professional objectivity by restraining their own cultural influences when they engage in a professional relationship with clients from different cultures. However, this assumption has seldom been examined empirically. Based on the findings of an exploratory qualitative study, this article reports how 30 social workers in the Metropolitan Toronto area, different in terms of gender, age, ethno-racial identity, length of time practicing social work, nature of practice, and service settings, engaged in cultural awareness in the practice as social workers. Since social work is a key helping profession in the mental health field, findings of this study may shed light on how other helping professionals engage in cultural awareness when working with a culturally diverse population.

FINDINGS

Most of the participants in this study understood culture as a totalized and encompassing entity that includes ways of life, ways of coping, beliefs, values, norms, practice, rites, customs and traditions, religion, expectations of others, language, and food and dress.

The encompassing nature of culture is particularly demonstrated when many of the participants move their definition of culture beyond ethnicity and race. As indicated in the lived experiences of these participants, the complexity of these concepts is manifested as inter-mingled sets of characteristics of their "cultural background." As the interview process revealed, most of the participants identified themselves in a way that conflated culture, ethnicity, and race (Yan, 2008b).

The cultural identity of each of these 30 participants is complex. First, the majority of them tended to identify as a hyphenated ethno-cultural identity, such as Portuguese-Canadian, which carries a set of different ethnic cultures. This hyphenated identity is also intertwined with their own personal experiences, such as being an immigrant or being member of a marginalized group. Furthermore, their role as professionals working in a public institution also required them to be reflective on the professional and socio-organizational cultures that are in tension with both their own and their clients' cultures (Yan, 2008a). In a nutshell, the cultures on which these participants need to reflect are never monolithic and simple.

Most participants reported that they constantly engage in self-awareness when they work with culturally diverse clients in order to avoid bringing their biases into the helping process. Simply put, to almost all of the participants, awareness of their own cultures augments their professional competence to maintain a balance between preserving a non-judgmental attitude and presenting themselves as passionate human beings. However, the all-encompassing nature of culture prompts some people to suggest that culture to humans is like water to fish; people do not and cannot exist outside of their cultural contexts. Very often we live within our culture without knowing its existence and influence. Then, the question is, what triggers the professional's reflection? The findings of this study strongly suggest that the *presence of clients* is the most

important factor. The cultural similarities or differences between the workers and their clients, as indicated in this study, are the major contextual variables that influence the workers' reflection on their own cultures.

The findings of this study indicate that reflection is not simply a retrospection about what they did but also a strategic action of helping. At least two sets of strategic actions can be identified conceptually from the findings; these two sets are not mutually exclusive, and the choice of strategies may not be a conscious act.

CONTROLLING CULTURES

To control the influence of their cultures on their work which is a relatively common reaction when working with clients from a different cultural background, these participants try to withhold the influences of their non-professional cultural identities and the sets of cultures and experiences attached to these identities. The participants presented at least six ways of controlling their cultural influences.

1. DETACHING ONESELF FROM ONE'S OWN CULTURE

To be professional, many participants have to detach their ethnic/racial identity from their professional role, sometimes even when their ethnic/racial identity is under attack. In fact, unlike the Caucasian participants, most of the racial minority participants have experienced being rejected by their Caucasian clients. Surprisingly, almost none of them reported being involved in any direct confrontation as a result of these kinds of racial attacks. Instead, several visible minority participants reported that, on hearing their clients criticize people from the participants' own racial/ethnic background, they tried to detach themselves from the clients' racist criticism, or like one participant noted, *"So when I hear this thing, I will be very conscious to separate this, [as this] is a client talking about his or her experience, it is not about you although this is a situation that requires challenging."*

2. SEPARATE LIFE DOMAINS

Many participants try to keep their work and non-work life domains separated, especially when they are not fully coherent with each other. Most minority participants are eager to keep their cultural roots at home while they try to adapt to the dominant culture at work. The underlying assumption of separating life domains is literally that culture can be controlled. As a Black social worker in Children's Aid stated, *"Work might be a little different from home because home tends to be more typical. The home culture, that is your own home.... but coming to work, I leave a little bit at home and take more of the Canadian norms to work. Yes, so it's partly different. I might do things at home that I might not do at the office."*

3. SWITCHING HATS

Having a multiple cultural identity, many of the participants report that they are wearing more than one cultural hat to work. At work, they have to switch their non-professional cultural hat to their professional one by endorsing the culture embedded in this identity. In the meantime, by switching hats, their own cultures and experiences are contained, if not at home, at least during the moment of working with a client. To many participants, this may be necessary to maintain the balance between the professional and personal selves. As a Chilean-Canadian worker employed in a hospital observes, *"Well, I think every social worker has to, at one level or another, separate them[selves] professionally. And personally we will hear a story and get pissed off."*

4. SELECTIVE PRESENTATION OF SELF

Most participants tend to think that with experience and good skills, they can be competent social workers who transcend cultural barriers. They also believe that, from a client's perspective, whether a worker is competent depends on how well he/she can help the client. Therefore, selectively presenting themselves as competent helpers to their clients becomes a major way to control their cultural image. As an Iranian-Canadian working in a mental health clinic reported, *"I certainly try to project myself as a person who is professional about my job. I am maintaining appropriate boundaries. [I am] somebody who is competent, reliable... that's how I want them to see me."*

5. ASSUMING THE "WHITE" IDENTITY

Regardless of their ethno-racial background, participants of this study tend to point out, one way or another, that the "Whiteness" image—that of a mainstream worker—is perceived as the standard by which they (and their clients) measure their level of competence. This sense of "Whiteness," according to many participants, is embedded in their training, their practice setting, and the nature of the profession. Therefore, to be seen as competent in this profession, even minority workers must, insofar as it is possible, take on a "White" identity. Linda, a Chinese-Canadian who works in a children's mental health agency, explains her reasons for assuming this "White" identity:

> *For me, as a minority therapist, I face double challenges. When I work with minority people, I have my counter-transference towards them too because I am also a minority. I also don't want them to see me as powerless, weak. To be seen as small, weak and helpless, right? So there is a counter-transference part from my position. When I see White*

people,... I will identify with the aggressor, so I would want to join them.... And I think I also want to prove to my colleagues, I can do the same work as them. It's not a conscious choice, though.

6. RETROSPECTION

Despite all the strategies that the participants used to control or restrain their culture from intervening in their work, cultures and experiences may still slip into their interactions with clients without prompting the workers to engage the self-awareness mechanism. For instance, a Chilean-Canadian working in a hospital remembered a time that she was unconsciously critical of a daughter who intended to abandon her mother, a patient in her hospital. In the worker's own non-professional cultural practice, such abandonment by a daughter was unacceptable. Instead of becoming cognizant of her feelings at the time, however, and consequently working to control or contain these feelings, she condemned the daughter for her intentions. In cross-cultural social work literature, retrospection, a form of anecdotal self-awareness, is an expected practice for social workers. By deliberate retrospection through recording, peer consultation, and clinical supervision, social workers will try to catch those cultural influences that escaped into their practice. Remedies will be sought afterward.

USING CULTURES

According to the findings of this study, in addition to controlling or containing their cultures, almost all participants consciously and purposefully use their own cultures and experiences as means of helping clients, especially those who share similar cultural backgrounds or experiences with them. In general, three major strategies of "using" cultures can be identified.

1. EMPATHETIC UNDERSTANDING BASED ON SIMILARITY

Workers can often build a more effective working relationship through an empathetic understanding with clients who share similar cultures and experiences. Based on cultural or experiential similarities, many participants felt that they may have an added intimate dimension in interacting with their clients. For instance, many Caucasian participants always referred to their traveling experience when trying to understand clients from countries which they visited. Sharing similar immigration experiences, as many participants have been immigrants themselves, allows them to establish special rapport with immigrant clients. Many participants felt that having a similar cultural and experiential background to their clients helped them to go to a deeper level to understand clients' problems and thus establish a closer relationship with them.

2. THERAPEUTIC SELF-DISCLOSURE

Self-disclosure is another technique through which participants used personal experience to assist clients. Most minority participants reported that clients are especially interested in asking them questions related to their cultural identities in order to verify whether the workers are capable of helping them. In a worker's cross-cultural engagement with a client, disclosing some parts of the worker's personal experience and culture is useful for helping the clients. These participants disclose their own cultural information in order to make a connection with, empower, and gain trust from their clients. Nevertheless, not all of the social worker's culture and personal experience is subject to disclosure. To many participants, disclosing is a purposeful and selective strategy. A boundary needs to be set between what can and cannot be shared. As one participant observed, *"Is it for the benefit for yourself? Is it for the benefit of your client? Be really mindful about when you use self-disclosure within your therapy. I think about that often and how that relates to boundar[ies]."*

3. BRIDGING CLIENTS TO THE DOMINANT CULTURE

Many minority participants, particularly those who have been immigrants, will use their cultural and experiential knowledge to help their clients adapt to a new culture they themselves have successfully acclimated to. A newcomer from Africa working in child protection services offered a vivid illustration of how he helped an African family who had struggled with the child protection agency for a few years to reclaim their child. By using his own experience, he taught them how to understand and adjust to the cultural expectations of the dominant society. In this way, social workers who use their own stories to bridge clients to a new culture also become agents of social integration.

DISCUSSION

These findings show that cultural awareness occurs before, during, and after the intervention, and that social workers may engage with their cultures in multiple ways as a strategy of helping. Blocking one's own culture, the course most often proposed by the literature, involves a series of strategic actions. The findings also indicate that these 30 social workers, and perhaps other helping professionals, have been strategically utilizing their own cultures and experiences as a part of the cultural awareness process. This strategic use of one's own culture challenges the conventional assumption that cultures are always biased and therefore need to be contained. Using one's culture in a professional capacity creates possibilities that allow for a more creative and proactive approach to working with culturally different clients. This study helps

to confirm that many social workers and other helping professionals categorize "being culturally aware" as a responsible professional act that facilitates effective service for culturally different clients.

However, the findings also raise some issues that need further study and discussion. The conflation of culture, race, and ethnicity has distracted attention away from some structural problems in the helping relationship and process. The inseparableness of culture, ethnicity, and race in their stories, their detachment from their own ethno-racial identity even as their clients attack people of that identity, and their justification for being rejected by Caucasian clients, to name but a few examples, demonstrate that many of these participants try to avoid challenging the racially oppressive conditions in which they and their clients are located. Even with an active and strategic reflection on their cultures, without critically examining "Whiteness" as a measure of professional competence, many visible minority social workers and clients are still struggling to fit in a culturally biased mode of helping.

This study affirms that cultural awareness is an interactive, selective, and contingent process. Perhaps the key to meaningful cultural awareness is the dialogical understanding of oneself (Yan & Wong, 2005). As noted in this study, this dialogical process is affected by the similarities and differences between the workers and their clients, which are not only cultural but also structural, in terms of their social positions (e.g., race, gender, and class) and the context in which the workers and their clients are located. Social workers therefore need to *reflexively* reflect not only on their cultures but also on the invisible privileges embedded in their social positions. Finally, this study offers only a preliminary understanding of how some social workers practice cultural awareness. To better understand this complex process and its significance in social work practice, more studies are needed.

REFERENCES

Yan, M. C. (2008a). Exploring cultural tensions in cross-cultural social work practice. *Social Work*, 53(4), 307-316.

Yan, M. C. (2008b). Exploring the meaning of crossing and culture: An empirical understanding from practitioners' everyday experience. *Families in Society*, 89(2), 282-292.

Yan, M. C., & Wong, Y. L. R. (2005). Rethinking self-awareness in cultural competence: Towards a dialogic self in cross-cultural social work. *Families in Society*, 86(2), 181-188.

FOOTNOTES

This article is an abbreviated version of a published manuscript. For a full version of this paper, please refer to Yan, M. C. (2005). How cultural awareness works: An empirical examination of the interaction between social workers and their clients. *Canadian Social Work Review,* 22(1), 5-29.

DEVELOPMENT OF A CULTURALLY SENSITIVE SCREENING TOOL: POLICY AND RESEARCH IMPLICATIONS[1]

Shahlo Mustafaeva is an international student from Uzbekistan currently pursuing her degree in Clinical Psychology at the University of Regina.

Regan Shercliffe is an Associate Professor of psychology at the Luther College, University of Regina.

ABSTRACT

During the past two decades, Canada has received a large influx of refugees from Asian countries (Noh, Speechley, Kaspar, and Wu, 1992). Upon arrival, refugees are offered health screenings, specifically for communicable diseases, such as tuberculosis, Hepatitis B and for general pre-existing medical problems. Unfortunately, the same attention is rarely given to potential mental health needs. Research has shown that the refugees are at high risk for developing depression compared to non-refugee populations, yet they are not screened. The purpose of this article is to outline the process of developing culturally sensitive depression screenings tools for Karen refugees. The need and implications of this measure are further discussed.

INTRODUCTION

Depression is one of the leading mental health problems facing individuals in all demographic and ethnic groups (Baker and Woods, 2001). The symptoms of depression are psychiatric (e.g., anxiety/nervousness and reduced concentration), behavioural (e.g., social with-drawal and crying spells), and physical (e.g., pain, headaches, and insomnia). Over time, many of the symptoms of depression can become debilitating in nature and impact both the patient's medical treatment and workplace productivity (Greenberg et al., 2003). Psychiatric and physical impairments associated with depression generate a significant cost burden not only for sufferers, but also for their employers, third-party payers, caregivers, and society in general. Depression is associated with a loss of personal productivity, diminished quality of life, poor psychological adjustment, reduced income, high health care utilization, and a markedly increased risk for suicide (Katon et al., 1986). In 1990, the economic burden of depression in the United States alone was estimated between $43.7 billion and $52.9 billion, based on the cost of depression treatment, lost earnings due to suicides, and workplace absenteeism (Greenberg et al., 1993; 1996). During the past two decades, Canada has received a large influx of refugees from Asian countries (Noh, Speechley, Kaspar, and Wu, 1992). Given this population trend the economic burden of depression may have increased from that of the 1990s as the prevalence rates of depression in refuge population is higher compared to that of non-

refugee population (Carlson and Rosser-Hogan, 1991). The purpose of this article is to outline the development of a culturally sensitive screening tool and it proposes that this culturally sensitive screening tool can be developed and used in understudied, culturally distinct refugee populations, and that such use will help health care professionals in identifying depression in immigrant populations.

DEPRESSION AS A GLOBAL PROBLEM

Epidemiological studies have identified depression as the most prevalent disorder in refugee populations and one of the ten leading causes of disability worldwide (Steel, Silove, Phan, and Bauman, 2002; Mollica et al., 2004). The process of displacement has a tremendous impact on the health, social and cultural well-being of refugees, as well as host countries. Upon the arrival of refugees, health care agencies focus their attention on meeting basic needs such as controlling infectious diseases and other health conditions. Although this focus is crucial, the psychological well-being of newly arrived refugees is often neglected. All too often refugees who have come to Canada have experienced or witnessed traumatic events including war, forced displacement, famine, etc (Arcel, 1995; Lipson and Omidian, 1995). In the country of resettlement, refugees continue to face a number of stressors such as financial difficulties, broken extended families, loss of family support, cultural and linguistic isolation, and/or

struggles to learn a new language and culture (Lipson and Omidian, 1997; Hauff and Vaglum, 1995). While many refugees are resilient, these various pre- and post-migration stressors put refugees at high risk of developing depression, as such, accurate screening of depression early in the immigration process is urgently needed for detection and treatment purposes.

CHALLENGES IN PRIMARY HEALTH CARE SETTINGS

Depression is one of the most common mental health problems seen in the general medical setting. Although increasing attention has been paid to depression in the research on the general population; public health efforts in screening for depression in refugee populations still lags behind. Refugees are more likely to seek care from general health practitioners than from mental health providers because it is less stigmatising. In addition, refugees, especially from Asian cultures, present with somatic symptoms (e.g., physical pain, headaches, weakness in the body etc) when expressing depression which puts them at risk of being misdiagnosed or treated with inappropriate medications for extended periods of time. Some health care agencies use readily available depression measures that are derived from Western definitions of depression, and these measures are translated for use with different refugee populations. The use of translated depression measures with refugee groups is an understandable starting point. However, many researchers suggest that the application of existing instruments to the assessment of depression in ethnic minorities may not only misrepresent the illness they suffer from but may also mislead prevention and treatment efforts (e.g., Kim, 2002; Phan, Steel, and Silove, 2004; Miller et al., 2006; Okello and Ekbald, 2006). A strict reliance on the Western understanding of depression risks inappropriately prioritising psychiatric syndromes that are familiar to Western health care professionals, but may lack meaning to non-Western populations for whom local expressions and idioms of distress are more salient (Miller et al., 2006).

Although depression-screening instruments have been validated and extensively studied in Western countries and various translating methodologies have been employed to enhance the linguistic equivalence of measures, their translation and use with other cultures is not nearly as simple as it might appear (Ahmad, Kernohan, and Baker, 1989; Bravo, Canino, Rubio-Stipec, and Woodbury-Farina, 1991; Bravo, Woodbury-Farina, Canino, and Rubio-Stipec, 1993). Symptom terms often sound awkward or incomprehensible when translated, even if the wording is semantically correct (Yeung et al., 2002). Although terms that address biologically-based symptoms (e.g., fatigue, insomnia, appetite) can be more

easily translated and understood across cultures, subjective psychological aspects of depression (e.g., feeling sad, feeling blue, depressed) are much more influenced by culture and language and vary across cultures (Ghubash, Daradkeh, Naseri, Bloushi, and Daheri, 2000). Thus, the application of these instruments to people whose culture differs from the population on which they were initially developed and validated could lead to erroneous conclusions and misdiagnosis (Kazarian and Evans, 1998). Culturally sensitive approaches in screening refugees play an essential role in planning services and prevention strategies. Depression is a universal mental health phenomenon that is amenable to treatment once diagnosed (Westermeyer, 1991; Weissman et al., 1996). If undetected and untreated, however, depression can become a debilitating problem for any person of any age and ethnic group.

DEVELOPING A CULTURALLY SENSITIVE SCREENING TOOL

Cultural sensitivity in assessing mental health problems and the development of effective psychological interventions requires an understanding of the ways in which people in particular cultures articulate the ways they have been affected by adverse life events (Rogler, 1999; Summerfield, 1999). Familiarity with culturally specific idioms or expressions of distress allows health care practitioners to communicate effectively with distressed community members and to develop mental health interventions that are likely to be perceived as responsive to local beliefs and values (Summerfield, 1999). Culture affects aspects of the illness such as the way symptoms are described and it also affects the experience of illness. Thus, symptoms associated with depression may vary from culture to culture and some symptoms may be more prevalent in one culture than in another (Levek 1991; Suleiman, Bhugra, and Silva, 2001). Therefore, for accurate diagnosis and treatment, health care professionals should first identify and attempt to understand cultural expressions, symptoms, and understandings of depression.

NEEDS ASSESSMENT

The Regina Community Clinic, who screens all refugees in Regina, has indicated that symptoms of depression among Karen refugee groups are high, however, accurate diagnosis is difficult. The physicians report that Karen refugees often present with many somatic complaints such as headaches, body aches, weakness in the body, heart problem or "heart disease"; but the medical tests administered fail to find any physical pathology. The misdiagnoses and related treatments of the somatic symptoms then generate considerable health care expenditures in terms of clinic

visits, laboratory testing, medication prescribing, test ordering, and other medical costs, and result in preventing the initiation of timely and appropriate treatment for depression. The reality is that there is still a paucity of culturally appropriate screening tools that can help health care professionals screen for depressed and non-depressed refugees, and this is most certainly the case for Karen refugees. Moreover, there are no data available indicating the extent to which symptoms of depression are present in this particular population nor has a system been developed to allow systematic screening/monitoring of this refugee group. As a result, there are no specific reports of mental health needs among Karen refugees.

Given the absence of culturally sensitive screening tools, the exact rate of depression in this population is unknown. The Karen community is one of the largest refugee groups in Saskatchewan and has been exposed to traumatic events prior to their arrival to Canada. Thus, it is important to address their mental health needs in a culturally-appropriate manner.

DEVELOPMENT OF KAREN DEPRESSION TOOL

In order to address this issue of a lack of appropriate assessments and to develop a culturally sensitive screening tool for depression, the authors conducted a project which investigated understandings of depression among a number of Karen men and women. Karen refugees participated in focus group discussions designed to explain how this particular population understands and deals with the symptoms commonly regarded as "depression." Participants were presented with a short story derived from the works of Wig et al (1980) and Karasz (2005) describing individual's emotional and somatic symptoms of depression. The story was used as a means of portraying depression without using technical language.

> For the past two weeks Sara/Nick had felt that something was wrong with her/him. S/he complained of different troubles at different times; troubles such as headaches, pains in the stomach, general weakness of the body, difficulty breathing and tiredness. S/he couldn't do her/his work as well as s/he usually could. Often during the day her/his eyes filled with tears, and she/he felt intense sadness. Her/his close friends and relatives couldn't cheer her/him up. S/he found it difficult to fall asleep and s/he lost her/his appetite (Wig et al., 1980; Karasz, 2005).

The purpose of using this story was to ascertain the perception of depression from Karen refugee men and women. Specifically, we wanted to gather information from the focus group participants (1) whether the individual in the vignette has a problem/illness; (2) what are the symptoms this illness/problem; (3) what other terms and expressions one would use to describe the illness/problem; (4) the causes of this illness/problem; (5) who the person in the story should seek help from: mental health professional, general practitioner, or somebody in the community; (6) stigma associated with mental health issues.

IMPLICATIONS

The results of this project assisted us in identifying the ways in which Karen refugees express depression, the symptoms they associate with depression, their help-seeking behaviour, and the stigma associated with mental health issues. More importantly, based on the results of this project we were able to develop a culturally-sensitive screening instrument for use with Karen refugees in screening for depression. Early and accurate detection of depression in this population will improve Karen refugees' well-being by providing timely and appropriate interventions. This project, and the screening tools developed from it, offers health care professionals a reliable and valid tool that will help them identify Karen men and women who are depressed. The second phase of this project, where the screening tool was implemented, proved the Karen Depression Screening tool to be more accurate in detecting depressed patients than a widely used Western measure of depression (i.e., Center for Epidemiologic Studies Depression Scale).

The accurate differentiation of depressed and non-depressed patients is important in the Karen population as they are inclined to present with somatic symptoms to their primary care physicians which then lead to misdiagnosis when the physician is not aware of Karen cultural expressions of depression. Thus, our findings indicate it is crucial that the health care professionals use the Karen Depression Screening tool to screen them for depression first before a costly search for unlikely diseases and unnecessary treatments. Early detection and treatment of depression will greatly assist the settlement process of refugees, will support strained family and community relationships, and in the long term provide real cost benefits and improved health outcomes for the Karen population. Identification of culturally distinctive features of depression will also help to pave the way for sensitive clinical inquiry and the effective delivery of therapy for the Karen population. Being aware of culture-specific symptoms of depression among Karennis can assist clinicians in minimizing misunder-

standings of depressive symptom expression, in developing therapeutic alliances, and preventing Karennis from premature treatment termination.

The use of culturally appropriate screening tools in primary health care will also lessen the burden on clinical services because somatic complaints cause excess visits to clinics. Furthermore, accurate screening of depressed and non-depressed patients can help prevent excessive utilization of the health care services and the high expenses associated with such services. Also, the availability of a culturally sensitive screening tool will enable researchers to have insight into prevalence rates of depression in these groups.

Health care professionals and researchers can use the data collected from our project to begin to identify meaningful patterns and important cultural differences within larger ethnic populations. Such instruments are also helpful in understanding cross-cultural differences and similarities in the experience of mood disorder. The results of this study may also prove valuable to researchers and public health professionals in developing culturally-relevant interventions for Karen and other ethnic minority groups.

CONCLUSION

Refugees often experience numerous traumatic events; forced displacement from their homes/countries, loss of/separation from loved ones that can increase the likelihood of developing depression, and they continue to face numerous challenges as they settle and integrate into the mainstream society. Early and accurate detection of mental health problems will improve the well-being of *new Canadians* by providing timely and appropriate interventions. The results of our project show that with careful planning and execution, it is feasible to construct culturally and linguistically valid instruments for screening for depression in the primary health care setting.

REFERENCES

Ahmad, W., I., U., Kernohan, E., E., M., & Baker, M., R. Cross-cultural use of socio-medical indicators with British Asians. *Health Policy* 13 (1989): 95-102.

Arcel, L.T. 1995. Core experiences of the refugees: In L. T. Arcel, V. Folnegovic-Smalc, D. Kozaric-Kovacic, & A. Marusic (Eds.) *Psycho-social help to war victims: Refugee women and their families.* Copenhagen: International Rehabilitation Council for Torture Victims.

Baker, C. B., & Woods, S. W. Cost of treatment failure for major depression: Direct costs of continued treatment. *Administration and Policy in Mental Health*, 28(2001): 263-277.

Bravo, M., Canino, G., J., Rubio-Stipec, M., Woodbury-Farina, M. A cross-adaptation of a psychiatric epidemiologic instrument: the diagnostic interview schedule's adaptation in Puerto-Rico. *Culture, Medicine and Psychiatry* 15 (1991): 1-18.

Bravo, M., Woodbury-Farina, M., Canino, G., J., & Rubio-Stipec, M. The Spanish translation and cultural adaptation of the Diagnostic Interview schedule for Children (DISC in Puerto Rico. *Culture, Medicine and Psychiatry* 17 (1993): 329-344.

Carlson, E. B., & Rosser-Hogan, R. Trauma experiences, post-traumatic stress, dissociation, and depression in Cambodian refugees. *American Journal of Psychiatry* 148 (1991): 1548-1551.

Ghubash, R., Daradkeh, T., K., Al Naseri, K., S., Al Bloushi, N., B., A., & Al Daheri, A., M. The performance of the Center for Epidemiologic Study Depression Scale (CES-D) in an Arab female community. *International Journal of Social Psychiatry* 46 (2000): 241-249.

Greenberg, P. E., Stiglin, L. E., Finklstein S. N. et al. The economic burden of depression in 1990. *Journal of Clinical Psychiatry* 54 (1993): 405-418.

Greenberg, P. E., Kessler, R. C., Neils, T. L., et al. 1996. *Depression in the workplace: An economic perspective.* New York: John Wiley & Sons.

Hauff, E., & Vaglum, P. (1995). Organized violence and the stress of exile predictors of mental health in a community cohort of Vietnamese refugees three years after resettlement. *British Journal of Psychiatry* 166 (1995): 360–367.

Kazarian, S. S., & Evans, D. R. 1998. *Cultural clinical psychology: theory, research, and practice*. New York: Oxford University.

Kim, M., T. Measuring depression in Korean Americans: development of the Kim Depression Scale for Korean Americans. *Journal of Transcultural Nursing,* 13 (2002):109-117.

Leveck, P. G. 1991. *The role of culture in mental health and illness.* Reading, MA: Addison-Wesley.

Lipson, J. G., & Omidian, P. A. Afghan refugee issues in the U.S. social environment. *Western Journal of Nursing Research* 19 (1997): 110–126.

MacArthur, J. R., Dudley, S., Williams, H. *Approaches to facilitating health care acceptance: a case example from Karenni Refugees.* Washington, DC: American Anthropology Association.

Miller, K., E., Omidian, P., Quraishy, A., S., Quraishy, N., Nasiry, M. N., Nasiry, S., Karyar, M., N., & Yaqubi, A., A. The Afghan Symptom Checklist: a culturally grounded approach to mental health assessment in conflict zone. *American Journal of Orthopsychiatry* 76 (2006): 423-433.

Mollica, R. F., Cardozo, B. L., Osofsky, H. J., Salama, A. A. P. Mental health in complex emergencies. *The Lancet* 364 (2004): 2058-2067.

Noh, S., Avison, W. R., & Kaspar, V. Depressive symptoms among Korean immigrants: assessment of a translation of the Center for Epidemiologic Studies-Depression Scale. *Psychological Assessment* 4 (1992): 84-91.

Okello, E., S., & Ekbald, S. Lay concepts of depression among the Baganda of Uganda: a pilot study. *Transcultural Psychiatry* 43 (2006): 287-313.

Phan, T., Steel, Z., & Silove, D. An ethnographically derived measure of anxiety depression and somatization: the Phan Vietnamese Psychiatric Scale. *Transcultural Psychiatry* 41 (2004): 200-232.

Rogler, L., H. Methodological sources of cultureal insensitivity in mental health Research. *American Psychologist* 54 (1999): 424-433.

Sulaiman, S., O., Y., Bhugra, D., & Silva, P. Perceptions of depression in a community sample in Dubai. *Transcultural Psychiatry* 38 (2001): 201-218.

Summerfield, D. A critique of seven assumptions behind psychological trauma programmes in war-affected countries. *Social Science and Medicine* 48 (1999): 1449-1462.

Weissman, M. M., Bland, R. C., Canino, G.J., Faravelli, C., Greenwald, S., Hwu, H., Joyce, P. et al. Cross-national epidemiology of major depression and bipolar disorder. *Journal of the American Medical Association* 276 (1996): 293–299.

Westermeyer, J. 1991. Special considerations. In J. Westermeyer, C. L. Williams, A. M. Nguyen *Mental health services for sefugees.*Washington, DC: U.S. Government Printing Office.

Wig, N., N., Suleiman, M., A., Routledge, R., Murthy, R., S., Ladrido-Ignacio, L., Ibrahim, A., & Harding, T., W. Community reactions to mental disorders: a key informant study in three developing countries. *Acta Psychiatrica Scandinavica* 61 (1980): 111-126.

FOOTNOTES

IN THE INTEREST OF WORKING WITH SURVIVORS OF WAR, TORTURE AND ORGANIZED VIOLENCE: LESSONS FROM A UNIVERSITY/ COMMUNITY RESEARCH COLLABORATIVE IN SOUTH-WESTERN ONTARIO

Ginette Lafrenière is an associate professor at the Faculty of Social Work at Wilfrid Laurier University and is the Director of the Social Innovation Research Group.

Lamine Diallo is an associate professor at Laurier Brantford and the Co-Chair of the Tchepo Institute which is a research institute dedicated to the study of contemporary Africa.

ABSTRACT

This article examines the highlights of an exhaustive research and training project entitled 'Project Access'. Researchers from Wilfrid Laurier University and a Francophone community health centre (CHC) in Hamilton, Ontario (Centre de santé communautaire de Hamilton/Niagara) came together to understand how the CHC could best respond to members of various cultural communities who were survivors of war, torture and organized violence. The research discovered the need for organizations to adapt their services in ways which were responsive to the particular needs of the survivors. These needs and approaches to mental health care for those who are survivors of war, torture and organized violence are examined.

INTRODUCTION

In 2005, an exciting university/community collaborative unfolded between researchers at Wilfrid Laurier University and a Francophone community health centre (CHC) in Hamilton, Ontario (Centre de santé communautaire de Hamilton/Niagara). For approximately eighteen months (18) an exhaustive research and training project entitled 'Project Access' was engaged in order to understand how the CHC could best respond to members of various cultural communities who were survivors of war, torture and organized violence. The basis of the research was to unearth certain elements of best practices which could enhance the skills of health care and social service professionals working with this particularly vulnerable target group. What the research discovered was the need for organizations to adapt their services in ways which were responsive to the particular needs of the survivors. Demystifying the importance of mental health services for survivors was an especially challenging element which characterized the work of providers. Additionally, creating nurturing physical environments for clients as well as having diverse human resources who were regularly exposed to continuing education and training were important themes which emerged within the research. Attention to issues relative to spirituality or religiosity also emerged as an important determining factor enhancing the quality of the helping relationship with survivors.

FRANCOPHONE IMMIGRATION IN HAMILTON

One of the determining characteristics of immigration patterns in Hamilton/Niagara is the increasing number of Francophone immigrants and refugees moving into this geographic area. Among these newcomers, the majority are coming from Francophone African countries influenced by war and political upheaval. According to the CHC, there are an overwhelming number of people from the Congo, Tchad, Rwanda, Central Africa, Burundi, Guinée and the Ivory Coast coming to Hamilton or are on their second migration from Quebec. The arrival of these 'New Franco-Ontarians' has pushed health and social

services to adapt to this particular clientele which very often is unilingual Francophone and grappling with the after effects of war and torture while attempting to integrate within an Anglophone, mainstream environment. As a result of witnessing the enormous difficulties that many of the stakeholders within these various cultural communities experience relative to the integration process, the CHC in Hamilton decided to undertake an ambitious project in order to best respond the needs of this particular clientele. The leadership of the CHC successfully applied for funding to the Ministry of Health and hence 'Project Access' emerged.

OBJECTIVES OF 'PROJECT ACCESS'

In 2004, the CHC witnessed an increasing number of clients from Francophone cultural communities who seemed to be presenting with an array of issues which characterized them as being somewhat more vulnerable than many other clients of the CHC who were not survivors of war and torture. In an effort to be responsive to this particular group of clients, the CHC endeavoured to take action and engage the following research and training project which held the following objectives:

- Identify best practices in order to best serve Francophone immigrants and refugees who are survivors of war, torture and organized violence;
- Develop a training manual for health care and social service professionals working with this particular clientele;
- Develop a pedagogical training video for all incoming human resources working at the CHC;
- Offer a series of training workshops in order to enhance the skills of health care and social service providers working with this particular clientele.

In order to honour these objectives, researchers from Wilfrid Laurier University were called upon to work within a framework of university/community collaboration in order to fulfill the mandate of the project:

- The research team conducted a thorough literature review on the subject of trauma and the contexts of best practices in which to intervene. The literature review enabled us to review hundreds of documents on different types of trauma and ways in which professionals have worked with survivors within organizations dedicated to survivors both in North American and African contexts;
- Sixty key informants were interviewed including 23 survivors, 27 professionals working in health care and social services and 15 experts working in some capacity with survivors of war and torture. Among the experts interviewed, a few were survivors themselves and were now working either as researchers or in the area of health care or social services.
- University/community collaboration was the framework

which informed this project and as such monthly meetings were organized between the research team and representatives of the CHC through an advisory committee. The research team met several times with staff and key informants and two community forums were held in both Welland and Hamilton in order to get feedback and share the data collected from all research stakeholders;

- Five all day training sessions were offered approximately every four months during the life of the project and were dedicated to enhancing the skills of the staff of the CHC on the following subjects: organizational change in the face of diversity, how to intervene with survivors of trauma, working with survivors of sexual torture, working with survivors of female genital mutilation (FGM), and models of intervention from five Canadian agencies;
- A short documentary informed by survivors as well as health care and social service professionals was developed in order to highlight certain strengths and challenges which both workers and survivors experience within the context of helping relationships.

RESULTS OF INTERVIEWS WITH SURVIVORS

The interviews with survivors of war, torture and trauma enabled the research team to determine the types of situations which the key informants faced as *survivors,* the challenges linked to their integration into Canadian society, their needs relative to services and support as well as solutions to the various challenges which they experienced.

The various forms of violence which the research participants experienced were either linked to social situations, such as FGM, forced marriages, or to war and organized political violence. Research participants shared stories of being imprisoned, tortured by military or armed individuals, rape and sexual harassment, witnessing the death of a loved one or enduring physical limitations due to torture as well as experiencing trauma due to unsafe living conditions in refugee camps.

CHALLENGES LINKED TO INTEGRATION

The research participants shared stories of being confronted with numerous challenges relative to their integration within Canadian society. Several were still waiting to hear word on their status (i.e. refugee status, landed immigrant status, permanent resident status) which they said augmented their level of emotional and financial stress. Research participants shared the following challenges as most important relative to their compromised ability to integrate within mainstream society:

- Inadequate services linked to learning English;
- Lack of information relative to education and training needs;
- Frustrating lack of recognition of levels of education,

diplomas and work experience in countries of origin;
- Facing discrimination while attempting to access housing;
- Physical or mental issues impeding the ability of survivors to access and maintain employment;
- Accessing health and social services in French;

Despite the difficulties which survivors shared with us, they nonetheless had very clear ideas on factors which could ease their integration within Canadian society. The most important factor was the idea of having a "guichet unique", a one stop space whereby survivors could access services in French for all levels of integration from accessing information for employment, housing, legal aid, health and social services. Not having to relate their horrific stories repeatedly was something which was of the utmost importance for most of the research participants. For many, having to repeat their stories, deal with systemic discrimination, racism and exclusion only served to aggravate their feelings of trauma and stress. Additionally, a very important factor which was shared by most of the research participants (survivors) was the idea that those professionals working in the area of health and social services needed to create spaces for dialogue around the idea of spirituality or religiosity. Finally, survivors want to be heard. It was found that survivors wanted to be able to tell their stories and have the professionals with whom they were working believe their stories and advocate for them. Also, the research participants (survivors) wished to be active stakeholders on boards, or committees which are dedicated to working with survivors in order that they can be agents of their own program development and influence ways in which professionals work with survivors.

RESULTS OF INTERVIEWS WITH HEALTH CARE AND SOCIAL SERVICE PROVIDERS

The health care and social service providers interviewed were primarily from the CHC in Hamilton as well as their satellite service in Welland, Ontario although some who were interviewed worked directly with survivors in other agencies. The professionals interviewed were nurses, nurse practitioners, doctors, social workers, community workers, educators and mental health counsellors. Fifty-one per cent (51%) were female and all research participants had received post secondary education. Most research participants stated that they had never received training specifically related to working with survivors of war, torture and organized violence. Only 25% of research participants shared that they had received some training in working with survivors of trauma and most stated that the training was insufficient or did not specifically relate to survivors coming from various cultural communities. All research participants stated that they would like to receive training and super-

vision relative to working with survivors of war, torture and organized violence.

The research participants shared the following challenges and barriers which according to them, compromised their ability to work with survivors in an effective manner:

A. COMMUNICATION

Communication was identified as the most challenging element of the work which characterized the relationships which professionals entertained with survivors. Several health care and social service providers felt that they did not have the necessary tools to adequately diagnose a client and several felt that they were unsure in being able to assess if someone had been tortured or not. Many shared feelings of inadequacy and frustration given that they did not know many of the cultural practices of certain clients and that assessment tools, particularly as it related to mental health, were culturally inapplicable to the clients which they were seeing.

Issues with accessing interpreters who could translate judiciously the thoughts and feelings of survivors was an issue for several service providers who felt that many ideas and information were lost in translation, thus compromising yet again the way in which they could provide adequate service. Challenges with having family members act as interpreters as well as individuals uncomfortable with the vocabulary of health and trauma were also cited as being frustrating factors which impeded adequate service provision.

B. PROFESSIONAL COMPETENCY

Several service providers shared stories of feeling inadequate and at times vulnerable as they did not feel that they were providing adequate services to survivors. Several experienced survivors as uncommunicative, uncooperative relative to following and carrying out medical requests (i.e. taking medication, following through on other tests, etc…). A few service providers shared thoughts of feeling manipulated at times by survivors and had difficulties believing their stories. Others still, shared feelings of being horrified and overwhelmed by survivor stories. There is at times, tension and friction between service providers and survivors whereby an aura of mistrust permeates both actors in the helping relationship.

C. DEMYSTIFYING MENTAL HEALTH SERVICES

For several health care and social service providers, a most frustrating element of their work is trying to explain and demystify the legitimacy of mental health services to survivors. According to the providers, not only do many survivors not know how to navigate the

health care system generally, there is a feeling that survivors do not understand the scope of mental health services in particular. This idea is confirmed by some of the survivors we interviewed who resist the idea of being stigmatized as being "crazy" (their words) and thus do not wish nor seek mental health services despite the fact that many present with symptoms related to trauma and post traumatic stress.

Other issues relative to religiosity and spirituality, vicarious trauma amongst service providers, and addressing tensions between Franco-Ontarians and Francophone immigrants were highlighted within the context of the research as important issues which needed to be further explored if service providers were to be able to adequately respond to survivor needs.

The most important element which emerged from the provider interviews was the need for ongoing training and supervision relative to the specificity of survivor needs.

LESSONS LEARNED

This project was and is important for all stakeholders who wish to enhance services dedicated to survivors of war, torture and organized violence. What we have learned from this research is immeasurably important on many fronts. We have learned that:

- Working within a framework of university/community collaboration is an imitable form of community based research as it creates spaces of equity and personal agency for those who are most affected by the research;
- Survivors wish to be heard and want health and social service structures to honour their voices and experiences in ways which do not treat them as exotic elements but as invested stakeholders who can enhance the design and spectrum of services deployed towards immigrants and refugees, many of whom are survivors of war, torture and organized violence;
- Health and social service providers must engage dialogue with their funders, managers, supervisors and boards of directors in order to fully commit to the arduous task of re-examining the ways in which services are dedicated to survivors and that these services are redesigned to be more responsive to the needs of survivors. Concretely this means being able to dedicate more time to survivors within intake and helping relationships, providing comfortable and nurturing physical spaces which will minimize the chances of triggering survivors, and providing training and supervision opportunities to health and social service providers in order to enhance service delivery. With regards to Francophone providers and survivors, creating spaces for dialogue between Francophones "de souche" and Fran-

cophone immigrants and refugees is imperative in order that socio-political spaces are shared and that harmonious alliances can be developed;
- Mental health services must be holistic and honour traditional forms of healing; this may include creating spaces for religiosity and spirituality or creating spaces for advocacy, truth and reconciliation initiatives or by expanding services which could include art, music and other forms of complementary therapies;
- Honouring the different ways in which mental health services can reach out to men, women and children must be considered in order to effectively provide services to various groups of survivors; paying attention to the gendered realities of survivors is crucial in order to address issues relative to trauma and PTSD;
- Breaking down the misguided elevation of one form of practice (clinical) over another (community) in social services is crucial if providers wish to effectively work with survivors; this means that creative community based healing initiatives should be considered and informed by survivors in order that veritable healing can take place;
- Health and social service providers should be encouraged to embrace the merits of research and ongoing evaluation of their practices in order to document and share promising practices with various stakeholders working with survivors of war, torture and organized violence.

DU GLOBAL AU LOCAL : REPENSER LES RELATIONS ENTRE L'ENVIRONNEMENT SOCIAL ET LA SANTÉ MENTALE DES IMMIGRANTS ET DES RÉFUGIÉS

Cécile Rousseau diplômée en médecine de l'Université de Sherbrooke a pratiqué 4 ans la médecine générale au Guatemala. Elle a complété ses études en psychiatrie transculturelle à l'Université de Montréal et McGill. Elle travaille en soins partagés dans des quartiers pluriethniques avec le CSSS de la Montagne et poursuit ses recherches sur les programmes de prévention en milieu scolaire pour les enfants immigrants et réfugiés.

Ghayda Hassan est professeure adjointe au département de psychologie de l'Université du Québec à Montréal (UQAM). Ses intérêts cliniques et de recherches se centrent autour de trois axes principaux de la psychologie clinique culturelle : 1) l'intervention en violence conjugale et les mauvais traitements envers les enfants dans un contexte de diversité culturelle ; 2) l'identité et la santé mentale des enfants et adolescents issus des minorités ethniques et 3) le vivre ensemble et les relations intercommunautaires. Elle travaille au sein de l'Équipe d'Intervention et de Recherche Interculturelle (ERIT) dirigée par la docteure Cécile Rousseau, où elle participe, entre autre, à la formation et à la supervision de stagiaires en psychologie clinique.

Nicolas Moreau détient un doctorat en sociologie de l'UQAM (Université du Québec à Montréal). Il est professeur remplaçant à l'École de service social de l'Université d'Ottawa, chercheur au sein des équipes MEOS (Équipe du médicament comme objet social) et ERIT (Équipe de recherche et d'intervention transculturelles). Ses publications dans les champs de la santé mentale et de l'interculturel sont nombreuses.

Uzma Jamil est doctorante en sociologie à l'Université du Québec à Montréal (UQAM). Elle est également chercheure associée au sein de l'Équipe de recherche et d'intervention transculturelles de l'Université McGill (ERIT). Elle travaille, à Montréal, avec les communautés musulmanes d'origine sud-asiatique sur les questions de construction identitaire et de relations de pouvoir entre les immigrants et la société québécoise et canadienne suite aux événements du 11 septembre 2001.

Myrna Lashley is a professor of psychology at John Abbott College and a lecturer in the McGill University Summer School on Transcultural Psychiatry. She is an internationally recognized clinical, teaching and, research authority in cultural psychology, and serves as an expert psychological consultant to governmental institutions, including the juvenile justice system and federal, provincial and municipal police systems. She has also worked as a consultant to First Nations and Jewish communities.

RÉSUMÉ

Dans le contexte de la « guerre au terrorisme », l'augmentation de formes explicites et implicites de discrimination est associée à plus de détresse psychologique au sein de certaines minorités. Parallèlement, l'apparition de stratégies d'affirmation identitaire et d'une cohésion interne accrue a des conséquences sur le plan de relations intercommunautaires.

Alors que beaucoup d'études sur la santé mentale des immigrants et des réfugiés continuent à mettre l'accent sur la psychopathologie et les facteurs de risque pré-migratoires, l'importance de l'environnement post-migratoire s'impose de plus en plus comme un déterminant majeur de la santé mentale de ces populations traditionnellement considérées comme à risque (Porter et Haslam, 2005). Le phénomène de globalisation entraîne une transformation des phénomènes migratoires et des relations internationales. Ainsi, les environnements d'accueil évoluent de façon rapide et exigent des changements paradigmatiques non seulement au niveau de la compréhension des enjeux pour la santé mentale des immigrants mais aussi sur le plan de la planification des services et des programmes intersectoriels.

Cet article propose un survol d'études québécoises récentes, conduite par l'équipe de recherche et d'intervention transculturelle (ERIT) réalisées auprès d'immigrants et de réfugiés, d'adultes et d'enfants, de la grande région montréalaise en ce qui a trait à la dialectique entre les contextes local et international. En présentant des recherches portant sur 1) les familles originaires des philippines et des caribes anglophones, 2) les communautés du Maghreb/Moyen-Orient et haïtienne ainsi que 3) les communautés musulmanes du sud-asiatique, cet article se veut une réflexion sur les associations complexes entre les spécificités québécoises et canadiennes et les enjeux plus globaux. Nous interrogeons les liens possibles entre des évènements publics (tels que le débat sur les accommodements raisonnables ou encore sur les évènements de Montréal Nord), les nouveaux visages de la discrimination, la montée de la suspicion face à l'Autre (généralement associée à la guerre contre le terrorisme) et la santé mentale des familles appartenant à des communautés minoritaires.

UN FUTUR IMPOSSIBLE ? DISCRIMINATION ET SANTÉ MENTALE POUR LES JEUNES ORIGINAIRES DES CARAÏBES ET DES PHILIPPINES.

Deux études réalisées entre 2004 et 2006 interrogent le décalage entre, d'une part, les perceptions d'institutions québécoises, tels que les commissions scolaires ou les services sociaux et de police qui rapportent des problèmes importants de comportement chez les jeunes et, d'autre part, la compréhension des représentants des communautés qui perçoivent les transgressions des jeunes comme étant davantage le fruit de facteurs environnementaux. Ces derniers soulignent le rôle de la discrimination qui survient dans un contexte d'immigration marqué par des séparations familiales prolongées fragilisant les familles (Lashley, 2000 ; Measham, 2002).

La première étude (Rousseau, et coll. 2008 ; Rousseau

et coll. 2009) interroge 254 familles originaires des philippines et des caraïbes fréquentant des écoles secondaires Montréalaises. La deuxième étude (Lashley et coll. 2005) porte, quant à elle, sur 63 jeunes originaires des caraïbes dans les CEGEP anglophones de Montréal. Les résultats révèlent que dans les deux études sus mentionnées, la discrimination vécue est significativement plus présente pour les jeunes issus des Caraïbes comparativement à leurs pairs philippins (t = 4.38 ; p<.001). Dans les classes de niveau secondaire, 12.7 % des jeunes issus des caraïbes disent avoir été frappés pour cause de racisme, 43.2 % avoir été insultés, 34.7 % avoir subi des impolitesses et, enfin 32.3 % avoir été traités injustement. Dans le cadre de la première étude, les analyses des régressions logistiques montrent que la discrimination émerge comme facteur prédicteur significatif des troubles de comportements pour les jeunes issus des Caraïbes et des Philippines alors que ceci n'est pas le cas ni pour les variables d'âge et de genre (classiquement associées à ces problèmes), ni pour le vécu de séparation familiale pourtant très fréquent chez ces groupes de population. Globalement, la prévalence des troubles de comportement chez les 254 jeunes recrutés demeure significativement plus faible que chez leurs pairs Québécois dans les mêmes environnements scolaires (Rousseau, et coll. 2008). Cependant, chez les jeunes originaires des Caraïbes, les problèmes de comportement augmentent significativement avec la durée de séjour au Québec, ainsi que chez les jeunes de deuxième génération.

Les données qualitatives des deux études susmentionnées révèlent que la discrimination est au cœur du vécu des familles et des jeunes rencontrés (et ce qu'ils soient issus des caraïbes ou des philippines) (Rousseau et coll. 2009). De plus, ces jeunes s'indignent du silence et de la résignation de leurs parents face à la discrimination. Alors que les jeunes Philippins conservent des espoirs de changement et d'ascension sociale, ceux originaires des Caraïbes sont plus pessimistes quant à leurs possibilités de sortir de l'exclusion sociale vécue leurs parents et d'accéder à des emplois correspondants à leurs compétences. Les données sur les facteurs associés à la réussite des jeunes originaires des caraïbes dans les CEGEP révèlent que ceux-ci canalisent leur colère et leur révolte face à la discrimination et à l'absence de perspective d'avenir en investissant, de manière résiliente, dans leurs études et en s'appuyant sur leur confiance dans leurs familles et en Dieu. Plusieurs demandent à Dieu de les soutenir dans leurs efforts de réussite et de les aider à ne pas se fâcher contre des figures d'autorité du pays hôte (Lashley, et coll 2005).

Les résultats de ces deux études mettent en lumière la gravité des formes implicites et «politiquement correctes» de racisme qui entretiennent l'ambiguïté et placent perpétuellement ces jeunes et ces familles en

position d'agresseur, dans la mesure ou ils deviennent d'une certaine façon responsables des formes intangibles de discrimination qu'il dénoncent.

ÉVALUATION : PERCEPTION DE LA DISCRIMINATION (1998-2007) ET SANTÉ MENTALE CHEZ LES NOUVEAUX ARRIVANTS

En 1998, l'enquête sur les communautés culturelles du Québec (ci-après ECC) a dressé un portrait de la santé des immigrants récents (arrivés au Québec depuis moins de 10 ans) issus des quatre communautés culturelles suivantes : 1) Maghrebine/Moyen-Orientale, 2) chinoise, 3) haïtienne et 4) hispanophone (ISQ, 2002). En 1998, les individus issus des communautés du Maghreb/Moyen-Orient rapportaient le plus faible taux de discrimination (25.8 %) comparativement aux membres de la communauté chinoise (39 %), haïtienne (31.1 %) et hispanophone (31.8 %). La perception de la discrimination constituait alors un déterminant plus important de la santé mentale chez les immigrants récents que l'emploi ou la maîtrise d'une des deux langues officielles (Rousseau et Drapeau, 2002).

En 2007, nous avons réalisé une étude comparant, à l'aide des mêmes échelles, la perception de la discrimination chez deux de ces communautés (haïtienne et Maghrebine/Moyen-Orientale) après le 11 septembre 2001 afin de mesurer l'éventuel impact de la guerre au terrorisme et du discours sécuritaire sur les relations intercommunautaires.

Les résultats montrent que la perception de la discrimination a presque doublé de 1998 à 2007, et ce quelle que soit l'origine ethnique (haïtienne ou arabe) ou religieuse (musulmane ou chrétienne) des répondants. La discrimination perçue passe de 31.1 % en 1998 à 54.3 % en 2007 pour les haïtiens et de 25.8 % en 1998 à 37.4 % en 2007 pour les arabes. Néanmoins, et malgré cette crois-sance significative de la discrimination, les répondants rapportent, en moyenne, moins de détresse psychologique qu'en 1998. De plus, si on compare les deux communautés culturelles entre-elles, on constate que l'impact de la discrimination sur la santé mentale négative (SCL-25) est, en moyenne, plus élevé chez les sujets arabes-musulmans interrogés en 2007, comparativement à ceux de 1998. Comment expliquer ces résultats ? D'une part, il semble que l'emploi – qui était dans une période faste à cette époque – a joué un rôle protecteur sur le plan de la santé mentale. D'autre part, les expériences de discrimination semblent renforcer les solidarités communautaires, particulièrement chez les participants arabes-musulmans. Ces solidarités se manifestent autour d'un niveau de reli-giosité plus élevé (r=.193, p<.05), qui à son tour, est associée à une meilleure estime de soi collective(r=.304, p<.001). Ainsi, la religiosité protégerait la santé mentale

des participants arabes-musulmans contre les effets négatifs de la discrimination en renforçant leur sentiment d'appartenance au groupe et en leur procurant confort et soutien à travers une plus grande observance des rituels religieux, possiblement, dans un geste de résistance (Bierman, 2006). Cette stratégie, a priori protectrice, peut toutefois constituer une arme à double tranchant, puisque les solidarités religieuses et l'exhibition des symboles et pratiques islamiques est aujourd'hui perçue comme une source de menace pour les valeurs et à la sécurité du groupe majoritaire (Esses, Dovidio et Hodson, 2002).

FAIRE SENS D'UN CONTEXTE MENAÇANT ET LE TRANSMETTRE : LES FAMILLES MUSULMANES DU SUD ASIATIQUE

Alors que la guerre en Irak menaçait d'éclater, nous avons collaboré avec certaines écoles afin d'essayer d'atténuer les contrecoups du contexte international qui se traduisent par une polarisation des revendications identitaires et religieuses dans certains quartiers (Rousseau et Machouf, 2005). Subséquemment, nous avons mis sur pieds, en partenariat avec les communautés pakistanaise et Bengali, deux recherches qualitatives portant sur la compréhension du contexte international et les conséquences possibles de ce dernier sur la santé mentale des familles dans le quartier parc Extension de Montréal.

Une petite ethnographie comparant l'expérience de sujets pakistanais de Parc Extension à celle de Pakistanais vivant à Karachi (Rousseau et Jamil, 2008) a révélé que ces deux groupes de populations n'adhèrent pas aux thèses occidentales dominantes dans les médias au sujet des attentats du 11 septembre. Ainsi, la théorie du complot est largement reprise et le recours à des «preuves» pour l'étayer, évoque en miroir les positions de l'administration américaine de l'époque. Au-delà de ces convergences, certaines différences apparaissent autour des possibilités de s'exprimer sur ces sujets. À Karachi, les répondants donnent libre cours à leur colère face aux contrecoups sociaux et politiques du contexte international dans leur pays et face à une ingérence étrangère qu'ils perçoi-vent comme injuste. Cela n'est pas le cas à Montréal puisque la peur menant au silence et à l'évitement prévaut, les individus ne se sentant pas assez en sécurité pour parler librement.

Étant donné l'ampleur du fossé entre les perceptions des communautés et celles du pays hôte, une recherche subséquente a essayé de comprendre les modalités de communication entre parents et enfants autour de cette délicate question. Il s'agissait de saisir le rôle que les parents attribuaient aux écoles quant au positionnement moral de leurs enfants face à un contexte international omniprésent dans les foyers par le biais des médias. Vingt

familles (parents et enfants) d'origine bengalaise ou pakistanaise ont participé à des entrevues qualitatives. Les résultats confirment l'évitement et les peurs suscités par les questions de politique internationale. Alors que l'ensemble des parents reconnaissent le rôle majeur de l'école afin de sensibiliser et de mobiliser les enfants dans le cas de catastrophes naturelles, la plupart s'oppose à ce que l'institution scolaire aborde les questions politiques, jugeant que les positions présentées seront trop partiales. Leurs craintes sont que les éventuelles discussions autour de cette thématique n'aggravent la polarisation existante entre «eux» et «nous». Les parents ayant une vision moins clivée et plus rassurante de la société hôte ont, quant à eux, tendance à conférer à l'école un mandat d'information et d'éducation autour de questions sensibles dont l'abord requiert un climat de respect mutuel. Du côté des jeunes et des enfants, les résultats indiquent que ceux-ci perçoivent et internalisent les peurs de leurs parents, même si, de par leur appartenance à des écoles multiethniques, ils ont souvent des positions moins tranchées que leurs ainés. Plusieurs jeunes ont également mentionné avoir un rôle actif à jouer dans l'amélioration des relations intercommunautaires, et ce en mettant l'accent sur leur capacité de complexifier les représentations de leur communauté ainsi qu'en promulguant les solidarités entre jeunes.

CONCLUSION

L'ensemble des recherches évoquées suggère que l'espace montréalais du vivre ensemble est soumis à des tensions croissantes, même si celles-ci demeurent généralement en deçà de ce qui est rapporté dans d'autres métropoles multiethniques. Les tensions intercommunautaires locales sont associées par les communautés minoritaires aux conflits globalisés et aux transformations des manifestations du racisme dans un contexte ou celui-ci, non seulement persiste, mais resurgit (Bourgeault, 2004). Les communautés vivant la discrimination raciale depuis longtemps subissent également le contrecoup du discours sécuritaire même si elles ne font pas spécialement parties des communautés actuellement visées (cf. communauté haïtienne), comme peuvent l'être les communautés musulmanes (Helly, 2004 ; Razack, 2008). Ces contextes social et politique ont un impact complexe sur la santé mentale des communautés, tant chez les adultes que chez les enfants. D'une part, les peurs – alimentées par une actualité sensationnaliste autour d'évènements publics (débats sur les accommodementsraisonnables, émeutes de Montréal-Nord) – génèrent une détresse psychologique d'autant plus importante que les représentations du «eux» et «nous» sont nettement dichotomisés. D'autre part, on assiste à l'émergence de stratégies de résistance

comprenant, en outre, une affi mation identitaire et une cohésion accrue des groupes qui se sentent menacés. Si ces stratégies permettent tempora irement de maintenir un équilibre, elles creusent aussi un fossé de plus en plus grand entre les communautés, entre la société hôte et les groupes minoritaires.

Bien que toutes ces recherches présentent des limites et doivent conséquemment être interprétées avec la prudence requise, elles confirment l'urgence de promouvoir des collaborations autour de l'élaboration de programmes de lutte contre le racisme et la discrimination entre professionnels de la santé mentale, écoles et autres acteurs sociaux, tels que les médias et la police. Ces collaborations devraient, nous semble t-il, être fondées sur des stratégies élaborées *par* et *avec* les familles appartenant aux minorités, en reconnaissant la légitimité de leur résistance face aux injustices sociales. De tels programmes doivent aussi s'adresser aux peurs et aux sentiments de menace d'une majorité fragilisée pour s'adresser aux tensions qui, s'ils débordent l'espace social Québécois, y réactive de vieilles blessures identitaires. Les interventions doivent être repensées de façon créatrice en misant sur les solidarités sociales existantes.

BIBLIOGRAPHIE

BIERMAN, Alex. «Does religion buffer the effects of discrimination on mental health? Differing effects by race.» *Journal for the Scientific Study of Religion*, vol. 45, (2006), p.551-565.

BOURGEAULT, Guy. « La constance résurgence du racisme. Pourquoi ? » *Racisme et discrimination Permanence et résurgence d'un phénomène inavouable* Saint-Nicolas: Distribution de livres, 2004, Univers, p. 260-280.

ESSES, V.M., J.F. Dovidio, J et G. Hodson. «Public Attitudes Toward Immigration in the United States and Canada in Response to the September 11, 2001 "Attack on America». *Analysis of Social Issues and Public* Policy, vol.2, no 1, (2002), p 69-85.

HELLY, Denise. «Are Muslims discriminated against in Canada since September 2001?» *Journal of Canadian Studies*, vol.36, no1, (2004), p.24-47.

LASHLEY, Myrna. The unrecognized social stressors of migration and reunification in Caribbean families. *Transcultural Psychiatry*, vol. 37, no 2, (2000), p. 201-215.

LASHLEY, Myrna., et coll. *Student Success: The identification of strategies used by Black Caribbean youth to achieve academic success.* Montreal: FQRSC, (2005).

MEASHAM, Toby. *Children's representations of war trauma and family separation in play.* Unpublished master's thesis, Thèse soutenue pra l'auteur à l'université McGill, en 2002.

PORTER, Matthew., et Nick Haslam,. «Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis». *JAMA*, vol. 294, no 5, (2005), p. 602-612.

RAZACK, Sherene. *Casting out: The eviction of Muslims form Western law and politics.* Toronto: University of Toronto Press, 2008.

ROUSSEAU, Cécile., et Aline DRAPEAU, « Santé mentale – Chapitre 11 », *Santé et bien-être, immigrants récents au Québec : une adaptation réciproque ? Étude auprès des communautés culturelles 1998-1999*, Montréal: Les Publications du Québec, 2002, p. 211-245.

ROUSSEAU, Cécile., et coll. *Prevalence and correlates of conduct disorder and problem behavior in West Indian and Filipino immigrant adolescents* (en ligne), 2008 (consulté le 21-4-2008). Sur internet : http://dx.doi.org/10.1007/s00787-007-0640-1. doi:10.1007/s00787-007-0640-1.

ROUSSEAU, Cécile., et coll. «From the family universe to the outside world: Family relations, school attitude and perception of racism in Caribbean and Filipino adolescents». *Health and Places*, vol. 15, no 3, (2008), p. 721-730.

ROUSSEAU, Cécile., et Uzma JAMIL. «Meaning and perceived consequences of 9/11 for two Pakistani communities: From external intruders to the internalisation of a negative self-image». *Anthropology and Medicine,* vol. 15, no 3, (2008), p.163-174.

ROUSSEAU, Cécile., et Anousheh MACHOUF. «A preventive pilot project addressing multiethnic tensions in the wake of Iraq war». *American Journal of Orthopsychiatry,* vol. 75 no 4 (2005) p. 466-474.

COMMUNITY ENGAGEMENT AND WELL-BEING OF IMMIGRANTS: THE ROLE OF KNOWLEDGE

Yvonne Lai, Ph.D., is the Outreach Coordinator of the New Canadians Centre and the Peterborough Partnership Council for Immigrant Integration. Her doctoral degree in Psychology utilized mixed methodology to explore the factors related to successful engagement of immigrants in small urban communities.

Michaela Hynie, Ph.D., is Associate Professor of Psychology at York University and the Associate Director of the York Institute for Health Research. Her research interests focus on culture, immigration and newcomer physical and mental health. Most recently, she has been working on social support, mental health, and accessing health care with recent newcomers.

ABSTRACT

Participation, integration and engagement in one's community lead to a range of individual and community benefits. However, civic and social engagement can be challenging for immigrants. We review the literature on community engagement and present data on barriers and facilitators of community engagement in newcomer communities.

Community engagement has been recognized as playing a central role in the well-being of individuals and communities. Evidence for the benefits of integration into one's community comes from a range of disciplines, using different terminology and focusing on different outcomes, but coming to similar conclusions. Community engagement research in the context of immigration and ethnic minorities often focuses on social exclusion of specific groups, where social and structural barriers prevent certain social groups from participating fully in their communities. Exclusion from the social life of one's community has negative consequences for the well-being of excluded individuals, and that of the community as a whole. It prevents excluded individuals from having full access to community resources such as education, employment or housing, and from achieving socially valued capabilities. It can also lead to elevated levels of unemployment and social unrest, and a weakening of social values in the community as a whole (Bhandari, Hovarth and To 2006; Schellenberg and Maheux 2007). Social support researchers studying the social isolation of individuals, as opposed to groups, consistently find serious negative consequences for physical as well as psychological well-being, with social isolation being linked to increases in both morbidity and mortality even after controlling for other social and health related variables (House, Landis and Umberson 1988). These findings support the importance of governmental and non-governmental organizations' efforts to improve the social, economic and political engagement and integration of diverse community members (e.g., Singh and Hynie 2008).

BENEFITS OF COMMUNITY ENGAGEMENT

Community engagement can occur through both social and civic participation. Social participation includes informal activities, such as visiting with neighbours; group activities, such as joining support groups; and activities in public spaces, such as attending community fairs or street parties. These activities build social networks and opportunities for participation in reciprocal social support relationships. Civic participation is comprised of volunteer activities for the benefit of others in the community and may be undertaken individually or in a group. Examples of individual activities include voting or signing a petition, while a group activity may be illustrated by one joining a community action group. Some forms of participation include a mix of social and civic participation. For example, participation in a group associated with one's place of worship may be social but also civic in nature, depending on the group's activities.

Participation in community events is both determined by, and results in, a feeling of attachment to a community and concern for its outcomes. Chavis and colleagues refer to this feeling of attachment as a "sense of community" (Chavis et al. 1986). Having a psychological sense of community has been associated with a range of positive psychological outcomes. It enables

community members to develop emotional ties with each other and to develop a sense of membership and belonging. It imbues individuals with feelings of autonomy, environmental mastery, and purpose in life. Research suggests that it also promotes personal growth and self-acceptance (Evans 2007).

Community engagement by individuals also benefits the community as a whole by contributing to its social capital. Social capital refers to relationships and structures within a community that promote cooperation for mutual benefit (Minkler and Wallerstein 2005; Putnam 1995). Social capital is observed in healthy communities with high levels of leadership, skills, networks, psychological attachment to the community, understanding of community history, and critical reflection (Goodman et al. 1998). Participation in community activities plays a key role in developing these resources. Social capital enables communities to maximize their potential, and progress from individual to collective action to achieve social and political change that can more effectively influence the well-being of community members (Butterfoss 2006).

PARTICIPATION AMONG IMMIGRANTS

Despite the benefits of active community involvement on individual and collective well-being, research suggests that civic engagement may be decreasing in inverse proportion to communities' increases in diversity through immigration and settlement. In the United States, residents in highly-diverse communities are less likely to trust their neighbours, regardless of whether they are from different or same cultural groups (Putnam 2007). They report lower socio-political control, lower confidence in political leaders, decreased instances of registering to vote, volunteering and charitable giving, constricted social networks, and weak confidence in personal and collective efficacy in influencing community outcomes. These results persist even when controlling for factors that have typically been associated with engagement, such as increased pressure on time and financial resources. While similar research has not been conducted in Canada, the tensions associated with reasonable accommodation of cultural differences suggest decreased social cohesion among at least some communities in the face of real or potential community diversity (Bouchard and Taylor 2008).

While all members of diverse communities may demonstrate reduced engagement, enhancing community engagement among immigrant community members may be particularly challenging. Immigrant individuals and communities in Canada achieve social inclusion, identification and engagement in their communities with varying degrees of success. In an analysis of data from the Longi-

tudinal Survey of Immigrants to Canada, Schellenberg and Maheux (2007) found a substantial portion of immigrants to Canada struggle to build social relationships in their communities. Seven percent of recent immigrants to Canada reported that lack of social relationships and interactions was one of their greatest challenges since arriving, more than the number citing discrimination or racism, access to housing or education, or access to professional services or childcare as one of their greatest problems. Rates of participation in volunteer activities are lower among immigrants to Canada than among non-immigrant Canadians, and especially among recent immigrants. The results from the 2004 Canada Survey on Giving, Volunteering and Participating indicated that approximately 30% of immigrants volunteered between 2003 and 2004, in comparison with almost 45% of the Canadian-born population (Statistics Canada 2006). Similarly, approximately 60% of immigrants voted during these years, compared to 75% of the Canadian-born population. These data show that immigrant community members experience less social and civic engagement than their Canadian born peers. Given the benefits that engagement and participation can bring to individuals and communities, understanding variables that can increase community engagement in immigrant communities is essential.

BARRIERS TO ENGAGEMENT AND PARTICIPATION

While recent immigrants may value participation, research suggests that many experience social exclusion as a result of multiple barriers, which include language differences, time constraints, and discrimination (Goodkind and Foster-Fishman 2002). Perhaps as a result of these barriers, immigrant families that are trying to establish themselves in new environments typically rely upon closely-knit, but small, social networks established within their cultural communities (Omidvar and Richmond 2003). In the Longitudinal Survey of Immigrants to Canada, among immigrants who made new friends, three-quarters reported that at least half of these new friends were of the same ethnic or cultural group (Statistics Canada, 2005). Thus, new immigrants are more likely to establish social networks with individuals from the same ethnic background as themselves. Moreover, they are more likely to volunteer with religious groups, which are less likely to be integrated in the larger community, than with community service organizations (Scott et al. 2006).

Other factors influencing participation that have been identified include the physical characteristics of the community (Oliver 2000), access to financial and time resources (McBride, Sherraden and Pritzker 2006) and

length of residence in Canada. Participation and community engagement may be particularly challenging for recent newcomers because they are struggling with limited personal resources. This lack of resources can make it difficult to provide support for others which prohibits participating meaningfully in reciprocal social support networks (Osborne, Baum and Ziersh 2009). Thus, at a time when support networks might be most needed, participating in social networks may actually increase immigrants' stress and distress, rather than contributing to their well-being (Hynie and Cooks 2009; Stewart et al. 2008).

Barriers to participation can also vary as a function of the size of the community to which newcomers have immigrated. Large metropolitan areas, like Toronto, facilitate culturally-based social and community groups as they are the hubs of immigration and sustain a large pool of diverse immigrants. The situation is different in smaller urban municipalities. However, social isolation seems to have a weaker negative impact in small communities and some researchers argue it may be because small urban centres foster more social integration (House, Landis and Umberson 1988). An interesting question is thus whether immigrants become more engaged in smaller communities. In one study conducted in Peterborough, a town of approximately 71, 000 people, we interviewed recent newcomers about the barriers they experienced to participating in local community events and organizations (Lai 2009) and found patterns of engagement that differed from those of larger metropolitan centres.

Twenty-one participants participated in semi-structured interviews about their participation and engagement. Participants came from a range of different countries and had been in Canada for an average of about 18 months. These recent newcomers were satisfied with the physical characteristics of their community and appreciated the relative calm and safety of being in a smaller urban centre, and were optimistic about their future there. Despite positive attitudes towards the community, however, recent newcomers noted several barriers to engagement. Several structural barriers to engagement existed. For most newcomers, facility with the English language was a major challenge, without which they felt as if "they have their tongues cut off." However, many were unable to attend formal and informal English language classes because of conflicts with work or childcare responsibilities, making this a difficult challenge to overcome. They also faced high rates of unemployment, a challenge shared by many in this small urban centre. Participants also reported that they actively refrained from joining community activities because they felt that "[staff and volunteers of community-based organizations] can't understand immigrants".

They did not report feeling discriminated against, but, rather, felt that community organizations were unaware of the unique experiences and needs of new immigrants and this discouraged them from participating.

At the same time, the participants reported very little knowledge of opportunities for participation in their community. Participants were unaware of any other community organizations in Peterborough outside of the settlement agency they were recruited through, including potentially useful services like Ontario Works, language training classes, and Legal Aid. None of the participants talked about seeking volunteer opportunities via notices on bulletin boards, despite wanting to feel that they were engaged in useful activities in the eyes of the community. Moreover, none utilized the drop-in services at the Family Resource Centre, or sought counseling services either in person or on the telephone via crisis help lines despite reporting a need for these services.

Interestingly, and in contrast to findings from larger metropolitan centres (e.g., Simich et al. 2005) participants did not highlight seeking support from other members of their own cultural groups. Rather, their support network tended to consist of immigrants from other cultural communities with whom they interacted at activities organized by the local settlement agency. By staying within the "comfort zone" of these activities, immigrants' exposure to services offered and activities organized by other community agencies may have been limited. Likewise, their exposure to other community members was limited to only other newcomers using these services, newcomers who also had limited knowledge of and engagement with the larger community. This social network was therefore unlikely to help them build an understanding of ways to engage and participate in the broader community. As a result, they may have been deprived of significant opportunities for assistance.

THE ROLE OF KNOWLEDGE IN ENGAGEMENT

In the study described above, several structural and personal obstacles emerged to recent newcomers' engagement and participation in their community. One barrier that could easily be addressed, however, was a lack of information and knowledge about one's community. Immigrants who were unfamiliar with the structure of formal social support services in the community were faced with navigating the system on their own or with informal assistance from friends who, in this case, often had little more information than they did. It seemed possible that increasing knowledge would be a simple intervention to help promote engagement among newcomer communities. We therefore conducted a second study to evaluate whether increasing knowledge about a community issue of relevance to immigrants

would be sufficient to increase immigrant engagement in this issue.

In collaboration with the Community Legal Clinic of York Region, we created an education program about property by-laws for immigrant residents of Markham, a moderately sized community (population over 260 000) situated just north of Toronto. Seventy recent newcomers participated in the education session and completed brief surveys before and after participation. Participants were more likely to participate by signing a petition to change property by-laws if they felt a stronger sense of community and community empowerment. A sense of community, in turn, was related to their knowledge of the Markham community. Increases in knowledge of the by-laws, however, did not increase participation by signing the petition. These results suggest that the effects of knowledge on community engagement are tied to a sense of knowing the community, rather than just knowing about specific issues. Indeed, knowledge of a community may be a by-product of engagement, rather than the other way around. What seems most likely, however, is that knowledge and engagement bear a reciprocal relationship to one another; you need to know about opportunities to participate in order to engage, but engagement in community activities will then increase your knowledge.

A greater focus on education and publicity may therefore be beneficial to engaging community members, but it needs to be a broad-based education about community norms, services and functioning, and it needs to be paired with initiatives to reduce structural barriers to participation. Two recent initiatives by the federal government reflect these priorities. The Welcoming Communities Initiative is a series of strategies between federal departments, aimed at improving the awareness and knowledge of discriminatory practices, and developing ways to counter these behaviours at a community-level. Another goal of the program is to increase immigrants' knowledge of their rights and entitlements in Canada (Citizenship and Immigration Canada 2006). This is supported by the Local Immigration Partnership program which supports communities in enhancing their capacities for delivering services to new immigrants (Citizenship and Immigration Canada 2008).

The programs described above support the move away from the traditional needs-oriented perspective which fosters a reliance on outsiders to fix community problems, and towards an asset-based community development where members are encouraged to identify, nurture, and utilize their own assets (McKnight and Kretzmann 1990). At the same time, involvement of government and non-governmental agencies to provide additional support is essential to address the challenges faced by newcomer individuals and communities who may struggle with limited resources, especially in the first years of settlement. The increasing profile of diversity in Canadian society, occurring in tandem with the trend of immigration, has the potential of adding vitality to community life. Working with these communities to build their capacity for engagement and well-being will ensure that this potential is realized.

REFERENCES

Bhandari, B. S., Horvath, S. and To, R. "Choices and Voices of Immigrant Men: Reflections on Social Integration". *Canadian Ethnic Studies* 38 (2006): 140-148.

Bouchard, G., and Taylor, C. 2008. *Building the Future: A Time for Reconciliation*. Québec: Commission de consultation sur les pratiques d'accommodement reliées aux différences culturelles.

Butterfoss, F. "Process Evaluation for Community Participation." *Annual Review of Public Health* 27 (2006): 323-340.

Chavis, D. M. et al. "Sense of Community Through Brunswick's Lens: A First Look." *Journal of Community Psychology* 14 (1986): 24-40.

Citizenship and Immigration Canada. "Welcoming Communities Initiative." 2006. http://atwork.settlement.org/sys/atwork_library_detail.asp?docid=1004152 (18 June 2009).

Citizenship and Immigration Canada. "Local Immigration Partnerships." 2008. http://atwork.settlement.org/sys/atwork_library_detail.asp?doc_id=1004478 (18 June 2009)

Evans, S. D. "Youth Sense of Community: Voice and Power in Community Contexts." *Journal of Community Psychology* 35 (2007): 693-709.

Goodkind, J. R. and Foster-Fishman, P. G. "Integrating Diversity and Fostering Interdependence: Ecological Lessons Learned About Refugee Participation in Multiethnic Communities." *Journal of Community Psychology* 30 (2002): 389-409.

Goodman, R. et al. "Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement." *Health Education & Behavior* 25 (1998): 258-278.

House, J.S., Landis, K.R., and Umberson, D. "Social Relationships and Health." *Science* 241 (1988): 540-545.

Hynie, M. and Crooks, V. A. 2009. "Patterns of Social Support Seeking and Use by Newcomer Women: The Costs and Benefits of Relying on Ethno-Cultural Networks." *Journal of Community & Applied Social Psychology.* [Manuscript under review.]

Kawachi, I. and Berkman L. F. "Social Ties and Mental Health."*Journal of Urban Health* 78 (2001): 458-467.

Lai, Y. 2009. Combining Qualitative and Quantitative Approaches to Community Belongingness and Empowerment. Toronto, ON: Doctoral dissertation, York University.

McBride, A. M., Sherraden, M. S. and Pritzker, S. "Civic Engagement Among Low-Income and Low-Wealth Families: In Their Words." *Family Relations* 55 (2006): 152-162.

McKnight, J. and Kretzmann, J. 1990. *Mapping Community Capacity.* Evanston, Ill.: Northwestern University.

Minkler, M. and Wallerstein, N. 2005. "Improving Health Through Community Organisation and Community Building: A Health Education Perspective." In M. Minkler (Ed.), *Community organising and community building for health* (2nd ed). New Brunswick, NJ: Rutgers University Press. 26-50.

Oliver, J. E. "City Size and Civic Involvement in Metropolitan America." *American Political Science Review* 94 (2000): 361-373.

Omidvar, R. and Richmond, T. 2003. *Immigrant Settlement and Social Inclusion in Canada.* Toronto: The Laidlaw Foundation.

Osborne, K., Baum, F. and Ziersch. "Negative Consequences of Community Group Participation for Women's Mental Health and Well-Being: Implications for Gender Aware Social Capital Building." *Journal of Community & Applied Social Psychology* 19 (2009): 212-224.

Putnam, R. "Bowling Alone: America's Declining Social Capital." *Journal of Democracy* 6 (1995): 65-78.

Putnam, R. "E Pluribus Unum: Diversity and Community in the Twenty-First Century – The 2006 Johan Skytte Prize Lecture." *Scandinavian Political Studies* 30 (2007): 137-174.

Schellenberg, G. and Maheux, H. 2007. Immigrants' Perspectives on Their First Four Years in Canada: Highlights from Three Waves of the Longitudinal Survey of Immigrants to Canada. Ottawa, ON: Canadian Social Trends, Statistics Canada.

Scott, K., Selbee, K., and Reed, P. 2006. *Making Connections: Social and Civic Engagement among Canadian Immigrants.* Ottawa, ON: Canadian Council on Social Development.

Singh, M. and Hynie, M. "An Evaluation of an Inclusivity Action Plan." *The International Journal of Diversity in Organisations, Communities, and Nations* 8 (2008): 117-124.

Simich, L. et. al. "Providing Social Support for Immigrants and Refugees in Canada: Challenges and Directions." *Journal of Immigrant Health* 7 (2005): 259-268.

Statistics Canada. 2006. Caring Canadians, Involved Canadians: Highlights from the 2004 Canada Survey of Giving, Volunteering, and Participating. Ottawa, ON: Statistics Canada.

Stewart et al. 2008. "Multicultural Meanings of Social Support among Immigrants and Refugees." *International Migration* 46 (2008): 123-159.

DETERMINANTS OF MENTAL HEALTH FOR NEWCOMER YOUTH: POLICY AND SERVICE IMPLICATIONS

Yogendra B. Shakya is the Director of Research at Access Alliance Multicultural Health and Community Services. His research interests include social determinants of newcomer health, racialized health disparities, and globalization and community based research.

Nazilla Khanlou is OWHC Chair in Women's Mental Health Research, Faculty of Health & Associate Professor, School of Nursing, York University & Adjunct Professor, University of Toronto. Her research interests include mental health promotion among youth and women in multicultural and immigrant-receiving settings. She was the Health Domain Leader of the Centre of Excellence for Research on Immigration and Settlement in Toronto (2001-2008).

Tahira Gonsalves was the Research Coordinator for the Newcomer Youth Mental Health Project and is a PhD student in Sociology at York University. Tahira's research interests include immigrant mental health and second generation youth religious identities.

ABSTRACT

Drawing on our study[1] with newcomer youth from four communities in Toronto, this article discusses post-migration determinants of mental health for newcomer youth in Toronto and reflects on policy implications. Preliminary study findings indicate that settlement challenges and discrimination/exclusions are salient risks to the mental wellbeing of newcomer youth and their families.

INTRODUCTION

There is a paucity of Canadian literature on the mental health of newcomer youth. Our study sought to fill this gap by investigating the social determinants of newcomer youth mental health.[2] We focused on newcomer youth (between the ages of 14-18 who have been in Canada for five years or less) and their families from four communities in the Toronto area: Afghan, Colombian, Sudanese, and Tamil. The project was grounded in an academic-community collaboration between the Faculty of Nursing at the University of Toronto and Access Alliance Multicultural Health and Community Services; we also incorporated several principles of Community-based Participatory Research (CBPR) including involving newcomer youth from the four communities as peer researchers and as advisory committee members.[3] Drawing on the qualitative component of our research, this article discusses the relationship between settlement stressors, discrimination/exclusion, and the mental health of newcomer youth and their families.

SNAPSHOT OF NEWCOMER YOUTH IN CANADA

The number of newcomer youth between the ages of 15-24 settling in Canada has been steadily growing during the last decade from 28,125 arriving in 1999 compared to 37,425 arriving in 2008 (24.9% increase). The trend in newcomer youth migration to Canada since 1999 is presented in Figure 1. On average 35,000 immigrants and refugee youth between the ages of 15-24 settle in Canada every year; this represents roughly 15% of the approximately 250,000 permanent residents that come to Canada annually. The composition of youth within refugees settling in Canada is slightly higher (20.4%) compared to youth in other groups. The majority (79.8%) of youth who settle in Canada are from racialized 'visible minority' backgrounds. A large percentage of immigrant youth settle in the three metropolitan cities in Canada (Toronto, Montreal and Vancouver); immigrant youth thus comprise a significant segment of youth population in these cities. In the City of Toronto, for example, immigrant youth between the ages of 15-24 constitute 39.5% of all youth in that age group.[4]

According to the 2006 Canadian Census, the unemployment rate for recent immigrant youth was 15.4% compared to 12.5% for Canadian-born youth. More strikingly, the low-income rate for recent immigrant youth was 3 times higher (45.8%) than that of Canadian-born youth (15.7%) (Census Canada 2009).

SETTLEMENT RELATED STRESSORS AND MENTAL HEALTH OF NEWCOMER YOUTH

We asked newcomer youth from all four communities to identify key stressors and challenges that they and their families face and how these stressors impact their general and mental wellbeing. Study findings indicate that the majority of stressors, barriers and challenges faced by newcomer youth and their families are related to settlement and discrimination/exclusion.

Settlement related stressors are ones that are experienced due to being new to the country and/or due to limitations in settlement policies and services for newcomers. Other researchers have also highlighted that the immigration and settlement process itself is a major stressor and that settlement related challenges can compound mental health issues among newcomer youth (Anisef and Kilbride 2000; Beiser and Hyman, 1997; Berry et al., 2006; Khanlou et al., 2002; Ngo and Schliefer 2005). Our study adds to this body of evidence on settlement related mental health stressors.

Linguistic barriers (including challenges with learning English), barriers in entering the labor market (particularly for parents and older relatives), and challenges associated with adjusting to the Canadian educational system were identified as major settlement related stressors by newcomer youth from all four communities. Youth also discussed isolation and access/information barriers that they face. They also talked about acculturation challenges to a host of formal and informal processes (including to Canadian laws, communication patterns, food and customs, cold weather, dating system

etc). Youth identified the mental health implications of these settlement related challenges including stress, low self-esteem, anxiety, worry, sadness and depression. Below, we focus our discussion on settlement stressors related to linguistic barriers, adjusting to Canadian educational system, and barriers entering the labor market.

Newcomer youth, their parents, and service providers identified linguistic barriers as one of the biggest challenges in the settlement process. Our findings suggest that having no or low English language fluency amplify the barriers and challenges that newcomer youth face including difficulties in making friends, understanding the teacher and curriculum being taught, and being bullied due to having low English fluency or having accents; in turn, these experiences resulted in low self-esteem and compounded stress and anxiety. Youth also discussed stressors related to learning English, particularly in ESL classes. They pointed out that while they are able to learn English more easily than adults, there is some stigma associated with being an ESL student. The following quote from a service provider exemplifies the negative perceptions that newcomer youth and others may have about being an ESL student:

> "The kids at the same time feel as though they are less worthy than the regular students because they are in the ESL classes. With the ESL, many think that because you don't have English, then you don't have the intelligence so the material that is being taught is like kindergarten material."

FIGURE 1: Permanent Resident Arrivals in Canada, Ages 15-24, by Category, 1999-2008
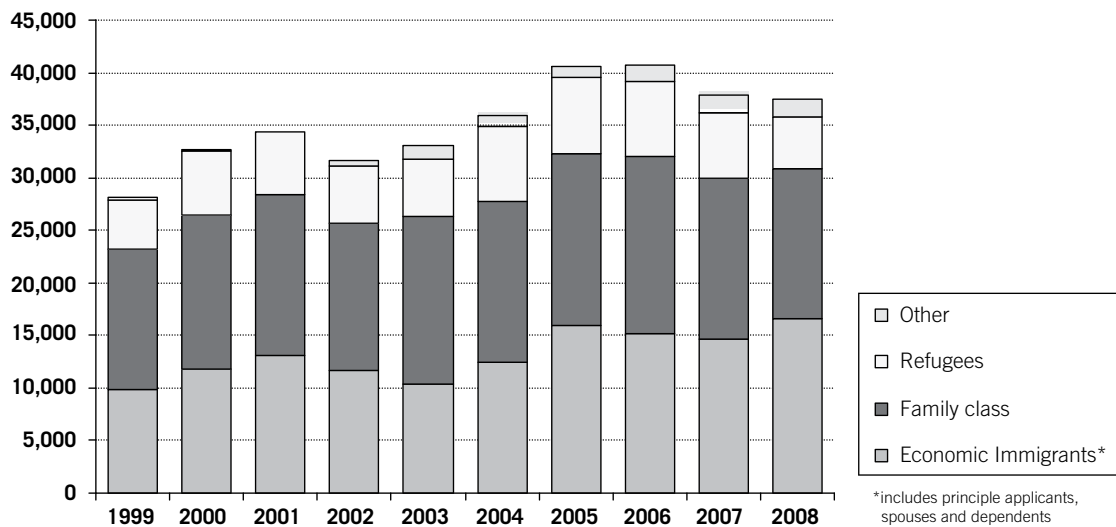
Source: Citizenship and immigration Canada. Developed by Access Alliance.

Adjusting to the Canadian education system also appears to be a major stressor for newcomer youth due to multiple barriers they face within the system. Several newcomer youth indicated that they had faced barriers in getting their foreign academic credentials recognized by their educational institutions leading to misplacement in grades and courses. Other stressors include inadequate academic bridging support to newly arrived immigrant students, lack of guidance in managing the heavy load of school assignments (compared to 'back home'), and bullying. They pointed out that adjusting to these new systems was quite stressful for them and their parents (who have to help them with their school work).

Our study findings indicate that the most profound stressor on newcomer youth results from the barriers that their families (particularly their parents) face in entering the Canadian labor market. Newcomer youth (between the ages of 14-18) are less concerned about getting jobs for themselves since at this age they are mostly interested in getting part-time jobs, which they mentioned are fairly easy to get. However, the majority of youth in our study emphasized that the difficulties that their parents face in entering the Canadian labor market not just undermined the income security for their families but also was a key cause of depression, sadness, family tensions and other mental health stresses on their family. Our study reveals that newcomer youth are acutely aware of the labor market challenges that their families face and the resulting socio-economic impacts (de-professionalization, income insecurities) and mental health impacts. The following narrative illustrate this point:

> "Sometimes my mom regrets coming from Colombia to here because she had a really good job over there too and she had everybody there to support her… I think coming from that great job that you had, coming to something lower is very hard for them because they want the best for their kids. When I was smaller, and spent two years here already, I used to tell her that I hated her for making me come here and I guess that didn't help her much but now I support her because I know that she just wanted the best. Sometimes she gets depressed because of her job and stuff."

Many of the youth respondents mentioned that while they could assist their families in overcoming other barriers and stressors (for example, acting as interpreters and service navigators for their parents), there was "little" they could do about the labor market barriers that their parents faced.

DISCRIMINATION/EXCLUSION AS DETERMINANT OF MENTAL HEALTH

Many youth from our study (all from racialized backgrounds) talked about having experienced (or witnessed) discrimination after coming to Canada, particularly race-based discrimination. We also found that racialized newcomer youth are aware of multiple forms of systemic social exclusions that they, their families and their communities (ethnic and geographic) face. For example, youth expressed deep concern about the way some teachers streamlined racialized youth into non-academic, trades based programs and careers, regardless of their actual aspirations. Several youth also pointed out the disparities in services in neighborhoods with high immigrant and racialized populations.

Several studies have examined the relationships between perceived discrimination, mental health and well-being, and ethnic/racial identity of immigrant youth populations (Phinney & Devich-Navarro, 1997; Jakinskaja-Lahti & Liebkind, 2001; Verkuyten, 2002; Shrake & Rhee, 2004; Khanlou, Koh & Mill, 2008). Studies in Canada and the United States have found negative physical and psychological health outcomes, such as elevated stress, lowered self-esteem, depression and behavioral problems (e.g. violence and drug use) related to perceived discrimination and experiences of racism (Dubois et al., 2002; Noh, Kaspar, Beiser, Hou, & Rummens, 1999; Surko et al., 2005).

Youth respondents recounted with sadness the direct experiences of race-based discrimination that they have faced or witnessed, often from teachers and people who are supposed to assist youth. Youth talked about being shocked, 'hurt' and 'getting really mad' due to these experiences of race-based discrimination.

An Afghan newcomer youth described his experience with racism and its impact in the following way:

> "When I first came here, everyone was making jokes about Afghanistan and terrorists. So every time I told them I was Afghan, they'd ask me if I was a terrorist. So like that really hurt. So after that every time people would ask me questions like that, I'd start asking them questions. So if they'd ask me if I was a terrorist, I'd say, 'do you see a bomb on me?'"

Similarly, a Colombian youth mentioned how his supply teacher had said that he wished he could 'close the border for Latin people' because 'he hates them'. Several Sudanese youth critiqued how people immediately associated them with war and the Darfur region when they said that they were from Sudan.

The following quote from a Tamil youth illustrates the sadness and long term impact (on self confidence and communication) that experiences of discrimination can have:

> "You get sad and become sad and you don't feel comfortable enough to talk to people more often. So you try to avoid talking to different people. So you ask yourself why, they're only making fun of you. So you stop talking to them."

STRATEGIES AND BARRIERS IN ADDRESSING MENTAL HEALTH DETERMINANTS/ISSUES

Preliminary analysis of our findings suggests that newcomer youth and their families rely more on informal systems of support rather than on formal services for emotional/mental support as well as for help in overcoming the determinants/stressors. In particular, newcomer youth from all four communities indicated that they do not have adequate knowledge about the mental health service sector in Canada and that they and families rarely access formal mental health services. For example, many youth in the study mentioned that they are not used to going to guidance counselors at their school even though they may be aware that it is a 'good thing to do.' One youth recounted how crisis counseling was available at her school after a shooting incident. While she acknowledged that it was a 'very good thing' she did not avail of it, also mentioning that she did not have anything like that back home.

Youth from all four communities identified family, friends, one's ethnic community, and religious institutions as their first and often the only sources of emotional and other support. Our findings suggest that, newcomer youth negotiate and utilize these informal systems of support in strategic ways based on kinds and levels of support each informal system can offer. For example, most youth said that they preferred going to their friends because 'you can tell them anything' and there is no obligation to follow the advice that friends give, unlike with parents and other adults. Several youth indicated that they often provide emotional and other support to their friends when needed.

Many youth viewed their ethnic community as an important source of support since 'there is always somebody to help you.' Several youth (including those that are not necessarily religious) identified religious institutions as comfortable spaces for seeking settlement advice and other support.

In terms of formal supports, youth talked about the role of teachers, ESL classes, and youth-focused programs offered in their schools and their neighborhoods (homework clubs, youth sports clubs). Youth highlighted that teachers who offer proactive support and are welcoming and respectful help to make them feel comfortable and included. As one youth put it:

> "Mostly, [teachers] know it's hard and they ask personally, 'you know, you're always welcome to come and see me'… they make you feel more comfortable. It depends on the teacher."

Our study has also documented many examples of youth resilience, optimism and leadership. Some youth talked about how they help their families to navigate and access services and assist with interpretation and translation in English for family members facing linguistic barriers. Some youth also mentioned that compared to adults, it was easier for them to make friends and that they 'made friends like crazy'. Youth in our focus groups often mentioned how they had 'gotten over things,' or moved on. However, as noted in the earlier section, newcomer youth usually felt helpless when it came to critical systemic stressors like labor market challenges, income insecurity, and racialized discrimination/exclusion that they and their families face.

CONCLUSION

Findings from our study indicate that many determinants of the mental health of newcomer youth and their families are closely linked to settlement related stressors and barriers. We argue that 'settlement is a health issue' and highlight that current limitations in settlement policies and services not only undermine the socio-economic wellbeing of newcomer youth and their families but also pose multiple risks to their mental health. Our study also found that systemic discrimination and exclusions are salient risks to the socio-economic and mental wellbeing of racialized newcomer youth and their families.

Based on our analysis, we recommend a multi-pronged approach to promoting the mental health of newcomer youth that includes (1) proactively addressing the determinants of newcomer youth mental health, particularly those linked to settlement and discrimination/exclusion(2) making mental health services more sensitive and accessible to the needs of diverse newcomer communities; (3) implementing innovative mental health promotion (MHP) programs that help to overcome stigma, and build positive knowledge about mental health issues; (4) promoting collaboration between the settlement and health sectors; and (5) implementing youth empowerment and community development programs that build youth leadership and involve newcomer youth meaningfully as agents of change in critical pathways (research, planning, decision making, community building etc).

REFERENCES

Anisef, P., and K. Kilbride. "The needs of newcomer youth and emerging "best practices" to meet those needs: Final report." 2000. http://www.ceris.metropolis.net/Virtual%20Library/other/anisefl.html (3 March 2006).

Beiser, M. "Health of Immigrants and Refugees in Canada." *Canadian Journal of Public Health* 96 (2005): S30-44.

Beiser, M., and I. Hyman. "Refugees' time perspective and mental health." *American Journal of Psychiatry* 154 (1997): 996-1002.

Bieser, M., F. Hou, I. Hyman and M.Tousignant. "Poverty, family process, and the mental health of immigrant children in Canada." *American Journal of Public Health* 92 (2) (2002): 220-227.

Berry, J.W., J.S. Phinney, D.L. Sam and P.Vedder. 2006. *Immigrant youth in cultural transition: Acculturation, identity and adaptation across national contexts*. New Jersey: Lawrence Erlbaum Associates, Inc.

Statistics Canada. "2006 Census Release Topics." 2009. http://www12.statcan.gc.ca/census-recensement/2006/rt-td index-eng.cfm (14 Dec. 2009).

Choi, H. "Understanding adolescent depression in ethnocultural context." *Advances in Nursing Science* 25(2) (2002).: 71-85.

Citizenship and Immigration Canada. "Facts and figures 2008: Immigration overview." 2009. http://www.cic.gc.ca/english/resources/statistics/menu-fact.asp (14 Dec. 2009).

Galabuzi, G. 2001. *Canada's Creeping Economic Apartheid: The economic segregation and social marginalization of racialized groups*. Toronto, ON: Center for Social Justice Foundation for Research and Education.

Jakinskaja-Lahti, I., and K. Liebkind. "Perceived discrimination and psychological adjustment among Russian-speaking immigrant adolescents in Finland." *International Journal of Psychology* 36 (3) (2001): 174-185.

Khanlou, N. "Influences on adolescent self-esteem in multicultural Canadian secondary schools." *Public Health Nursing* 21(5) (2004): 404-411.

Khanlou, N., M. Bieser, E. Cole, M. Freire, I. Hyman and K. Kilbride. 2002. *Mental Health Promotion Among Newcomer Female Youth: Post-Migration Experiences and Self-Esteem*. Status of Women Canada. Health Canada.

Khanlou, N., J. Koh and C. Mill. "Cultural identity and experiences of prejudice and discrimination of Afghan and Iranian immigrant youth." *International Journal of Mental Health & Addiction* 6(3) (2008): 494-513.

Ngo, H.V., and B. Schliefer. "Immigrant Children and Youth in Focus." *Canadian Issues: Immigraiton and Intersections of Diversity* (Spring 2005): 31-35.

Noh, S., V. Kaspar, M. Beiser, F. Hou, and J. Rummens. "Perceived racial discrimination, depression, and coping: A study of Southeast Asian refugees in Canada." *Journal of Health and Social Behavior* 40 (1999): 193-207.

Pumariega, A.J., E. Roth and Pumariega "Mental Health of Immigrants and Refugees." *Community Mental Health Journal*, 41 (5) (2005): 581-597.

Shrake, E., and S. Rhee. "Ethnic Identity as a predictor of problem behaviors among Korean American adolescents" *Adolescence* 39 (155) (2004): 601-622.

Surko, M., D.Ciro, C. Blackwood, M. Nembhard and K. Peake. "Experience of racism as a correlate of developmental and health outcomes among urban adolescent mental health clients." *Social Work in Mental Health* 3(3) (2005): 235-60.

Verkeyten, M. "Perceptions of ethnic discrimination by minority and majority early adolescents in the Netherlands." *International Journal of Psychology* 36 (6) (2002): 321-332.

FOOTNOTES

[1] The Newcomer Youth Mental Health Project was funded by the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. Dr. Khanlou and Dr. Shakya were Principal Investigators. Dr. Carles Muntaner was Co-Investigator.

[2] Our investigative and analytical framework is grounded in a social determinants of health (SDOH) perspective since the focus of our study is less on diagnostic processes for acute mental illnesses and more on understanding systemic risks and stressors to mental wellbeing and access barriers to mental health services.

[3] The study employed mixed-methodology comprising of focus groups, interviews and a questionnaire that included three psychometric instruments: Rosenberg Self-Esteem Scale (RSE), selected scales from the Health Behaviour in School-Aged Children (HBSC) instrument and the Current Self-Esteem Scale (CSE). We held a total of 6 focus groups with youth (2 Afghan, 2 Colombian, 1 Sudanese, 1 Tamil) 1 focus group with service providers, 16 in-depth interviews (2 Afghan youth, 4 Sudanese youth, 4 Sudanese parents, 1 Colombian parent, and 5 service providers). The questionnaire was administered to 56 youth.

[4] All statistics taken from Citizenship and Immigration Canada 2008.

THE MENTAL HEALTH OF IMMIGRANT AND REFUGEE CHILDREN IN CANADA: A DESCRIPTION AND SELECTED FINDINGS FROM THE NEW CANADIAN CHILDREN AND YOUTH STUDY (NCCYS)

Morton Beiser is Professor of Distinction and Program Director Culture, Immigration and Mental Health, Dept of Psychology, Ryerson University; Crombie Professor Emeritus of Cultural Pluralism and Health, University of Toronto; and Founding Director and Senior Scientist, Ontario Metropolis Centre of Excellence for Research on Immigration and Settlement (CERIS). Past academic appointments include Associate Professor of Behavioral Sciences, Harvard School of Public Health (1965-1975); Professor and Head, Division of Cultural Psychiatry, Dept of Psychiatry University of British Columbia (1975-1991), David Crombie Professor of Cultural Pluralism and Health, and Head, Culture, Community and Health Studies, University of Toronto (1975-2002).

ABSTRACT

One in five children living in Canada was born either outside the country or to recently arrived immigrants. Helping the children of new settlers adapt to their schools, integrate with the larger society and stay happy and healthy during the process are important goals for all immigrant receiving countries. However, there is a dearth of knowledge about what promotes adaptation and integration on the one hand, and what jeopardizes the well-being of immigrant and refugee children on the other. This article describes the New Canadian Children and Youth Study (NCCYS), a longitudinal investigation of personal and contextual factors affecting immigrant and refugee children's health, mental health and development, designed to fill some glaring gaps in current knowledge.

ACKNOWLEDGEMENTS:

INTRODUCTION AND BACKGROUND

As part of Canada's commitment to a national children's agenda, Statistics Canada and Human Resources and Social Development Canada (HRSDC) initiated the National Longitudinal Survey of Children and Youth (NLSCY) in 1994, a long-term study focused on the development and well-being of more than 35,000 Canadian children from birth to early adulthood. This still-ongoing study is producing valuable information about factors influencing children's social, emotional and behavioural development. However, because immigrant and refugee children are severely underrepresented in the sample, insights gleaned from the NLSCY tell only part of their story.

Migration and resettlement create unique developmental challenges. Policy makers and the helping professions need to understand what these challenges are, how children and their families respond to them, which responses are successful and which are harmful.

An article that several colleagues and I published a few years ago (Beiser et al 2002) containing a surprising finding about immigrant children attracted a flurry of media attention. It also stimulated the creation of the New Canadian Children and Youth Study (NCCYS).

This was the surprise. Poverty is one of the most potent of all factors that place children's mental health at risk. Using data from the first wave of the NLSCY, my colleagues and I compared mental distress and behavioural problems within the NLSCY's small sample of immigrant children and native-born children. Since immigrant families were more than twice as likely as non-immigrants to be living in poverty, we hypothesized that immigrant children would have higher rates of distress and disturbance. The findings were the exact opposite: foreign-born children had fewer emotional and behavioural problems than their native-born counterparts.

Further probing of the paradox highlighted the role of the immigrant family as a source of resilience. Poor immigrant families were much less likely than poor native-Canadian families to be broken families, and poor immigrant parents were less likely to be ineffective or dysfunctional parents. Although the material effects of poverty affected the mental health of both immigrant and non-immigrant children, the strength of immigrant family life apparently mitigated its psychological toxicity. Since the immigrant families studied had all been in Canada ten years or less, it is tempting to speculate that hope helped sustain them through the initially difficult years. Anecdotal evidence suggests that many new settlers perceive poverty and its effects as bumps along the road to eventual integration. By contrast, for far too many poor native-born Canadian families, poverty is the end of the road. The study raised a number of intriguing and important questions, for example: Did the good news about mental health apply to all children, refugee and immigrant alike? To visible minority as well as non-visible minority children? and, did factors such as the circumstances of migration or region of resettlement in Canada have mental health effects? The NLSCY sample of immigrant children was too small to permit investigation of such questions.

THE NEW CANADIAN CHILDREN AND YOUTH STUDY (NCCYS)

Investigators affiliated with the BC, Prairies, Ontario and Quebec Metropolis Centres of Excellence on immigration research initiated the NCCYS to investigate questions about the health, mental health and development of immigrant and refugee children that would contribute to the advancement of theory and to the development of policy and practice. Start-up funding from the federal departments of Health Canada, Canadian Heritage and Citizenship and Immigration Canada, from the four Metropolis centres, from the Fonds de la recherche en santé du Québec (FRSQ) in Quebec and Alberta Heritage Foundation for Medical Research (AHFMR) in Alberta supported the development of an interdisciplinary team made up of approximately 30 researchers from many of Canada's leading universities partnered by local immigrant and service-provider communities. The study team developed a research framework focusing on risk and protective factors important for the mental health of all children, such as parental mental health, poverty and parenting styles which could be considered universal risk and protective influences, and factors more or less specific to the immigration and resettlement experience, such as discrimination, the struggle with competing ethnic and civic identities, and the availability of a like-ethnic community as a source of social support. According to the NCCYS framework, immigrant and refugee children's well-being results from a dynamic process, the components of which include individual characteristics, pre- and post-migration stressors, and the individual and social resources children use to cope with stress.

The NCCYS team compiled a questionnaire covering universal and immigration specific general health and mental health risk and protective factors. After master versions of the questionnaires were prepared in English and in French, community advisory councils made up of community representatives examined each question to determine its acceptability, and cross-cultural translatability. The questionnaires were translated into 15 different heritage languages, and then back-translated. When discrepancies between the original and back-translated versions of a particular question arose, the community councils examined them to determine

whether a better translation was possible. The relatively few questions that defied translation had to be dropped.

The study involved six cities—Montreal, Toronto, Winnipeg, Edmonton, Calgary and Vancouver and 16 ethnocultural communities. A number of criteria guided the selection of target groups for the study: . *Significant presence:* Within each of the regions, the team selected three country-of-origin groups that were among the top ten with respect to numbers of new settlers during the ten years prior to the initiation of the study. According to 2001 census data, the three groups qualifying for inclusion according to this criterion were: Hong Kong (HK) Chinese, Chinese from the People's Republic of China (PRC) and Filipino. 2. *Groups of particular interest.* In order to investigate the effects of immigrant versus refugee status, visible minority status, and the availability of an established like-ethnic community during the time that new settlers arrive, we selected communities within each region in order to ensure that at least one case in the total sample fit each possible study profile—for example, refugee, visible minority, non-established community; or immigrant, non-visible minority, established community. In addition to the three national samples, that were represented at each site, there were site-specific samples (defined by source country and/or ethnicity) as follows: 1. Vancouver: Iran, Afghanistan, India (Punjabi) 2. Prairies; Vietnam, Central America, Kurdish 3. Toronto: Serbia, Ethiopia, Sri Lanka (Tamil) 4. Montreal: Haiti, Lebanon.

The NCCYS team focused on two age groups—children between the ages of four and six (to make it possible to follow children through the important developmental stage of starting school) and 11 to 13 (in order to follow children from pre-adolescence into early adolescence).

With the partnerships and collaborative arrangements in place, the NCCYS researchers developed and pilot-tested questionnaires for the planned biennial interview with parents and children. We then applied for, and received funding from the Canadian Institutes of Health Research to conduct two waves of interviews with the parents and children taking part in the NCCYS. The two survey waves have now been completed.

RESULTS FROM WAVE 1 OF THE NCCYS

The first publication from the NCCYS, a paper entitled "Predictors of emotional problems and physical aggression among children of Hong Kong Chinese, Mainland Chinese and Filipino immigrants to Canada" which appeared in the journal *Social Psychiatry and Psychiatric Epidemiology.* The article had two major aims, the first to demonstrate that, over and above the factors that affect the mental health of children in general, there

are factors specific to the immigrant experience that have to be taken into account, the second to explore the mental health salience of two immigration-specific factors—country of origin and region of resettlement in Canada. To address these two questions, the article focused on the NCCYS's three national groups—HK Chinese, PRC Chinese and Filipino.

The results showed that, in many ways, immigrant children's mental health is affected by the same factors that affect the mental health of children in general. For example, boys were more likely than girls, and younger children more likely than older, to display physical aggression. As is the case for children in general, maternal depression increased the probability that an immigrant child would have emotional problems.

However, in addition to risk factors such as parental mental disorder and protective factors such as good family functioning that affect the mental health of all children, factors more or less specific to the immigrant experience affected the mental health of children in newly resettling families, net of universal risk and protective factors. Immigrant children whose parents spoke little or no English or French were more distressed than children whose parents had better degrees of linguistic fluency, immigrant children whose parents were suffering a good deal of resettlement stress and who had experienced discrimination had an elevated risk of emotional problems and of physically aggressive behaviour.

The mental health salience of the country of origin and the region of resettlement were the two most original findings of the study.

PRC Chinese children experienced a lower risk of developing mental health problems than either HK Chinese or Filipino youngsters. These findings call attention to the circumstances of their family's migration, in particular the phenomenon of transnational families. Filipino migration is often initiated by women who respond to inducements such as those offered by Canada's live-in care-giver program that offers the possibility of landed immigration status after a mandatory period of service caring for children or the elderly. During the three to four years it takes to establish their status and save enough money to re-unite their own families, the women's own children stay behind in the home country with their fathers or members of the extended familyWhen family reunification eventually takes place; it can be complicated by children's resentment over perceived maternal abandonment. Immigration from Hong Kong is very different. Many HK Chinese families apparently came to Canada with plans to stay long enough to ensure their children' education, but with the ultimate goal of returning to the home country. Authorities have raised concerns about the possible mental health consequences of prolonged

parental absences, and of pursuing the goal of returning to their country of origin rather than of integrating into the society of the host county. By contrast, PRC Chinese families migrate as intact units with the goal of permanent settlement. Although it is tempting to speculate that the increased mental health risk among HK Chinese and Filipino children may be at least partially attributable to parental absences consequent on transnationalism, drawing such conclusions would be premature. Future analyses of NCCYS data is anticipated and will examine whether the findings can be explained by separations between parents and children, or whether other explanatory factors are at work.

Since family separation is, to a certain extent, amenable to changes in policy, these results cast a potentially important light on the importance of speeding up family reunification. With respect to services, if children in transnational families are indeed subject to particular mental health risks, meeting their needs may call for special training programs for service providers, including the need to plan for family life post-reunification.

Despite Toronto's reputation as a multicultural city, immigrant children living there had worse mental health than children living in the other five NCCYS sample cities. Although the gaps have been closing in recent years, the children in the NCCYS sample spent their early years in regions of the country that offered newcomers differing "levels of hospitality," that is macrosocial climates that can affect mental health. Inter-provincial disparities in the amounts of money spent per immigrant [Canadian Task Force 1988, CIC 2006) translate into differential access to language training, day care, job training programs and health care, each of which may affect the well-being of parents and children.

In the early 1990s, immigration began taking on cachet in Quebec, the Prairies and British Columbia. For example, in 1991, the federal government signed an accord with Quebec, devolving jurisdiction as well as funding for settlement and integration services to the Province. Similar accords were signed with Manitoba in 1996, with British Columbia in 1998, and with Alberta in 2002. By contrast, during the mid- to late 1990's, Ontario provided severely limited amounts of the kinds of social support that many immigrant families require during the early years, remained cool towards immigrants, and suspicious of federal policies of devolution. It was not until 2004 that the province signed an initial letter of intent to proceed with negotiations regarding immigrant selection, destination and integration. Despite being the largest magnet for immigrants, Ontario may not have presented the most welcoming environment.

Future analyses of NCCYS data will be concerned with defining indices of immigrant receptivity, and comparing these across regions in an attempt to explain the regional differences displayed in immigrant children's mental health. School climate will be one of these indices. An NCCYS paper recently submitted for publication (Hamilton et al unpub,) examined relationships between children's mental health and parent's perceptions of their schools. Schools with the most negative parental ratings were the schools in which immigrant children showed the highest levels of physical aggressiveness. It remains open to question whether poor school environments jeopardize mental health or whether parents of disruptive children blame the schools for their children's bad behaviour. The longitudinal data will help determine the sequence of events. Regardless of causal direction, the findings point to the need for schools to improve communication with the parents of immigrant children.

Canada expects a great deal from newcomer children. Immigrant parents also have high hopes for their children. To help both families and the country realize their aspirations, we need to know a great deal more than we currently do about what jeopardizes immigrant children's mental health and what factors—personal, familial, social and societal—help ensure their well-being and success. Adapting to and integrating with a new society are not easy tasks. The fact that most immigrant children meet the challenge is testimony to their resilience, a resilience based on personal qualities, the strength of the immigrant family and to the social resources they manage to find in Canada. All is not well, however, if almost a third of immigrant families with children live in poverty, if one in five immigrants experiences discrimination, if parents feel alienated by their children's schools, and if there are disparities in well-being traceable to where people choose to live in Canada. More can and must be done to ensure that immigrant children become part of Canada's children's agenda.

REFERENCES

Peer-Review Journals

Beiser, M. Hou, F., Hyman, I., Tousignant, M., "Poverty and Mental Health Among Immigrant and Non-immigrant Children." *American Journal of Public Health.* 2002, Vol 92 No. 2, 220-227.

Beiser M., Hamilton H, Rummens JA, Oxman-Martinez J, Ogilvie L, Armstrong R, Humphrey C, (in press) Predictors of Emotional Problems and Physical Aggression among Children of Hong Kong Chinese, Mainland Chinese and Filipino Immigrants to Canada *Social Psychiatry and Psychiatric Epidemiology.*

Hamilton HA, Marshall L, Rummens JA, Fenta H, Simich L. (unpub. under review) Immigrant Parent's Perceptions of School Environment and Children's Mental Health and Behaviour.

Reports

Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. (1988). After the door has been opened (Cat. No. Ci96 38/1988E). Ministry of Supply and Service, Ottawa.

Citizenship and Immigration Canada, Facts and Figures (2006). Immigration Overview: Permanent Residents, www.cic.gc.ca/EnGLIsh/resources/statistics/facts2006/permanent/12.asp.

MENTAL HEALTH PROMOTION THROUGH EMPOWERMENT AND COMMUNITY CAPACITY BUILDING AMONG EAST AND SOUTHEAST ASIAN IMMIGRANT AND REFUGEE WOMEN

Yuk-Lin Renita Wong, PhD. is Associate Professor at the School of Social Work at York University. Her research interests include: gender, migration and mental health; critical social work, spirituality and social justice, community-based action research, and post-earthquake community rebuilding in Sichuan China.

Josephine P. Wong, RN, MScN, has been a public health consultant and researcher for seventeen years. She is Associate Professor at the Daphne Cockwell School of Nursing at Ryerson University, and a doctoral candidate at the Dalla Lana School of Public Health at the University of Toronto.

Kenneth P. Fung, MD FRCPC MSC, is Assistant Professor at the Department of Psychiatry at the University of Toronto and the Clinical Director of the Asian Initiative in Mental Health (A.I.M.) at Toronto Western Hospital of the University Health Network, Toronto.

ABSTRACT

This article presents a demonstration project that used inclusive health promotion to address the mental health needs of East and Southeast Asian immigrant and refugee women in Toronto. The project demonstrated that effective mental health promotion must consider the social determinants of health, and integrate the principles of social inclusion, access and equity into practice.

ACKNOWLEDGEMENTS:

INTRODUCTION

Migration stress has been identified as one of the major determinants of immigrant mental health. As individuals and families go through the transition of settlement, they are often faced with increased stress related to the demands of adjusting to a new way of living: loss of family and social network (Stewart et al. 2008), loss of gainful employment and socio-economic status (Dean and Wilkson 2009; Picot, Hou and Coulombe, 2008), changes in roles and intergenerational conflicts (Chuang, Su and Tamis-Lemonda 2009; Este and Tachble 2009) and difficulties in social integration and accessing health and social care due to language and systemic barriers (Sabatier et al. 2008; Yee 2003). Immigrant and refugee women experience additional stress because they bear the extra burden of caring for their spouses, children, elders and other family members (Guruge and Collins 2008; Williams 2008; Zadeh, Geva and Rogers 2008).

Canada's immigration patterns have changed significantly since the 1970s. Over the past three decades, over half of all newcomers are from Asia; China, Hong Kong, Korea, Taiwan and Vietnam have been on the top ten source countries of immigrants.[1] Studies have shown that Asian immigrant and refugee women tend to have a much lower rate of health service utilization compared to their counter parts in general (Lee 2002; Li and Browne 2000; Tu et al. 1999). While some researchers attribute this low health service utilization to Asian cultural values, or health beliefs and practices (Chiu et al. 2005; Gilbert et al. 2004; Tsang 2004), other studies highlight the systemic barriers for newcomers to access services (Bottorff et al. 2004; Fung and Wong 2007).

This article presents the processes and outcomes of a demonstration project that used inclusive health promotion to address the mental health needs of East and Southeast Asian immigrant and refugee women in Toronto. The project considered and incorporated the diverse and unique contexts of the six target communities in its design and implementation. Consequently, the project demonstrated that effective mental health promotion must consider the social determinants of health, and integrate the principles of social inclusion, access and equity into practice.

THE PROJECT FRAMEWORK: PROMOTING HEALTH THROUGH COLLECTIVE EMPOWERMENT

In 2001, the authors collaborated with an ethno-specific mental health agency (Hong Fook Mental Health Association) to carry out an action research project funded by the Ontario Women's Health Council (OWHC) to identify the mental health needs of immigrant and refugee women from Cambodia, Hong Kong, Korea, Mainland China, Taiwan, and Vietnam, who lived in the Greater Toronto Area. The goals of the project were to promote mental health literacy among the women from the six communities and support them to make informed choices about their mental health needs and access to care. The project included two components: community assessment and peer-to-peer empowerment education.

Recognizing that our mental health is influenced by a myriad of socio-environmental factors beyond biology and genetics (Jackson 2004; Mawani 2008; World Health Organization 2001), this project used a comprehensive empowerment approach to promote mental health among women and their families in the six project communities. Empowerment refers to "a social action process that promotes participation of people, organizations and communities towards the goals of individual and community control, political efficacy, improved quality of life and social justice" (Wallerstein 1992, 198).

WOMEN'S HOLISTIC HEALTH PROMOTION: INTEGRATION OF THEORY, RESEARCH AND PRACTICE

There is a growing impetus for evidence-based policy and practice in health promotion; however, most knowledge translation and exchange (KTE) activities tend to privilege the interactions between researchers and policy-makers (Mitten 2007); frontline service providers and users are seldom included in the KTE process. With funding support from the Ontario Women's Health Council (OWHC), the Women's Holistic Health Promotion Project was able to engage community members, service providers and organizations to take part in an action research and follow-up program design. To ensure that the project was inclusive, a Community

Advisory Committee with members from each community was established to advise the project at every stage. Furthermore, the project used an unconventional method to hire its staff. Recognizing that newcomers experienced systemic barriers to employment, the project made it a point to eliminate 'Canadian work experience' as a job requirement and hired five newcomer women. It also hired three Canadian-born or 1.5-generation young women who desired to connect to their cultural roots through community work. Bringing a diverse project team together facilitated cross-cultural exchange.

PHASE I – COMMUNITY ASSESSMENT: DOING RESEARCH WITH AND NOT FOR THE COMMUNITY

Effective health promotion starts from the perspectives and experience of the community members. Using mixed methods of focus groups, in-depth interviews and surveys, we conducted a community needs assessment to explore how women in the target communities conceptualized mental health, experienced migration and settlement, defined their mental health needs, and managed their stress and health. A total of 22 interviews with service providers (including spiritual leaders) of the six communities were conducted to gain a general understanding of the historical, cultural and local systemic environment that the women of the target populations faced.

The research respected community self-determination and exercised flexibility to enable the communities to define their research questions and needs. For instance, the Cambodian communities preferred to engage in KTE of previously completed research instead of engaging in a new research because of 'research fatigue'. Similarly, community consultation with stakeholders suggested the need to respect the distinct historical, political and cultural differences among the Taiwanese, Mainland Chinese and Hong Kong Chinese communities; as a result, the project re-allocated its resources to meet the unique needs of the three communities to ensure that all the research and empowerment education activities were conducted accordingly.

Fifty-four women, of 25 to 75 years of age of diverse socioeconomic backgrounds, participated in the in-depth interviews sharing with us the challenges they faced, the strategies they used, and the resources they mobilized in re-making their life in Canada. A total of 102 women, of 18 to 60 years of age, took part in 13 focus groups, where women articulated their conceptions of mental health and mental illness, as well as discussed factors that affected and helped maintain their mental health. The women participants' diverse articulations of mental health challenged the stereotypical characterizations of Asian women and the dominant Western views of mental

health; they viewed mental health and its social determinants as inseparable (Wong and Tsang 2004).

Developed in consultation with the Community Advisory Committee, a community survey of 1,000 self-administered structured questionnaires was conducted to identify the women's health status, and the relation between their mental health beliefs and help-seeking behavior. Contrary to the common discourse that immigrant women are reluctant to access mental health care because of stigma associated with mental illness, the survey results showed that the most important factor predicting attitudes towards seeking professional help was the women's perceived access to culturally appropriate services (Fung and Wong, 2007).

PHASE II – PARTICIPATION AS A PATH TO EMPOWERMENT

Informed by the results of the community assessment and guided by the framework of empowerment and capacity building, Phase II of the project emphasized the social determinants of mental health. It consisted of two key components: 1) health communication; and 2) empowerment education to promote health literacy, self-efficacy and collective empowerment.

1) Health Communication: Mental Health As Understanding

The goal of the campaign was to raise awareness of the mental health issues faced by women in the six project communities and the mental health resources available to them. The campaign theme of "Mental Health as Understanding" was identified from the preliminary findings of the focus groups and through consultation with our Community Advisory Committee. The Campaign included a 30-second Public Service Announcement (PSA) on TV and radio, and other print media in the six target communities. The PSA captured the following themes:

• the challenges for newcomers to gain adequate employment as they experience cultural, language and systemic barriers

• financial hardship experienced by low-income immigrant/refugee families in the settlement process;

• relationship tension and conflicts related to re-negotiation of gender roles in Canada;

• intercultural and intergenerational differences within the family; and

• the challenges of sole parenting for women whose partners have to work in Asia to support the family financially.

As part of the Health Communication Campaign, a Holistic Health Infoline for Women was set up to provide information and referral in the five project languages. A total of 236 calls to the Infoline and 552 calls to Hong Fook's Intake Line were received over a period of 3 months immediately following the campaign; these calls represented a 67% increase in comparison to the calls received over the 3 months before the campaign.

2) Peer Leadership Training and Peer-to-Peer Outreach

The Women's Holistic Health Peer Leadership Training Program was developed based on adult learning theory and critical pedagogy (Freire 1971). It aimed to support the participants to identify their individual and collective strengths to overcome the cultural and systemic barriers they encounter in their daily lives. In this context, empowerment is not about service providers giving power to women in the community. Rather, it is about creating opportunities for women to participate meaningfully within their communities and integrate into society at large (Labonte 1994).

Furthermore, the peer leadership training used a train-the-trainer model, whereby the project staff went through an intensive course of training that consisted of 10 sessions. Upon its completion, the project staff recruited women from their respective communities to take part in the peer leadership project; they also applied their new knowledge and skills to train more women to become peer leaders. The training program was free of charge and in return the women peer leadership course graduates were encouraged and supported to do holistic health promotion outreach and education to other women or families in their own cultural communities.

Two project manuals were developed for the leadership training: 1) a training manual used by the project staff to train the women peer leaders; and 2) a workshop manual used by the women peer leaders to facilitate discussion groups and workshops among their peers in the communities. The manuals covered a range of topics derived from the research results and existing literature, including collective learning, migration and settlement experience, women's identity and family relations, social determinants of health, effective communications, stress management, and collective actions to promote health.

In April 2002, the first round of "Women's Holistic Health Peer Leadership Training" program recruited over 161 women from the six project communities to form 11 peer leadership groups. Over a period of five months, a total of 127 women peer leaders completed the training program These peer leaders were proactive in their peer outreach; they collaborated with other community agencies and faith organizations to provide workshops and outreach activities on holistic health. Between July 2002 and March 2003, they conducted over 79 workshops and outreach activities, reaching 5,029 participants. They also put together a collective book project, *Beyond rice & noodles—Our stories, our journey*, to share their migration

stories and their strategies of maintaining health in the midst of hardships.[2] The women peer leaders' commitment and successes were celebrated at the Women's Holistic Health Peer Leadership Graduation Ceremony held in October 2002.

In addition to the above collective actions, the women leaders also demonstrated increased self-efficacy in political action beyond their cultural communities; for example, during an advocacy campaign to "Save Medicare", the Korean peer leaders collected over 10,000 signatures from the Korean churches, street campaigns, and from their social networks to present to the provincial legislature. Towards the end of this pilot initiative, the original peer leaders were supported to become co-facilitators in the training of new groups of peer leaders. This model provides leadership opportunities, skill building and expansion of social support network.

SUSTAINABILITY

Sustainability of health promotion programs is a well-recognized challenge among practitioners, administrators and policy-makers alike. Many innovative and effective programs delivered by small agencies eventually dissolve due to the lack of strategies and resources to sustain these programs. Furthermore, there is not a clear definition of sustainability (St Leger 2005). To develop sustainable programming, an organization must have a clear definition of what constitutes sustainability and what are the necessary conditions. In the context of this project, sustainability means the agency's ability to continue the empowerment education and outreach beyond the funding provided by the OWHC. Thus, program sustainability is dependent on other resources in addition to funding, such as the program's fit with the organization's mandate; its flexibility to be modified to meet the changing needs of the community; its ability to outreach to the intended clients, and the capacity of the key stakeholders (Sheirer 2005).

Upon the completion of the pilot project, the peer leadership initiative took on a life of its own. Hong Fook adopted empowerment and peer leadership as its program mandate in mental health promotion. Many women peer leaders continued to do outreach activities in their communities, where they met many individual and families experiencing mental health problems. They recognized that stigma associated with mental illness was a significant barrier to promoting mental health and collective empowerment; they expressed the need for additional training on mental illnesses and anti-stigma strategies. Based on their feedback, Hong Fook worked with the peer leaders to develop materials for a new phase of training, which focused on two key topics: mental health and illness as a continuum, and stigma as a deter-

minant of health. This time, the agency also included men who were interested in the peer training.

Before 2001, Hong Fook had a total of 50 volunteers committed to community outreach and promotion. In 2003, Hong Fook integrated empowerment and capacity building into its health promotion program. The agency has since increased their pools of volunteers to more than 200 holistic health women and men peer leaders who do outreach at the grassroots level to provide culturally appropriate health information and to influence community attitude in reducing stigma about mental illness.

CONCLUSION: INCLUSIVE AND EQUITABLE SERVICES AS BEST PRACTICES

The peer leadership training and outreach initiative, which started as a pilot project in 2001, has proven to be an effective and sustainable health promotion program. Over the past eight years, project staff have reviewed and reflected on the processes and outcomes of this initiative and shared this knowledge with researchers, service providers and policy makers (Wong et al., 2002; Wong, 2003; Wong, Wong and Fung 2003; Wong, Wong & Yoo, 2009). Within the mental health field, there is a recent call for moving mental health promotion into the mainstream. The Hong Fook peer leadership training initiative has demonstrated that mental health promotion is achievable through the use of collective empowerment and capacity building as key strategies. More importantly, best practices are 'best' only if they are relevant and effective. To be effective, we must go beyond the popular discourses of 'cultural competence' and 'cultural sensitivity' to integrate the principles of social justice, access and equity into the research-policy-practice cycle to guide interventions at the grassroots, and mandates and directions within health organizations and public policy in the government sector, with the common goal of addressing the social determinants of mental health.

REFERENCES

Beeker, C., C. Guenther-Grey and A. Raj. 1998. "Community empowerment paradigm drift and the primary prevention of HIV/AIDS." *Social Science and Medicine* 46(7): 831-842.

Bottorff, J. L. et al. 2004. "Othering and being Othered in the context of health care services." *Health Communication* 16(2): 253-271.

Chiu, L. et al. 2005. "Spirituality and treatment choices by South and East Asian women with serious mental illness." *Transcultural Psychiatry* 42(4): 630-656.

Chuang, S. S., Y. Su and C. Tamis-Lemonda. 2009. "Says who?: Decision-making and conflicts among Chinese-Canadian and Mainland Chinese parents of young children." *Sex Roles* 60(7-8): 527-536.

Dean, J. A., and K. Wilson. 2009. " 'Education? It is irrelevant to my job now. It makes me very depressed.': Exploring the health impacts of under/unemployment among highly skilled recent immigrants in Canada." *Ethnicity & Health* 14(2): 185-204.

Este, D. C., and A. A. Tachble. 2009. "The perceptions and experiences of Russian immigrant and Sudanese refugee men as fathers in an urban center in Canada." *Annals of the American Academy of Political and Social Science.* 624: 139.

Freire, P. 1971. *Pedagogy of the oppressed.* New York: Seabury Press.

Fung, P. K., and Y. L. R. Wong. 2007. "Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women." *International Journal of Social Psychiatry* 53(3): 216-231.

Gilbert, P., J. Gilbert and J. Sanghera. 2004. "A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby." *Mental Health, Religion and Culture* 7(2): 109–130.

Guruge, S., and E. Collins. 2008. "Emerging trends in Canadian immigration and challenges for newcomers." In S. Guruge and E. Collins (eds.), *Working with immigrant women: Issues and strategies for mental health professionals.* Toronto: Centre for Addiciton and Mental Health. 3-15.

Jackson, A. 2004. "The unhealthy Canadian workplace." In D. Raphael (ed.), *Social determinants of health: Canadian perspectives.* Toronto: Canadian Scholar's Press. 79-94.

Lee, M., F. Lee and S. Stewart. 1996. "Pathways to early breast and cervical detection for Chinese American women." *Health Education Quarterly* 23(Suppl): S76-S88.

Li, H. Z., and A. J. Browne. 2000. "Defining mental illness and accessing mental health services: perspectives of Asian Canadians." *Canadian Journal of Community Mental Health* 19(1): 143–159.

Mawani, F. N. 2008. "Social determinants of depression among immigrant and refugee women." In S. Guruge and E. Collins (eds.), *Working with immigrant women: Issues and strategies for mental health professionals.* Toronto: Centre for Addiciton and Mental Health. 67-87.

Mitton, C. et al. 2007. "Knowledge transfer and exchange: review and synthesis of the literature." *Milbank Quarterly* 85(4): 729-68.

Picot, G., F. Hou and S. Coulombe. 2008. "Poverty dynamics among recent immigrants to Canada." *International Migration Review* 42(2): 393-424.

Sabatier, C. et al. 2008. "The role of family acculturation, parental style, and perceived discrimination in the adaptation of second-generation immigrant youth in France and Canada." *The European Journal of Developmental Psychology* (Print), 5(2): 159-185.

Scheirer, M. 2005. "Is sustainability possible? A review and commentary on empirical studies of program sustainability." *American Journal of Evaluation* 26(3): 320–34.

St Leger, L. 2005. "Questioning sustainability in health promotion projects and programs." *Health Promotion International* 20:317-319.

Stewart, M. et al. 2008. "Multicultural meanings of social support among immigrants and refugees." *International Migration* 46(3): 123-159.

Tsang, H. W. H. 2004. "Comments on an article by Chen H. Krammer et al." *Psychiatric Services* 55(2): 194.

Tu, S. P. et al. 1999. "Breast cancer screening by Asian American women in a managed care environment." *American Journal of Prevention Medicine* 17(1): 55-61.

Wallerstein, N. 1992. "Powerlessness, empowerment and health. Implications for health promotion programs." *American Journal of Health Promotion* 6: 197–205.

Williams, D. R. 2008. "Racial/ethnic variations in women's health: The social embeddedness of health." *American Journal of Public Health* 98(Suppl 1): S38-S47.

Wong, J. P., Y. L. R. Wong and L. Yoo. 2009. "Integrating research into practice: A capacity building approach to promote mental health and reduce stigma among immigrant and refugee communities." Workshop presentation paper at the Expanding our Horizons: Moving Mental Health and Wellness Promotion into the Mainstream Conference (February 25). Toronto: Mental Health Commission of Canada.

Wong, Y. L. R. et al. 2002. "Challenging stereotypes, embracing diversity: Developing culturally competent practices with East and Southeast Asian immigrant/refugee women." Keynote panel presentation paper at the Gender, Migration and Health: Asian-Canadian Perspectives Conference (November 22). Toronto: York Centre for Feminist Research and Hong Fook Mental Health Association.

Wong, Y. L. R. 2003. "Deconstructing culture in cultural competence: Dissenting voices from Asian-Canadian practitioners." *Canadian Social Work Review* 20(2): 149-167.

Wong, Y. L. R., and K. T. Tsang. 2004. "When Asian immigrant women speak: From mental health to strategies of being." *American Journal of Orthopsychiatry* 74(4): 456-466.

Wong, Y. L. R., J. P. Wong and K. P. Fung. 2003. "Currents and Undercurrents—Traversing the Paths of Mental Health." Keynote panel presentation paper at the Forum on Bridging Policy, Research and Practice in Cross-cultural Mental Health (November 14). Toronto: Hong Fook Mental Health Association.

World Health Organization. 2001. *World Health Report 2001. Mental health: New understanding, new hope.* Geneva: World Health Organization.

Yee, B. 2003. Asian mental health recovery—follow-up to the Asian Report. New Zealand: Mental Health Commission. Occasional Paper, 3.

Zadeh, Z. Y., E. Geva and M. A. Rogers. 2008. "The impact of acculturation on the perception of academic achievement by immigrant mothers and their children." *School Psychology International* 29(1): 39-70.

FOOTNOTES

[1] All information about the top ten source countries of immigrants to Canada since 1979 is retrieved from the annual statistics tables provided by Citizenship and Immigration Canada. Available online: http://www.cic.gc.ca, retrieved on June 2, 2004.

[2] Altogether, four project publications were published and made available for service providers and women peer leaders. They were: "Women's Holistic Health Peer Leadership Training: Training Manual"; "Embracing Our Body, Mind, and Spirit: Holistic Health Promotion for Women: Community Workshop Manual"; "Stress and Mental Health Pamphlet"; and "Beyond Rice & Noodles—Our Stories, Our Journey: Health Strategies of East and Southeast Asian Immigrant Women". They are available from the Hong Fook Mental Health Association Webstie, http://www.hongfook.ca/en/health _info/OtherPublications.asp.

WORKING WITH IMMIGRANT WOMEN: GUIDELINES FOR MENTAL HEALTH PROFESSIONALS

Sepali Guruge, Ryerson University

Enid Collins, Ryerson University

Amy Bender, University of Toronto

Women may choose to migrate for a variety of reasons including economic incentives, family reunification, and educational opportunities, as well as to escape from gender-based and/or political violence and to gain more social independence (DeLaet1999). The numbers of women immigrants and refugees to Canada have increased over the years and the percentage of women settling in as immigrants (and refugees whose claims have been approved to become permanent residents) is usually 2 to 7% higher than that for men (Citizenship and Immigration Canada [CIC] 2006). In addition, the number of women entering Canada as economic immigrants, in comparison to those entering as family class immigrants, is slowly increasing. This is partly due to the increase in the number of women arriving as skilled or professional workers. Approximately half of refugees are women, and women also comprise a significant proportion of illegal immigrants. These statistics call attention to the need for health sciences research specifically on the health of women immigrants.

Upon arrival in Canada, immigrants[1] are generally in better health than those born in Canada (Chen, Ng & Wilkins 1996a, 1996b; Parakulum, Krishnan & Odynak 1992). Factors related to immigration selection criteria (e.g., rigorous health screening) and the immigration process itself (e.g., healthier people tend to move more than those with a poor health status) have been associated with this *healthy-immigrant effect*. However, after 10 years in Canada, immigrants are more likely to be in poorer health than their Canadian-born counterparts (Chen et al. 1996a, 1996b; Hyman 2001; Vissandjee et al. 2003). The research is less clear about the healthy immigrant effect in relation to mental health (Canadian Task Force on Mental Health Affecting Immigrants and Refugees 1986; Hyman 2004; Mental Health Commission of Canada, 2009). One of the reasons for this lack of clarity is the limited health sciences research on mental health and illnesses of immigrants.

Home-country circumstances notwithstanding, there are common factors that immigrants face following migration that are associated with health status. Most of these have been recognized as social determinants of health, and include income and social status, employment and working conditions, physical and social environments, social networks, gender, culture, and access to health services (Health Canada, 2002). Additional determinants of mental health for immigrants include social isolation, language barriers, financial and employment constraints, role reversal, new intergenerational struggles, racism, and discrimination (Hyman & Guruge, 2006). Some of these aspects of the settlement process may be dehumanizing and particularly stressful (Sandys, 1996). For example, having to respond to repetitive questions regarding experiences of violence and abuse in the context of immigration procedures, can have profound implications for mental health. Mental disorders such as depression, anxiety disorders, and post-traumatic stress disorder may be precipitated in part by repeated re-traumatizing experiences.

Access to services is one determinant of health that can be overlooked for its effects on mental health. While there are many services that are intended to assist newcomers during the post-migration period, the actual experiences of accessing such services can be difficult. Practically navigating bureaucratic hurdles, completing many application forms, or physically getting to various agencies that may not be in close geographical proximity are some examples of this (Collins, Shakya, Guruge & Santos, 2008; Guruge & Humphreys, 2009). Additionally, language barriers insidiously contribute to these difficulties. Sometimes volunteer or un-trained interpreters may not translate/interpret accurately (Abraham & Rahman, 2008), which may compromise situations involving government authorities such as immigration, child welfare, and/or legal aid (Guruge, 2007). By extension,

the stress of such circumstances may affect psychological and emotional wellbeing, and exacerbate existing mental illnesses.

Challenges of the post-migration context in Canada persist for women specifically, even after the initial resettlement period. Material, social, and systemic challenges might include downward career mobility, immigration requirements that restrict women's choices (e.g., when dealing with abusive employers or abusive husbands), unsafe work conditions, and lack of social support for raising children or caring for elderly family members. While some of these concerns can be experienced by Canadian-born women and/or immigrant men, immigrant women consistently experience most of these challenges, and/or to a greater degree. For example, immigrant women are disproportionately poorer than Canadian-born women and men, as well as immigrant men (CIC 2006). Furthermore, immigrant women have to cope with these realities of daily life while navigating social systems, government bureaucracy, and new cultures in an unfamiliar setting and, perhaps, in an unfamiliar language. In the post-migration context women often experience changes in gender roles, are forced into low paying jobs, and may have to work at home and in paid jobs without the support of extended family and/or community (Baya, Simich & Bukhari, 2008). Also, violence may be precipitated by social conditions such as isolation, changed gender roles, and possibly a clash of cultural norms and intergenerational expectations regarding women's rights and responsibilities (Guruge, Khanlou & Gastaldo, 2010).

Such post-migration contextual factors are indications of the troubling influence of the social determinants of immigrant women's health, which are reflected in the growing body of literature addressing the topic (e.g., Oxman-Martinez, Abdool & Loiselle-Leonard, 2000; Vissandjee et al., 2001; Hyman 2002; Hyman & Guruge, 2006). In addition, some women who migrate may have lived through war, slavery, political violence (Tsang & George, 1998) and violence at home (Guruge, Khanlou & Gastaldo, 2010) in the pre-migration context. Such experiences, whether as isolated encounters or long-standing relational situations, can intersect with the post-migration social determinants to affect women's mental health and exacerbate existing mental illnesses (Mawani, 2008).

How immigrant women respond to and deal with these issues is unique to each woman's situation and position in society based on the intersections of such aspects of identity as age, race, class, ethnicity, language, education, and sexual orientation, along with the economic, cultural, socio-political, historical, and geographical contexts of their daily lives (Guruge & Khanlou, 2004). Yet the majority of immigrant women actively participate in shaping their health and that of their families, despite the post-migration challenges and barriers they face in Canada. Women are also engaged participants in various community activities and in organizations including schools, places of worship, and volunteer sectors to improve the health and wellbeing of their communities. This is a testament to their strengths and resilience.

IMPLICATIONS FOR RESEARCH, EDUCATION, PRACTICE, AND POLICY IN MENTAL HEALTH

Migration experiences can have a negative impact on mental health for both women and men; however, research on immigrant women has limited representation in health sciences literature. In order to address changes in mental health practice, there is a need to examine macro, meso and micro systems, to determine how knowledge is generated, how practitioners are educated, and how preventive and curative aspects of care happen at both the face-to-face relational level and within communities. In this final section, we present some recommendations, based on several chapters in our book, *Working with Immigrant Women: Issues and Strategies for Mental Health Professionals*, categorized according to future directions for research, education, practice, and policy in mental health.

RESEARCH

While there have been considerable collaborative efforts in expanding mental health research on immigrant women, certain research questions still require answers. Broadly, how is women's mental health defined and understood? How do the social determinants of mental health manifest in women's lives? How do perceptions of one's mental health differ for young girls, adolescent girls, adult women, and older women? Specifically, how do immigrant women's mental health statuses change over time, and across countries? Are there current holistic interventions for addressing women's mental health issues? What are some innovative strategies for addressing challenging aspects of the immigration experience that impact on mental health? How do health care professionals engage in diminishing the negative effects of post-migration determinants of women's mental health? Finally, within the area of mental disorders, what are the direct links between a particular social condition and the symptomatology of specific disorders, and how does migration itself confound these?

Limited empirical research exists on the mental health concerns of newcomer girls and female youth (Berman & Jiwani, 2008), those who have been trafficked, who are homeless/street-involved (Collins & Guruge, 2008) , or lesbian, bi-sexual, or trans-gendered immigrant

women (Doctor & Bazet, 2008). Little attention has been focused on older women's health, both physical and mental health, in the post-migration context (Guruge, Kanthasamy, & Santos, 2008; Guruge & Kanthasamy, 2010). Research gaps also remain in such areas as the intersections of immigrant experiences and homelessness, addictions, and violence and trauma. The need for further work in the area of intimate partner violence in the post-migration context is particularly highlighted by the limited number of health research publications on the subject (Fong, 2010; Guruge, 2007; Hyman, Guruge, & Mason, 2008). Furthermore, we know little about the growing number of immigrants who are under-housed or live on the street, and how experiences of violence in these situations either contribute to or exacerbate mental illnesses. Finally, research approaches to understanding violence must widen to address the broader social conditions such as patriarchy, racism, and poverty.

Researchers must pay close attention to the theories and conceptual frameworks, and the methodologies that they employ in their research to ensure that the work that is done is collaborative, inclusive, and based on social justice and equity. Developing and testing culturally appropriate multidimensional instruments to assess stress, conflict, violence, and mental illness is critical (Guruge et al., 2007; Sidani, Guruge, Miranda, Ford-Gilboe, & Varcoe, in press). In terms of research team composition, immigrant women themselves ought to be included in the research process to strengthen their awareness of their abilities and resources, strengthen the quality of the final product, and support women's efforts to mobilize for change and facilitate their input into policy and decision-making.

EDUCATION

Mental health professionals in Canada are educated in a wide range of disciplines with each possessing its own professional culture and emphasizing specific areas of knowledge and skills. In all of the health disciplines, education has developed primarily from the Western medical model and reflects Canadian socio-political and cultural perspectives. This preparation does not reflect Canada's changing demographics, the significant presence of immigrant groups, and the increasing numbers of women from diverse ethno-cultural groups who are consumers of mental health services. There is a pressing need for education that accounts for and responds to these shifts to better prepare mental health professionals to respond appropriately to the needs of diverse groups. Such initiatives are possible only when administrators of educational institutions commit resources to organizational changes in faculty staffing and curricula that reflect diversity, inclusiveness, and capacity-building. As Sleeter

(1993) pointed out, educators who represent minority groups are likely to bring experience that facilitates a critique of the dominant standpoint. Collaboration with community agencies that reflect the changing needs of ethno-cultural and racialized groups ought to be a priority for clinical practicum experiences, where students may have opportunities to learn from and work with immigrant women who may staff and/or draw from these services. Additionally, all faculty members (from senior tenured professors to contract teaching staff) ought to become familiar with and utilize the growing body of research on mental health and illnesses of immigrant women.

PRACTICE

Mental health professionals in various practice settings are in key positions to recognize the often negative experiences of immigration and settlement on mental health and illness. In particular, they must pay attention to the following questions: What forms of trauma and violence have clients/patients encountered in the pre-migration contexts? How do these experiences influence women's ability to cope in their new environment? What are their border-crossing experiences? What are their post-migration experiences? How are these affecting their mental health? And what can be done to intervene? What are the ways in which they cope with mental illnesses? What are the ways in which their access to care for mental illnesses can be improved?

Service agencies that espouse a vision of mental health promotion must implement programs and strategies that practically reflect a supportive environment for cultivating women's strengths and resilience. For example, programs could be organized to bring together women and young children to share resources and experiences, and build supports within their own communities. Mental health practitioners must also examine their own values, beliefs, powers, and privileges in order to identify how actions in their practice support immigrant women and facilitate their resilience, or how the practitioners themselves and/or organizational structures create barriers and disadvantage for these clients/patients (Gustafson, 2008).

POLICY

It seems evident that governments at all levels must continue to provide appropriate funding support for new immigrants arriving in Canada. The Task Force on Mental Health Issues Affecting Immigrants and Refugees (1986) recommended that Health and Welfare Secretary of State and the Status of Women develop and provide multilingual educational materials on women's rights and roles in Canada for discussion within immigrant services, general community service agencies, and ethno-cultural agencies.

The changes that have taken place since, however, require further work. To this end, the Mental Health Commission (2009) has proposed a plan for a National Mental Health Strategy, with four pillars: co-ordination, information, community engagement, and more appropriate services. Each pillar implicates the need for specific attention to women. For instance, information brochures are available in some languages other than English and French, especially where there are large numbers of a population who speak a non-official language, however with the growing number of ethnic groups especially in urban centres, the language challenges in reaching all women are great, and require creative solutions. On another level, legislation governing immigration and refugee claims should be amended to reflect gender-specific issues that have an impact on women; for example, under current immigration laws, when families apply to immigrate, men tend to apply under the economic class, and the women then tend to be assigned dependent status (Vissandjee et al., 2003; 2007) even when both hold equal or comparable education and employment skills and experience. Changes to this legislation are critical because the current system fails to acknowledge women's potential for economic contribution (Guruge & Collins, 2008).

Finally, policy development should reflect the voices and aspirations of the women to whom policy is directed. Representatives from groups who have expertise in mental health issues affecting immigrant women should be consulted in the development of collaborative mental health promotion strategies for immigrant populations across various sectors including government agencies, educational services, and ethno-cultural agencies.

CONCLUSION

While there are many benefits to immigrating to a country like Canada, immigrant women's mental health in the new context is also negatively influenced by post-migration social determinants such as to racism, sexism, social isolation, among others. For some individuals, stressors are resolved positively while others experience mental illnesses. Increasingly, newcomers are accessing mental health services but are also facing many barriers, related to unfamiliar culture, language, and limitations in the services themselves. We believe that significant changes need to be made in delivery of mental health services to include innovative holistic approaches that address the needs of immigrant women in Canada.

REFERENCES

Abraham, D. and Rahman, S. 2008. "The community interpreter: A critical link between clients and service providers." In S. Guruge and E. Collins (eds.), Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Toronto: Centre for Addiction and Mental Health. 103-118.

Baya, K., Simich, L., and Bukhari, S. 2008. "A Study of Sudanese Women's Resettlement Experiences." In S. Guruge and E. Collins (eds.), Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Toronto: Centre for Addiction and Mental Health. 157 –176.

Berman, H. and Jiwani, Y. 2008. "Newcomer girls in Canada: Implications for interventions by mental health professionals." In S. Guruge and E. Collins (eds.), Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Toronto: Centre for Addiction and Mental Health. 137 –156.

Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. After the Door Has Opened: Mental Health Issues Affecting Immigrants and Refugees. Ottawa, ON: Minister of Supply and Services Canada. 1986.

Chen, J., E. Ng and R. Wilkinson. "The Health of Canada's Immigrants in 1994 –1995." *Health Reports* 7.4 (1996a): 33–45.

Chen, J., E. Ng and R. Wilkinson. "Health Expectancy by Immigrant Status." *Health Reports* 8.3 (1996b): 29 –37.

Citizenship and Immigration Canada (CIC). (2006). Facts and figures 2006. Immigration overview: Permanent residents. Available: www.cic.gc.ca/english/resources/statistics/facts2006/permanent/31.asp. Accessed December 31, 2007.

Collins, E., Y. Shakya, S. Guruge, and Santos, J. 2008. "Services for women: Access, equity and quality." In S. Guruge and E. Collins (eds.), Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Toronto: Centre for Addiction and Mental Health. 119 –133.

DeLaet, D.L. 1999. "Introduction: Invisibility of Women in Scholarship on International Migration." In G.A. Kelson and D.L. Delaet (eds.), Gender and Immigration. New York: New York University Press. 1–17.

Fong, J. 2010. "Out of the Shadows. Women Abuse in Ethnic, Immigrant, and Aboriginal Communities." Toronto: Women's Press.

Guruge, S. 2007. *The Influence of Gender, Racial, Social, and Economic Inequalities on the Production and Responses to Intimate Partner Violence in the Post-migration Context. Unpublished doctoral dissertation.* University of Toronto, Toronto, Canada.

Guruge, S., M. Ford-Gilboe, C. Varcoe, and Sidani, S. 2007. Translation and Psychometric Evaluation of Selected Measures of the Social, Economic and Health Impact of Intimate Partner Violence in Immigrant Women. Ryerson SRC grant application.

Guruge, S., and J. Humphreys. "Barriers that affect abused immigrant women's access to and use of formal social supports." Canadian Journal of Nursing Research, 41.3 (2009): 64–84.

Guruge, S., and P. Kanthasamy. 2010. *Older Women's Experiences of and Responses to Abuse/violence in the Post-migration Context*. Unpublished research report.

Guruge, S., P.Kanthasamy, and Santos, J. 2008. "Addressing older women's health: A pressing need." In S. Guruge and E. Collins (eds.), Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Toronto: Centre for Addiction and Mental Health. 235 –256.

Guruge, S., and N. Khanlou. "Intersectionalities of Influence: Researching the Health of Immigrant and Refugee Women." *Canadian Journal of Nursing Research* 36.3 (2004): 33–47.

Guruge, S., N. Khanlou and D. Gastaldo. "Intimate Male Partner Violence in the Migration Process: Intersections of Gender, Race, and Class." *Journal of Advanced Nursing* 66.1 (2010): 103–113.

Gustafson, D.L. 2008. "Are sensitivity and tolerance enough? Comparing two theoretical approaches to caring for newcomer women with mental health problems." In S. Guruge and E. Collins (eds.), Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Toronto: Centre for Addiction and Mental Health. 39 –63.

Health Canada. (2002). *Population Health.* http://www.phac-aspc.gc.ca/ph-sp/phdd/.

Hyman, I. 2001. *Immigration and Health* (Working paper 01-05, Health Policy Working Paper Series). Ottawa: Health Canada.

Hyman, I. 2002. "Immigrant and Visible Minority Women." In D.E. Stewart et al. (eds), Ontario Women's Health Status Report. Toronto: Ontario Women's Health Council.

Hyman, I. Setting the Stage: Reviewing current knowledge on the health of Canadian immigrants: What is the evidence and where are the gaps? *Canadian Journal of Public Health* 95.3 (2004): 15-17.

Hyman, I., and S. Guruge 2006. "Immigrant Women's Health." In R. Srivastava (ed.). The Health Care Professional's Guide to Cultural Competence. Toronto: Mosby, Elsevier. 264–280.

Hyman, I., S. Guruge, and R. Mason "The impact of post-migration changes on marital relationships: A study of Ethiopian immigrant couples in Toronto." *Journal of Comparative Family Studies* 39.2. (2008):149-164.

Martinez-Schallmoser, L., S. Tellen and N.J. MacMullen. "The Effect of Social Support and Acculturation on Postpartum Depression in Mexican American Women." *Journal of Transcultural Nursing* 14 (2003): 329–338

Mawani, F. 2008. "Social Determinants of Depression among Immigrant and Refugee Women." In S. Guruge and E. Collins (eds.), Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Toronto: Centre for Addiction and Mental Health. 67–88.

Mental Health Commission of Canada. 2009. "Understanding the Issues, Best Practice and Options for service development to meet the needs of ethno-cultural groups, immigrants, refugees, and racialized groups. http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2009/Consultation%20Document_Final.pdf (January, 2009).

Oxman-Martinez, J., S.N. Abdool and M. Loiselle-Leonard. "Immigration, Women and Health in Canada." *Canadian Journal of Public Health* 91 (2000): 394–395.

Parakulum, G., V. Krishnan and D. Odynak. "Health Status of Canadian-born and Foreign-born Residents." *Canadian Journal of Public Health* 83 (1992): 311–314.

Sandys, J. 1996. *Immigration and Settlement Issues for Ethnoracial People with Disabilities: An Exploratory Study.* http://ceris.metropolis.net/virtual %20Library/RFReports/Sandys1996.pdf (12 June 2007).

Sidani, S., S. Guruge, J. Miranda, M. Ford-Gilboe, and C. Varcoe. "Cultural Adaptation and Translation of Measures: An Integrated Method." *Research in Nursing & Health.* (in press).

Sleeter, C. 1993. "How White Teachers Construct Race." In C. McCarthy and W. Crichlow (eds.), Race Identity and Representation in Education. New York: Routledge. 157 –171.

Tsang, A.K.T., and U. George. "Towards an Integrated Framework for Cross Cultural Social Work Practice." *Canadian Social Work Review* 15.1 (1998): 73–93.

Vissandjee, B., M. Weinfeld, S. Dupéré, and S. Abdool "Sex, gender, ethnicity and access to health care services: Research and policy challenges for immigrant women in Canada." *Journal of International Migration and Integration*, 2.1 (2001): 55–75.

Vissandjee, B., Desmeules, M., Cao, Z., Abdool, S., and Kazanjian, A. 2003. "Integrating ethnicity and migration as determinants of Canadian women's health." In M. Desmeules, D. Stewart, A. Kazanjian, H. Maclean, J. Payne, B. Vissandjée (Eds.). *Women's Health Surveillance Report: A Multidimensional Look at the Health of Canadian Women*. Ottawa: Canadian Institute for Health Information.

Vissandjee, B., Thurston, W., Apale, A., and Nahar, K. 2007. "Women's Health at the Intersection of Gender and the Experience of International Migration." In M. Morrow, O. Hankivsky and C. Varcoe (eds.), Women's Health in Canada: Critical Perspectives on Theory and Policy. Toronto: University of Toronto Press. 221–243.

Canadian Immigration: Economic Evidence for a Dynamic Policy Environment

Edited by Ted McDonald, Elizabeth Ruddick, Arthur Sweetman and Christopher Worswick

Economic and social issues regarding immigration are at the forefront of the Canadian policy agenda. Given the marked decline in immigrants' labour market outcomes over the past few decades and the important changes in the policy environment, expanding the evidence base for new immigration and integration policy is crucial.

This volume of essays extends and updates our understanding of economic and closely related social factors regarding immigration. Each chapter is an empirical investigation, with topics addressing labour market integration, including ethnic and gender aspects; immigrant economic returns to schooling; employment and self-employment; the skilled worker program; temporary foreign workers; housing; an international comparison of immigrant children's success in school; fertility; and health.

"What makes this book special is that it focuses on research that can be used to inform policy, drawing on the latest research using Canadian data by a group of top-notch economists from Canada and around the world. The result is a great collection of papers that brings state-of-the-art empirical techniques and the latest data together to shed light on the most important policy challenges related to immigration."

Krishna Pendakur, Professor of Economics, Simon Fraser University, and Co-Director, Metropolis British Columbia Centre of Excellence for Research on Immigration and Diversity

"*Canadian Immigration* is an eye opener for US policy-makers and scholars of US immigration. Its relevance to US immigration policy debates is clear, both because of the similarity of the challenges facing Canadian and American immigration policy-makers and because of the authors' adept use of U.S.-Canadian comparisons to highlight policy effects. Moreover, it extends an analytical eye to areas of immigrant integration vital to ongoing immigration debates, yet rarely the focus of scholarly attention."

Harriet O. Duleep, Professor, School of Public Policy, William and Mary College

In partnership with:

METROPOLIS

Contributors: Alicia Adsera (Princeton U), Barry R. Chiswick (U Illinois at Chicago), Ana Ferrer (U Calgary), Tara Gilkinson (Citizenship and Immigration Canada), David A. Green (U British Columbia), Michael Haan (U Alberta), Ted McDonald (U New Brunswick), Paul W. Miller (U Western Australia), Elizabeth Ruddick (Citizenship and Immigration Canada), Herbert J. Schuetze (U Victoria), Arthur Sweetman (Queen's U) Casey Warman (Queen's U), Christopher Worswick (Carleton U), Li Xue (Citizenship and Immigration Canada), Jun Zhao (Health Canada)

✓ **YES** I would like to subscribe to ACS publications
OUI J'aimerais m'abonner aux publications de l'AEC

A C S • A E C
Association for Canadian Studies • Association d'études canadiennes

RECEIVE All new issues of **Canadian Issues** and **Canadian Diversity**
RECEVEZ Tous les nouveaux numéros de **Thèmes canadiens** et de **Diversité canadienne**

And automatically become a member of the **Association for Canadian Studies**
Et devenez automatiquement un membre de l'**Association d'études canadiennes**

Name/Nom : _____

Address/Adresse : _____

City/Ville : _____ Province : _____

Postal Code/Code postal : _____ Country/Pays : _____

Phone/Téléphone : _____

PAYMENT/PAIEMENT

Send with/Envoyer avec

☐ **Check/Chèque**

☐ **Visa credit card/Carte de crédit visa**

Visa Card no./Nº de la carte visa :

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Exp. Date/Date d'expiration :

☐☐ ☐☐
month years
mois   année

Amount/Montant : _____ $

CANADIAN ISSUES
THÈMES CANADIENS

CANADIAN DIVERSITÉ CANADIENNE

MEMBERSHIP FEES/FRAIS D'ADHÉSION
Magazine shipping included/Envoi postal des revues compris

	Canada	USA/États-Unis	International
Regular—1 year/ Régulier—1 an	$55	$90	$125
Regular—2 years / Régulier—2 ans	$100	$170	$240
Institutional/institutionnel	$90	$125	$160
Student or Retired/étudiant ou retraité	$25	$60	$95

PLEASE SEND FORM TO:

Association for Canadian Studies
1822-A Sherbrooke W, Montreal, Quebec, H3H 1E4
By fax: 514 925-3095

**Or become a member through the ACS website
at www.acs-aec.ca**

ENVOYER FORMULAIRE À :

Association d'études canadiennes
1822-A, rue Sherbrooke O., Montréal (Québec) H3H 1E4
Par télécopieur : 514 925-3095

**Ou devenez membre sur le site web de l'AEC
à www.acs-aec.ca**

Pour assurer le développement de votre marque, créer des outils de communication qui vendent ou faire de votre site web un succès...

100%
sans diva

Ça prend de grandes idées.
Pas de gros égos.

You want to take your brand to the next level, create marketing tools which sell, make your website stand out...

100%
ego free

That takes big ideas.
Not big egos.

BANG
marketing

13th National Metropolis Conference
13e Congrès national de Metropolis

METROPOLIS

METROPOLIS BRITISH COLUMBIA
Centre of Excellence for Research on Immigration and Diversity

Sheraton Vancouver Wall Centre
Vancouver, British Columbia
March 23-26, 2011

www.metropolis.net
www.mbc.metropolis.net