

# Immigrant and refugee mental health in Canada: lessons and prospects

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## Editors' introduction

Different countries face different levels of migration and varying numbers. Each country deals with the issues related to migration in its own way, and the focus varies from multiculturalism in the UK to the melting pot in the USA and the rainbow nation in Canada. The reception granted to migrants varies according to social policy and political ideologies. Psychiatrists must be aware both of social policy and political views in the new culture so that adequate, appropriate and accessible services can be provided to migrants as well as other ethnic and cultural groups. These services will depend upon resources made available in the healthcare system. In this chapter, Simich and Beiser highlight the Canadian experience of migrants and refugees to illustrate rates of mental health problems, subpopulations at risk and social determinants of risk and resilience. Using migrant and refugee settlement programmes, multiculturalism and social policy appear to be welcoming; inevitably, however, increasing the local labour market will place newcomers at a disadvantage. The authors describe and review the data which demonstrates resettlement-related mental health risk factors, especially unemployment. Rates of disorders will vary as social and health inequalities grow. Simich and Beiser conclude that specific interventions are helpful and needed.

## Introduction

When immigrants arrive in Canada, they are, on average in better mental health than native-born Canadians (Ng *et al.*, 2008). This chapter focuses on two decades of Canadian migrant mental health research, some of it devoted to exploring personal and social factors that jeopardise this initial mental health advantage, some of it to explicating the factors that contribute to maintaining it. As is the case for the population at large, some immigrants develop frank psychiatric disorders. The availability and effectiveness of mental health services for this subpopulation is another major research trend reviewed in this chapter. A description of immigration, demographic, and social trends in Canada opens the chapter and provides a backdrop for considerations about mental health. The review of *After the Door Has Been Opened* (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988), a landmark Canadian document on immigrant and refugee mental health that follows, provides a context for evaluating developments over the subsequent two decades. The chapter then reviews selected migrant mental health research findings to highlight the extent of mental health problems, subpopulations of immigrants and refugees at particular risk, and the social

determinants of risk and resilience. A brief discussion of emerging issues, suggestions for future research, and service and policy recommendations concludes the chapter.

## Immigration, demographic and social trends in Canada

Canada's first immigrants were English, French and other European colonisers who began trading and settling on native lands in the sixteenth century. Immigrant intake peaked in the first decade of the twentieth century, retreated during the Great Depression and post World War 2 years, and then rebounded in the latter half of the century. By the opening decade of the twenty-first century, Canada had become one of the most culturally diverse places on Earth. The country's multiculturalism policies (Kymlicka, 1995) and refugee resettlement programmes have been favourably contrasted with more problematic integration scenarios in Europe or with the USA's 'sink or swim approach' (Van Selm, 2003). Although a comparative analysis of the history of immigration in North America is beyond the scope of this chapter, some trends provide a backdrop to understanding immigrant integration, social determinants of mental health and migrant mental health research in Canada.

Comparisons between immigrant integration in Canada and in the USA suggest the advantages of certain Canadian policies, while others are grounds for concern. Immigrants in Canada are, on average, much more likely eventually to become citizens than their US counterparts and to acquire citizenship much faster (Bloemraad, 2002). Although there is no research addressing a possible relationship between mental health and becoming a citizen, this action on the part of new settlers may be an indicator of a sense of belonging and inclusion. As described later, however, this is only one indicator of settlement and integration success; demographic changes and economic outcomes also have the potential to affect immigrant mental wellbeing.

The last half of the twentieth century was a time of profound changes in Canadian immigration. Prior to 1960, a frankly discriminatory admissions policy helped ensure that immigrants would be predominantly Northern European and white. The Immigration Act of 1976, which introduced a colour-blind points system based on human capital characteristics such as education, linguistic fluency and occupational skills geared to government-defined labour force needs, changed everything. Of the 250 000 immigrants admitted to fill Canada's annual immigration target (Citizenship and Immigration Canada, 2009), many now come from areas other than the so-called 'traditional' source countries. Over half (52%) of immigrant admissions in 2007 came from 10 source countries: People's Republic of China, India, Philippines, USA, Pakistan, UK, Iran, Republic of Korea, France and Colombia.

Approximately one of five persons living in Canada is foreign-born. However, since the vast majority (70%) of recent immigrants to Canada settle in the country's major cities, the immigrant presence is felt even more profoundly in places such as Toronto, Montreal and Vancouver than in the country's rural areas (Statistics Canada, 2008). Over half Toronto's population is foreign-born, with a mother tongue other than English or French, Canada's two official languages.

Unlike its immigrant intake, which is overtly driven by self-interest, Canada's admission of refugees is based on humanitarianism, and by the country's voluntary participation in the UN Convention on Refugees. Between 1980 and 2001 Canada received a total of 535 131 refugees from a wide variety of source countries. The annual numbers ranged from a high of 40 000 in 1980 (at the height of the 'boat people' crisis in South-east Asia, an event that stimulated the largest admission of refugees in Canada's history) to a low of 15 000 in 1983 (DeVoretz *et al.*, 2005). Between 1999 and 2009, the number of refugee arrivals stabilised at roughly 25 000 per year, approximately 10% of all immigrant admissions (CIC *Facts and Figures*, 2009). About half of Canada's refugee admissions come from refugee camps abroad,

the other half as a result of successful claims for refugee status by persons who manage to come to Canada on their own and establish a refugee claim under international agreement. Canada's widely admired reputation for refugee resettlement practices derives from the South-east Asian refugee experience, for which the UN awarded Canada the Nansen medal for humanitarianism. On a per capita basis, Canada continues to accept more refugees for permanent resettlement than any other country.

After immigrants are admitted to Canada, responsibility for their healthcare falls under the jurisdiction of the provinces. Although Canada boasts universal healthcare, services for immigrants are uneven and dependent upon provincial policies. Some provinces, for example, impose a 90-day waiting period before immigrants become eligible for insured services. Under the Interim Federal Health Program, Citizenship and Immigration Canada provides limited direct healthcare for refugees and refugee claimants covering emergency and essential medical services – including short-term mental health consultations – but there are many gaps in entitlements and coverage.

With its well established immigrant and refugee settlement programmes, multiculturalism policies and good record of citizenship acquisition, Canada presents the surface appearance of a nearly ideal resettlement country. Beneath the surface, however, is an increasingly competitive domestic labour market which is placing recent newcomers at an increasing disadvantage (Badets and Howatson-Leo, 2000; Kunz *et al.*, 2002; Li, 2000; Reitz, 1998; Smith and Jackson, 2002). As a result of labour market difficulties, poverty, with its attendant risk for mental health, has reached unprecedented levels among new Canadians (Kazempur and Halli, 2001). In 2004, more than one in five recent immigrants of working age was living in poverty compared to fewer than one in ten other Canadians (Fleury, 2007: 25).

Immigrants to Canada also tend to be under-paid and under-employed. Regardless of national origin, recent immigrants aged 25–54 experience more difficulties in the labour market than the Canadian-born (Gilmore, 2009). In 2006, the unemployment rate for the Canadian-born was 4.4%, while the rate for recent immigrants was 11%. In 2008, the average hourly wage of an immigrant worker was 90% that of a working age (25–54-year-old) Canadian-born employee. For immigrants present in Canada for less than 5 years, the corresponding figure was 80%. Canada's selection policies ensure that most immigrants are well educated. Educational advantage does not, however, translate into labour force benefit. In 2008, 42% of immigrants were under-employed; that is, working at jobs at a lower level than would be expected based on level of education (Gilmore, 2009). Lack of recognition of immigrants' educational credentials and discrimination in the labour market are two major contributors to this problem. Visible minorities are more likely to be in low-wage jobs than are white Canadians and to receive lower pay when occupying jobs comparable to non-minorities (Pendakur and Pendakur, 2007). Thwarted ambitions and unmet expectations take an emotional toll on migrants (Beiser *et al.*, 1981; Simich *et al.*, 2006a).

Multiculturalism, a policy of supporting cultural retention while at the same time encouraging successful integration (Berry, 1984), has likely had salutary effects on migrant mental health in Canada. Implementing less discriminatory admissions criteria for immigrants in the 1970s did not, however, guarantee fair treatment after admission. Resettlement stress is an ongoing problem, as is the disconnect between immigration and health policy and practice. In 2002, the Immigration and Refugee Protection Act opened Canada's doors to refugees with serious health problems. Although this laudable humanitarian gesture obviously required additional healthcare resources, none were provided.

## The Canadian Task Force on Immigrant and Refugee Mental Health

Immigrant and refugee mental health rocketed to national prominence in 1986 with the formation of a national Task Force on Mental Issues Affecting Immigrants and Refugees in Canada, followed by the release of the task force report, *After the Door has been Opened*, in 1988. The task force was created by two federal government departments: the Multiculturalism Sector of the Department of the Secretary of State, and Health and Welfare Canada. The government action was a response to concerns raised by a great number of community, service and advocacy groups across the country. The 12 members of the task force included psychiatrists, psychologists, nurses, social workers and academics, as well as front line workers, drawn from across the entire country.

Based on an extensive review of the literature as well as written and oral submissions from more than 300 organisations, the task force reached consensus on a central point. *It is not the experience of migration per se that jeopardises mental health: instead, it is the contingencies surrounding migration and resettlement that determine whether relocation creates mental health risk, or new opportunities for personal and economic fulfilment.*

*After the Door has been Opened* identified resettlement-related mental health risk factors, emphasising among these the deleterious effects of unemployment and under-employment, separation from family, inability to speak English or French and negative public attitudes towards immigrants in general and ethnocultural minorities in particular. The report also called attention to the supportive contribution of the like-ethnic community. Groups requiring special attention, either because of special needs, or because they had been neglected by researchers, policy-makers and service providers, included children and youth, women, seniors and victims of torture and other catastrophic stressors. The report included 27 recommendations. These included broad policy issues such as accelerating the process of family reunification to prevent loneliness, parent-child separations, and family breakdown, ensuring access to language training, and creating at least three centres dedicated to immigration research and to professional training. The recommendations also included specific preventive and intervention strategies, such as professionalising the training of interpreters and creating materials for newcomers that addressed the process of resettlement, its frustrations and disappointments, and that made recommendations about coping with them.

## Two decades of immigrant mental health research in Canada

Since the 1980s, the migrant mental health field in Canada has continued to grow in depth and breadth, and has benefited from interdisciplinary and policy-orientated research approaches. Going beyond a narrow biomedical perspective, and using both quantitative and qualitative methods, Canadian researchers have investigated social and cultural determinants of immigrant mental health. In a reprise of the earlier task force initiative, the new Mental Health Commission of Canada's Task Group on Diversity undertook a review of Canadian research literature about migrant and ethnoracial mental health as of 2009, and including an examination of which, if any, of the recommendations in *After the Door Has Been Opened* had been implemented. The task group reported that only six recommendations had been implemented in full. However, more than 50 studies in the two decades since *After the Door Has Been Opened* have investigated mental health or mental health problems

among ethnoracial groups in Canada (Mental Health Commission Task Group on Diversity, 2009). Most of these studies focus on rates of mental illness, healthcare for immigrants and refugees, and risk and protective factors for mental health.

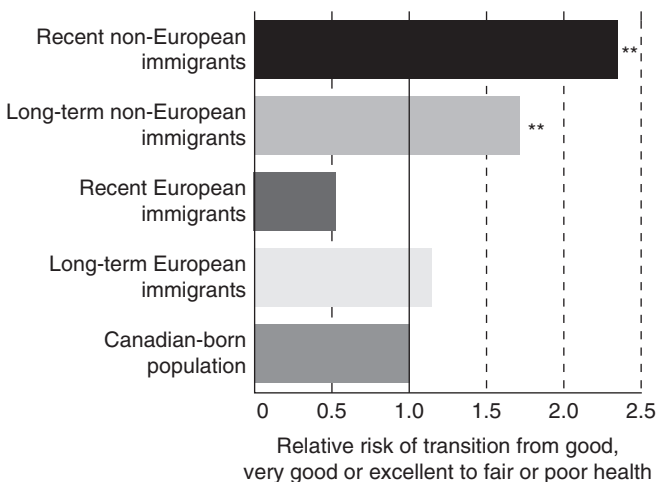
The studies make clear that neither the migration process nor migrants themselves are inherently unhealthy; rather, migrant mental health depends to a large extent on post-migration conditions in the resettlement society. Because they are young, self-selected for migration, and have passed an entrance health examination, newcomers to Canada are generally healthy on arrival. Although it is important to recognise this initial immigrant health advantage, it does not justify complacency.

## Rates of mental illness and changes over time

According to research carried out under the so-called 'healthy immigrant effect', immigrants tend to lose their health advantage over time. Immigrants from non-European source countries seem to be at greater risk than immigrants of European origin for developing chronic health problems (Ng *et al.* 2005); Figure 25.1.

The data for mental health are not as clear. Results from the Canadian Community Health Survey suggest that immigrants have significantly lower rates of anxiety, depression and alcohol dependence than Canadian-born residents, and that this effect is stronger among more recent than among longer stay immigrants, an observation that has led some researchers to conclude that the 'healthy immigrant effect' applies to mental health (Ali, 2002). However, the cross-sectional survey methods used in the Canadian Community Health Survey are not sensitive to the heterogeneity of immigrant populations, to regional variations, or to complex interactions and changes in social and cultural factors over time (Beiser, 2005). Specific subpopulations such as women and refugees may be more vulnerable and experience particular stresses (Ahmad *et al.*, 2004; Rousseau *et al.*, 2001).

Canadian national surveys also include some data relevant to migrant mental health, but aggregate population data do not always allow fine-grained or in-depth exploration of issues. Local studies with specific immigrant and refugee or ethnic groups may provide more meaningful, specific information for the development of mental health services (Mental Health Commission Task Group on Diversity, 2009). National surveys tend to



**Figure 25.1** Non-European immigrants are more likely than the Canadian-born to report a deterioration in health (Ng *et al.*, 2005).

compare immigrants in general with non-immigrants, and to lump diverse immigrant groups together. The data do not reveal important variations by immigration classes, source areas, ages or gender. For example, as part of Canada's commitment to developing a national children's agenda, the government-initiated the National Longitudinal Survey of Children and Youth (NLSCY), a longitudinal investigation of the development and wellbeing of more than 35 000 Canadian children from birth to early adulthood. This still-ongoing study is producing valuable information about factors influencing children's social, emotional and behavioural development. However, because immigrant and refugee children are severely under-represented in the sample, insights gleaned from the NLSCY tell only part of their story.

An article based on NLSCY data with a surprising finding illustrates the importance of data based on adequate samples of immigrants and refugees (Beiser *et al.*, 2002). Since poverty is one of the most potent of all factors that place children's mental health at risk, and since recently arrived immigrant families are more than twice as likely as non-immigrants to be living in poverty, the guiding hypothesis was that immigrant children would have higher rates of distress and disturbance. The findings were the exact opposite: foreign-born children had fewer emotional and behavioural problems than their native-born counterparts. Further probing of this epidemiological paradox highlighted the role of the immigrant family as a source of resilience. Poor immigrant families were much less likely than poor native-Canadian families to be broken families, and poor immigrant parents were less likely to be ineffective or dysfunctional parents.

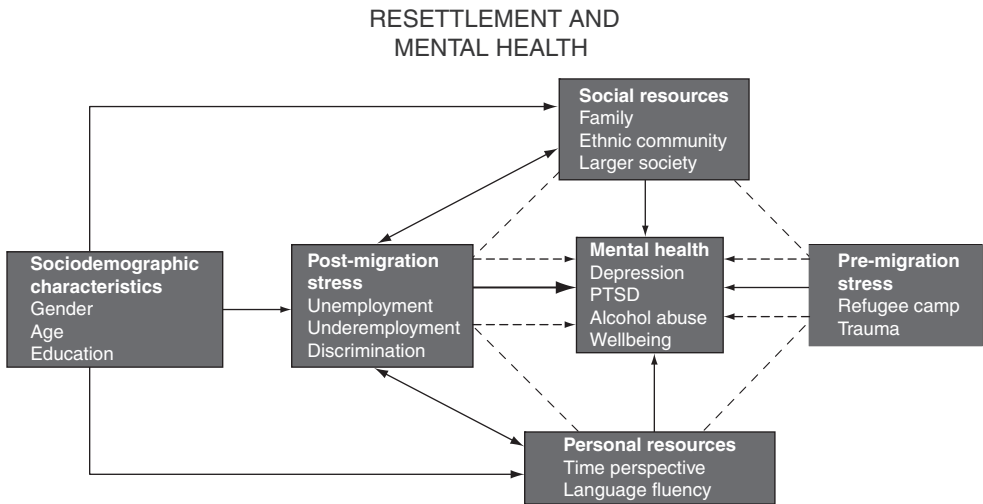
## Service utilisation

Immigrants are less likely than Canadian-born residents to use mental health services (Kirmayer *et al.*, 2007). Social conditions that affect migrant mental health include perceptions of the formal mental health system and existing professional practices in Canada, where reasons for immigrants' reluctance to use mental health services include negative perceptions of current practices, such as doctors' lack of time for patients and over-reliance on medications in treatment (Simich *et al.*, 2009a; Whitley *et al.*, 2006). Other studies have focused on unmet mental health service needs and barriers, including new settlers' lack of knowledge about where to get help and concerns about stigma (Hsu and Alden, 2008; Li and Browne, 2000).

## Risk, resilience and mental health

An interactive paradigm that includes both risk and resilience factors for immigrant mental health is essential for research, policy and practice. The resettlement stress and resilience model in Figure 25.2 has guided epidemiological studies among South-east Asian refugees in Vancouver, British Columbia, Tamil refugees in Toronto, immigrant and refugee children across Canada, and cross-national studies involving Canada, Ethiopia and Israel.

Intuition and theory would predict considerable mental health salience for pre-migration stressors, particularly among refugees. However, research demonstrates that the mental effects of pre-migration tend to disappear shortly after permanent resettlement has been attained, perhaps to reappear many years later (Beiser, 2009). Suppression of memory probably helps refugees deal with the mental health risk of past trauma, at least during the early and mid term years of resettlement (Beiser and Hyman, 1997). Thus, suppression can be a coping strategy that helps preserve mental health rather than the pathological defence



**Figure 25.2** Resettlement and mental health. Adapted from Beiser, M. (1999). *Strangers at the Gate: The Boat People's First Ten Years in Canada*. Toronto; University of Toronto Press.

mechanism it is often considered. As people age, however, the recall of memory, both painful and pleasant, is probably ineluctable. Research (Beiser and Wickrama, 2004) demonstrates that, although such recall constitutes a risk for depression, a stable work history and a stable relationship each act as protective mental health factors.

To promote migrant mental health, it is as important to identify protective factors as it is to ascertain vulnerabilities. Sometimes, a particular factor can be both. For example, unemployment is a risk factor for depression among immigrants just as it is among the population at large (Beiser *et al.*, 1993; Wickrama *et al.*, 2002). Stable employment, on the other hand, mitigates the mental health risk invoked by refugees' recall of painful memory (Beiser and Wickrama, 2004). Social support and social networks have been shown to decrease the isolation of African refugee and Asian immigrant groups (Beiser, 1999; Stewart *et al.*, 2008). For some mental health problems, such as suicide, rates among immigrants are generally half that of the non-immigrant population in Canada, and closer to the rates reported in the countries of origin. Although the rates increase among immigrant seniors, they decrease among immigrants living in such major cities as Montreal, Toronto and Vancouver, probably because of the protective effect of cultural and community ties (Malenfant, 2004).

On the other hand, immigrants can become cocooned by the like-ethnic community, with such long-term deleterious effects as decreased probability of learning the language of the receiving society, decreased social contact outside the ethnic community, and heightened risk of entering employment tracks with little prospect for upward mobility (Beiser, 1999, 2009). The possible mental health effects of non-ethnic support, for example through sponsorship and hosting programmes, has received less research attention. Canadian immigration law permits private sponsorship of refugees. As part of its strategy of responding to the South-east Asian Boat People crisis of 1979–1981, the Canadian government encouraged private citizens to become private sponsors, thereby assuming financial as well as other responsibilities during the first year of resettlement in return for which the government

brought in refugees under government sponsorship. Studies (Beiser, 1999, 2009) suggest that sponsorships that involved misunderstandings between sponsors and refugees jeopardised mental health. On the positive side, sponsorships appeared to enhance long-term language acquisition, employment and contact with the larger community (Beiser and Johnson, 2003). Theory suggests that a strongly held sense of ethnic identity promotes self-esteem and social belonging. However, research suggests a complex interaction: a strong sense of ethnic identity can be protective for immigrants and refugees who experience difficulty in acquiring tools such as language that permits them to participate in the larger society, but it can, on the other hand, amplify the deleterious effects of perceived discrimination (Beiser and Hou, 2006).

Aside from contributing indirectly to mental health problems by creating barriers to employment, discrimination affects migrant mental health directly (Beiser *et al.*, 2002; Dion, 2001; Noh *et al.*, 1999). According to Canada's Ethnic Diversity Survey (Badets *et al.*, 2003; Statistics Canada, 2003), 20% of people reported experiencing discrimination 'sometimes or often' in the 5 years prior to being interviewed. Almost one-third (32%) of blacks reported experiencing discrimination, compared to 21% of South Asians and 18% of Chinese in Canada. The survey also found that perceived discrimination does not lessen with the passage of time or among the ranks of second generation immigrants.

The study of mental health among the small cohort of immigrant children included in Canada's National Longitudinal Survey of Children and Youth raised a number of intriguing and important questions; for example, Did the good news about mental health apply to all children, refugee and immigrant alike? To visible minority as well as non-visible minority children? and, did factors such as the circumstances of migration or region of resettlement in Canada affect mental health? The NLSCY immigrant child sample was too small to permit the required analyses. To help answer such questions, researchers from 10 universities across Canada, most of them affiliated with the national metropolis centres of excellence for research on immigration, together with ethnocultural community and service groups, created the New Canadian Children and Youth Study (NCCYS), a longitudinal investigation of health and development involving more than 4000 immigrant and refugee children and their families living in six cities across Canada.

A publication from the NCCYS (Beiser *et al.*, 2009) demonstrates that, in many ways, immigrant children's mental health is affected by the same factors that affect the mental health of children in general. Immigrant boys are more likely than immigrant girls, and younger children more likely than older, to display physical aggression. As is the case for children in general, maternal depression increases the probability that an immigrant child will have emotional problems. However, factors more or less specific to the immigrant experience affect children's mental health, net of universal risk and protective factors. Immigrant children whose parents speak little or no English or French are more distressed than children whose parents have better degrees of linguistic fluency, and immigrant children whose parents suffer a good deal of resettlement stress and who experience discrimination have an elevated risk of emotional problems and of physically aggressive behaviour. In addition, the region of resettlement in Canada has apparent mental health salience. Children living in Toronto and Montreal had more mental health and behavioural problems than children living in Winnipeg, Calgary, Edmonton or Vancouver. There were different reasons for these regional differences. Immigrant parents living in Montreal were less fluent in the dominant society language than those living elsewhere, and this accounted for Montreal's relatively poor showing. Toronto, on the



other hand, apparently offered poorer institutional responses, for example through its service agencies and its schools, as well as a less welcoming environment for newcomers (Beiser, unpublished data).

Among other contributions, *After the Door Has Been Opened* foreshadowed the need to include immigrants in consultation and research. Three decades later, participatory action research has become an effective and empowering method for engaging immigrant groups in Canada in the design, execution and dissemination of immigrant mental health research. For example, the recently completed Community–University Research Alliance Study, *Taking Culture Seriously in Community Mental Health*, brought together over 40 community, university, service agency and umbrella organisation partners (Maiter *et al.*, 2008; Simich *et al.*, 2009a, b; Westhues *et al.*, 2008) to explore, develop and pilot community mental health initiatives in five ethnocultural communities in Ontario, Canada’s most populous province. Such qualitative research studies have helped to ‘flesh out’ an understanding of migrant mental health by describing subjective experiences of mental health during settlement that are meaningful for understanding unmet needs, cultural values and community-based solutions. Innovative participatory research projects have also come out of non-university settings, such as community health centres and other community agencies serving immigrants and refugees. Employing community-based research methods has also been beneficial in creating partnerships among researchers and service providers. *A Community in Distress*, a mental health survey in Toronto’s Tamil diaspora, the largest in the world, was conducted from 2001 to 2004 (Beiser *et al.*, 2003). The research partnership of community professionals and academics, an essential component of the project, outlasted the study itself. The partnership catalysed a community-wide response to combat mental distress and feelings of helplessness among Tamils in the diaspora, who were confronted with daily news about the devastating impact of the December 2004 Asian tsunami on family and friends in Sri Lanka (Simich *et al.*, 2008). In sum, university–community research partnerships can help make migrant mental healthcare initiatives more informed and effective.

## Emerging issues in immigrant mental health in Canada

As already noted, the 1988 landmark National Task Force on Mental Health of Immigrants concluded that migration may be stressful, but it does not necessarily threaten mental health unless post-migration stresses overcome the personal and social resources available to cope with them. Data about the incidence and prevalence of mental disorders is still limited for most specific immigrant or refugee populations in Canada, but what evidence there is points consistently to the association of mental distress with post-migration contingencies. For example, the 28% rate of depression among Ethiopians in Toronto is much higher than depression rates for Ethiopians in their homeland, a finding strongly suggesting a combination of high risk and depleted resources for Ethiopian immigrants (Fenta *et al.*, 2004). One might not expect the ‘healthy immigrant’ effect to apply to refugees as it does to their carefully selected immigrant counterparts. However, the South-east Asian refugees who came to Canada during the ‘boat people’ crisis (1979–1981) had lower rates of depression than native-born Canadians (Beiser, 1999). Such apparent discrepancies highlight the need for future studies to employ standardised, culturally appropriate methods, and for more investigations comparing mental health among immigrants and their counterparts in home countries, as well as among immigrants and native-born residents of receiving countries.

The match between mental health need and availability of services is another important area for further research. Mental healthcare systems commonly lack the cultural and linguistic competence and will to respond to mental healthcare challenges resulting from immigration (Bhui *et al.*, 2007; de Jong and Van Ommeren, 2005; Ingleby and Watters, 2005). In both Canada and the United States, minority and ethnolinguistic communities are underserved (James and Prilleltensky, 2003; Kirmayer *et al.*, 2007; United States Department of Health and Human Services, 2002). Despite Canada's universal healthcare system, equitable access to good quality mental healthcare for immigrants and refugees is far from guaranteed (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Gagnon, 2002; Standing Senate Committee on Social Affairs, Science and Technology, 2006). For example, Toronto is home to the largest Tamil diaspora in the world, and a mental health survey has shown that Toronto Tamil refugees experience PTSD at a rate of 12% (which is comparable to other refugee populations), yet only one in 10 persons qualifying for a diagnosis of PTSD has received treatment of any sort (Beiser *et al.*, 2003). Studies have revealed language barriers and incompatibility between the values, help-seeking strategies and expectations of migrants and the Canadian mental health system (Sadavoy *et al.*, 2004; Wang *et al.*, 2008). More critical analyses of how the medical system and migrants interact are required. Finally, research on the mental health of irregular or undocumented migrants and lack of access to health services in Canada is still in its infancy (Simich, 2006b; Simich *et al.*, 2007), but has the potential to precipitate humanitarian responses despite the difficult social and economic context.

## Summary of lessons and prospects

Canada has an enviable reputation as a destination country for immigrants and refugees. To maintain its reputation, more attention needs to be paid to migrant mental health. In the 1980s and 1990s, Canadian migrant mental health research demonstrated that even the most disadvantaged migrants can achieve good health and social integration over the long term under favourable settlement conditions. Multiculturalism, though sometimes criticised, has probably had a salutary effect on migrant mental health. Like-ethnic community support is especially important in the early years of settlement, and well designed and well executed welcoming and sponsorship programmes can probably aid long-term integration and play a significant role in protecting mental health.

Social and health inequities in Canada are, unfortunately, growing. Recent research has shown that discrimination and slower economic integration are having a deleterious impact on migrants, but disillusionment and mental distress are not inevitable. Given the lessons learned from the Refugee Resettlement Project and other studies in the past two decades, it is time to acknowledge that migrant mental health is an important aspect of human capital (Beiser, 2009), and to invest accordingly in culturally appropriate services, illness prevention and community mental health promotion (Mental Health Commission Task Group on Diversity, 2009).

Several specific initiatives would be helpful. For example, language interpretation services are not currently mandatory in Canada's health system, although they are in the courts. Given the relevance of language in delivering good quality mental health services, this should change. National immigration policy is seldom congruent with provincial health service delivery, so migrant mental healthcare tends to be neglected. This problem is slowly being addressed by current research, such as the Refugee Mental Health Practices study, and pilot

settlement sector programmes. Mental health literacy and anti-stigma campaigns under consideration by federal and provincial agencies, if funded and implemented well, would also help to bridge the medical and social divide in migrant mental health.

The depth and breadth of migrant mental health research in Canada has expanded, not only in academic settings, but also with greater participation from immigrant communities and agencies, as well as increasing interest from policy-makers. Past research suggests the importance of pursuing longitudinal and mixed methods studies in migrant mental health, and of doing research that takes into account important distinctions such as gender and legal status. Studies that investigate social determinants of mental health in addition to the complexities of trauma and recovery are increasingly the norm. Most migrants in Canada do not become mental health casualties, a fact that provides the opportunity to investigate what keeps migrants mentally healthy and to translate this knowledge into improved policy and practice.

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