IMMIGRANT MENTAL HEALTH POLICY BRIEF

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GLOSSARY OF TERMS[1]

Government-Assisted Refugees: "Permanent residents in the refugee category who are selected abroad for resettlement to Canada as Convention refugees under the Immigration and Refugee Protection Act or as members of the Convention Refugees Abroad Class, and who receive resettlement assistance from the federal government" (Citizenship and Immigration, 2008).

Immigrant: This category will be used to refer to permanent residents who have voluntarily migrated to Canada as business, economic or family class immigrants (Citizenship and Immigration Canada, 2008 a). In this policy brief we will distinguish between immigrants and other migrant groups such as those who are refugees, refugee claimants and/or those with precarious status as outlined below.

Mental Health/ Wellbeing: Mental health is "a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 2007).

Mental Health Promotion: A process which entails "enhancing the capacity of individuals and communities to take control over their lives and improve their mental health" (Centre for Health Promotion, 1997).

Migrant: For this policy brief we will use the term migrant to refer to immigrants, refugees, refugee claimants and/or those with precarious status. Migrant will thus indicate anyone who has moved from another country to Canada.

Newcomer: There are variations in the usage of this term. In general, it has been used to refer to those who are permanent residents in Canada and who arrived within the last 3-5 years (although at times the range can extend to 10 years). The term is considered to "soften the stigma of difference or otherness associated with the terms 'immigrant' or 'refugee', " (see Sadiq, 2004, p. 1).

Precarious Status: Precarious status is a term used to describe the immigration status of those who may or may not be legally residing in Canada. Legal precarious status is held by those who are: sponsored family members, temporary residents, or live-in caregivers (Oxman-Martinez et al., 2005: 248). In this policy brief, we will use the term precarious status to refer to those who have no legal status in the country, and who do not possess legal immigration papers.

Refugee Claimant: Those who request "refugee protection upon or after arrival in Canada. A refugee claimant receives Canada's protection when he or she is found to be a Convention refugee (according to the United Nations 1951 Geneva Convention) or when found to be a person needing protection based on risk to life, risk of cruel and

[1] Many of these categories are not mutually exclusive and an individual may inhabit one or more of these categories, and this may also change over time.

unusual treatment or punishment, or danger of torture as defined in the Convention Against Torture. A refugee claimant whose claim is accepted may make an application in Canada for permanent residence. The application may include family members in Canada and abroad" (Citizenship and Immigration Canada, 2008 a).

Refugee: Refugees are persons who "fear persecution or who may be at risk of torture or cruel and unusual treatment or punishment, and unwilling or unable to return to their home country" (Citizenship and Immigration Canada, 2007 b).

Social Determinants of Health (SDOH): SDOH are the myriad social, political, economic, and environmental factors that can affect an individual's or a group's general level of health.

Systems Approach: A systems approach considers multiple levels of influence on a particular phenomenon: the micro (individual), meso (intermediate), and macro (systems) levels.

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IMMIGRANT MENTAL HEALTH POLICY BRIEF

1.0 INTRODUCTION

Canada's active immigration policy has led to an increasing cultural and ethnoracially diverse society. Each year significant numbers of newcomers enter Canada and begin the process of resettlement. Traditional source countries of immigration are being replaced by new source countries creating changes in the demographic makeup of Canadian society. Pluralistic societies offer unique and dynamic opportunities for inter-group diversities and growth; however, they also have particular challenges, which can have implications for the mental wellbeing of individuals.

This policy brief addresses the mental health of migrant populations in Canada. First, a brief contextual overview (demographic statistics) is provided. This is followed by definitions of mental health, social determinants of mental health, and mental health promotion. Findings from the literature review are considered next using a systems approach. Drawing from empirical evidence, policy implications are then presented. The policy brief is complemented with an extensive bibliography and a selected annotated bibliography.

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

Second, our notion of immigrant/migrant is not a monolithic one. We have attempted to distinguish between the categories of immigrants, refugees, and those with no legal status (or precarious status [2]). However, within each of these categories are many diversities. In order to recognize the intersections of gender, cultural background, racialized status, lifestage, and other influences, we have applied a systems approach to organizing the findings from the literature review and considered the micro, meso, and macro level factors influencing migrant mental health.

2.0 CONTEXT

[2] There are varied definitions of precarious status, which include people who are living in Canada legally and illegally. The latter are also referred to as non-status or people with irregular status, that is, those who do not possess legal immigration papers, due to "expiry of papers, smuggling or trafficking" (Oxman-Martinez et al., 2005).

The 2006 Census found that close to 20% of the population (over 6 million) were foreign-born, the highest proportion in 75 years (Statistics Canada, 2007). Between 2001 and 2006 over 1 million immigrants entered Canada (Statistics Canada, 2007). Approximately 60% of newcomers are from Asia (compared to 12% in 1971), 16% from Europe (62% in 1971), 11% from Central and South America, and 11% from Africa (Statistics Canada, 2007). Approximately 70% of recent immigrants were in the Toronto, Montreal and Vancouver census metropolitan areas (CMAs) (Statistics Canada, 2007).

Statistically disaggregated data is increasingly available to examine the demographic composition of immigrant groups. With reference to age, in 2007, 22% of the population was 0-14 at the time of landing, 15% was between 15-24, 48% was between 25-44, 13% was between 45-64, and 3% was 65 and above (all figures have been rounded off, Citizenship and Immigration Canada, Facts and Figures, 2008 b).

Between 2001 and 2006, 1.4 million newcomers were admitted as permanent residents into Canada (Statistics Canada, 2007). Canada also admits a significant number of refugees. For instance, in 2003, close to 26, 000 refugees arrived in Canada (CIC, 2003 in Khanlou and Guruge, 2008). While there are no official numbers for those who do not have status, research conducted with service providers in community health centres, amongst others, demonstrates that there are significant numbers who are here without legal immigration status as well. Estimates by such organizations provide a range regarding the number of non-status people living in Canada, often thought to be close to 200,000 and with the majority thought to be living in Toronto (see Khanlou, et al., manuscript in progress).

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

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

Mental health is a state of wellbeing that arises from interactions between the individual and his or her environment (Khanlou, 2003). Mental Health Promotion (MHP) is,

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

The health and mental wellbeing of migrant populations is influenced by complex and interrelated factors. According to Ornstein (2002), the social determinants of health,

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

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

Given the increasing numbers of immigrants to Canada, intersections of gender, life stage, cultural, migrant and racialized status on mental health promotion in multicultural settings must be considered (Khanlou, 2003; Khanlou et al., 2002).

There is growing attention towards both the conceptual and practical aspects of MHP (Khanlou, 2003). MHP models and approaches grounded in majority-culture based research, however, may be limited in that they do not necessarily take into account multiple cultural, linguistic, and systemic barriers to maintaining and promoting mental health in the post-migration and resettlement context. Understanding, developing, and implementing specific MHP principles and strategies offer important opportunities for enhancing the mental wellbeing of diverse segments of society.

MHP compliments a Social Determinants of Health (SDOH) approach. SDOH entails an understanding of the myriad factors that can affect an individual's or group's general level of health. These include social, political, economic, and environmental factors. In the context of migrant mental health, there are the added factors of settlement and integration that can affect mental health.

4.0 STATE OF KNOWLEDGE: LITERATURE REVIEW

In health research, the impact of migration on the health and well-being of migrants has been described through three dominant approaches. In the first approach, the hypothesis is that newly arrived immigrants have worse health than the general population. This approach is referred to as the "morbidity-mortality" hypothesis. A second approach, referred to as the "healthy immigrant effect," proposes that immigrants tend to have better health than the general population (Hyman, 2004; Alati et al. 2003). The final approach, referred to as the "transitional effect," suggests that the

health advantage that immigrants demonstrate upon arrival decreases the longer they live in the country (Alati et al., 2003).[3]

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

4.1 BRIEF OUTLINE OF SEARCH STRATEGY

To identify relevant literature for this policy brief, online searches were conducted on various databases, including MEDLINE (the National Library of Medicine's database), HEALTHSTAR, CINAHL (Cumulative Index to Nursing and Allied Health Literature), PsychoINFO, PUBMED, Sociological Abstracts, and Psychological Abstracts. Various combinations of keyword searches with Boolean operators (and/or/*/?) were used: Canada, health disparities, disparity, immigrant (immigrants), immigration, migration, migrants, mental health, refugee (refugees), unregistered, undocumented, illegal, alien, and precarious status. The search year range was from 1980 to the present. The initial focus was on Canadian based articles, however, relevant studies from other countries such as the USA, Australia, the United Kingdom, and other countries in Europe were

[3] Beiser (2005) notes that the links between health and immigration have tended to be based on two paradigms. These are: the "healthy immigrant paradigm" (also referred to as the "healthy immigrant effect") and the "sick immigrant paradigm" (also referred to as the "morbidity-mortality paradigm") (Beiser, 2005 and Alati et al., 2003). Beiser argues for a third – Interactive Paradigm – that accounts for both genetic disposition and socio-environmental factors in explaining immigrant health outcomes (Beiser, 2005: S30). Studies reveal that often it is a combination of the healthy immigrant effect and transitional effect that explains the reality of immigrant health trajectories. Immigrants are often healthier than their Canadian-born counterparts when they first arrive, but over time, their health deteriorates (Newbold, 2005). This is also known as the "transitional effect" (Alati et al., 2003). The same "healthy immigrant effect" can be found for immigrant mental health. "Whether this pattern reflects greater resiliency or a difference in how immigrants approach stress and adversity in their lives is a question that could be addressed in future research" (Ali, 2002, p. 6).

also consulted. Using this search strategy, over 70 articles were found. This was further supplemented by articles, books and book chapters related to migrant mental health.

4.1.1 Grey literature

Various Governmental and research institute sites were consulted. Government sites include: Citizenship and Immigration Canada, Statistics Canada, Status of Women Canada, and the Public Health Agency of Canada. Other sites include: CERIS: the Metropolis Project, and various sites of community health centres (see Section 6: Examples of Best Practice).

4.2 FINDING OF REVIEW OF MENTAL HEALTH OF MIGRANT POPULATIONS

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

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

4.2.1 Individual influences

Age

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

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

Adolescents have both specific challenges as well as resiliencies in the post-migration context (Khanlou et al., 2002; Khanlou & Crawford, 2006). Caught between their own

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

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

Gender

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

Gender and age as intersecting variables create an added layer of complexity for post-migration contexts, where adolescent women face different barriers than their male counterparts, and younger migrants also have different challenges than older ones. Women with precarious status are also at risk of being exploited and subject to unsafe or unclean working environments. Women with no legal status may have family members who depend on their income and are therefore unwilling and unable to report exploitative work practices (Guruge & Collins, 2008).

Cultural background, spirituality and religious identity

Mental health services that attempt to fit migrants into categories of western clinical knowledge, do not capture the cultural and spiritual or religious factors that may be involved in migrant mental health (James & Prilleltensky, 2002; Collins, 2008). Research in ethnically diverse cities has shown that spirituality and cultural context often construct mental health and mental illness in very different ways (Fernando, 2003; Collins, 2008; Across Boundaries). Keeping this in mind, western models of mental health promotion can be supplemented by culturally-specific programs (Khanlou, 2003; Khanlou et al., 2002)[4].

Religion in particular plays an important role in the lives of different groups of immigrants, and their religious affiliations may even be strengthened post-migration, whether for reasons of renewed religious belief in the context of marginalization of religious identities, or because religious institutions become locations of community

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

support (Preliminary findings, Khanlou, Shakya, and Muntaner, CHEO, 2007-2009; for the importance of religious education, see: Zine, 2007).

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

4.2.2 Intermediate influences

Family and social support networks

The family and social networks of migrants can be an important source of support in the resettlement context and promote mental wellbeing. Research findings reveal that immigrants tend to rely first and foremost on extended family members (especially those who have been in the country longer) for various settlement related needs and also for a social support network (Preliminary findings, Khanlou, Shakya, and Muntaner, CHEO, 2007-2009). While Canadian immigration policy previously encouraged family reunification (Government of Canada, Immigration Act, 1978), in reality, this is difficult for refugees or those with precarious status. The ways in which family is defined in legislation, may not always accord with the reality of immigrant families' lives. The specific needs of a potential immigrant, and the importance of extended family members needs also to be taken into consideration (Canadian Association for Community Living, 2005).

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

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

Acculturation

Acculturation is a process whereby contact between different cultural groups results in changes in both groups (Berry, 2001: 616). Acculturation is premised on the existence of

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

4.2.3 Systems influences

Economic barriers

Economic hardship is a significant determinant of health and linked to health disparities. One of the most significant stressors for mental health identified by immigrants is the underemployment or unemployment that they must deal with upon arrival. The story of the doctor driving a taxi or of an engineer doing janitorial work is a reality for a growing number of newer waves of immigrants to Canada.

Economic barriers to integration became significant sources of stress in immigrants' lives, affecting their families. Immigrant youth often internalize the frustration of their parents and this in turn affects their own performance in school (Khanlou, Shakya, & Muntaner, CHEO, 2007-2009). On the other hand, some research also indicates that even though foreign-born immigrant children are more than twice as likely to live in poor families, they show lower levels of emotional and behavioural problems (Beiser et al., 2002: 220). This may in part be due to the fact that hardship is expected by immigrants when they first come to the receiving country and the hope is that their situation will improve over time (Beiser et al., 2002; CHEO *op cit*). However, if poverty persists, this can have negative effects on a child's IQ, school performance and lead to behavioural problems (Beiser et al., 2002: 225).

Appropriate services

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

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

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

Migration status and access to healthcare

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

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

Prejudice, discrimination and racism

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

Immigrant health is composed of a multitude of factors that have to be further understood in the context of their intersectionalities (Khanlou et al., 2002; Oxman-Martinez et al., 2005), which has policy implications.

5.0 POLICY RECOMMENDATIONS

Conceptualizing migrant mental health

Beiser (2005) observes that prevailing paradigms towards immigrants affect health policy. [5] Conceptual approaches to studying immigrant health also need to account for not just multiple factors as variables, but also how and under what circumstances different influencing factors may be "activated" (Bergin, Wells, & Owen, 2008). Traditional paradigms that have been used to explain immigrant health (such as the healthy immigrant effect or the morbidity-mortality paradigm) need to be re-examined (Dunn & Dyck, 2000) in light of longer term outcomes and the heterogeneity of immigrants along the lines of gender, age, immigrant status, and the historical pre-migration context from which they come (Alati et al., 2003; Beiser, 2005; Salant, 2003).

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

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

<u>Recommendation</u>:

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[5] The sick immigrant paradigm has its roots in the 16th and 17th centuries when Europeans, who travelled to parts of North America, often brought with them measles, smallpox and other diseases (Beiser, 2005: S31). This idea that immigrants bring disease lasted well into the middle of the last century, and it dominated the anti-immigrant public policies of governments (Beiser, 2005: S32). The healthy immigrant paradigm on the other hand, focused on the good health, strength and resilience of immigrants and was also embedded within the political and economic context of the time. However, Beiser points out that neither of these paradigms adequately explain the complexity of the category "immigrant" (for example, the health of refugees may be quite different from other immigrants) and nor do they fully take into account the fact that the source countries of immigrants have changed over time (Beiser, 2005). The interaction paradigm that Beiser puts forward, takes into account multiple factors in the analysis of immigrant health: the pre- and post-migration stressors, individual genetic characteristics, and larger socio-economic factors that can facilitate coping strategies (Beiser, 2005: S36).

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

Recommendation:
Support integrated community-based mental health services that:

- **address the social determinants of migrant mental health,**
- **are gender and lifestage sensitive; and**
- **recognize both the challenges and resiliencies of diverse groups of migrants (newcomers, immigrants, refugees, precarious status).**

Recommendation:
Support education and training towards providing the following:

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

Recommendation:
Support policies that remove barriers to economic and social integration of newcomers (for example through recognition of previous training and education).[6]

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

6.0 EXAMPLES OF BEST PRACTICE

Many community-based organizations within the most ethnically diverse cities in Canada (Toronto, Montreal, Vancouver) have instituted successful programs, which approach mental health services from a culturally diverse perspective.

Across Boundaries – an ethnoracial community mental health centre – is one such organization. Working within an anti-racism framework, they take a holistic approach to mental health, focusing on the interconnectedness of the "spiritual, emotional, mental, physical, social, cultural, linguistic, economic and broader environmental aspects of

[6] Employment is recognized as a significant social determinant of health (WHO, 2008) and by extension, it is also a significant factor in determining mental health. Not only does unemployment or underemployment affect the individual, but also the entire family of that individual. In particular, adolescents can internalize the frustration and depression of their parents who lack meaningful employment (Preliminary findings, Khanlou, Shakya, and Muntaner, CHEO, 2007-2009).

health that affect the wellbeing of people of colour" (http://www.acrossboundaries.ca/). Through capacity building projects with local communities, they also work towards reducing disparities and racial inequalities in society.

Hong Fook Mental Health Association also works with non-mainstream populations, including the Cambodian, Chinese, Korean, and Vietnamese communities. In focusing on the linkages between policy, research, and practice, their programs incorporate support for families, training, and mental health promotion (www.hongfook.ca and Lo and Chung, 2005).

Access Alliance Multicultural Health and Community Services is another community health centre, whose main work is with refugees and newcomers to Canada. Access Alliance works within the anti-oppressive and social determinants of health perspectives, actively engaging community members in research, through the Peer Researcher Training Program. This program allows participants from within communities to identify issues of importance for research, as well as building capacity for continued work by the peer researchers (http://www.accessalliance.ca).

Women's Health in Women's Hands is another community-based health centre that works within an anti-racist, feminist, pro-choice, and participatory framework. They serve the metropolitan Toronto area, focusing on Black women and other women of colour. Much of their programming is on HIV/AIDS work, and mother and child-care and education (http://www.whiwn.com/who.htm).

The above list is not all inclusive, and other examples of best practice exist across Canada.

7.0 CONCLUSION

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

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

confirmed an amount of $130 million over 10 years to the Canadian Mental Health Commission (Health Canada, 2008).

The goals of the Mental Health Commission of Canada include: the facilitation of a national approach to mental health issues; reform of policies and improvements in service delivery; working to combat the stigma around mental illness; and dissemination of evidence-based findings on mental health and illness to stakeholders (Mental Health Commission of Canada, http://www.mentalhealthcommission.ca/mhcc-en.php). In particular, using social marketing, the Anti-Stigma and Discrimination reduction campaign will to focus on youth aged 12-18 and health-care professionals in its first year (Mental Health Commission of Canada). Working to reduce stigma and discrimination around mental health is also one of eight goals in the draft framework for a transformed system. Stigma, though it may take different forms within different cultural and linguistic contexts, exists in one form or another within every community in reference to mental illness. Thus when discussing the concept of mental health, in many linguistic and cultural contexts it is simply reduced to mental illness, accompanied by terms such as "crazy" and "mad" (Preliminary findings, Khanlou, Shakya, and Muntaner, CHEO, 2007-2009).

In January 2009 the Commission released its "Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada" as a draft summary for public discussion. In 2009 the Canadian Institute for Health Information also released its document entitled "Improving the Health of Canadians 2009: Exploring Positive Mental Health." On 12 February 2009 the Pan-Canadian Planning Committee for the National Think Tank on Mental Health Promotion released its document, "Toward Flourishing for All…National Mental Health Promotion and Mental Illness Prevention Policy for Canadians."

Media features and conferences are also addressing the gaps around the public discussion of mental health and mental illness in Canada. The Globe and Mail featured a series on "Canada's Mental Health Crisis," (http://www.theglobeandmail.com/breakdown). A conference (held in Toronto, 4-6 March 2009) in conjunction with the Mental Health Commission of Canada focussed on mainstreaming mental health and wellness promotion (http://www.cliffordbeersfoundation.co.uk/toronto.htm).

While such initiatives are very timely and are contributing to efforts in addressing mental health, wellbeing and promotion for all Canadians, attention is also needed on specific sub-groups of the population, such as immigrants.[7] Especially in light of the stigma around mental illness, as well as the barriers (such as have been discussed in this brief), to accessing mental health services for immigrants, mental health promotion campaigns need to consider how best to reach varied audiences. We hope that this policy brief will be a timely contribution to the broader movement towards the creation

[7] A guide by the Community Resource Connections of Toronto, entitled "Navigating Mental Health Services in Toronto: A Guide for Newcomer Communities" addresses newcomers and mental illness, and how to get help (http://www.crct.org).

of a national mental health strategy, an educational tool to create awareness around mental health promotion for migrant communities, and an impetus for specific policy initiatives promoting the mental wellbeing of migrant populations in Canada.

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APPENDIX 2

SELECTED ANNOTATED BIBLIOGRAPHY

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This article reports on findings from a longitudinal study begun in 1981 in Brisbane, Australia, of mothers and children of European and South East Asian backgrounds. Second generation children of immigrant parents were found to not have any significant mental health differences, as compared with their Australian counterparts. In fact, externalizing problems of aggression and delinquency were found to increase with time in the second generation children, to levels comparable with their Australian counterparts.

The authors also discuss the three dominant paradigms in understanding immigrant health: the 'migration-morbidity' hypothesis, the 'healthy immigrant' effect, and the 'transitional effect'. The first, migration-morbidity approach would suggest that migrants have worse (mental) health than the host population as changes and acculturation demanded of them to adapt to their new society, and the possibly traumatic experiences that they have escaped in their pre-migration context would contribute to their worse health status. The healthy immigrant effect however, proposes that only those migrants who are in good health are selected to come to the host country and/or that only those who are in good health self-select or are able to go to the host country. The transitional effect highlights the fact that over time, the health of the immigrant becomes more and more similar to that of the host country population.

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

In this article, Beiser discusses the two paradigms (the healthy immigrant and the sick immigrant paradigms) that have dominated immigrant health research over the last century. He argues that both of these paradigms are inadequate as they each leave out important pieces, and also do not account for both genetic predispositions and socio-environmental factors together. He further argues that the source countries from which immigrants tend to come has changed from before the 1970s to after this time. Given that most studies do cross-sectional rather than longitudinal analyses, there is the danger of confusing time with cohort effect. He also situates both of these paradigms within their socio-historical contexts.

Beiser proposes instead, an interaction model to understand migrant health, which takes into account genetic as well as social and environmental factors. The latter includes such factors as pre and post migration experiences, traumas and stressors and individual and community resources. The interaction paradigm is particularly useful to understand the ways in which health outcomes of immigrants depend on a layered set of factors, rather

than attempting to generalize one way or another about their perceived state of health upon arrival into a host country. It also allows for an analysis of the different statuses of migrants to the country (as the health outcomes and statuses of refugees for instance may be quite different from immigrants).

Finally he also makes a case for multivariate analysis, as well as specific attention to age and gender as factors affecting resettlement, and the use of culturally appropriate measures.

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

This article reports on the findings of a study of 647 Southeast Asian "Boat People". Respondents were asked to fill a questionnaire on a variety of topics such as: ethnic identity, demographic and employment information, language fluency, experiences with discrimination and depressive affect. The article places the findings within the context of shifting Canadian responses to refugees and the paradigm of segmented assimilation (p. 138), and demonstrates how varied identifications can be alternatively positively and negatively correlated with mental health risk.

The findings reveal that those with strong ethnic identification are at a higher risk for psychological distress if they experience or perceive discrimination. This is because experiences of discrimination will serve as reminders of marginalized status for ethnic minorities. However, the opposite is true in terms of language assimilation. Those with a strong sense of ethnic identity and lacking fluency in English are actually not at high risk for psychological distress, as their strong ethnic identification implies that they may not feel that English fluency is more important than native language retention.

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

This article applies the philosophical approach of critical realism to re-examining gender and mental health. Critical realism (CR), as the authors explain, suggests that the natural and social sciences can indeed have a shared epistemology and ontology. Further, CR occupies a liminal position between constructivism and positivism. So to put it more simply, CR as an approach is concerned with questions of 'being' (ontology) and questions of the theory 'of knowledge' (epistemology). Constructivists tend to relativize everything, while positivists focus too heavily on that which is empirically verifiable. CR argues instead that if we start with questions of what exists, (divided into the real, the actual and the empirical), we can understand levels of differentiation and stratification in the natural and social world and how they interact.

When applied to gender and mental health, CR can highlight both the factors that lead to particular outcomes (in mental health) but also understand how these different factors work and how they are 'activated' and under what conditions (p. 172). They use the

example of water as being composed of hydrogen and oxygen molecules, but that the properties of each do not provide any indication of what effect they would create when put together, namely, water. In terms of mental health, the authors show how a CR perspective can allow for analysis at multiple levels without reductionist (positivist) or relativist (constructionist) causes or explanations, while allowing us to theorize beyond what is known or only based on that for which we have language. They highlight this by showing how the definitions around mental health disorders keep changing over time.

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

Collins discusses the dominance of allopathic medicine in Western societies, which does not take a holistic view of the relationship between mind-body-spirit and instead treats disease within a bio-medical model, which uses drugs and surgery as cures. The importance of spirituality within many immigrant communities also tends to become marginalized in this bio-medical model. The author makes a distinction between spirituality and religion, where the latter is a more organized system of beliefs, and is often also connected to patriarchy in many societies. Spirituality is a more abstract model, that "encompasses the relationship of the individual to the wider universe" (p. 91). Studies have also linked positive health outcomes with both religion and spirituality.

Migrant women may also have strong beliefs that some problem they are experiencing has a spiritual reason and whether or not medical practitioners agree, they must take this understanding into account during treatment, without automatically labeling and prescribing medication.

Collins also highlights a framework for integrating spirituality in care, by Jean Watson (p. 97). Thus, because women's migratory experiences are varied (including violent, forced migrations), and despite the resilience that they show, their individual experiences and perceptions must be factored into the medical care they receive post migration.

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

This article reports on the results of a pan-Canadian research initiative that studied health service utilization and mortality amongst Canadian immigrants (defined as immigrant class, which includes refugees, economic and family-level immigration categories), using health databases. It was generally found that recent immigrants are on the whole "underusers" of the healthcare system. It is not known, however, whether this is due to reduced need or societal or cultural barriers. The research also bore out the idea of the "healthy immigrant effect", but again, this could also be due to selection bias, or methodological limitations. The research should work towards improving access to

health services for recent immigrants and to understanding and addressing health disparities amongst the population.

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

This article analyses results from the national cohort study, which demonstrated that immigrants on the whole show "lower all-cause mortality than the general Canadian population" (p. 221), but show elevated mortality rates when considering stroke, diabetes, and certain infectious diseases and cancers. Results also found that mortality rates differed by region of birth and were overall higher for refugees than for other immigrants. The authors argue that these results reiterate the need to formulate contextually sensitive and informed interventions for the heterogeneous immigrant population.

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

The authors use Canada's National Populations Health Survey data, to analyze differences between Canadians and immigrants with respect to health status, health care utilization, and differences between immigrants of European and non-European backgrounds and between those who have lived here for less than and more than 10 years. They use a 'population health' perspective, which suggests that the most important factors in human health are social and economic, rather than medical and behavioural.

While results show no specific associations between socio-economic factors and immigration characteristics with health status, the authors argue that this does not mean that socio-economic factors are not influential in shaping health status for immigrants. In fact, they argue the opposite, that in some of their regression calculations, socio-economic factors appear more important for immigrants than non-immigrants in some variables.

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

In this first chapter of the book, the editors highlight some emerging demographic trends in immigration. They begin by providing definitions for the different categories of immigrants and refugees, drawing attention to gendered distinctions that prevail. In terms of education, both male and female immigrants tend to have higher educational credentials than their Canadian-born counterparts (p. 6) however; the percentage of women with an M.A. or PhD. is higher than that of male immigrants (p. 6).

Women also migrate for a variety of reasons, but because it is assumed that they simply follow their male relatives, little is actually known about women's migratory processes (Delaet; Gastaldo et al., 2004 in book p. 7). Finally, the authors also point to the social determinants of health, which place immigrant women at greater risk of depression (including racism/discrimination, isolation, language barriers, unsafe, unclean and exploitative working environments) (p. 12).

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

This article reports on findings from a study that involved a 12-month review of referrals to an aged psychiatry community service in Australia. While Australia has a relatively young population by western country standards, the numbers of elderly non-English speaking immigrants in the country is rising. Studies in Australia suggest that there is under utilization of mental health services by immigrant groups, but there are variations between different ethnic groups. Referrals of elderly European migrants corresponded to their numbers within the local population, however, elderly migrants from Asia and non-European backgrounds were under-represented.

Hyman, I. (2007). Immigration and health: Reviewing evidence of the healthy immigrant effect in Canada. CERIS Working Paper Series, working paper n. 55, Toronto: CERIS.

This working paper discusses the results of an updated literature review (5 years later), on the earlier report commissioned by Health Canada on the health of Canadian immigrants. Evidence shows that there is a "healthy immigrant effect", but that certain sub-groups of immigrants experience higher rates of particular cancers, diabetes, and heart disease. This points to the role of genetic predispositions, as well as other environmental or acculturative factors in the differences. The author also highlights that there remain many unanswered questions about the relationship between immigration and health, and specifically, on the existence of health disparities based on sex, gender, ethnicity, and migration.

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

The authors make a case for incorporating philosophical, contextual, experiential, and pragmatic considerations of culture when dealing with patients in the area of mental health. Culture plays a very important role in mental health, as it "impacts the experience of people's afflictions" (p. 1134). The authors argue that understanding philosophical (what is the vision of the good person, the good life, good values), contextual (what are the social, cultural, religious and moral norms prevailing and how do they affect the conceptualization of mental health), experiential (what are the gaps that exist), and pragmatic (what can be done to address the gaps in the context of a particular community) aspects of a particular cultural community, can help in providing

more culturally sensitive treatments. The authors also show that traditionally, clinical psychology has been steeped in a North American cultural context that tends to focus on individualism and objectivity of therapy, and various other assumptions about psychological health and pathology, which may or may not be particularly relevant in other cultural contexts. The authors also work within an ecological approach using micro, meso and macro levels of analysis. They discuss their framework through examples of their work with the Portuguese immigrant community.

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

This chapter examines the specific aspects of mental well being and identity of female refugee youth. The authors provide relevant statistics on refugees globally and in Canada, and place their analysis within the context of the pre-migration, migration, and post-migration contexts. They discuss risks involved for adolescent refugee girls, given that identity is a part of mental well being and displacement as a refugee can negatively impact identity development. They pose a number of questions at the end of the chapter to guide further scholarship in the area, focusing on how the psychological stresses of life and displacement as a refugee can impact on the identity of female refugee youth.

Khanlou, N., Beiser, M., Cole, E., Freire, M., Hyman, I., and Kilbride, M. (2002). Mental health promotion among newcomer female youth: Post-migration experiences and self-esteem/Promotion de la santé mentale des jeunes immigrantes: Expériences et estime de soi post-migratoires. Ottawa : Status of Women Canada/ Condition féminine Canada. http://dsp-psd.communication.gc.ca/Collection/SW21-93-2002E.pdf

This report is based on the findings from a study that examined "mental health promotion issues of newcomer female youth attending secondary school" (from abstract). Findings suggested that young women had a dynamic notion of self, which was influenced by various factors, including: parents, friends, systems issues and a lack of proficiency in English. The authors outline 15 policy recommendations (which cover education, health and social services, resettlement, and inter-systems suggestions). The authors further highlight three underlying principles that can in part, "guide policy initiatives and mental health promotion strategies directed at newcomer female youth" (p. vi). These principles include the ideas that mental health promotion must involve youth participation; that the knowledge from studying mainstream youth cannot necessarily be assumed to stand for other groups as well; and finally, that given the multiple factors that affect the development of newcomer female youth, approaches "must be comprehensive and intersectoral across systems" (p. vi).

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

In this article, Mawani makes recommendations on how to address depression among immigrant and refugee women. Women tend to have higher rates of depression than men in general and immigrants, but visible minorities have tended to have better mental health profiles than non-visible minorities. Mawani argues that these mental health profiles of visible minority groups do not incorporate length of time in the country, migration status, gender, or inter-ethnic comparisons (p. 72). Evidence has also shown that refugees have high rates of depression (p. 72). The social determinants ("social conditions in which people live and work" p. 67) that affect depression for immigrant and refugee women, include: lowered social support, discrimination and lowered socio-economic status. All of these "can be disempowering through their effects on self-esteem and perceived control, particularly when they are experienced in combination with each other, and thus affect women's risk for depression" (p. 82).

There are both psychosocial and material pathways that can affect depression as above. Mawani makes the following recommendations: partner, collaborate, outreach and communicate with ethno-specific community-based agencies; address discrimination, SES, and social support for immigrant and refugee women, while advocating for systemic changes and screening for risk.

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

Results from qualitative field work with indigenous Oaxacan women who cross the border from Mexico into the USA are presented here. The authors place health in the larger context of its connections with global transnational migration, and neoliberal globalization. Using the metaphor of liminality, the authors show how the precarious position occupied by those who cross the border, leaves them at risk for "allostatic load" ("the accumulation of biological risk associated with persistent hyperarousal" p. 190). Their undocumented status leaves these women in heightened states of perpetual stress.

The authors further state that nursing practice or praxis must come from an emancipatory space that seeks to link global and local contexts.

Oxman-Martinez, J., Hanley, J., Lach, L., Khanlou, N., Weerasinghe, S., and Agnew, V. (2005). Intersection of Canadian policy parameters affecting women with precarious immigration status: A baseline for understanding barriers to health. *Journal of Immigrant Health*. Vol. 7, No. 4, 247-258.

This article examines the multiple intersecting barriers that serve to undermine accessibility to healthcare for immigrant women. The authors argue that precarious status (legal: sponsored family member, temporary resident, live-in caregiver and illegal: without legal immigration papers, either due to expiry of papers, smuggling or trafficking, p. 248) leaves women at risk. Primary and secondary policy and socio-cultural barriers lead to a lack of equitable access to healthcare for immigrant women. Addressing these multiple barriers must be done by studying gender, race, and ethnicity in context and within their intersections, and not in isolation.

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

The authors respond to the critiques that Canada has received in the areas of child and family poverty and the discrimination against Aboriginal groups and women, despite its reputation as a leader in health promotion. Three main reasons are cited: a) the epistemological dominance of positivist approaches in the health sciences; b) the dominance of the ideology of individualism in North America; and c) the increasing influence of market principles on public policy making.

The authors outline the difference between two approaches to policy development - "pluralist" (notion that policy is driven by public debate and ideas) and "materialist" (notion that policy is driven by elite or powerful in favour of their own interests, p. 3).

Contextualizing the social determinants of health within a broader perspective of the state (different models of the welfare state) and the above approaches, the authors show how education, motivation, and activation are needed to put the SDOH into practice. In so doing, they also cite successful examples from Scandinavian countries.

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

This article compares literature within the area of acculturation, specifically with reference to Asian populations in western immigrant receiving countries, and in three health domains: mental health, physical health and health services use. The article critically examines the conceptualizations and measures of acculturation used and the difficulty of comparison between diverse Asian populations. The authors also look at the extent to which critiques on acculturation measurement on Hispanic communities also apply to Asian communities. The authors argue that the acculturation literature (especially when only single scale measures are used) does not always account for "the complex nature of stress associated with immigration" (p. 73). The health effects of separate domains of acculturation need to be studied and in general, models of acculturation need to understand the multiple interrelations between acculturation and health outcomes, including gender and historical experiences of ethnic groups (bicultural or orthogonal cultural identification, rather than linear or unidirectional models of acculturation, p. 77).

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

The authors report on findings of a research project that involved interviews and focus groups with service providers and policy makers in 3 major cities in Canada (Toronto, Vancouver, and Edmonton) on the issue of social support as a determinant of health for immigrants and refugees. Results showed that social support is perceived to play an

important role in health outcomes for immigrants and refugees, but that how social support is defined and what it means, varies by people who require services. Common forms of support noted by those interviewed included: informational, instrumental, and emotional (p. 262).

Systemic and public discourse barriers that have negative impacts are also highlighted. The research suggests that there needs to be a more holistic approach taken, with a focus on service coordination (rather than the fragmentation that currently exists), improved governance (balancing the realities of social service provision with expected outcomes and deliverables), and "changes in public discourse about immigrants' contributions" (p. 259) that consider the resilience of newcomers, rather than simply seeing them as "needy service recipients" (p. 265).

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

This article describes a study of irregular immigrants and health security, in which 11 in-depth, semi-structured interviews were conducted with clients of Access Alliance, a community health centre in Toronto. They define irregular immigrants as those "who lack secure status in Canada, including visitors who overstay visas; refugee claimants awaiting status determination; and failed claimants remaining in the country without authorization, awaiting deportation or following alternative procedures when judicial appeal is impossible"(p. 369). The study sought to understand how living with irregular status affects mental well-being and social integration.

Contrary to the stereotypical image of refugees as those who 'take advantage' of the system, most are making every effort to lead productive lives, and contribute to their host society in economic terms. However, most lack wider social supports and this has had tremendous negative impact on their mental health, and has especially impacted children as well.

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

The author examines the concept of resilience, and shows that it needs to be understood within an ecosystemic context and not just within an individual context, as developmental psychology has tended to do. An ecosystemic framework involves the individual and their relation to the larger family, community, cultural/ethnic group, and notions of spirituality.

Waller highlights the need to factor in gender, race and ethnicity as variables, and argues that the "relationship between human beings and adversity is neither linear nor unidirectional" (p. 294), by examining the evolution of the concept of resilience, and describing risk and protective factors involved.

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

This article reports on a study conducted with 15 West Indian immigrants in Montreal, who were not using mental health services, but who reported somatic symptoms and mental health issues. Through the interviews, the researchers identified 3 significant explanations for the lack of metal health service use. These were: the patients perceived doctors as being too reliant on pharmaceutical medicines for mental health interventions; in previous encounters, patients had felt that doctors were dismissive and did not have time for them, and this deterred subsequent visits; and, to some extent, there was a belief in God and alternative types of medicine as having great healing power. While racism was not mentioned as a barrier to utilization, this may have been due in part to the interviewees' reluctance to report racism to white interviewers. The authors point out that these findings can be used to reduce disparities in health service use.