Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups

Issues and options for service improvement

Language and culture play an important role in mental health service delivery. For example, if I go to a service provider who doesn't know my language and is not familiar with my culture, first of all I will not be able to explain my problem to him/her as I want to say it, secondly, even if he/she gets me, will still not be able to provide me with culturally appropriate treatment which is very important. – Focus Group Participant

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We would like to acknowledge those who participated and organized in both the in-person and electronic consultations for your invaluable input. We are also grateful to those involved with the consumer focus groups. This includes those from Across Boundaries and the Canadian Mental Health Association Toronto Branch who organized and facilitated these groups as well as the participants of these groups. Thanks also to those who provided comments on this report. Finally, we would like to thank everyone who has provided feedback including those in the Diversity Task Group for their tireless efforts.

We gratefully acknowledge the support of the Mental Health Commission of Canada and the Centre for Addiction and Mental Health.

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Executive Summary

Improving services and outcomes for immigrant, refugee, ethno-cultural and racialized groups (IRER), is a common challenge for mental health systems in high income countries. The Service Systems Advisory Committee of the Mental Health Commission established a project to consider the issues and options for service improvement for IRER groups and to report to the Commission. The aim was to help their deliberations on how the goals of the Mental Health Strategy for Canada could be achieved.

The plan for service improvement outlined in this report is the result of a number of different lines of investigation and consultation. An analysis of the data from the 2006 census was used to produce a statistical picture of Canada's IRER groups and a literature review was then performed. Data from these two sources and the experience of a steering group of experts in multi-cultural health from across Canada was used to help develop a draft paper outlining the issues and potential options for service improvement for IRER groups. A web-based consultation for the draft paper was undertaken, hard copies of the paper were sent to health planners in Federal Government, the provinces, territories, regions and to the different Committees of the MHCC, and there were consultation focus groups in seven centres spanning Canada from Vancouver to Halifax. Once all the results had been considered focus groups of people with lived experience were undertaken to ensure that there had not been drift and the recommendations continued to be in line with their aspirations. Finally a national consensus meeting was set up in May 2009 to review the findings and recommendations.

The plan is not a protocol for service development but an outline of the issues that policy makers, health planners and service providers across Canada may find beneficial to consider when embarking on strategies to improve mental health services for IRER groups.

Issues

The census data gives a snapshot of Canada's diversity. Every province, territory and region has an IRER population. These are growing but at different rates. The demographic challenges 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 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. Meeting this need is a particular challenge.

There is a 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. Most provinces, territories and regions do not have a local evidence base to use for developing services.

The literature in general suggests that IRER groups are more exposed to the known social determinants that promote mental health problems and illnesses as well as novel social determinants such as migration, discrimination and language difficulties. National studies report lower rates of mental health problems and illnesses in immigrant groups but numerous local in depth studies report increased rates of mental health problems and illnesses in specific groups in particular areas. The rates of mental illness differ in IRER groups. The literature on barriers to care such as stigma, awareness of services and language difficulties reports that these delay access to treatment. A number of studies, however, present factors such as literacy, trust in services, cultural competence and targeted health promotion which facilitate pathways to care.

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 are presented in this document have a firm foundation in the 7 goals of the Mental Health Strategy for Canada. The Strategy will be based on the principle of a public health approach to improving mental health and well-being and the development of better services and supports for people with mental health problems and illnesses across the lifespan. For the adult population, services and supports are built on a recovery model. For children and youth, services and supports are geared to the various development stages with the goal of maximizing mental health by adulthood. The focus for seniors is on maximizing quality of life and dignity as they age.

This issues and options paper takes the position that the challenges faced by IRER populations need a mainstream service response as well as increasing the diversity of services and providers. All services will need to be capable of offering equitable care to Canada's diverse population.

The plan for moving towards the vision of improved services for IRER groups has 3 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. 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 – organisational 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

This paper includes 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 or

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.

Introduction

Improving services and outcomes for immigrant, refugee, ethno-cultural and racialized groups (IRER), is a common challenge for mental health systems in high income countries. Increased rates of illnesses, poorer access to care and care outcomes and poorer satisfaction with services have been reported in these groups in Canada and internationally. 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 meet the challenge of providing mental health services to their multi-cultural population, and develop health promotion strategies that improve the health status of IRER groups.

The Service Systems Advisory Committee of the Mental Health Commission established a project to consider the issues and options for service improvement for IRER groups and to report to the Commission. The aim is to help their deliberations on how the goals of the Mental Health Strategy for Canada, currently in development, could be achieved.

The strategies in this document are the result of 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 specialised mental health librarian. These two sources of information and the experience and knowledge of a steering group of experts in multi-cultural 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 MHCC website and on the Centre for Addiction and Mental Health 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 the network of the SSAC, through the networks of the steering group and through other professional 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 the settlement and welfare of immigrants and refugees. The document was also sent out to different advisory bodies within the Mental Health Commission of Canada. Face to face focus groups of professionals, service providers, community organisations and settlement and education services were undertaken in 7 centres across Canada. 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 and the results incorporated in the paper. Finally a consensus meeting of a diverse group of 35 people from across Canada including some people who had taken part in the focus groups and representatives of bodies named in the document recommendations were invited to Toronto for a day to review the near final draft. Results of this meeting were shared with MHC board and advisory committee members. Their views were included and this final draft was then sent back to the steering group and the SSAC for their review and approval.

The strategies for service improvement outlined in this final report are thus 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. This is followed by recommendations for service improvement as well as some examples of how these ideas are being implemented in various parts of Canada[i].

Service model

The service improvement recommendations that are presented 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, and 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[1].

This issues and options paper takes the position that the challenges faced by IRER populations need a mainstream service response. 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.

Which groups were considered by the project?

Canada is the most diverse country in the world. This 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). There is no one term that encompasses all of these categories so the acronym is used. Canada's IRER groups are themselves diverse and composed 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. We understand that for every statement where a group is considered as a collective there will be particular groups and individuals to

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[i] Throughout the report, there are shaded boxes which highlight some of the main issues from each section. Beside each issue is a number(s) which indicates which recommendation this corresponds with. Sixteen recommendations for service improvement can be found at the conclusion of this document.

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 for 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. We have tried to reflect this in the text when there is available research evidence.

This report makes some mention of the diversity within diverse populations but does not offer specific service development recommendations for the Lesbian, Gay, Bisexual, Transgender, Transsexual, Two-spirited, Inter-sexed, Queer, and Questioning (LGBTTTIQQ) population, 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 in these groups and a need for service improvement.

This report offers a framework for considering the issues and developing and implementing mental health service improvement for IRER populations in general. However, it is recognised that the diversity within this group may require additional specific targeted strategies to promote health equity for particular populations such as children, older adults, refugees and LGBTTIQQ. Further attention to these groups will be an important feature for future work of the MHCC.

Outline of the report

Issues:

Part 1
The demography of Canada's diverse populations, definitions of terms and discussion of the model used to consider the development of (i) mental health problems and illnesses and (ii) the pathways to getting care.

Part 2
A synthesis of research into the mental health problems and illnesses of IRER populations focussing on the Canadian literature.

Part 3
An outline of previous national policy papers on improving Canada's mental health services for IRER populations.

Options:

Part 4
A strategy for service development, recommendations and examples of initiatives across Canada.

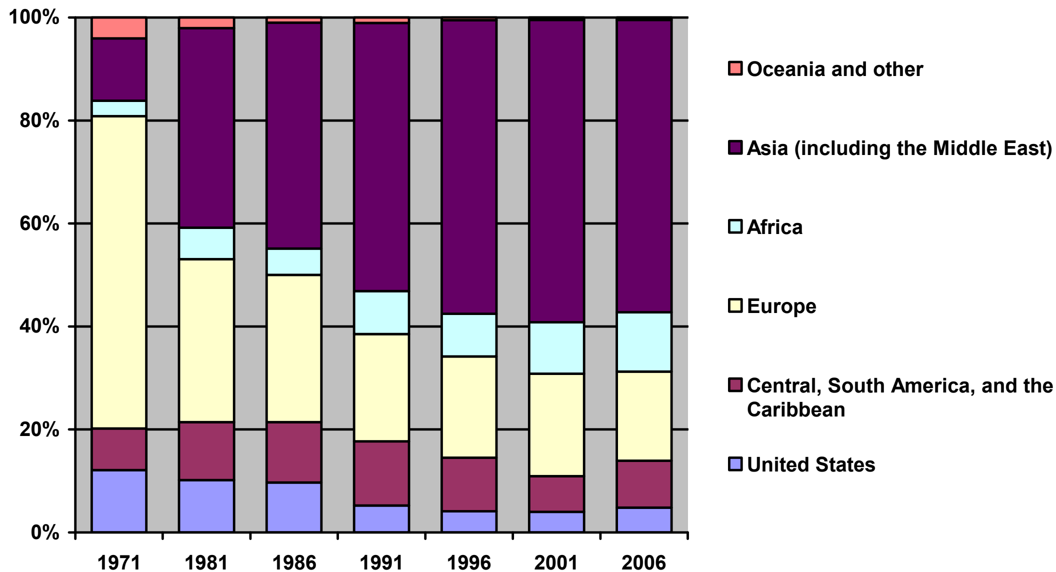
Part 1: Demography, definitions, and pathways to care

Demography

Canada is one of the most diverse countries in the world. Nearly 20% of the population was born in another country and hundreds of thousands of new immigrants arrive each year[2]. In some parts of the country, visible minorities[ii] comprise over 40% of the population. Canada's future economic prosperity will depend in part on population growth and, presently, Canada's main driver for population growth is immigration. Because of this, immigrants are an important national resource.

Until the 1960's, immigration to Canada was mainly from Europe. This has changed so that now immigration is mainly from South and East Asian countries. As Canada grows it is becoming more diverse. Diversity, due to newcomers, makes the headlines but the majority of people who identify themselves as belonging to minority groups are Canadian citizens. Some have been in Canada for centuries, however, the majority are first or second generation Canadians[3].

Region of birth of recent* immigrants to Canada, 1971 to 2006[3]



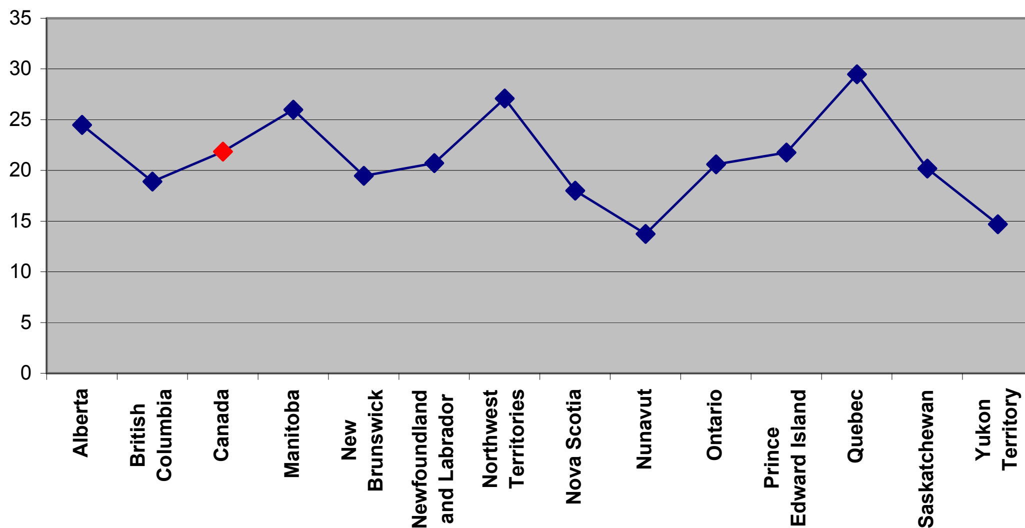
*'Recent' is described as arriving in Canada during the 5 year period between censes

Canada's IRER populations mainly live in or around major cities but there are significant rural populations. Every province and territory in Canada has an IRER population. They are different sizes, are growing at different rates, and come predominantly from different places. In some provinces and territories the population is small but in others it is up to a quarter of all the people who live there.

[ii] Visible minority is a term used in the Canadian Census which includes individuals who are not Aboriginal, Caucasian, or White in race.

For instance, Nova Scotia has a small immigrant population but many provinces and territories are growing at rapid rates. Cities like Montreal, Toronto and Vancouver have large IRER populations that used to settle in the urban core but are now increasingly settling in suburban areas. This is certainly the case with Toronto and Vancouver where more and more immigrants are moving to and settling in the surrounding areas.

As the graph below indicates, between 2001 and 2006 the immigrant population in Canada grew between 14-30% with Quebec having the most significant growth[4]. However, in terms of actual numbers, Ontario, British Columbia, and Quebec continue to have the highest immigrant populations.



These different trends in growth for IRER groups in different geographic locations offer a challenge for any mental health strategy. It needs to be flexible enough to be useful to areas with stable populations as well as ones where populations are growing rapidly. Any strategy has to meet the challenge of more populous areas as well as areas where IRER groups are a small proportion of residents.

Issues:

1. Canada's population is becoming increasingly diverse.
2. All provinces and territories will have demographic changes in their IRER populations that may require a mental health service response (*Recommendation 1, 2*).
3. The demographic challenges will be different with some areas having substantial existing IRER populations that need to be served, others having small populations, and others still having rapidly growing populations (*Recommendation 2*).

Mental health in IRER groups

In order to properly consider mental health and mental illness and problems in IRER groups, we need to define our terms and have a model for how mental health problems and illnesses develop and how people get treatment.

Definitions:

Mental health: The World Health Organization describes mental health as a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community. There are individual, psychological and social factors that are known to influence each person's ability to achieve the best possible mental health and well-being.

Mental health problems and mental Illness: Mental health problems and illnesses are clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering, or impairment in one or more areas such as school, work, social and family interactions, or the ability to live independently. There are many different kinds of mental health problems and illnesses. They range from anxiety and depressive disorders through to schizophrenia and bipolar disorder, and are often associated with a formal medical diagnosis. There is no single cause for most mental health problems and illnesses. They are thought to be the result of a complex interaction among social, economic, psychological, and biological or genetic factors. They may have different causes and treatments which make discussing them as one group problematic at times, but they also have some similarities in their impact on individuals, their families and society.

While other countries such as the UK and US have published extensively on the health and mental health of IRER groups, research in Canada has been fairly limited, but is now increasing.

Mental Health of IRER communities

In any population people may have a variety of levels of mental health, regardless of whether or not they have a mental illness. For example, some people have tremendous resilience strength, healthy relationships, and a positive outlook. Others, may feel that day-to-day life is a struggle, that they have limited prospects, few friends, and are more easily set back by life's challenges.

The mental health of a person, their family or community depends on their resources and histories and their current social circumstances. The exact recipe for mental health varies from person to person and community to community. However there are clear pressures on IRER communities such as migration and racial discrimination which, though common, cannot be considered normal life stresses. They have impacts on the mental health of individuals and can decrease rate of mental health and well being in a community. For some, the experience of being an immigrant or refugee or belonging to an ethno-cultural or racialized group builds resilience. For others it undermines their mental health.

Being mentally healthy involves having a sense of coherence that helps people to function well despite the challenges they confront, as well as to have the resiliency to bounce back from setbacks. The evidence suggests that people who experience the best mental health – independently of whether or not they are living with symptoms of a mental illness – function better that those who are either moderately mentally healthy or in poor mental health.

Having good mental health helps to protect people from the onset of mental health problems and illnesses as well as buffering the impact of the stresses and hardships that are part of life for everyone.

But there is not a clear progression from people having difficulties with their mental health to developing mental health problems and illnesses. Rather, good mental health is just one of a number of factors that may be considered important in the prevention of and recovery from mental health problems and illnesses.

A model for the development of mental health problems and getting care

We spend most of our lives in balance, (that is free of distress and symptoms of mental health problems and illnesses**),** but we may move towards developing mental health problems and illnesses and seeking help because of things that happen to us in our lives. Scientists have demonstrated that some of our vulnerability is genetic and due to our biology. But there is little evidence that genetic or biological factors account for differences in the rate of mental health problems and illnesses between ethnic groups. These are likely to be due to factors in the social world.

When we encounter problems we may be able to shrug them off. We temporarily move from balance to distress and then back. Or we may progress down a pathway that can end with a mental health problem or illness linked to that particular difficulty.

The fact that most people move from distress back to balance reflects their internal resilience or other aspects of positive mental health, or the help they receive - say through the support of their communities, religious or spiritual communities, and families or through the societal safety-net of social services, family practitioners and mental health professionals. Social supports aim to restore us to psychological balance.

When our vulnerability, the events in our life, and stress are greater than our capacity to deal with them we move down the pathway. But as we summon up our resources we move back up towards balance. In this way, the pathway to mental health problems and illnesses can be seen as an interaction between forces that promote balance and those which promote mental health problems and illnesses. Of course if the stress is severe or the life event is great then we may not proceed through the pathway and may move directly from balance to a mental health problem or illness. Risk factors for the development of mental health problems and illnesses such as unemployment or migration may work by increasing stress and life events or decreasing resilience and social support.

This model is useful when considering not only how people develop poor mental health, or mental health problems and illnesses but also what we can do about them.

There are many different types of vulnerabilities, life events and social stresses. Differences in the rates of mental illness and the risk of mental health problems and illness between IRER groups are due to the balance of stresses and resources that each group has available to them.

It should be stressed that this pathway will reflect only one part of a person's existence. It captures a certain set of circumstances leading to the development of a particular mental health problem or illness. It is possible for an individual to develop a mental health problem or illness because of certain difficulties and vulnerabilities in one part of their life while still being mentally healthy in another part of their life and psychological functioning.

The importance of the model is to give an outline which helps us to understand how changes in risk increase the chance of a person developing mental health problems and illnesses that need care. It also gives a framework for understanding public, private and voluntary sector initiatives aimed at improving IRER communities could promote mental health as well as decreasing the rates of mental health problems and illnesses.

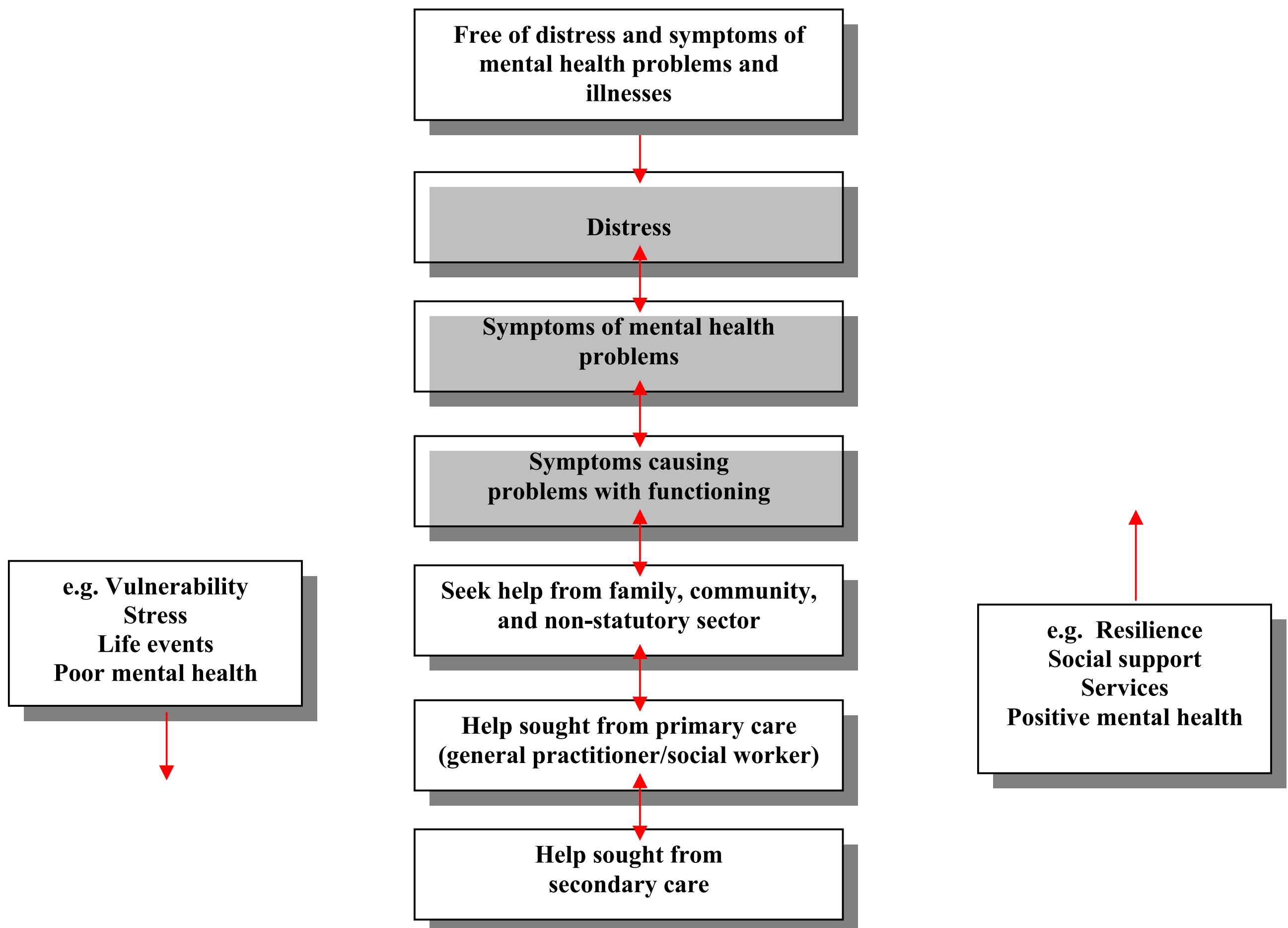


Figure 1

Part 2: Research studies into mental health and mental health problems and illness in IRER groups

Studies conducted around the world point to increased rates of mental health problems and illnesses in refugee groups, some recent immigrant groups and in existing racialized and ethno-cultural groups. For instance, the best analyses worldwide report that migrant groups have over twice the risk of schizophrenia compared to non-migrant groups[5] and the rates of psychological distress, post-traumatic stress disorder and depression are markedly raised in refugees[6]. Some of the factors driving increased risk of mental health problems and illnesses are common to these groups such as unemployment, financial insecurity, poverty and poor housing. Others, like pre-migration stress due to war, torture and rape and the stress of migration, will only impact some[7].

Canadian research

There have been many Canadian studies in the last 20 years that have investigated mental health or mental health problems and illnesses in IRER groups; most being conducted in Ontario, British Columbia, and Quebec. Studies using national samples tend to compare immigrants to non-immigrants while smaller local studies have offered more in-depth information about particular IRER groups.

In the last 20 years there has been an increase in research into the mental health of IRER groups, however when Canada compares to other countries it is clear that there is still much that can be done.

Although the research in Canada specific to IRER groups is of high quality, it only covers some groups and areas. Some regions (particularly Montreal, Toronto, and Vancouver) have rather extensive conducted and published research while other areas including entire provinces and territories have none at all. In addition, research that is conducted on IRER groups tends to focus on the adult population. There is a growing literature on the mental health of seniors from IRER populations but there is an urgent need for more research into the rates of mental health problems and illnesses and the appropriate service response in children and youth. As well as these age groups, there is also a need for more research into those with inter-sectoral issues such IRER groups with low income and the LGBTTTIQQ population.

There is little Canadian research on initiatives at a policy or service level that would improve pathways to mental health care, care received or outcomes for IRER groups.

Evaluating the findings of the research is complicated by inaccurate population counts and demographic differences between groups[8]. In addition, diverse IRER groups are often lumped together as one population or they are grouped by major geographic region (e.g. Asia, African or Europe). This blanket approach to categorisation of groups may not be sufficiently fine-grained for the development of equitable services at a local level. For instance, there are major cultural, religious, historical and language differences in people from Africa and these may be reflected in different needs at a service level.

The published research tends towards quantitative methods even when qualitative methods may have provided a better exploration of the issues[9].

This report will not discuss all of the research findings. It will highlight main messages from the research and illustrate them with specific papers.

In general research has focussed on:

a. Social factors associated with mental health problems in IRER groups.
b. Rates of mental illness.
c. Barriers to and facilitators of care.

a. Social factors and mental health problems

Social factors associated with mental health problems and illnesses are often called social determinants. This is because they are often not direct causes of mental health problems and illnesses but rather act as contributing factors. Mental health problems are rarely caused by a single factor; rather they are a balance between factors that move you up or down the pathway as demonstrated in Figure 1. The social determinants linked to developing mental health problems and illnesses may act on other interpersonal or social levels for instance by undermining resiliency and coping networks.

Social factors may have an influence over a life course to increase or decrease someone's risk of developing a mental health problem or illness. Some increase vulnerability while others act as factors that precipitate illness. Some prolong illness and still others prevent illness and restore health. Vulnerability at specific transitions in life, such as during migration, are due to a significant increase in life stresses at a time when the social safety-net may not be as strong.

The Public Health Agency of Canada has produced a list of 12 determinants of health that are applicable to all[10]. Eleven could be considered social determinants of health and may be particularly pertinent to IRER groups:

1. Income and Social Status
2. Social Support Networks
3. Education and Literacy
4. Employment/Working Conditions
5. Social Environments
6. Physical Environments
7. Personal Health Practices and Coping Skills
8. Healthy Child Development
9. Health Services
10. Gender
11. Culture

In addition, the research offered perceived racial discrimination, migration and language difficulties as social factors linked to mental health problems to which IRER populations are more likely to be exposed.

Income and social status

There is a strong link between low income levels, income inequality, financial insecurity, poverty and mental health problems and illness. All of these factors are more prevalent in IRER populations[11] and this is true for all age groups. Canada's IRER populations are more likely to be in the lower social classes and have lower status jobs[12]. A change in social status, particularly going from a higher status in the home country to a lower status in the host country, can also have a negative affect on mental health[13].

> *"Those who get money through ODSP are not well supported. They are confined to only a fixed amount of little money, but there is no other support. For example, they are not able to sponsor other relatives to support them which is an important factor in preventing mental health problems."* – Focus group participant

Research examples:

- Employment improved the mental health of South East Asian refugees[14].
- Increasing family income for the persistently poor decreased the rate of behavioural problems in immigrant children[15].
- Studies documented associations between poverty, financial insecurity, unemployment and underemployment and poorer mental health in a number of groups including immigrants in general[16], immigrant children[15], immigrant mothers[17], people from Afghanistan[18], Chinese women[19], Black African women[20], Latin American men[21] and South Asian refugees[22].

Social networks

A significant problem for immigrant groups is the fact that social support networks may be broken and lost when people move[23]. It takes considerable energy and time to reconstitute these networks and though there is a history of immigrant groups organizing to provide support, this support may be limited compared to the extensive networks that have been left behind.

Research examples:

- Social networks decreased isolation of South Asian women[24] and in South East Asian groups marriage improved mental health[14].
- A lack of social support and isolation were considered important determinants in causing mental health problems and illness in South Asian immigrant women[25] and Latin American men[21].

Education and literacy

The proportion of IRER groups with a degree is higher than the Canadian average[26]. Between 2001 and 2006 half the people who migrated to Canada had university degrees. This would be expected to decrease the rates of mental health problems and illness in IRER groups. But studies worldwide have shown that, at least for refugee populations, those with higher qualifications do less well[27]. The reasons for this may be that they are not able to work at the same level as they previously had and this loss of status has a detrimental impact on health. According to Statistics Canada reports, immigrants fare less well at work than people born in Canada despite their qualifications[28]. Though immigrants are more likely to have a degree, they earn less than their Canadian-born peers and are also more likely to live in low-income areas. Thirty percent of immigrant men with a university degree work in an occupation requiring only a high school diploma[26].

Employment/Working conditions

For recent immigrants to Canada in 2001, unemployment was consistently at least triple the rate for Canadian-born. Unemployment is not only more common for immigrants, but even more so for immigrants

> *"We would like to have employment opportunities based on our abilities and qualifications"* – Focus group participant

who are also racialized[iii]. In 2001, the unemployment rate for immigrant men was 29% if they were part of a racialized group and 16% if not. For women, the rates were 45% and 25% respectively. These rates narrow for Canadian-born racialized groups. Unemployed people experience higher levels of depression than those who are employed[29]. Employment provides not only an income, but also a sense of purpose and personal growth[30]. Among employed IRER populations, a constant fear of becoming unemployed is a specific stressor[31].

Research examples:

- Employment improved the mental health of South East Asian refugees in one study[14].
- Many of the studies documented associations between unemployment and underemployment and poorer mental health in a number of groups including immigrants in general[16], immigrant children[15], immigrant mothers[17], people from Afghanistan[18], Chinese women[19], Black African women[20], Latin American men[21] and South Asian refugees[22].

Social environments and physical environments

People from IRER groups are more likely to live in poverty and to live in areas that are poor[32]. They are also more likely to live in cities and in areas with poor housing stock. Living in cities increases the risk of a number of mental health problems and illnesses though the processes through which this happens are not clear. It may in part be due to the physical environment including pollution but also the harsh social environment, levels of crime and the diminished sense of community that characterizes some cities.

"Housing is a big issue. The housing provided to persons with mental illness is sub-standard and the ODSP money is not enough to rent a standard house." – Focus group participant

Research example:

- Mental health problems and illness in immigrant children and youth was associated with neighbourhood disadvantage as well as weak community involvement by IRER groups[33].

Healthy child development

Healthy child development depends on time, community resources and money. Over a third of immigrant children live in poverty in Canada. As a result of this, children are exposed to a significant number of social and environmental risks that can negatively impact their mental health. If a child is separated from their parents during the process of migration, they face an increased risk of a mental health problem or illness[15].

"There are many Afghan women whose husbands are separated and are either living back in Afghanistan or in other countries. No matter what the reason of the separation is, if the government helps these couples get together, it will prevent many mental health problems among women and especially among children." – Focus group participant

[iii] This includes immigrants who are not Caucasian in race or White in skin colour

Research examples:

- Mental health problems and illnesses in immigrant children and youth were associated with neighbourhood disadvantage as well as weak community involvement by IRER groups[33].
- Children with parents who have adapted well to Canada as well as maintained their traditional beliefs and practices tend to do better than children whose parents have completely assimilated[34].
- Youth can feel overwhelmed when trying to fit in with the new culture while maintaining components of their own[35].
- Immigrant children in families that consist of single-parents and/or are living in the low income bracket are less likely to do well in school and are more likely to get into trouble with authority[36].

Social factors specific to IRER groups
In addition to the standard determinants of health, there are specific factors that are important in the mental health of IRER groups.

Migration

Migration is a particular stressor for immigrant groups. The reasons for migration, the process of migration and the reception of the host population are all important factors. Pre-migratory stress in refugee groups and trauma such as war, torture, rape and natural disasters increase the risk of developing common mental health problems (anxiety and depression) as well as post-traumatic stress disorder[7]. The process of migration and acculturation can be stressful and may increase risk for mental health problems and illness.

"Some of us [Somali] had pre-immigration stress due to war in addition to the stress of migration. We need information that can raise awareness of the issues of mental illness and its treatments. We are in denial, and we need ethno-specific workers who can support and listen." – Focus group participant

Research examples:

- Negative impacts on mental health of migration and settlement issues in Canada have been reported in Cambodian women refugees[37] and Latin American men[21], migration stress in immigrant mothers[17], and remembering pre-migration stresses in South Asian women[22].

Perceived Discrimination

Perceived racial discrimination is a risk factor for mental health problems and illnesses that are more commonly experienced by IRER groups[38]. This is a complex social problem that has its impacts at a number of different levels; from racial abuse or attack through to more subtle forms such as stereotypes in the media. The economic disadvantage linked to discrimination at work is significant as is discrimination in the receipt of services. Some argue that in Canada there is a colour to poverty. Perceived discrimination impacts on mental health through direct effects on individual's psychology and physiology as well as through its links to other social determinants of health[39]. For example, some of the systemic issues leading to

"There is a big discrimination against immigrants. Because of their race, they are facing lots of obstacles. Although they are invited based on merits, when they come, their academic degrees are not recognized, therefore they are facing lots of frustrations." – Focus group participant

differences in employment / working conditions and income in the immigrant populations may include a lack of recognition of foreign credentials, qualifications, and experience.

Research example:

- A study reported discrimination as an important risk factor for the mental health of Korean immigrants[39].
- Some of the variables influencing a newcomer student's ability to do well include teacher biases and institutional or systemic discrimination[40].

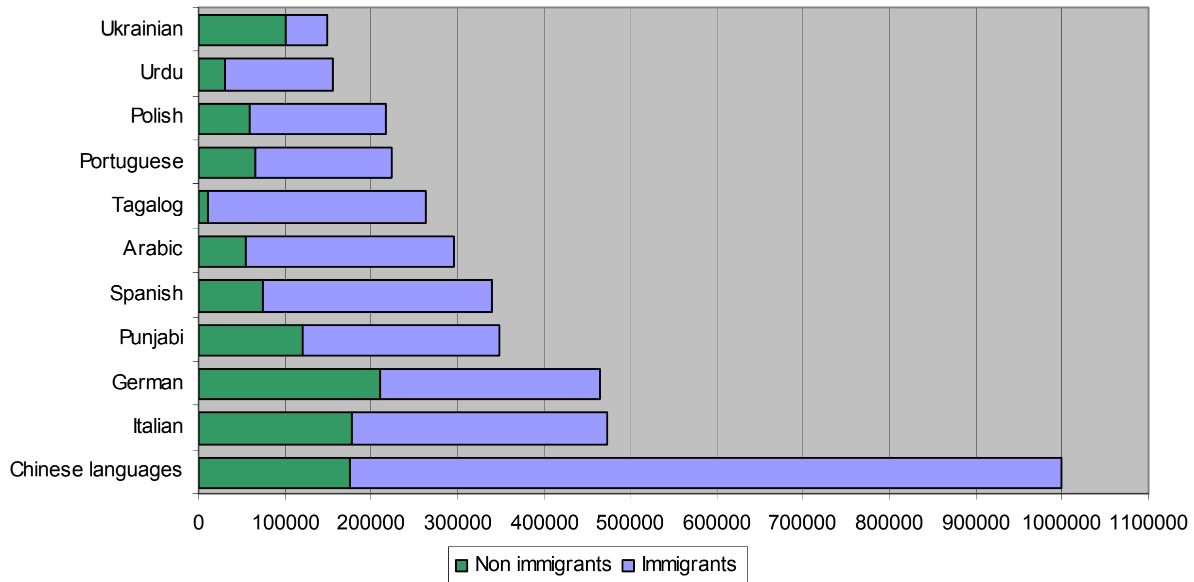
Language

Twenty per cent of the Canadian population have a mother tongue that is not English or French. There are over 200 languages spoken in Canada[41]. When people develop mental health problems or illnesses they may need to use the language in which they can communicate best to explain what they are experiencing; indeed this may lead to better outcomes[42]. The most common mother tongues apart from the official languages are Mandarin, Cantonese and South Asian languages (Urdu, Hindi and Punjabi). Less than half the people who speak these languages use English or French regularly at home.

Research example:

- Language problems were identified as a social determinant for most groups including Black African women[20] and Latin American men[21].

Number of immigrants and non-immigrants whereby English or French is not their first language, Canada, 2006[41]



Note: 'Chinese languages' includes Mandarin, Cantonese, Hakka, Taiwanese, Chaochow (Teochow), Fukien and Shanghainese, as well as a residual category (Chinese languages not otherwise specified).

Age

Older Adults

Older adults may have different needs to other age groups. Immigrant and refugee women over the age of 65 are among the poorest people in Canada[43]. They may never have worked before and therefore, have no source of income such as a pension to rely on. They are consistently poorer than immigrant men. There is a higher risk of mental illness in people who migrate after 65 years of age. This group may have problems adapting to a new culture because of language problems and limited access to lessons[44]. More than any other group, seniors have to rely on their children and grandchildren to assist them in daily activities[45]. Unlike younger age groups who are able to socialize at school or work, the elderly are much more isolated in that their families may be their only social contacts.

> *"I think old people are more at risk of mental health problems because they are alone and cannot take care of themselves properly"* – Focus group participant

Research examples:

- Being single, living alone, and having more service barriers were associated with having more depressive symptoms among South Asians[45].

Key Issues for Social Factors and Mental Health Problems and Illness

1. There is a link between a variety of social factors and mental health problems and illnesses. *(Recommendation 3)*
2. IRER groups are more exposed to current PHAC list of social determinants of health *(Recommendation 3).*
3. IRER groups are more exposed to other novel social determinants such as migration, discrimination and language difficulties. *(Recommendation 3).*
4. The impacts of social determinants can be complex for instance discrimination has a direct impact on individual's psychology and physiology as well as through its links to other social determinants of health at a group level *(Recommendation 3).*
5. The social forces that push people down the pathway from balance to the development of mental health problems and illnesses are increased in some IRER populations and those that push people towards balance such as social support, are diminished through their social status in Canada *(Recommendation 3).*

b. **Rates of mental illness**

Studies worldwide point to increased risk of mental health problems and illnesses in IRER groups[46],[47],[48]. The rates of mental health problems and illnesses in IRER groups in Canada however, are not consistently reported as elevated. There are a number of possible reasons for this including: (i) people with existing mental health problems and illnesses may be less likely to get through the immigration process or (ii) people who are recent immigrants may not disclose their mental health problems and illnesses.

The Canadian Community Health Survey (CCHS) offers one of the few national studies of mental illness in recent immigrants to Canada[49]. It reported what is known as the healthy immigrant effect. In this study, first generation immigrants to Canada had lower rates of depression than Canadian-born residents. However, the CCHS also reported that rates of depression increase in the second generation. Similarly in Canada it has been shown that second generation young people engage in high risk behaviours such as harmful drinking and illicit drug use more than first generation young people[50].

Local studies do not always concur with the results of the CCHS. For instance, a study of adolescents in Quebec found high rates of psychopathology in refugee youth and a study of Toronto University students found that mild depression was more likely in South Asian and South European students than students of East European and Anglo-Celtic backgrounds[51]. In Quebec, immigrant women belonging to minority groups were found to display higher depressive symptoms than women born in Canada or women from larger IRER groups[17] and a study of the Ethiopian origin population in Toronto reported a lifetime prevalence rate of depression at 9.8%[52]; higher than the national average which is between 7.9-8.6%[53].

European studies show that immigrants, particularly African-Caribbean immigrants are at an increased risk for schizophrenia and other psychoses[5]. There is some suggestion for this found in studies in Nova Scotia[54] and Quebec[51] but no large scale study has been conducted in Canada[55].

As many as two percent of all deaths in Canada are by suicide[56]. The Canadian Community Health Survey noted that in 2002, 3.7% of the population had suicidal thoughts[57]. In 1998-99, Statistics Canada researchers reported that there were 23,000 suicide attempts in Canada[58] while in 2001-02 Statistics Canada research noted that just over 15,000 people presented to Ontario hospitals with injuries caused by deliberate self infliction[59]. Research reports of immigrant groups place them in the lower risk range. However, studies of the mental health of Afghan youth note that almost 25% of the sample reported thoughts of suicide and 16% of the total sample had attempted suicide. Nearly two-thirds of this sample also reported experiencing war trauma. Hyman et al found that pre-migration trauma and stress greatly influenced mental health problems and illness in children[34]. In particular, refugee children exposed to natural and human-perpetrated disasters are at a higher risk for depression, anxiety, anger, and psychosomatic symptoms[34].

It may be that the lack of clear findings at a national level reflects the heterogeneity of rates of mental illness in different groups. If some IRER groups have high rates of mental illness and others do not then when all the groups are put together the different effects cancel each other out. More fine-grained analysis may be needed.

Rates of mental health problems and illnesses do not give all the information required to develop services. This study was unable to find data on needs for mental health services for IRER groups at a national or at a local level. If services are to be built to meet the requirements of populations, then urgent information is required on mental health needs for IRER groups.

Key Issues for Rates of Mental Illness

1. The rates of mental health problems and illnesses in IRER groups in Canada vary *(Recommendations 1-4).*
2. IRER groups are often considered as a single population which can create an inaccurate picture of the rates of mental health problems and illnesses among diverse groups *(Recommendations 2-4).*
3. International studies show that immigrant and refugee groups are at increased risk of mental health problems and illnesses[46],[47],[48] *(Recommendation 6).*

4. Local studies in Canada report high rates of mental health problems and illnesses in some IRER groups *(Recommendations 2-4).*
5. There are low rates of mental illness in immigrant groups when they arrive in Canada but these, and risk behaviours may increase over time *(Recommendation 3).*

c. **Barriers to and facilitators of care**

The need for services may be a more pertinent issue than simple rates of mental illness. Groups exposed to life events and social stress, low incomes, fractured support networks and poor societal safety-nets may be more likely to move down the pathway from the development of symptoms to needing to use mental health services. IRER groups are more likely to be exposed to social determinants that promote mental health problems and illnesses at a time when community and personal resources that support individuals and promote health are diminished.

However, most people in need of mental health care do not get it. Research studies raise concerns about access to mental health services for IRER groups and the care that is received[63].

Immigrants are less likely than their Canadian counterparts to use a mental health service in primary care or speciality settings[60]. A study by Whitley et al. found that some of the barriers to seeking treatment include a perception of doctor's over-willingness to prescribe medication, the interaction between the patient and doctor, and a stronger belief in traditional therapies[61]. Studies reported that mainstream mental health care was considered inconsistent with the values, expectations, and patterns of help-seeking of IRER groups. For instance, the incompatibility between services and Black women[62], South Asian women[24], Tamil and Asian seniors[63] and West Indian immigrants[64] have been documented. Those who are more educated tend to be more likely to seek services for their mental health problems and illnesses (both in the IRER populations and the non-IRER populations).

Language

Language was often cited as a barrier to care in the Canadian literature[65, 66]. As of the 2006 Census, 20% of the population (or just over 6 million people) do not speak English or French as their first language. Although newcomers may learn English or French through language courses, many continue to speak their first language at home. Because newcomers may not speak the language, they may not seek health or mental health services since they do not know where to go or because they are not able to convey how they are feeling in English or French. Generally, the longer someone is in Canada and is able to learn one of the languages, the more likely they are to use health services. Though interpreter services are mandated in the court system, this is rarely the case in the health system which can mean that children or non-medical staff will act as interpreters. Where translation and interpretation services are available, clinicians are rarely taught how to use them.

> *"As consumer survivors we need a companion and someone to talk to in our language. Some of our community members speak only their mother tongue; and would only be able to communicate with workers that speak their language".* – Focus group participant

Even if language services were fully available, some may question whether the same quality of treatment can be delivered through an interpreter. Some would argue that services in the same language as the person who is attending them are the only way of offering equitable care.

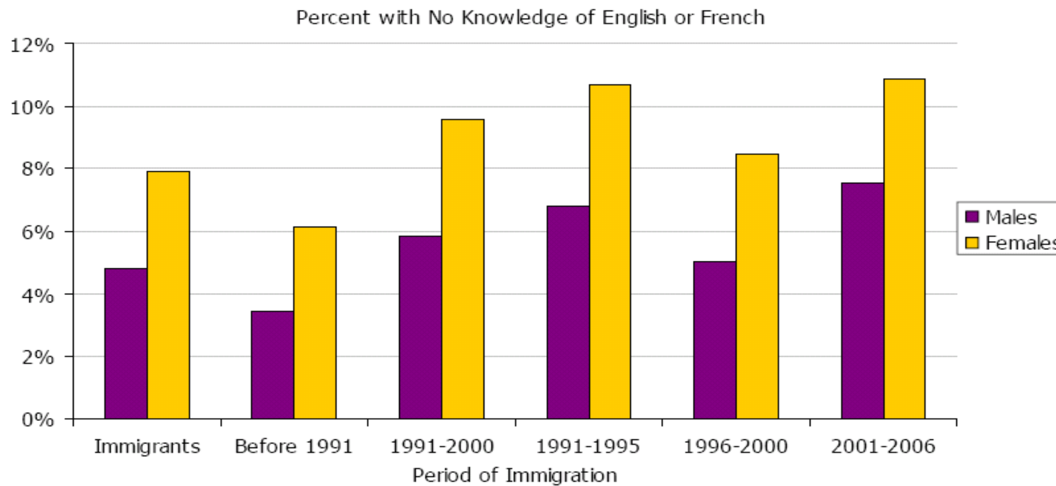


Figure 2[67]

Awareness of services

> *"We need to be educated so that we can understand and overcome the poor information about the availability of services."* – Focus group participant

Another issue in access to services is awareness. There are reports that some from IRER groups are either not aware of the services that are available to them, or do not understand how the health care system works[18]. If people do not know where to get help, they may wait until their symptoms are more severe before they receive care. Some have reported that in the absence of information about services, they find out how Canadian systems work through friends and family. They are less likely to ask about mental health systems because of possible stigma and this leads to people either not getting treatment or a delay in getting treatment. A lack of knowledge about where to get care was reported as an impediment by Afghani[18] and Asian Canadians[68] and poor information about available services was reported by Chinese immigrants[69].

Socio-economic barriers

Socio-economic barriers differentially affect IRER groups in Canada as these groups are more likely to be poor. Poor income decreases access to and utilization of health care services. Several provinces impose a three-month delay after arrival into Canada to receive health insurance. Certain categories of temporary workers, foreign students, visitors, and undocumented migrants are excluded from provincial health coverage[70]. Services are often only available during the week and this may act as a barrier for someone who is employed. Transportation costs can also impact service use. A lack of funds can also prevent people from purchasing necessary medications. This means that people may not be able to afford any or all of their medications which will further prevent treatment.

Perceived Discrimination

Studies of both Asian Canadians[42] and Black women[30] cited perceived racial discrimination as a barrier to care. Institutionalized discrimination has been a way of considering structural barriers to accessing mental health care by IRER groups. The argument has not been that practitioners directly and actively discriminate against particular groups but that the system of care works to offer poorer access and treatment to these groups. One size fits all services ignore the differential needs, presentation of problems and desires of groups and could lead to poorer outcomes. Studies have documented differences in presentation of problems in IRER groups in populations from immigrant children[71], East Asian university students[72] and Asian Canadians[42]. Some have indicated how therapies can be modified to make them more effective, such as problem focused therapy[73] being more effective for some problems in Korean immigrant groups and emotion-based coping[74] for some South Asian groups. However, these studies are rare.

Stigma

Stigma of mental illness and of mental health services is a significant barrier to care. Stigma refers to the negative perceptions people have about mental health problems and illness. Historically, people who suffered from a mental health problem or illness have been ostracized by their communities and families. Although misperceptions and stigma can be seen in all societies, there are some communities which experience a deeper level of stigma than others[75]. In some communities, acknowledging a mental health problem can bring significant shame not just to the individual but to the entire family[64]. Therefore, the decision to seek treatment for a mental health problem or illness is not only a personal choice, but can be a choice which may carry social consequences for the whole family.

> *"Getting rid of the "stigma" associated with the term "mental health". I must admit that I have fallen victim to this stigma on many events. I did not want other people to know about my illness because they would treat me badly. I think it's important to bring awareness to these stigmas as it may open the door for more people to discuss these issues."* – Focus group participant

Pathways to care

As noted earlier in this document, the first line of help-seeking is often the existing community, lay healers and religious groups. Religion and spirituality are important sources of support and help in the management of stress and mental health problems and illnesses [76]. It would not be surprising if alternative therapies and treatments from home countries were common in IRER groups. One study for instance reported the use of traditional healing practices in South Asian[24] and Tamil groups[77]. The next line of treatment is the family practitioner followed by possible referral to secondary care such as psychiatrists. There is little information on family physicians and mental health in IRER groups but there is some evidence that they find it difficult to locate culturally appropriate services to refer to when they consider the need[18].

> *"We think that services should be available in places of worship, where people can trust and feel at ease. Imam and other staff in the Somali mosque need education to reduce stigma."* – Focus group participant

There is some literature reporting factors that facilitate people from IRER groups in Canada getting care. For instance, in the Tamil population, this includes length of stay in Canada, trust in the system, knowledge and education and cultural competency[77]. In South East Asian university students, acculturation and co-operation between service providers has been reported as helpful[72] and in the Somali community ethno-specific health promotion and diversity of services including alternative approaches have been cited[78].

Key Issues for Barriers to and Facilitators of Care

Barriers:

1. A number of factors including awareness of services, stigma, socio-economic factors, perceived discrimination and language are potential barriers to care for IRER groups (*Recommendations 6-15)*
2. Though interpreter services are mandated in the court system, this is rarely the case in the health system which can mean that children or non-medical staff will act as interpreters *(Recommendation 14)*
3. Structural barriers, such as institutionalized racism, mean that IRER groups are less likely to get the care they need *(Recommendations 6-15)*

Facilitators:

4. Those who are more educated, have been in Canada longer and are able to learn an official language are more likely to seek services for their mental health problems and illnesses.
5. Trust in the system, cultural competency of services and co-operation between service providers may decrease barriers to care *(Recommendations 6-13)*[77 72].
6. Ethno-specific health promotion and diversity of services including alternative approaches have been cited in some communities to facilitate care[78].*(Recommendations 12, 13)*

Key Issues for Part 2

1. There is a link between a variety of social factors and mental health problems and illnesses.
2. IRER groups are more exposed to current PHAC list of social determinants of health *(Recommendations 1, 6, 14).*
3. IRER groups are more exposed to other novel social determinants such as migration, discrimination and language difficulties. *(Recommendation 6).*
4. The impacts of social determinants can be complex for instance discrimination has a direct impact on individual's psychology and physiology as well as through its links to other social determinants of health at a group level *(Recommendation 6).*
5. The social forces that push people down the pathway from balance to the development of mental health problems and illnesses, are increased in some IRER populations and those that push people towards balance such as social support, are diminished through their social status in Canada *(Recommendation 6).*
6. The rates of mental health problems and illnesses in IRER groups in Canada vary *(Recommendation 4).*
7. IRER groups are often considered as a single population which can create inaccurate picture of the rates of mental health problems and illnesses among diverse groups *(Recommendations 4, 5).*
8. International studies show that immigrant and refugee groups are at increased risk of mental health problems and illnesses[46],[47],[48] *(Recommendation 6).*
9. Local studies in Canada report high rates of mental health problems and illnesses in some IRER groups *(Recommendations 4, 5).*
10. There are low rates of mental illness in immigrant groups when they arrive in Canada but these, and risk behaviours may increase over time *(Recommendations 4, 6).* A number of

factors including awareness of services, stigma, socio-economic factors, perceived discrimination and language are potential barriers to care for IRER groups

11. Though interpreter services are mandated in the court system, this is rarely the case in the health system which can mean that children or non-medical staff will act as interpreters.
12. Those who are more educated, have been in Canada longer and are able to learn an official language are more likely to seek services for their mental health problems and illnesses.
13. Trust in the system, cultural competency of services and co-operation between service providers may decrease barriers to care[77 72].
14. Health promotion and diversity of services specific to ethnic communities, including alternative approaches have been cited in some communities to facilitate care[78]

Part 3: Building a response to the issues

The response of provinces and territories

Provinces and territories have the major responsibility for delivering mental health services. The architecture of services, organisation of funding, planning and governance varies. There has been a similar variety of responses to the challenges of developing mental health service for IRER populations. For instance at a provincial level the Alberta Health Services is working towards developing an approach to achieving diversity competency and, in the interim, the Regional Diversity Directional Document, vetted through the Regional Diversity Advisory Committee in Calgary, will be used to articulate the way in which Alberta Health Services will work to become a proficient diversity competent health organization, At a regional level the Vancouver Coastal Health Authority (one of six British Columbia Health Regions) co-ordinates Vancouver's cross cultural mental health services which originally developed organically in the primary, secondary and tertiary care sectors. At a local level, Toronto Local Health Integration Units are requesting plans to move towards health equity from service providers.

All provinces were contacted for the purpose of this study. They reported 66 services or initiatives specifically targeted at IRER groups. Such initiatives may improve services and outcomes for people with mental health problems and illness.
No province, territory or region had linked organisational cultural capability to direct service provision and evaluate their outcomes.

With regards to wellness, improving the mental health of IRER groups is complex and the impact of the social determinants of health requires that significant planning, cross-sectoral support and so political will. This project was unable to identify any province, territory or region with a comprehensive strategy for improving the mental health of IRER populations.

The federal response – After the Door Has Been Opened

The mental health of immigrant populations has been of interest for many years. A national task force was established in the mid-1980s to investigate this topic. Their findings were reported in 1988 (*After the Door Has Been Opened)*[79]. A thorough literature review was conducted as well as presentations and written submissions from respondents across Canada. The Task Force concluded that, while moving from one country and culture to another inevitably entails stress, it does not necessarily have to threaten mental health. The mental health of immigrants and refugees becomes a concern primarily when additional risk factors combine with the stress of migration. One of the main issues this report describes is the fact that immigrants and refugees do not have a voice in the mental health care system either from the point of view of people living with mental health problems or illnesses, or as service providers.

The Task Force noted three principles:

1. The mental health issues affecting immigrants and refugees include both issues of cause and issues of cure. To meet the mental health needs of Canada's migrants, risk-inducing factors must be mitigated and remedial services made universally accessible.

2. The steps required to prevent and treat emotional distress in immigrants involve the persons with whom migrants come into contact as much as they do the migrants themselves. Sensitizing Canadian-born persons – immigration officers, settlement workers, teachers, neighbours and mental health personnel - to the ways in which culture

can affect encounters between themselves and newcomers to this country can help eliminate major sources of distress for migrants and facilitate effective mental health care.

3. The Task Force recommendations reflect the fact that no single governmental body or level of government is or can be responsible for the mental health of Canada's immigrants and refugees. For newcomers to adapt to and integrate with Canadian society, their strengths, needs and perspectives must be taken into account by decision-making bodies at each level of government, by planners and by service providers.

They then offered 27 recommendations for Citizenship and Immigration Canada, Health Canada, and other federal bodies to improve mental health for immigrant groups (Please see Appendix A).

For the purposes of this project, the research team attempted to investigate how much progress had been made on these recommendations. So far in the twenty years since the report was published, only 6 of the recommendations have been implemented in full.

Citizenship and Immigration Canada's direct role in the provision of mental health services is through the Interim Federal Health Program[80]. This offers health services to recent immigrants, current refugee claimants, refugees, detainees in immigration detention centres and failed refugee claimants still in Canada who are unable to pay for their health care services. It covers essential and emergency medical services, including mental health services such as consultations with a physician, hospitalization and essential medication.

Although Health Canada was named in the recommendations, they explained to this research team that they have difficulty enforcing or contributing to them because they are a federal body that does not actively deal with service delivery. Provincial health departments are responsible for services for IRER populations.

The Senate report: Out of the Shadows at Last

The Senate report, *Out of the Shadows at Last*[80] took evidence on mental health services for refugee and immigrants some 17 years after *After the Door has been Opened*. It underlined the fact that after admission to Canada, the expectation is that the delivery of programs and services related to mental health that fall into the public health care sphere will be a responsibility of the provinces and territories.

The report called for Canada's commitment to provide safe refuge to include assurances that individuals have access to health services to help them with any mental health problems they face. It identified a role for an external body to provide oversight and assessment of how well the federal government is meeting its commitments to immigrants and refugees. It recommended that:

> "the federal government establish an entity for immigrants and refugees, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee; That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of immigrants and refugees; That this entity provide an annual report to Parliament."

It also supported the greater involvement of immigrant and refugee communities as partners in research, program development and service delivery. The report argued that there is a need for more Canadian research into the identification and evaluation of culturally appropriate systems of care for immigrant populations, particularly in relation to vulnerable populations such as children, women and seniors.

Key Issues:

1. The Federal policy response has focussed on the minority of Canadians from IRER groups who are new immigrants or refugees. *(Recommendations 15-16)*
2. There is evidence of only action on 6 of the 27 recommendations made by *After the Door Has Been Opened (Recommendations 15-16).*
3. The Senate Report emphasized the need for more Canadian research into the identification and evaluation of culturally appropriate systems of care for immigrant populations *(Recommendations 13, 15,).*

Part 4: A recommended model for service improvement

Canada's population is becoming more diverse with some regions' IRER populations increasing significantly each year. Mental health services will need to reflect these population shifts. Several issues have been raised including the social determinants of health, differences in rates of mental health problems and illnesses, barriers to care and need for services. Some key concerns centre on the mental health impacts of unemployment, under-employment, low income, language difficulties, social isolation, migration, and discrimination. Other factors which require special attention include specific age groups such as children and the elderly.

The issues are complex. There is not an extensive Canadian literature on mental health, mental health problems and illnesses and service needs of IRER populations but what there is indicates that socio-environmental factors may increase the risk of mental health problems and illnesses over time in some IRER groups. There is a significant body of research detailing the barriers that IRER groups have to getting good quality care indicating that these groups are more likely to be underserved. Language is a particular barrier to care.

There has been some consideration of refugee and new immigrant groups but there has not been a concerted effort at a national level to consider the needs of existing racialized and ethno-cultural groups.

There is little Canadian research on initiatives at a policy, service or educational level that could improve the mental health or mental health care for IRER groups. But there is an international literature which could offer some direction[81],[82].

Improving mental health and the outcome of mental health problems and illness will require action across a number of sectors. In order to match the challenge of the census data and literature, private and voluntary sectors as well as a range of public organizations – not just traditional health services – will need to be involved. The need will be to promote strong and healthy communities and build resiliency rather than just to improve services.

The Mental Health Strategy for Canada proposes seven linked goals for a transformed mental health system:

1. People of all ages living with mental health problems and illnesses are empowered and supported in their journey of recovery and well-being.

2. Mental health is promoted, and mental health problems and illnesses are prevented wherever possible.

3. The mental health system responds to the diverse needs of all people living in Canada.

4. The role of families in promoting well-being and providing care is recognized, and their needs are supported.

5. People have equitable and timely access to appropriate and effective programs, services, treatments and supports, that are seamlessly integrated around their needs.

6. Actions are based on diverse sources of knowledge and evidence, outcomes are measured, and research is advanced.

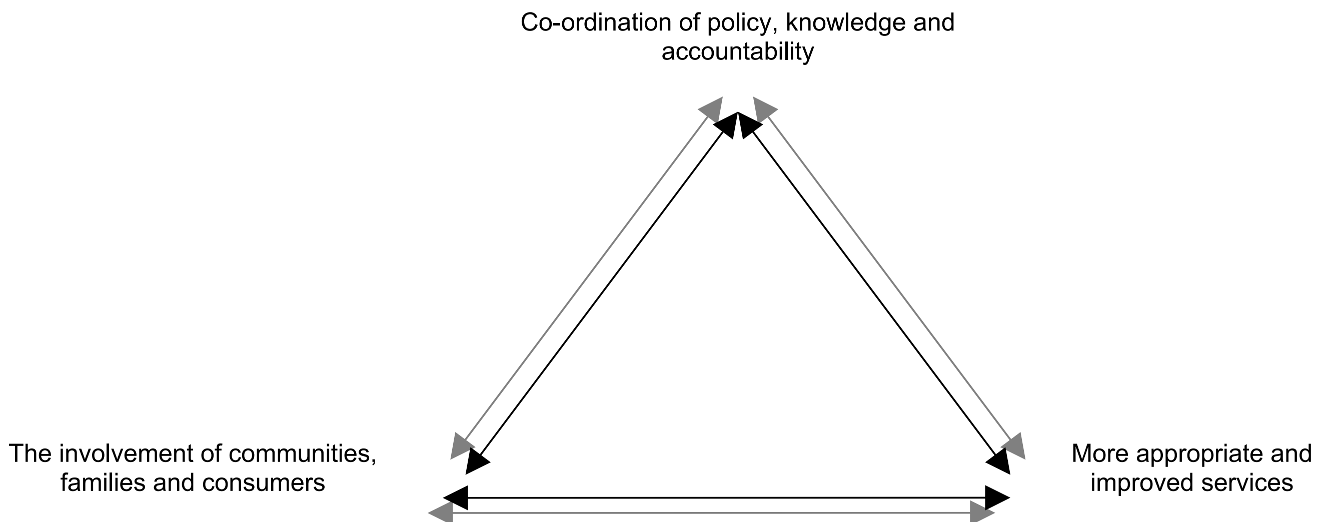
7. People living with mental health problems and illnesses are fully included as valued members of Canadian society.

Action in each of these linked goals will be needed in order to meet the challenge of offering equitable services to Canada's IRER population.

One approach which brings many of these actions together would be to develop population-based, flexible services that use the involvement of IRER communities to understand and meet their needs. Using such an approach provinces, territories and regions would be able to tailor service development to their demographic imperatives. In addition, the experience of local communities and people with lived experience could be employed to help develop services that are suitable for the people who are likely to use them.

Three intertwined groups of actions may help deliver such a strategy:

1. Co-ordination of policy, knowledge and accountability;
2. The involvement of communities, families and consumers;
3. More appropriate and improved services



These arrows on the diagram are bi-directional indicating that this is an iterative process.

Co-ordination of policy, knowledge and accountability

There needs to be policy development on at least two fronts:
1) To improve the mental health and decrease the risk of mental health problems and illness in IRER groups and
2) To improve services for IRER people with mental health problems and illnesses.

The evidence of the importance of the social determinants argues for a more fundamental need to develop efforts to decrease individual and community exposure to factors that harm mental health and increase the risk of mental health problems and illnesses as well as developing effort to improve communities and build resiliency. Such efforts will need to include the private and voluntary sectors as well as those involved in setting mental health, public health and social policy. The accountability for this is diffuse and lies with a number of different departments of

government at different levels. While the direction or goals of a mental health service may be agreed across provinces, the delivery of many of the changes needed will be the responsibility of individual provinces, territories and regions. There needs to be effective leadership and liaison between these groups if a co-ordinated public health approach is to be taken to these issues. This will require a whole government rather than siloed approaches and consideration of place based policy and strategy.

During our study we discovered many different services trying to offer care to IRER groups. In some areas there were mainstream services and ethno-specific services offering mental health care but these were not co-ordinated in any meaningful way. The focus was on getting a service running and treating people rather than planning a service. Some were offering high quality care to those who were fortunate to get their services but most people were not that fortunate.

For there to be effective service development so that the largest numbers of people are reached, there needs to be co-ordination and a strategy. This needs to lead to a plan backed up by a data stream and evaluation. Improving services for IRER groups is no different. Making sure the plan works requires a framework of accountability and monitoring.

Alignment of plans at different levels of federal, provincial and regional jurisdiction would bring best results but may be difficult to achieve; provincial and local alignment may be more possible. Clearly, the benefit of co-ordinated plans is that they can increase productivity and decrease duplication. Plans that aim to integrate better different service providers and sectors of care and which aim to consider services in other sectors linked to health, such as settlement services, will be most effective. However, a plan at any level, even if it is not co-ordinated will be better than none.

A plan can have other benefits. The process of developing a plan can be used as an initiative for developing partnerships and networks, uncovering local good practice and building capacity, as well as delivering a blue print for service improvement.

Plans would, of course be best built on local information. Some data is available from routine sources and the census but in many places there may need to be an initiative to develop the knowledge base.

In an evidence-based system, information is the building block of services and is also a way of monitoring success. The lack of data on the needs for mental health services and the use of mental health services by IRER groups undermine the ability to plan care. For instance, most IRER groups have an age distribution skewed towards youth which predict a significant increase in older people from IRER groups in the next two decades. In addition, there was a significant increase in migration from non-European countries from the 1960s onwards. These groups are getting older and may be an increasing population in need of psychiatry services for IRER seniors. Plans may want to target early treatment and prevention in youth but the demographic of the aging population may bring more Canadians with different needs, cultures, traditions and languages into contact with old age mental health and care services.

Quantitative data is important but qualitative data will be needed so that experiences that cannot be captured by numerical data can inform service delivery. Quality of data may be improved if IRER groups are involved in all aspects of knowledge development from design of the investigation to analysis and presentation.

Data by itself does not change services. These data will need to be used intelligently and linked to those who make policy as well as those who plan and operate services if they are to make a difference.

Given the complexities, some areas may not have the expertise to analyze cross cultural data, or to consider what the literature reports concerning appropriate service models or risks. One way

to assist where this is lacking would be to develop an independent quality assured national group of experts, including members of IRER communities to provide technical assistance. This could be done from existing expertise across Canada in a virtual centre. Such a centre would need to be clearly linked to the community as well as academic expertise. The group could also help areas produce the data on needs required for their plan.

The development of knowledge about the diversity of the community served and data can be used to monitor access to services and service usage. This can help service providers to consider the most appropriate service developments and plans and help funding bodies ensure that their diverse communities are being served. A framework for accountability and feedback will be required to ensure that plans are implemented as expected.

Without a clear plan and without data, ad hoc services are being developed across Canada. Excellent services have been produced in this way. However, it is not clear that services in any area formed a coherent response.

Moreover, the process of planning used creatively can achieve a lasting change in relationships which will be a beneficial architecture for future development and interactions with IRER groups in other spheres.

Involving communities, families and consumers

Improving mental health services does not rely only on data and knowledge of the demographics of the population, but also an understanding of the population's views on service delivery. Knowing the views of all stakeholders can improve the efficacy of services.

There may be different ideas concerning who should be offering services, where they should be offered and how they should be best configured. Communities and people with lived experience should be included in the decision-making process.

Services are increasingly moving towards models where consumers and families are an important voice in their configuration.

At another level, engaging better with communities can decrease duplication of services and offer new and more efficient models of service delivery. Diversifying models of care through the encouragement of local ethno-specific solutions to challenges could offer and adjunct to an improved response of mainstream service; the aim would be to harness the expertise of communities, increase community efficacy as well as to improve the local safety net.

Developing networks of consumers, family members and community representatives who are interested in the improvement of the service response is an important step. The network can act as a conduit for knowledge exchange about needs, services that are available, and problems with accessing services. Including diverse communities in health planning and setting up structures is also a way of investigating the needs of particular groups for instance LGBTTTIQQ. Specific processes to ensure all voices are heard are paramount.

In an information age we need to consider knowledge transfer. Not only do services need to be better informed about communities but the process can be used to increase the awareness of communities about existing services.

During our consultations, lack of awareness of services was a recurrent theme.

Better and more appropriate services

A plan, local knowledge and the involvement of the community are pre-requisites for the development of more appropriate services. The actions required to improve mental health services for IRER groups can be considered in five groups and they work in concert to produce services that are capable of meeting the needs of the IRER population:

1. Changed focus
2. Improvement within services
3. Improved diversity of treatment
4. Linguistic competence
5. Needs linked to expertise

Changed Focus

In addition to policy development aimed at decreasing the impact of social determinants of health and specific risk factors such as the impact of migration, racial discrimination and language barriers which affect IRER groups the focus of service will need to change to embrace health promotion and illness prevention.

Promotion efforts focussed on IRER groups can be effective. They can improve pathways to care and decrease exposure to risks. During the consultations, some participants stated that stigma was a particular problem in some IRER groups and that specific targeted anti-stigma campaigns would be an important facet of any strategy.

Some of the groups such as youth could be offered opportunities for creative health promotion and prevention strategies. For example, it was recommended that youth in the Somali community can be trained in mental health as a way of raising family and community awareness[36].

Improvement within services

There was general agreement in the consultations that improving services to meet the needs of IRER groups may be easier if there is a diverse workforce that reflects the population it serves. For progress to be made, improved representation is best at all levels including the leadership of both purchasers and providers of care.

Improving the diversity of staff and developing leadership may help service transformation but there will need to be organisational strategies for cultural competence. This will lead to improved understanding of the community and an environment where more appropriate services can flourish.

Organizational cultural competence will be reflected in such things as the working environment, the policies of the organization including race relations policies, and attention to the minimization of structural barriers to care through the development of an active network of community partners.

In addition to organizational cultural competence, there is a need for direct care staff and others who come in contact with the population to be more culturally capable.

There is a vast literature on training to improve cultural awareness and competence. There is evidence that training can change attitudes, knowledge and skills when treating people from IRER groups[83],[84]. However there is little data on whether it changes outcomes. Two factors are involved here: the first is the fact that outcomes are not measured, and the second is the fact that

for knowledge, attitudes and skills to be translated into better outcomes, there needs to be a structure within an organisation that allows and supports practice change.

The need for training to improve the capacity of service providers to meet the needs of diverse IRER groups was endorsed strongly by participants in the consultations but it should be made clear that such training by itself in the absence of service and organizational development strategies that are supportive of inclusion/ diversity is unlikely to improve the experience of mental health services for IRER groups. For instance, in a situation where an IRER group has problems with accessing hospital-based services because of their location or because of a lack of awareness, training staff is unlikely to make a significant difference. The staff may be well trained but the clients may still not have access to services. It is also important to note that there are many forms of training and their assessment has mainly been outside Canada. There is not as yet consensus on what the best forms of training are to meet the specific social context, levels of immigration, history of immigration and diversity of IRER groups in Canada.

Improved diversity of treatments, providers and institutions

The issue of the need for more diversity in mental health service provision has been a clear theme of the research and our consultations. The models of care of different cultural groups need to be recognised, understood and respected by the health care sector. There is a need recognized in *Out of the Shadows at Last* for a better understanding of strategies that work in IRER mental health and a dissemination of that knowledge. Models of care such as cultural interpretation services and cultural liaison services have been developed and may offer one service response. Across Canada, *s*ame language services and IRER service providers exist in pockets. In addition, some have expressed the wish for services to be where people want them such as one stop centres and mall based mental health services as well as services for children in guidance offices at school. Given the diversity of the IRER population and the differences in demographic changes and urgency in different areas there is unlikely to be a one-size fits all solution to service models. Knowledge about the development and evaluation of new service models may increase the choice that planners have in deciding what is possible in their area.

Linguistic competence

Language is a barrier to good care. As noted previously, approximately 6.2 million Canadians do not speak English or French as their mother tongue. Given this, the development of a comprehensive linguistic competence strategy may be a clear target for service improvement. The breadth and balance of this may be different in different areas depending on need. But it could include language supports at a number of levels including a plain language strategy for those who speak English or French and interpretation, translation and cultural interpretation services for those who speak other languages. Signage, documentation and information leaflets should be translated to meet the needs of the population. Very few jurisdictions in Canada provide this in health or mental health services while it is available in the legal system.

Such strategies may lead to a need for training for practitioners on how to work with interpreters. Interpreters themselves may need training in mental health and accreditation, and bilingual practitioners will need to be supported. In some instances, ancillary services such as tele-interpreting may be of use.

Linking needs to expertise

Different provinces and areas have different percentages of IRER groups leading some to believe that the development of specific services is neither possible nor strategically important. The challenge is how to offer high quality services in areas where there are few people from IRER groups. One strategy would be for more populous regions or areas with expertise to partner with

areas consisting of low concentrations of IRER groups. Centres of excellence could offer satellite services or clinics and IRER groups could also be offered an option of same language services via telemedicine.

There is a possibility of developing existing e-health resources and techniques, including online treatment and education, to make them more accessible to IRER groups. There will also have to be strategies developed that are not dependent on access to a computer but can leverage phone or smart phone technology. The central aim in all of this is to link people with the right information and expertise, and to link organizations with the expertise to those who may find it difficult to offer services because their populations are too small for quality services to be developed and sustained.

Conclusion

This issues and options paper suggests that the major plank of any initiative to improve the mental health, to decrease the risk of developing mental health problems and mental illness and to improve the outcomes of care for of IRER groups is developing a plan based on population level data and knowledge about the needs of communities that are served. The plan would focus on policy improvement and public health interventions aimed at health promotion and illness prevention as interventions targeted at service improvement. The exact extent of the plan depends on the needs of the population and, of course the resources available. Including IRER population groups in the planning helps in the development of more appropriate services and also allows for linkage to community based services, decreasing duplication and increasing the diversity. This will improve awareness and access. With data and community connections, services can forge a path of internal development including training and organizational change to facilitate clinicians using their knowledge, attitudes and skills concerning cultural competence and promoting access and partnerships. Across Canada pockets of good practice exist though we were unable to find any province, territory or region whose respondents said they were effectively meeting the service needs of IRER populations at a systems level.

Recommendations for Service Improvement

In order to be more specific for the Commission, provinces, territories and regions we have offered 16 recommendations for service improvement. They will help move towards the overall three stage plan described in the remainder of this report, but particular areas may decide to start with some actions that they can achieve and build an improved service response stage by stage. Other actions may be taken up at a national level to facilitate service improvement. The recommendations were developed by the Diversity Task Group from the literature and the consultations. Each targets one or more of the main issues and where possible, provides an example of how a similar idea is being implemented or developed in Canada. The aim is to offer interested parties possible contacts for partnerships.
Beside each recommendation is a number(s) which represents which Mental Health Commission Strategy Goal they correspond with. This is not and exhaustive list of all that could or should be done. The aim is not to be proscriptive. Local groups closer to the needs of their populations may identify specific actions under each heading which works to improve the situation in their area.

The recommendations are divided under three pillars described above.

1. Co-ordination of policy, knowledge and accountability

Recommendation 1 (goals 3 and 6)

Each province and territory should include strategies and performance measures in their mental health plans to address the needs of immigrant, refugee, ethno-cultural, and racialized (IRER) groups. These strategies could usefully align with the Mental Health Strategy for Canada by including specific co-ordinated initiatives for mental health promotion, mental illness prevention and the development of appropriate and responsive services for the IRER populations for which they are responsible.

Example:

- Alberta Health Services is working towards developing a provincial approach to achieving diversity competency. In the interim, the *Regional Diversity Directional Document*, vetted through the Regional Diversity Advisory Committee in Calgary, will be used to articulate the way in which Alberta Health Services will work to become a proficient diversity competent health organization, and a model to other health organizations. In detailing the integrated planning necessary to building diversity competence, the document highlights the way in which this planning will increase access, reduce barriers and improve health system experiences for diverse populations[85].

Recommendation 2 (goals 3 and 6)

Each province should gather data on the size and the mental health needs of their IRER populations. They should plan their services based on this population data.

Example:

- www.albertasocialmapping.ca – this site uses Census data and can be used as an example of a way to conduct large amounts of data on particular groups.

Recommendation 3 (goals 2 and 3):

The mental health strategy of each province should consider a cross-sectoral plan for improving the social determinants of mental health problems and illness for IRER groups.

Recommendation 4 (goals 3 and 6)

A virtual national centre for research into the mental health and mental health problems and illness in IRER groups should be developed. The Centre could perform a regular one-day mental health census of mental health care service use and a community needs survey sampled by province.

Example:

- The Office for Minority Health in the United States has an extensive website with detailed information about illness (including mental illnesses) affecting IRER groups. It also has statistical information, a large virtual library, and information about cultural competency. This site can be found at http://www.omhrc.gov/.

Recommendation 5 (goal 6)

Health Canada, Canadian Institutes of Health Research and the provinces and territories should produce a research and development fund for studies aimed at answering strategic policy and practice questions for IRER groups' mental health and service provision. For instance there is an urgent need for Canadian research into the identification and evaluation of culturally appropriate systems of care for immigrant children and youth.

2. The involvement of communities, families and consumers

Recommendation 6 (**goals 3, 4 and 6)**

A central part of each provincial and regional plan to improve the mental health of immigrant, refugee, ethno-cultural and racialized groups must include the involvement of IRER communities, consumers, and families in planning, decision-making, implementation, and evaluation.

3. More appropriate and improved services

Recommendation 7 (goals 3 and 4):

Health funders should require that service providers take steps to attract a more diverse workforce and that there is a monitoring of the workforce to assess how it reflects the communities being served.

Recommendation 8 (goal 3):

Service provider organizations and provincial ministries should develop strategies to enable good candidates from IRER groups to advance into appropriate leadership positions within their organizations.

Recommendation 9 (goals 3 and 5):

Each service provider should have an organizational cultural competence strategy.

Recommendation 10 (goals 3 and 5):

Cultural competence training should be made available to all who have direct contact with clients and should be provided to existing staff in all service organizations. Training should include interactive, case based discussions and consultation.

Recommendation 11 (goal 3):

Cultural competence training should become a standard part of the training of all professional care staff. This should be insured through standards of accreditation of training programs and institutions and licensing professions.

Recommendation 12 (goals 3 and 5):

Provinces and territories should encourage diversity in the organizations that provide care, the models of care used, and the sites at which care is offered in order to meet the mental health needs of IRER groups.

Recommendation 13 (goals 3 and 5):

A knowledge transfer strategy for promising practices in the delivery of care to IRER groups developed and implemented so that the most effective models are known to and can be deployed by providers.

Example:

- The Multicultural Mental Health Resource Centre is a website that has resources designed for patients, families, community organizations, professionals and health planners. This site may be found at http://www.mcgill.ca/mmhrc/.

Recommendation 14 (goals 3 and 5):

A linguistic competence strategy should be mandatory for local/ regional service providers and funding for this should be provided by their funders.

Examples:

- BC has interpretation services in place for anyone who requests it.
- Alberta has a service called *Language Line* whereby people may receive interpreters that are not local – for the sake of confidentiality
- Staff at Alberta Health Services are tested to become certified interpreters.
- Eastern Health (the largest health authority in Labrador/Newfoundland) is funded to provide interpretation services.

Recommendation 15 (goals 3, 6):

A virtual centre of excellence in the treatment and support of immigrant and IRER groups should be developed. This would include representation from each province and each provincial health department could join it. This centre would facilitate the access to care for IRER groups by sharing knowledge and expertise. It would also facilitate resolution and discuss any problems with licensure that arise.

Example:

- Alberta Health Services – Addiction and Mental Health already has a virtual centre that could form the foundation of this initiative. The "Virtual Research Centre: Alberta Research and Innovation Centre" for mental health knowledge transfer. This mandate could be expanded to encompass IRER groups

Recommendation 16 (goals 3, 5, 6):

The MHCC could develop a project similar to the national homelessness demonstration project to plan, document and evaluate promising practice in the development of diversity strategies in at least five communities across the country. The initiatives would be rigorously evaluated. This would add to the Canadian and international evidence base, they would capture the practical obstacles to and the facilitators of service development for IRER groups. The projects would serve a capacity building function, developing groups of champions from a variety of disciplines and from different sectors (including peer to peer, community voluntary and mainstream services). These champions would in turn offer their support and expertise to those who subsequently embark the journey towards the development of improved services for IRER groups.

Example:

Information on the homelessness demonstration project can be found at http://www.mentalhealthcommission.ca/English/Pages/homelessness.aspx.

Focussed implementation sites of Delivering Race Equality in mental health services UK http://www.mentalhealthequalities.org.uk/our-work/delivering-race-equality/dre-fis-reports/

Appendix A: Recommendations from *After the Door Has Been Opened*

	Recommendation	Result

1	CEIC develop a multilingual series of premigration orientation programs in collaboration with immigrant service agencies and ethnocultural organizations for dissemination in refugee camps and at Canadian embassies abroad (Chapter 2, p.22).	• 1998 CIC implemented the Canadian Orientation Abroad Program
		    ○ Free sessions
		    ○ Offered abroad
		    ○ Provided in partnership by IOM
		    ○ 60+ countries involved
		    ○ Provided through local visa office and refugee camps
		    ○ Information includes health and integration into Canadian society
		    ○ Training lasts 1-5 days depending on need of migrant
		    ○ Local or locally engaged people provide orientation
		    ○ This is voluntary
		    ○ Have asked for basic stats on number of participants
		    ○ Project funded by CIC

2	CEIC expedite changes in admission criteria to accommodate a broader definition of family, and changes in admission procedure to accelerate the process of family reunification (Chapter 2, p.21).	• Family is defined as per the legislation • There is a family fast-track for people in this category • For health conditions that are terminal or costly, immigrants are not accepted into the country – **family class and refugees are excluded from this**

3	CEIC, Health and Welfare and Secretary of State provide core funding to immigrant service agencies to guarantee their maintenance on a long-term basis (Chapter 2, p.21).	• Provide funding to service organizations
		• Provide funding to settlement and welcome centers
		    ○ Immigrant Settlement and Adaptation Program (ISAP)
		    ○ The Language and Integration for Newcomers (LINC) program
		    ○ The Enhanced Language Training falls

		under this category ○ Interim Federal Health Program ▪ Provides some interpretation for health visits ▪ Very specific and need prior approval ▪ All organized through service provider ▪ CIC looking to develop program for specialized services as well (including mental health services) • CIC does not offer training for translators/interpreters • Encourages resettlement to culture-specific areas
4	Health and Welfare and Secretary of State encourage and support the development of seniors' groups and programs in immigrant service agencies, general community service agencies, and ethno-cultural organizations (Chapter 11, p. 81).	
5	Health and Welfare, Secretary of State, and Status of Women Canada develop and provide multilingual educational materials on women's rights and roles in Canada for discussion at immigrant service agencies, general community service agencies and ethno-cultural organizations (Chapter 10, p.76).	
6	Health and Welfare and Secretary of State work with their provincial counterparts to ensure that the curricula and environments of schools, preschools and daycare facilities reflect the cultural diversity of the children attending them (Chapter 9, p.70).	
7	Secretary of State, in cooperation with provincial ministries of education, encourage and support boards of education to adopt multicultural race relations policies similar to those that have already proven successful in Canada (Chapter 1, p.14).	
8	CEIC, Ministry of Communications, and Secretary of State	• This was previously being done by Heritage

	increase public education regarding the benefits of cultural pluralism, the contributions of immigrants to Canadian society, the difficulties faced by newcomers, and the effects of prejudice on both victim and perpetrator (Chapter 1, p.14).	Canada but will likely be turned over to CIC in the near future • CIC website includes public education for population-specific initiatives • Metropolis main department for government-wide initiatives

9	CEIC enable all immigrants and refugees to have equal access to official language education whether or not they are destined for the labour market. Basic training allowances must be available regardless of the immigration class of training applicants (Chapter 3, p.28).	• LINC
		  ○ Available to everyone
		  ○ Gain access through local CIC office
		  ○ Border services agencies
		  ○ Through service provider
		• CIC does not provide any service directly to the schools – service providers do this

10	CEIC, in coordination with Secretary of State, expand and ensure the flexibility of official language training programs with respect to the level of mastery assumed, objectives of course content, duration of program, scheduling of instructional hours, and location of classes (Chapter 3, p.28).	• Enhanced Language Training ○ This is specifically for labour-market orientation training • Service Canada website • CIC website
11	CEIC, Ministry of Labour and Secretary of State enter into negotiations with their provincial counterparts to provide criteria and guidelines for entry into professions and trades by persons trained outside of Canada (Chapter 4, p.34).	• HRSBC ○ Involved in most of these issues • Foreign Credential Recognition Program • Collaboration between many departments including National Licensing Bodies • CIC facilitates these procedures and sits on relevant committees
12	Health and Welfare establish a national advisory body to coordinate and monitor social, health and mental health services to ethnic minorities, with participation from professional associations, service administration, and immigrant service agencies (Chapter 6, p.52).	
13	Health and Welfare invite requests for proposals on the development of cross-cultural training modules in education, family practice, nursing, psychiatry, psychology and social work	

	(Chapter 7, p.57).	
14	Health and Welfare, Secretary of State and their provincial counterparts encourage institutions of higher learning to identify cross cultural education as a priority, particularly for students of education, medicine, nursing, psychiatry, psychology and social work (Chapter 7, p.57).	
15	Health and Welfare and Secretary of State encourage all funders of social and health services to require that organizations applying for funds provide evidence of efforts to make their services to ethnic minorities accessible and to provide evaluations of their effectiveness (Chapter 6, p.52).	
16	Health and Welfare identify immigrants and refugees as well as multicultural concerns among its priority areas for Health Promotion contributions, research and National Welfare grants, and other funded activities (Chapter 6, p.52).	
17	Health and Welfare, in collaboration with immigrant service agencies and ethno-cultural organizations, develop multilingual educational materials on the psychological consequences of migration and the resources for mental health care. Health and Welfare should provide these materials to provincial ministries of health and immigrant service agencies for dissemination through front-line service providers and ethnic media (Chapter 5, p.45).	
18	Health and Welfare and its provincial counter parts encourage all social, health and mental health service agencies to increase their hiring of ethnic minority staff through the adoption of equal employment opportunity policies (Chapter 8, p.62).	
19	Health and Welfare and Secretary of State encourage the admissions committees of social, health and mental health service training programs to recognize as assets, fluency in a non-official language and intention to work with clients who speak that language (Chapter 8, p.62).	

20	Health and Welfare encourage provincial mental health services to employ mental health practitioners at major immigrant service agencies (Chapter 5, p.46).	
21	Health and Welfare, in collaboration with provincial ministries of health and immigrant service agencies, develop a curriculum for training interpreters used by mental health services. Immigrant service agencies and provincial ministries of health should be provided with this curriculum for use in classes supported by Health and Welfare (Chapter 5, p.46).	
22	Health and Welfare support research and health promotion initiatives to delineate the psychological consequences of torture and to develop effective treatment modalities for survivors of torture and their families (Chapter 12, p.86).	
23	Health and Welfare encourage provincial mental health services to give special consideration to the funding of ethno-specific rehabilitation and reintegration facilities (Chapter 5, p.46).	
24	CEIC, Health and Welfare and Secretary of State establish across Canada at least three centres of excellence for research on issues affecting immigrant mental health. These centres would be dedicated to designing and carrying out empirical studies on topics such as the effects of negative attitudes on mental health; the mental health of migrant children, women, the elderly and victims of catastrophic stress; and how culture affects the assessment, treatment and rehabilitation of the mentally ill. In addition, these centres would be involved in the evaluation of new models of care. Each centre should receive assured funding for at least five interdisciplinary core staff, four postdoctoral fellowships, and two predoctoral scholarships. Immigrants and refugees and members of newer ethnic groups in Canada should be recruited for a significant number of the staff and training positions. Funding should be provided for pilot research projects. For large-	• Major funder for Metropolis for research and development for immigration ○ Draft public policy from federal government perspective • CIC funds some organizations directly (e.g. trauma center in Montréal) • CIC plays active role especially with refugees • Puts refugees directly where family/culture is – process called ‘destining’

	scale inquiries, the centres should apply for funding through regular channels.	
25	CEIC, Health and Welfare and Secretary of State establish across Canada at least three centres of excellence for cross-cultural training. In addition to training students and practitioners in the social and health service professions, these centres would provide training for persons who must in turn educate others who come into contact with immigrants: employment counsellors, second language instructors, and lawyers. The centres would also conduct periodic surveys to determine how cultural awareness is being introduced in mental health training programs in Canada and how this determines qualifications for licensure and practice. Funding should enable these centres to offer training fellowships to individuals from a wide range of disciplines and occupations and from immigrant, refugee and newer ethnic groups in Canada. Seed funding should also be provided to enable these centres to develop pilot projects to test innovative models of service delivery and new research and demonstration projects. For more definitive studies, the centres should apply through the regular funding channels.	• Has not been addressed through Centres of Excellence • ISAP provide some sponsor help – not health related • CIC does not train Canadians directly • Service providers include local NGOs

26	CEIC, Health and Welfare and Secretary of State establish a single, computerized information centre to collect, coordinate and disseminate the results of research and evaluations as well as descriptions of service and training programs directed to migrants and ethnic minorities in Canada. Information would be gathered from, and made available to government departments, professional associations, general community and immigrant service agencies, academic institutions and ethnic organizations. Ideally, funding should provide not only for the specific sources of information to be made known but also for authorized abstracts of the research findings and evaluations to be disseminated.	• Metropolis is public access although need permission to access most datasets
		• Metropolis is an international body – in Canada since 1995
		    ○ Current funding includes 7.5 million for 5 years for globalization and diversity research
		• CIC has research and evaluation branch
		    ○ Can fund directly
		    ○ Mainly for internal policy development
		• CIC website
		    ○ Basic data/stats

27	Health and Welfare and Secretary of State create a national body to advise on and monitor the implementation of the Task Force	

	recommendations. Government, service providers, planners and research workers are constantly being encouraged to make preventive programs and treatment services more culturally sensitive and appropriate. Although information exists on which programs could be built, large gaps in knowledge and experience remain. Until these gaps are bridged, all the goodwill in the world will not be sufficient to address the concerns presented to the Task Force. As the Director of Out-patient Services, Camp HUI Hospital, Halifax expressed it:	

Appendix B: Cross referencing issues, options/recommendations and the goals of the mental health strategy for Canada[4]

Issues	Recommendations / options	Mental Health Strategy for Canada Goal
Canada's population is becoming increasingly diverse. All provinces and territories will have demographic changes in their IRER populations that may require a mental health service response.	1, 3	3
The demographic challenges will be different with some areas having substantial existing IRER populations that need to be served, others having small populations, and others still having rapidly growing populations.	2	3
There is a link between a variety of social factors and mental health problems and illnesses. IRER groups are more exposed to the social determinants of health found in PHAC's current list. IRER groups are more exposed to other novel social determinants such as migration, discrimination and language difficulties. The impacts of social determinants can be complex. For instance, discrimination has a direct impact on individual's psychology and physiology as well as through its links to other social determinants of health at a group level. The social forces that push people down the pathway from balance to the development of mental health problems and illnesses are increased in some IRER populations and those that push people towards balance such as social support, are diminished through their social status in Canada.	3	2, 3, 6
The rates of mental health problems and illnesses in IRER groups in Canada vary.	1, 2, 3, 4	3
IRER groups are often considered as a single population which can create inaccurate picture of the rates of mental health problems and illnesses among diverse groups. International studies show that immigrant and refugee groups are at increased risk of mental health problems and illnesses. Local studies in Canada report high rates of mental health problems and illnesses in some IRER groups.	2, 3, 4	3
There are low rates of mental illness in immigrant groups when they arrive in Canada but these, and risk behaviours may increase over time.	3	1, 2, 3, 4
A number of factors including awareness of services, stigma, socio-economic factors, perceived discrimination and language are potential barriers to care for IRER groups Structural barriers, such as institutionalized	6, 7, 8, 9, 10, 11, 12, 13, 14, 15	3, 5

[4] The MHCC Goals can be found in Appendix C.

discrimination, mean that IRER groups are less likely to get the care they need		
Though interpreter services are mandated in the court system, this is rarely the case in the health system which can mean that inappropriate non trained staff or family members act as interpreters.	14	3
Trust in the system, cultural competency of services and co-operation between service providers may decrease barriers to care.	6, 7, 8, 9, 10, 11, 13	3, 5
Ethno-specific health promotion and diversity of services including alternative approaches have been cited in some communities to facilitate care.	12,13	3
There is no extensive Canadian academic literature on initiatives at a policy, service or educational level to improve mental health care for IRER groups.	4, 5, 13, 15, 16	6
The Federal policy response has focussed on the minority of Canadians from IRER groups who are new immigrants or refugees. There is evidence of only action on 6 of the 27 recommendations made by *After the Door Has Been Opened*.	15, 16	6
The Senate Report emphasized the need for more Canadian research into the identification and evaluation of culturally appropriate systems of care for immigrant populations.	13, 15	3, 6

Appendix C: Mental Health Commission's Goals from the Mental Health Strategy for Canada

1. People of all ages living with mental health problems and illnesses are empowered and supported in their journey of recovery and well-being.

2. Mental health is promoted, and mental health problems and illnesses are prevented wherever possible.

3. The mental health system responds to the diverse needs of all people living in Canada.

4. The role of families in promoting well-being and providing care is recognized, and their needs are supported.

5. People have equitable and timely access to appropriate and effective programs, services, treatments and supports, that are seamlessly integrated around their needs.

6. Actions are based on diverse sources of knowledge and evidence, outcomes are measured, and research is advanced.

7. People living with mental health problems and illnesses are fully included as valued members of Canadian society.

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