Canadian Immigrant Mental Health

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Abstract

Canada is a nation of immigrants, with about a fifth of the total population being foreign born. It has come a long way from exclusionary immigration policies to embracing multiculturalism, a mosaic vision of society, with the province of

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Quebec pursuing a model of interculturalism. Nevertheless, the examination of the 'healthy immigrant effect' suggests that for some immigrants, their physical and mental health deteriorate to non-immigrant level or in some cases worse. Some of this may be accounted for by acculturative challenges as well as the impact of social determinants of health. To enhance the mental health of immigrants, systemic changes are needed to address social inequities and oppression, reflected in the higher unemployment and underemployment rates, poverty, racism, discrimination, and the culmination of intersectional marginalization. Immigrants often underutilize mental health services until later on in the course of illness due to multiple access barriers. Further, cultural competence at both the clinical level as well as the organization level is needed to provide effective care. A number of care models in Canada have begun to address these needs, including ethnospecific services and the cultural consultation model.

Keywords
Immigrants · Mental health · Healthy immigrant effect · Acculturation · Cultural competence · Ethnospecific services · Cultural consultation · Social determinants

Introduction

Canada is often referred to as a land of immigrants. After the initial period of British and French settlement in Canada, there has been a history of successive waves of immigration from varying sources of country of origin. Based on latest statistics from 2011, about 6,775,800 Canadians, a fifth of the total population are foreign born, the highest proportion among G8 countries (Statistics Canada 2013). The breadth of diversity is equally impressive, including more than 200 ethnic groups. Although most immigrants were from Europe including the United Kingdom, Italy, Germany, and the Netherlands prior to the 1970s, these demographics have changed significantly over time. Between 2006 and 2011, about 56.9% came from Asia and the Middle East with the largest regional sources of immigration arriving from the Philippines (13.1%), China (10.5%), and India (10.4%). There was also an increase in immigration from Africa (12.5%) as well as the Caribbean and Central, and South America (12.3%) in recent years. About 78% of immigrants between 2006 and 2011 were visible minorities. In total, 6,264,800 Canadians or about one fifth of the Canadian population self-identifies as being a visible minority. The current inclusive Canadian reality is reflected by the increasing presence of elected parliamentarians, governor generals, professionals, and civil servants from visible minorities and immigrant or refugee origins.

The majority of immigrants live in four of the ten provinces: Ontario, British Columbia, Quebec, and Alberta, with about 63.4% of immigrants located in three urban centers: Toronto, Vancouver, and Montreal. About 72% of immigrants had a mother tongue other than the official languages of English and French, with Chinese being the most common language (38.2%). About 6.5% of immigrants reported that they did not speak either of the official languages. About two thirds of Canada's

population is affiliated with a Christian religion, including 12.7 million Roman Catholics. About one million Canadians identify themselves as Muslim. Among recent immigrants, 47.5% were Christians and 19.5% had of no religious affiliation. Muslim, Hindu, Sikh, and Buddhist immigrants represented 2.9% of immigrants before 1971 but account for 33% of immigrants between 2001 and 2011.

Immigration Policies

While early Canadian policies related to immigration were focused on protecting the public against communicable disease, including quarantine measures (Gushulak 2010), policies also evolved to explicitly restrict entry for perceived social, economic, or political negative effects. This had led to various historical policies of exclusion, including some criteria influenced by eugenics ideology (e.g., "prohibit or limit the admission of persons by reason of nationality, ethnic group, occupation, lifestyle, 'unsuitability' with regard to Canada's climate and perceived inability to become readily assimilated into Canadian society") and others based on health problems (e.g., "deformed, handicapped, or mentally ill"). Contemporary policies, including the current Immigration Act, no longer have blanket exclusion of groups of people and evaluate entry criteria by individual case assessments with a more inclusive policy on the health and well-being of newcomers. While the immigration policy protects Canada against excessive burden on the health-care and social systems, amendments to the Immigration and Refugee Protection Act in 2001 exempted the excessive demands exclusion criteria on refugees and members of immigrant families (Gushulak 2010).

Canada's policy on multiculturalism proposed in 1971 became a law in 1988 under the Canadian Multiculturalism Act (Gushulak 2010). The federal law sought to "preserve and enhance the multicultural heritage of Canada" and sought to guarantee individual rights and overcome discrimination based on race and ethnicity (Chiasson 2012). While multiculturalism favors hybridity within a mosaic vision of society, Quebec pursued a model of "interculturalism" as a paradigm which emphasizes social cohesion within a francophone society and integration to the communal values of Quebec while protecting differences and diversity (Bouchard and Taylor 2008; Chiasson 2012). Quebec has sought to balance its fundamental adherence to the primacy of the French language as a minority within Canada and its desire to preserve the unique heritage of Quebecois culture. The integration policies of Quebec include a larger provincial mandate distinct from other provinces on deciding immigration entry and an integration policy that balances assimilation into a francophone society and respect for Quebec's unique cultural context. Bill 101, for example, limited access of immigrants and refugees to French school boards and denied access to English schooling reflecting policies of integration through an interculturalism approach. The resurgence of Quebec nationalism in the 1960s had influence the binary nature of Canada as a bicultural and bilingual state in an evolving relationship within Canada. In addition, there is the impact of the Truth and Reconciliation Commission in addressing the cultural "genocide" as an

aftermath of residential schools. This removal of native children from their families to acculturate them in government schools across Canada has led to an official recent apology by the federal government for earlier systemic violations of human rights of those communities. These dynamics and tensions continue to evolve, generating a debate on mental health policy and patient access within a diverse Canadian reality.

Since the post Holocaust era, Canada has increasingly offered a haven to refugees in times of crisis and increased its immigration of non-European origin applicants. In 1960, Canada accepted 3500 refugees including 325 with tuberculosis, and in 1979, 60,000 refugees from Vietnamese, Laos, and Cambodia were resettled in Canada. Most recently, the federal government endorsed a plan to resettle 25,000 Syrian refugees.

Early Canadian history reflected policies of exclusion and racism particularly of Chinese and South Asian immigrants from the late 1800s embedded in a "white Canada" sentiment. While Canada welcomed immigrant labor, their wives and families were excluded and citizenship was not permitted to some minorities. A particular salient example of ethnic exclusion and discrimination in Canadian history was against the Asian and Chinese immigrants (Calgary Chinese Cultural Centre 2008). Many Chinese immigrants were brought in to build the railway that unified the country, with an average of four Chinese dying per mile of railway due to the dangerous conditions that they were assigned to work in. When the railway was completed in 1885, the government imposed a head tax on Chinese immigrants, raised as high as $500 in 1903 or about 2 years of wages. In 1923, the Chinese Immigration Act (Chinese Exclusion Act) further effectively excluded Chinese from immigrating to Canada. This was repealed in 1947, although discriminatory restrictions were in place until around 1967 with the introduction of a point system. In 1947, South Asians from India were granted the right to be citizens though they had been migrating from the late 1800s (Jagpal 1994). The Immigration Act, which affirmed a more inclusive policy, came into effect in 1976. The act also introduces the concept of "excessive demand" on Canadian health and social services as grounds for turning down immigration. The current point system helps to make the immigration process more transparent and equitable, favoring education, work skills, and economic benefits for Canada and for skilled immigrants. The selection process of immigration is one of the factors proposed to underlie the healthy immigrant effect.

Canadian Immigrant Mental Health and Illness

Research from various countries has found that immigrants may have better physical and mental health than the general population. This has been termed the "healthy immigrant effect." Possible explanations for this include immigration criteria that select for a healthier cohort, the attributes of people who choose to immigrate or have successfully navigated the point system of entry, as well as health examination procedures that screen out those with severe illness. In reviewing four major national health surveys drawing data from 1996 (NPHS Cycle 2) to 2005 (CCHS Cycle 3.1), the healthy immigrant effect was reflected in parameters showing consistently lower rates of depression, alcohol dependence, and self-rated mental health (Ng and

Omariba 2010). Based on more recent data from the 2011 Canadian Community Health Survey, 6.8% of immigrants reported that they suffer from an anxiety or mood disorder diagnosed by a health professional, lower than that of the general population and showing little signs of change over the last decade based on survey data (Mental Health Commission of Canada 2015).

As part of the healthy immigrant effect, there is a concern that the mental and physical health of immigrants deteriorates progressively, either to nonimmigrant Canadian level or worse. This may be due to the complex interaction of premigration factors and effects of convergence, i.e., where immigrants are exposed to similar stressors and begin to adopt similar lifestyle choices, as well as various post-migration stressors (Beiser 2005). A number of research studies support this analysis, although results vary on how long the advantage effect is sustained before there is deterioration (Vang et al. 2015). For example, Wu et al. found advantage for recent (less than 10 years) immigrants but not for established (greater than 10 years) immigrants, while Aglipay et al. found advantage for immigrants regardless of duration in terms of anxiety disorders (Aglipay et al. 2012; Wu and Schimmele 2005).

There is evidence that the healthy immigration effect does not describe all groups of immigrants. In reviewing the literature, Vang et al. found that, while Canadian studies in mental health tend to confirm this for adults, it may be weak or absent in the youth or elderly (Vang et al. 2015). One potential explanation is that unlike the adult population, the selection pressure may be less applicable in these groups, such as immigrating as a family member. A recent study using the Canadian Health Survey of 2011 analyzed mood disorders by age of immigration from childhood to adulthood, showing higher rates of affective disorder for immigrants migrating in early childhood (Islam 2015). Immigrant women had worse mental health risk for perinatal depression in five out of the eight studies reviewed (Vang et al. 2015). Thus, it is important to consider the specific immigrant population, the particular context an ethnic group faces, as well as the specific mental disorders being studied in considering mental health risk of Canadian immigrants.

In a retrospective cohort study based on administrative data of 4.28 million in Ontario, significantly higher rates of psychotic disorders were found among immigrants from Caribbean and Bermuda; lower rates were found among Northern and Southern Europe and East Asia (Anderson et al. 2015). Refugee status, including East African and South Asian refugees, had significantly higher rates of psychosis.

Analysis of data on suicide suggests that immigrants have a lower rate of suicide than those born in Canada. This trend is especially noted for the three urban centers of Toronto, Montreal, and Vancouver which receive the most immigrants (Malenfant 2004). Urban metropolis may offer some protective effect given the higher immigrant and ethnic density which may contribute to greater community support, as well as potentially greater availability and access to employment and services and lower discrimination. A recent Canadian study found that prevalence of suicidal ideation was higher among rural minority immigrants than urban minority immigrants or white immigrants (rural or urban). A protective effect of immigrant density was observed only for rural minority immigrants; for each 10% increase in immigrant density, there was a 67% lower risk of suicidal ideation. A sense of belonging was independently

associated with lower suicidal ideation among immigrants. More refined epidemiological studies are needed to identify the prevalence among specific diverse communities and to understand the nature of suicidal behaviors within cultural and contextual parameters. This is exemplified by a qualitative study exploring cultural factors for Korean Canadians revealing that this minority population experienced vulnerabilities for suicide, specifically related to themes of academic and work pressures, estranged family relations, and altered identifies as immigrants (Han et al. 2013).

Acculturation

As immigrants settle in Canada, the process of acculturation progresses as they make psychological and cultural adaptations to their new home (Fung 2012). Some studies use language fluency or years in Canada as a proxy for acculturation, limiting accurate interpretation of these findings (Vang et al. 2015). Acculturation measures have been constructed to assess this phenomenon. A linear unidimensional model of acculturation would assume that on the one end of the spectrum would be "fully Canadian," while the other pole would be identification with the country of origin's heritage culture, with "bicultural" individuals being in the middle of this spectrum. A recent Iranian geriatric immigrant study found that higher acculturation was associated with increased life satisfaction, although it did not directly correlate to measures of depression (Moztarzadeh and O'Rourke 2015). In Canada, especially with the official policy of multiculturalism, acculturation is better conceived as a bidimensional or multidimensional rather than a linear construct, as outlined in Berry's model of acculturation (Berry 2003; Ryder et al. 2000). Immigrants may identify with both their heritage and Canadian culture strongly using an acculturative strategy of *integration*. Alternatively, they may identify with Canadian culture while losing their identification with their heritage culture through *assimilation*, or they may retain strong identification with their heritage culture while not embracing aspects of Canadian culture through an adaptive strategy of *separation*. Others may not feel identification with either culture, resulting in a sense of *marginalization*. Integration may potentially result in optimal adaptation, while marginalization may result in distress. The effectiveness of the other two strategies may vary depending on the sociocultural context of the particular community including the size of the ethnic community.

In an Ontario cross-sectional study with immigrant mothers of preterm infants, lower identification with Canadian culture correlated with higher depression scores, while identification with heritage culture was not significantly correlated with depression (Ballantyne et al. 2013). In a sample of Chinese Canadians presenting to primary care, higher identification with Chinese culture was associated with decreased alexithymia, while identification with Canadian culture was not associated with alexithymia (Fung 2003). These studies suggest the need to investigate differential acculturative effects on various mental health outcomes using a multidimensional approach. At the same time, it must be recognized that acculturative strategies may depend on various individual and systemic factors, including ethnic density and the receptiveness of the local community (Fung 2012).

Children may acculturate at different rates from their immigrant parents. Often, they may function as parental children acting as the main spokesperson or bridge for the family with the mainstream society. The generation gap may be exacerbated by a cultural gap, creating tension and conflict in the family, often more evident in adolescent or young adult phases of development. Second-generation children exposed to different and potentially conflicting cultures may experience distress that evolves in a different process from first generation immigrants. Research on second-generation Canadian immigrant children have indicated complex findings with mixed outcomes (Vang et al. 2015). A national-level estimate found better mental health for first generation children compared to Canadian-born, second- or third-generation children (Beiser et al. 2002).

Social Inequities and Social Determinants of Health

Poverty, Underemployment, and Unemployment

Immigration is a social determinant of health as immigrants face a number of systemic factors that affect their essential needs. While poverty is a well-established social determinant of health, its effect may be particularly devastating for new immigrants who are struggling to establish themselves. Canadian immigrants on average had a 1.5–2.5 times risk higher than that of the Canadian-born population for low-income rates, with worst rates for recent immigrants (Picot and Hou 2014). This substantially accounts for the rise in overall low-income rates in Canada in the 1980s and 1990s. While there was a decline in low-income rate in 2000s, this decline was primarily driven by fall among the Canadian-born population only. There were some regional exceptions to these recent trends. For example, Toronto low-income rates did not fall for immigrant or Canadian-born populations in the 2000s, while Manitoba and Saskatchewan had decreased relative low-income rates among recent immigrants to 1.2 times that of Canadian-born population.

Despite being a highly educated group, securing employment is one of the major challenges for immigrants possibly indicating systemic barriers. In 2011, about 75.6% of immigrants were employed compared to 82.9% Canadian-born, and the gap is wider for recent immigrants (Yssaad 2012). Language and Canadian work experience seemed to predict only short-term economic success, while higher education in the presence of good language skills and lower age are more powerful long-term predictors for higher immigrant earnings (Bonikowska et al. 2015; Hou and Bonikowska 2015). Not only do immigrants earn lower hourly wages than Canadian-born citizens, their quality of the employment are often inferior, including having lower union coverage or employer-sponsored pension plans and higher involuntary part-time work and temporary jobs (Gilmore 2009). About 42% of employed immigrants are underemployed in comparison to 28% of the Canadian-born population.

Another potential factor contributing toward lower immigrant household income is the lower employment rate among women. While about 70% of immigrant women are employed, this is lower than the national average of about 85%, with the

difference partly attributable to larger family size, country of origin effects, and lower wages for immigrant women (Galarneau 2016).

Racism and Discrimination in Canada

Although the 1985 Canadian Human Rights Act prohibits discrimination, about one in five immigrants experience discrimination according to a national survey in 2009. About 13% of immigrants versus less than 7% of nonimmigrants experience multiple experiences of discrimination (Nangia 2013). External characteristics were most likely the basis of discrimination, including 12.6% of immigrants reporting discrimination based on their ethnicity or culture, 10.6% based on skin color, and about 7.2% based on language. Overall, visible minorities were twice as likely compared to the host culture to encounter discrimination in a number of areas.

Discrimination can influence the physical and mental health of immigrants in multiple ways, including direct influences on the individual emotional well-being. Indirect impact on well-being are evident through the social determinants of health and how immigrants relate to institutions (Nestel 2012). A study of Afghan immigrant youth in Canada found that 15% reported experiencing racism and Islamophobia on a regular basis; about 15% of the sample also reported symptoms of depression and a quarter reported suicidal thoughts (Soroor and Popal 2005). A study of Korean Canadians indicated that not only did overt discrimination eroded positive mood, subtle perceived discrimination or micro-aggressions were related to depressive symptoms (Noh et al. 2007). Regarding the income inequality noted in immigrants, studies noted that the disparity persists between visible minorities and persons of European origin after controlling for educational qualification, and this finding may in part be related to racism (Hou et al. 2016). In a study of Tamil-Canadian immigrants, about 12% qualified for PTSD, but only 10% of these subjects sought treatment (Beiser et al. 2003). Among Tamil Canadians, about 10% of the sample reported experiencing racial discrimination when accessing health care. In a Montreal study, African Canadians admitted to hospital for psychosis were more likely to have been brought there by emergency services, indicating access behaviors, barriers, and systemic discrimination warrant more understanding to achieve health equity (Eric Jarvis et al. 2005).

Religion Tension and Moral Beliefs

In a diverse society, religion differences may become a particular source of conflict and tension. As a group, immigrants are found to be more religious and more likely to attend religious services than people born in Canada (35% vs. 21%) (Angus Reid Institute 2015). While there have been shifts in religious beliefs due to immigration, Canada is still largely dominated by Roman Catholicism and other Christian denominations. In a 2015 national opinion poll, the general public attitudes toward Catholicism, Christianity, and Buddhism are the most positively perceived. Sikhs, Mormons, and Muslims are the most negatively perceived, with 44% expressing

negative perception against Muslims. There are regional differences as well, with residents more likely to reject religion in British Columbia and Quebec. Concerns about religious intolerance may be especially intense in Quebec where "reasonable accommodation" sought to balance tensions between the protection of a francophone cultural identity and increasing diversity in the province (Bouchard and Taylor 2008). In 2013, the ultimately defeated proposal, *Charter of Quebec Values*, proposed a ban of public employees including in education, daycare, or hospital settings wearing religious symbols, raising concerns about its impact on the diverse population (Kirmayer and Guzder 2013), though this was ultimately defeated in the provincial assembly. A recent Quebec Human Rights Commissions survey found that 43% Quebecers believed that one should be suspicious of people openly expressing their religion and 49% felt uneasy around the sight of Muslim veils (Solyom 2015).

Intersectional Marginality

Bias and discrimination based on skin color, religion, sexual orientation, and illness often conjointly cause severe marginalization of certain immigrant groups and subgroups. Research with the immigrant, refugee, and non-status African-Caribbean, Asian, and Latino persons living with HIV in Toronto found that they encountered stigma and discrimination-based intersecting dimensions of race, class, gender, citizenship, sexualities, body norms, and HIV status (Wong et al. 2013). Some of the encountered discrimination can originate from within their own community, related to religious beliefs and stigma concerns of the immigrant community who may resist being seen as a problem minority for the majority community (Li et al. n.d.). When these patient populations proactively attempted to improve their mental health, they were often met with service provider bias or mistreatment, unavailability of appropriate services, and multiple access barriers (Chen et al. 2015). By working closely with religious leaders from these ethnic groups as well as people living with HIV through a combination of psychological intervention (using acceptance and commitment therapy) and a community-empowerment training of social justice and capacity building training, the interventions were found to shift some of these underlying stigmatizing attitudes, cultivate mutual compassion, and promote increased understanding, which mobilized the community toward positive action, integration, and change (Fung and Wong 2014).

Providing Care for Immigrants

Access to Care

Canadian immigrants face multiple barriers to services, reflected by many studies documenting underutilization of mental health services. A recent review of 131 articles in immigrant access to care identified three major categories characterizing these barriers (Thomson et al. 2015). Immigrants encounter barriers related to the use of health information and services, i.e., either lack of awareness about mental illness and

available services, or cultural factors that affect their use, such as stigma or different explanatory models of illness. Secondly, there are barriers related to the settlement experience, such as poverty and experiences of discrimination. Finally, there is an inadequacy of culturally and linguistically appropriate services. In our study of 1000 immigrant and refugee women from East and Southeast Asia in Toronto, the five ethnic minority groups of women differed in their explanatory models of mental illness and distress (Fung and Wong 2007). However, for most groups, the significant factor predicting attitudes toward seeking professional help was perceived access to cultural, language, and gender-appropriate services, rather than cultural causative categories, age, education, or acculturation.

Canadian Initiatives to Address Immigrant Mental Health

To improve the culturally competent care of immigrants, clinical guidelines have been developed by the Canadian Medical Association, including a set of guidelines for addressing common mental health problems of immigrants and refugees in primary care (Kirmayer et al. 2011). It recommends that the assessment of mental health problems should include consideration of premigration exposures, stresses and uncertainty during migration, and post-migration resettlement experiences that influence adaptation and health outcomes. Use of trained interpreters and culture brokers is recommended to negotiate linguistic and cultural differences that may impede communication and mutual understanding during assessment and treatment. While a review of refugee mental health is beyond the scope of the chapter, many immigrants from war-torn countries have been exposed to trauma (Rousseau et al. 2011). The guidelines caution against routine screening, based on the lack of evidence of benefits and the potential for harm as many cope well. Vigilance for symptoms of depression, anxiety, sleep problems, and somatic symptoms can help identify those who may need psychiatric interventions.

Training in universities across Canada is variable for health-care professionals, though the Royal College of Physicians and Surgeons has identified cultural psychiatry as a necessary part of training for psychiatrists. Of relevance, the Canadian Psychiatric Association has developed a position paper on postgraduate training in cultural psychiatry (Kirmayer et al. 2012). It captures the requisite attitudes, knowledge, and skills for psychiatrists and mental health professionals to be able to work effectively in cross-cultural clinical situations in an integrated model aligned with the CanMEDS roles (Fung et al. 2008; Kirmayer et al. 2012): medical expert, communicator, scholar, professional, collaborator, manager, and health advocate. This framework emphasizes the importance of addressing the needs of the diverse populations at different levels, from clinical to organizational to systemic levels. Without organizational cultural competence and systemic support, clinicians will not be able to serve the needs of the diverse immigrant population.

At the systems and program delivery level, the imperative to develop an approach for immigrant mental health has been noted since a senate report on mental health in 2006 (Kirby and Keon 2006). A comprehensive review further informed the Mental

Health Commission on the needs of the immigrant population (Hansson et al. 2010). This culminated in the National Mental Health Strategy launched in 2012, in which the fourth of six identified strategic directions is to "reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and northerners" (Mental Health Commission of Canada 2012). Under this strategic direction, Priority 4.2 is devoted to improving mental health services and supports for immigrant, refugees, ethnocultural and racialized groups (IRER). Specifically, it recommends expanding the use of standards for cultural competency and cultural safety; increasing access to information and services; evaluating traditional knowledge, customs, and practices to address mental health problems and increase access; supporting and collaborating with IRER organizations to assess and address local needs; and developing and implementing mental health plans to address needs of IRER with their full involvement. Priority 4.4 recommends improving access to mental health information, services, treatments, and supports for minority official language communities and developing programs to identify, train, recruit, and retain mental health service providers to offer services in nonofficial languages.

To build such capacity, an organizational cultural competent framework can be used for mainstream organizations to ensure that it strives to maximize accessibility and cultural competence. This includes assessing its capacity among eight domains: (a) Principles and commitment, (b) leadership, (c) human resources, (d) communication, (e) patient care, (f) family and community involvement, (g) environment and resources, and (h) data collection and evaluation (Fung et al. 2012). Specialized organizations and services can also be developed to address the specific needs of the diverse population. Over the years, many minority communities have taken such initiatives to offer advocacy or various levels of mental health-related services for immigrants and refugees. These services are more developed in urban centers such as Toronto, Montreal, or Vancouver but are also evident in other urban and semirural regions. Community services often provide the initial support for refugees or newly arrived immigrants seeking language classes, advocacy, legal advice, childcare services, or any number of instrumental supports. In addition, these may be essential first-line services for serious mental health issues including domestic violence, depression, or psychosis and may be the bridge to community clinics, hospitals, or other specialized resources. Canadian cities vary in their mental health responses to diversity as a challenge variable for access and equity, reflected in health-care disparities of cultural communities (Kirmayer et al. 2014). We will outline a few Canadian initiatives as examples of models of care.

Ethno-Specific Models for Immigrants

One of the exemplar ethno-specific model serving immigrant patients is Hong Fook Mental Health Association in Toronto, a community organization funded by the government and nongovernmental sources, such as the United Way. Started in 1982, it was initially conceived as a consultation liaison model to assist patients from the

Chinese and Vietnamese communities to overcome systemic barriers to receive adequate mental health services from the mainstream system (Lo 2005). At the time, an urgent service gap was noted in the two ethnic groups, given the large influx of refugees from Vietnam and Chinese being one of the largest immigrant groups in Toronto. Over time, Hong Fook has grown to serve six East and Southeast Asian community groups, including Chinese from Hong Kong, Taiwan, and Mainland China; Vietnamese; Korean; and Cambodian. The main model of service delivery has shifted from a liaison model to case-management services due to a persistent lack of culturally competent resources in the system. Its services have also substantively evolved and expanded, including a well-developed mental health promotion and prevention program, housing program, self-help groups, youth outreach, and family initiatives. Recent clinical developments include an Asian clinic, where ethno-specific psychiatrists help provide psychiatric consultations, and, in September 2013, a nurse-practitioner-led clinic, which provide integrated primary and mental health care, the latter also services Tamil-speaking South Asians in the region. In 2015, close to 2000 unique clients had been served by Hong Fook case managers of the 6 communities and close to 400 clients served by the Asian Clinic psychiatrists (Hong Fook Mental Health Association 2015).

To do its work, Hong Fook's resources have grown considerably over the years, from a budget of $100,000 in 1982 to a current budget of $4.7 million dollars. The successful development of Hong Fook's various service components has been guided by its capacity to identify and respond to the service needs of the ethnic communities (Lo 2005). This includes sensitivity to changes in immigration patterns sometimes ahead of ministry's awareness, such as the needs of newer migrant communities like the Mandarin-speaking Chinese and Koreans while respecting the readiness of the ethnic communities to engage in cultural mental health programming, such as the development of Cambodian instead of Laotian services. Pragmatically, some services and programs were developed to capitalize on unique funding opportunities from the government and other sources. Most importantly, its successful growth and outstanding reputation in the community has been guided by its unwavering commitment to underlying philosophies including social justice, community-based ("from the community, of the community, and for the community"), collaboration, education and health promotion, and consumer and family orientation.

Hong Fook's unique expertise is not only well recognized in its service to the ethnic communities including its leadership among other community agencies (such as the Chinese Interagency Network and other related community networks), it is often sought out by mainstream agencies for cultural competence training (such as its funding by the Citizenship and Immigration Canada to train settlement workers on cultural competent mental health care), by the government on immigrant mental health policy issues, and by researchers regarding collaboration on studies on the Asian community. In 2016, it will also be offered as an elective training site for psychiatry residents in community integrative care rotation in collaboration with the Asian Initiative in Mental Health Program (AIM).

The Asian Initiative in Mental Health Program (AIM) is another example of an ethno-specific model in Toronto. It is a unique hospital-based community program

serving primarily Cantonese- and Mandarin-speaking Chinese Canadians. Started in 2002, it has expanded from 1 psychiatrist/clinical director (author) and 1.5 clinician to 1 full-time and 2 part-time psychiatrists as well as 2 full-time and 5 part-time clinicians. Its core function includes provision of comprehensive biopsychosocial psychiatric assessment and treatment, including both individual and group programs. In addition to regular outpatient service, it also has an early-intervention program, the only ethno-specific one in the city. It also provides psychoeducation to patients, families, and the Chinese communities to increase awareness and decrease stigma. In 2015, it has served around 900 unique patients.

AIM has a close working relationship with Hong Fook at many levels and collaborates in many community initiatives together along with other partners. The AIM clinical director is one of the Hong Fook Asian Clinic psychiatrists and provides Hong Fook staff training and programing consultation. There are three especially noteworthy collaborations, including the response to crisis, development of clinical interventions, and capacity building.

At the time of the SARS crisis in 2003, the Chinese community in Toronto was particularly affected. Many in the community were anxious or traumatized by seeing their loved ones affected in Asia, and the vibrant local Chinese gathering places were suddenly deserted. Ethnic discrimination erupted, including a derogatory newspaper cartoon depicting Chinese people importing the yellow plaque of death into Canada, while Chinese school children were ostracized; the Chinese Canadian population were perceived as unwelcome foreigners. At the same time, there was concern about the lack of reliable information in Chinese, as the community was confused by conflicting advisories from China, Taiwan, and Hong Kong, all of which only worsened the public health response to implement effective quarantine precautions to curtail the spread of the virus. In an unprecedented community response, over 60 Chinese community agencies formed an ad hoc coalition, even bringing in collaboration between different political groups (e.g., from Taiwan and China). AIM and Hong Fook along with other partners were instrumental in helping to organize logistics, train volunteers, and implement a community support line, overcoming an impossibly tight timeline and coping with the daily changing health updates from the government (Dong et al. 2010). This ad hoc service fielded about 250 calls, and the experience highlighted how a crisis can easily precipitate underlying xenophobia in a multicultural society and the potential power of community mobilization to address these fears.

Another gap that AIM and Hong Fook have been collaborating on addressing is the development of culturally competent psychological intervention. In a 2004 resident survey at the University of Toronto, about three-quarters of trainees endorsed preferring to focus on using psychopharmacology with minority and immigrant communities while avoiding psychotherapy with this population. This model of treatment is in clear contrast to what the community wants. In working with the Cambodian population, who had been traumatized by Khmer Rouge and limited in education, many would not have been considered “psychologically minded” nor accepted to receive therapy. We have successfully piloted two groups in the conjoint use of acceptance and commitment therapy, a mindfulness-based psychological

intervention, with Buddhist dharma teachings provided by a psychiatrist (author) and the community Buddhist monk (Fung 2015). The congruence between ACT, Buddhism, and Eastern philosophies is noted, and ACT may be particularly effective in the Asian communities. For the Chinese Cantonese and Mandarin community, our collaboration also developed two group interventions. The Journey to Healing group is a ten-session weekly psychoeducation group, which includes two sessions led by a Chinese naturopath and a Chi-gong master, respectively. The Integrated Behavioral Group Therapy (IBGT) is developed as a 12-session group therapy with 6 sessions on cognitive behavioral therapy and 6 sessions using ACT. The project is conducted in collaboration with the Portuguese Mental Health and Addiction Services, with the groups also being offered in Portuguese.

As an example of capacity building, another successful collaboration spearheaded by AIM and Hong Fook is the organization of a biennial conference on diversity and equity issues. It is a grassroots conference which is uniquely planned by community agencies and academic institutions conjointly to focus on practical issues faced by frontline mental health and other service providers. Conference themes have included ways of collaboration; approaches to working with families and communities; stigma of mental illness; and the recovery model from a cultural perspective.

There are other examples of ethno-specific services in Toronto, such as the Mount Sinai Assertive Community Treatment Team, the only ethno-specific ACT Team in Canada (Chow et al. 2009). Across Boundaries is another community organization based on anti-racism framework and provides holistic care to minority populations. In a diverse community, these ethno-specific or specialized services can most optimally provide culturally competent care to immigrants and minorities. However, there are a number of common challenges (Lo 2005), limitations, and critiques. Some funders and critics are skeptical about such services, worrying that other underserved communities may demand their own services. Moreover, recruiting qualified mental health providers from small immigrant communities often proves challenging. Ethnically matched providers may or may not be culturally competent, and ethnic professionals may be reluctant to be designated as health-care provider for a community. The communities themselves may not welcome these services because of the stigma, and some patients worry about confidentiality in a close-knit community. While not a panacea, in an environmental context with a large enough minority immigrant population with the dominant system still being vastly inadequate to meet the mental health needs, the examples above demonstrate the substantial impact that small ethno-specific programs can have, not only to the benefit of ethnic communities but also helpful in increasing the overall capacity and quality of the mainstream system.

Cultural Consultation Model

The cultural consultation model (CCS) was developed within a unique provincial context as a largely francophone though bilingual city of Montreal with considerable ethnic diversity (Kirmayer et al. 2003). Immigrant and refugee mental health has to be understood within Quebec's distinct history as a "founding" francophone nation,

Table 1 Key features of the cultural consultation approach (Kirmayer et al. 2014, p. 10)

Focus on the social context of the patient's predicament and the clinical encounter
Recognize the ubiquity of culture in the lives of patients, clinicians, and institutions
Explore culture as explicit knowledge, values, and practices but also as implicit, embodied, and enacted
Use a systemic and self-reflexive view of mental health problems
Emphasize issues of power, position, and communication
Consider culture and community as resources for helping and healing
Work within the system while attempting to challenge and change it through advocacy, education, and critique

urban demographics, patterns of immigration, unique politics of identity, and configurations of ethnic communities. The service currently is located in the Jewish General Hospital, a McGill University teaching hospital located opposite a specialized refugee services, Program for the Settlement and Integration of Asylum Seekers (PRAIDA), which operates within a community clinic, Centre de Santé et de Services Sociaux de la Montagne (CSSS) and integrated with the hospital and a larger institutional network. The CCS receives referrals from health practitioners or organizations in the city who request a consultation for mental health concerns which implicate cultural issues (Kirmayer et al. 2014). The key distinguishing features of this approach is listed in Table 1. The service has been responsive to a range of mental health practitioners and organizations including schools, youth protection agencies, refugee centers, shelters, and community groups dealing with cultural minorities. Referring therapists along with culture brokers and translators are included in the initial consultation, followed by a CCS team consultation with referring therapists reviewing diagnosis, cultural formulation, and intervention concerns. In more than half of the referred patients, cultural formulation within the CCS model altered the diagnosis and management of the cases (Kirmayer et al. 2003, 2014). Knowledge transfer and building skills of referring teams or mental health workers are primary goals in addition to constructing a culturally competent model of care. Child and family initiatives have now been developed within multiple community services as well as CCS with research and clinically based initiatives of Dr. Cecile Rousseau, Dr. Luci Nadeau, Dr. Toby Measham, and Dr. Jaswant Guzder.

Clinical CCS Case Example

The CCS was contacted by a nurse and social worker from a specialized pediatric center after they received a call from a mother with infanticide impulses. A single consultation visit was urgently arranged for a 32-year-old Tamil-speaking married woman, Anjali, who attended the appointment with her social worker and pediatric nurse. An interpreter was arranged by the CCS services. Anjali did not want her husband to be present.

Anjali and her family migrated from the war-torn Jaffna region to India. Her family remained in South India when her marriage was arranged with a Tamil Sri Lankan man, who had been sponsored to Canada by his relative and living in Montreal for some years. Anjali had been socially and linguistically isolated since her arrival. She was an overburdened mother with three children, including a 6-year-old and 18-month-old infant suffering a rare genetic disorder, as well as a 5-year-old with a serious learning disability and delays. Her oldest son's critical illness from birth and years of rehabilitation care had been very traumatic for her as he had remained in hospital for his first 3 years. She later realized that this same genetic disorder had led to the death of her first-born son immediately after childbirth in India, while she was still waiting for her immigration papers. She became quite distressed that the same disorder was identified in her 18-month-old daughter and in her husband's relatives.

Anjali presented as hopeless and depressed. She had not wanted a third child and had asked that the baby not be afforded aggressive methods or resuscitated if born with the same rare genetic disorder. However, she was never given an interpreter as the hospital staff had always used her husband for interpretation. Although he reassured her that he agreed with her decision, he signed papers for the hospital staff to pursue aggressive life-saving measures. He told the hospital staff that he would stay home to care for the infant if necessary though in fact Anjali was left alone and he continued to work.

Anjali's husband's insistence on having the third child had put her at high risk of having another sick child who "would put me back in the nightmare" of reliving her oldest son's medical care experiences. "I would do this for a son but not a daughter," she shared. Her husband, on the other hand, had insisted on having a daughter to "care for me as a son would not." She revealed that she tried appealing to her mother in India to allow her to get a divorce, as her husband was also physically abusive. Her mother threatened to disown her as this was seen as bringing shame to her family.

Anjali was further infuriated that her husband continued to be the only parent the pediatric staff consulted. They had noted that she had not bonded well with the infant girl without understanding her domestic situation. Although the treatment team had known her for 6 years, they had inadvertently denied her voice and agency by not having an interpreter.

The CCS consultation assisted the treatment team to understand Anjali's family context, cultural beliefs, and idioms of distress, structural gender violence, as well as formulating cultural aspects of her experiences of exile, silencing, and trauma. A diagnosis and treatment plan was made to address her severe depression and family context issues as well as underline the need for independent interpreters. Her inconsolable grief was understood not only as the aftermath for caring for their sick children but also in the context of the Sri Lankan war, domestic violence, and social isolation. The CCS consult situated Anjali's disempowered position as a daughter of a Hindu family who had been displaced in exile. In addition, her feelings of shame, her family's beliefs in karmic forces, and the cultural collectivist values were all elements that framed her predicament. Her suppressed feelings of helplessness and

distress of silencing inherent to her relationship with her mother and her husband was inadvertently mirrored by the treatment team. She had not acted on her infanticidal impulses, as she shared she was afraid of being imprisoned and not being able to care for her sons. She had understood that if she removed the child's tracheostomy tube and waited for sufficient time, her child would be beyond resuscitation. The CCS and referring team facilitated treatment of her depression, support for infant attachment and respite, and the option of placement to care for her child despite her husband's adamant refusal of such a plan. The team privately gave her a special code to immediately remove the child by ambulance if her feelings of desperation returned. A Tamil nurse, physician, and community support were engaged to explain and initiate antidepressant treatment, provide follow-up care, and institute close home monitoring.

This consultation illustrates the institutional and team consultation process that fosters changes in mental health frameworks when working in primary care and hospitals while integrating cultural formulation for intervention planning. Knowledge transfer and the cultural imagination of multiple idioms of distress is conveyed by co-construction of mental health-care parameters from these consultation processes, and for any treatment team, a seminar exchange allows all members of a referring team to benefit from the training and discussion.

Coordination of Cultural Services

A number of cultural programs have been developed in Vancouver similar to those described above over the past 35 years (Ganesan 2005). To serve its large immigrant population including the Chinese and South Asian population, both formal and informal sectors of health-care system have been providing primary, secondary, and tertiary levels of health care through hospital and community-based services. The Cross-Cultural Clinic at Vancouver General Hospital has 7 part-time psychiatrists speaking 22 languages and dialects, providing culturally sensitive, responsible, and language-specific assessment and treatment (Ganesan 2005; Ganesan et al. 2011). The clinic provides services to 5000 patients annually, including diagnosis, medication recommendations, education, facilitation of community resources, and group therapy. With the regionalization of health-care services, this clinic along with other cross-cultural mental health services such as the Vancouver Association for Survivors of Torture (VAST), interpretation services, and in-patient programs is better coordinated through a centralized administrative structure, the Vancouver Coastal Health Authority.

Conclusion

Immigration has been integral to the history of Canada, reflected in the culturally diverse mosaic of its citizens for generations and a federal policy of multiculturalism since the 1970s. Quebec as a francophone society has continued to refine and

develop a unique intercultural model to preserve the host society's culture while integrating increasing ethnic diversity after the 1960s, whereas bilingualism remains a federal orientation that has unevenly developed nationally. In this context, immigrants and their communities have been shown to be resilient, innovative, and resourceful while contributing to the economic and social development of Canadian life. Despite the positive integration of immigrants and refugees over the past decades, diversity presents specific vulnerabilities that remain a concern as well as specific challenges in the health-care system. In spite of the spirit and ideals of multiculturalism and the "reasonable accommodation" premise of Quebec's intercultural ideals, the psychological, social, and cultural dynamics of inclusion remain, as linguistic accommodations, barriers to access, and progressive recognition of a need for cultural competence and cultural safety in mental health-care delivery for ethnic minorities and First Nations peoples continue to evolve.

Research data indicate that current realities of social inequities affecting the social determinants of health erode the healthy immigrant advantage. These factors coupled with the lack of access to culturally competent services have a significant impact on health disparities. To meet these challenges, policy and training efforts continue to be undertaken by efforts at the individual, institutional, and community levels especially in major urban centers across the country. Training of health professionals, police, community workers, and caretakers has increasingly acknowledged the need to include cultural elements in addressing whole patient care. The solutions to health equity and a human rights perspective in delivery of services involve considerations of complex variables at societal, political, and health-care delivery levels, requiring further research in Canadian context. Increasing the cultural competence of mainstream organizations, supporting the development of specialized services, developing ethno-specific services for larger cultural groups including the First Nations, and providing cultural consultation services for diverse communities are initiatives that may foster systemic improvements to address the gaps in service. Canada needs to continue to refine its policies and to develop programs that improve access and delivery of mental health care through collaboration, capacity building, research initiatives, policy changes, and drawing upon the strengths of diversity.

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