Int. Migration & Integration (2012) 13:383–397
DOI 10.1007/s12134-011-0215-3

RESEARCH NOTE

Provider Perspectives on Barriers and Strategies for Achieving Culturally Sensitive Mental Health Services for Immigrants: A Hamilton, Ontario Case Study

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Published online: 29 July 2011

Abstract As research reveals that the healthy immigrant effect, whereby the health of immigrants at the time of arrival is high but subsequently declines and converges toward that of the native-born population, also extends to mental well-being, this paper aims to examine the barriers to mental health care for immigrants in Hamilton, Ontario. Through the use of face-to-face interviews with eight service providers, barriers to care were revealed to include cultural insensitivity, stigma and shame, and limited resources. Suggestions for improvements to mental health care are also discussed.

Keywords Immigrant · Mental health · Access to care · Cultural sensitivity · Stigma and shame

Introduction

Existing literature reveals a prevalent trend whereby newly landed immigrants' physical health status, which is usually higher than that of the native-born Canadian population, declines over time (Halli and Anchan 2005; Newbold 2005; Newbold and Danforth 2003). The degree to which this effect extends to mental health is a more recent topic of research, although studies suggest that immigrants' mental health also diminishes with time (Newbold 2009; Ali 2002; Lou and Beajot 2005;

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Wu and Schimmele 2005). According to Ali (2002), mental health problems are more prevalent among people experiencing more stress, as well as among economically and socially disadvantaged groups. Therefore, immigrants may experience mental health problems if they feel marginalized, encounter discrimination, or if they encounter stress associated with their immigration experience (Ali 2002). Ali (2002) also notes that previous research has found that immigrants experience elevated levels of depression, substance abuse and other psychiatric disorders in the period soon after immigration.

Stress and poor mental health, reflecting these difficulties, may ultimately impact on physical health (Newbold 2009). The study of Newbold (2009) based on analysis of Statistics Canada's Longitudinal Survey of Immigrants to Canada, reveals that although healthy at time of arrival and Wave 1 (at 6 months), rapid declines in self-assessed health, physical health, and mental health were noted amongst new arrivals in as little as 2 years after arrival. Thus, it is imperative that we understand why immigrants' mental health needs are not being met, and what barriers they face while accessing care in the hopes of learning how to make entry into the system smoother, and interactions with providers more sensitive to cultural variations.

In addition, previous research has largely examined the general immigrant population and/or has considered only the national scale, while neglecting local areas and communities where mental health services are located and/or respond to those with needs. In identifying the needs of newcomers in one Canadian city and local effects on accessibility, the researchers hope to provide a context in which policy changes can succeed. Therefore, this research aims to fill this gap in the literature by examining access to mental health care for immigrants in Hamilton, Ontario from the perspective of mental health care providers, in order to learn about how local conditions act as barriers to care for newcomers and their families.

The twin objectives of this paper are therefore to identify the barriers encountered by immigrants with mental health needs in Hamilton that hinder their ability to access mainstream mental health services, and to explore ways to make care more culturally sensitive in order to maximize the potential for and effectiveness of provider-patient contacts in Hamilton. Results enable greater understanding of the barriers to care that are experienced most often by newcomers in one Canadian city, but also suggest a number of recommendations to improve access to care. While the results are specific to the context of Hamilton, policy suggestions may also be useful for other Canadian cities as well as other developed countries that face similar access difficulties among their immigrant populations.

Review of the Literature

Determinants of Mental Health

Several studies have noted that immigrants, and particularly lower income, non-European immigrants, have poorer health status than the Canadian-born population (i.e. Dunn and Dyck 2000; Ng et al. 2005). While this linkage between physical health, as measured by self-assessed health status, chronic conditions, or disabilities, and immigrant status has been well-established in the literature, one's overall health,

as defined by the World Health Organization (1946) is "a state of complete physical, mental and social well-being and not merely the absence of disease of infirmity" (p.1). Therefore, it is necessary to consider mental health if we want to fully understand health within the immigration population.

To do so means exploring the various determinants of mental health (i.e. Evans and Stoddart 1990) including family and community support (or lack thereof), employment status, level of education and personal characteristics. For example, the work of Jarabek and DeMan (1994) reveals that limited education and low income may contribute to greater feelings of social distance, which suggests a possible psychosocial mechanism for the relationship between social status and health status.

The support an immigrant receives from his/her community is noted to be very important in maintaining good mental health (Hyman et al. 1996; Kawachi and Berkman 2001; Mclean et al. 2003; Noh and Avison 1996; Ornelas et al. 2009; Pumariega et al. 2005; Watters and Ingleby 2004; Wynaden et al. 2005). This can come in the form of both formal (i.e. government policy, service providers) and informal support, (i.e. community encouragement). Mclean et al. (2003), who examined African-Caribbean interactions with mental health services in the UK, revealed that informal support networks within the African-Caribbean community such as church groups, were a strength that could be built upon as stress-buffering support systems, a means of encouraging appropriate accessing of services, and advocacy and befriending services. Similarly, Ornelas et al. (2009), in a study of immigrant mothers from Mexico to North Carolina, found that those who reported more social support were found to be at lower risk for depression than those who reported less support.

The relationship between immigrants' social support and health status is further examined in Noh and Avison (1996) longitudinal study of Korean immigrants to Canada. They found that social and psychological resources, especially ethnic social support, tend to mitigate the effects of stressors and their outcomes as psychological distress. In addition to community support, family encouragement is also crucial in achieving good mental health. For example, refugee children separated from family members during the early years of resettlement experience increased mental health risks (Hyman et al. 1996). Furthermore, a study of Latin American refugee children in Toronto found that the presence of parents, positive coping by parents, and the availability of support from the Canadian and like-ethnic community each made important contributions to positive mental health (Hyman et al. 1996). Many of these studies have examined particular ethnic or cultural groups' immigration experience and their subsequent mental health status. While the results reveal significant policy implications in addressing the unique needs of these immigrant groups, it is difficult to say whether these findings can be extended to policy that confronts the mental health needs and barriers to care that all immigrants in a city experience.

Individual attributes of an immigrant and his/her personal experiences also contribute to mental health status in the new host country. For example, arriving as a refugee presents additional mental health risks, including, disorders associated with exposure and proximity to pre-migration and post-migration traumatizing events, poverty, education, subsequent unemployment, low self-esteem, and poor physical health (Pumariega, et al. 2005). Pumariega et al. (2005) study of refugees in the United States also revealed that older adults have the highest risk for mental health

problems resulting from migration. Lack of cultural flexibility, isolation from family members and the community, and health risk factors contribute to this increased risk (Pumariega et al. 2005).

Barriers to Service

According to a UK study by Mclean et al. (2003) discrimination in the workplace, such as less availability of employment-related opportunities, directly implicates the African-Caribbean community's relative economic disadvantage, which relates to the community's poorer mental health outcomes. Discrimination can also take its toll outside of the workplace. Ornelas et al. (2009) who studied the experiences of Mexican immigrant mothers in the United States and their barriers to maintaining emotional health, explain that women who had been discriminated against said it made them feel ashamed and embarrassed, especially when it occurred in front of their children or was related to their inability to speak English. Discrimination and prejudice are major stressors that come into effect even once the immigrant is better established and oriented to the mainstream culture (Pumariega et al. 2005). The same authors also claim that discrimination not only originates in the mainstream, but also often from other earlier-arriving immigrants, even from their nation or culture of origin, who feel the threat of displacement as far as job security and access to resources and opportunities. Ultimately, the relationship between perceived discrimination and depressive symptoms, as seen in Noh et al. (1999) study of Southeast Asian Refugees in Canada, is positive. Furthermore, the results of the study of Smith et al. (2007), which explored the interaction between immigration and low income status by gender, revealed that depression is more prevalent among women, non-recent immigrants and individuals with low income.

Barriers to mental health care can also occur due to the values and beliefs of the immigrant's family. Shame and stigma have been identified by Wynaden et al. (2005) as a major barrier to care in Australia. Immigrants with a mental illness, along with his/her family, may isolate themselves because they feel they would be labeled as different by their community and viewed negatively.

Another significant barrier to care is language difficulties. Halli and Anchan (2005) argue that language is one of the greatest deterrents to appropriate health care. They note that since many immigrants are not able to communicate in English, many are unaware of available services or how to use them. This may prevent them from consulting health care professionals in times of need (Halli and Anchan 2005). Furthermore, while young immigrants and refugees are able to learn the resettlement country's language and customs quickly, parents often resort to using their children as translators and cultural interpreters. These families may be at risk for role reversal, with resultant destabilization of normal lines of communication and authority (Hyman et al. 1996). In addition to language as a barrier, the culture of a patient and his or her physician's ability to provide treatment to someone of an unfamiliar ethnicity can also hamper access to care. Mclean et al. (2003) note a perceived failure on the part of mental health staff in the UK to understand the African-Caribbean community as a cultural entity, resulting in misdiagnosis and inappropriate treatment. Interviewees in this same study reported that the only difference acknowledged by service providers appeared to be skin colour, and that otherwise

the needs of African-Caribbean community members were viewed interchangeably with those of the white population (Mclean et al. 2003). Having minimal service options is another significant barrier to care that immigrants face regularly. Mclean et al. (2003) claim that there is a "centrality of whiteness" in institutions, and that there is significant stereotyping of black mental health service users as "mad, bad and dangerous" (p. 664). These service users often experience discrimination in the form of treatments offered, receiving only drug treatments and being excluded from non-drug therapies such as music therapy (Mclean et al. 2003).

Pre- and Post-Migration Stressors

Added stressors from the process of immigration itself can lead to increased risk for emotional disturbances in newer immigrants and refugees. Pumariega et al. (2005) reveal that a combination of traumatic exposures in homelands (war, torture, terrorism, famine and natural disasters), loss of extended family, and a traumatic journey to the host country can lead to an increased risk for emotional disturbance in newer immigrants. Furthermore, children often feel particularly vulnerable in these situations especially when their parents or guardians are themselves overwhelmed and unable to attend to their emotional needs (Pumariega et al. 2005).

Even once the journey is complete, immigrants and refugees experience post-migration stressors. Pumariega et al. (2005) show that refugees are often forced to inhabit over crowded inner-city homes where rent is low and crime is high. The cycle of poverty, coupled with limited education threatens to create declining financial opportunities, a process that immigrants may have difficulty avoiding (Pumariega et al. 2005). Hyman et al. (1996) reveal similar findings in their study of refugee children in Canada claiming that refugee children are highly likely to experience poverty, interracial conflict, parental psychological distress, family instability, youth unemployment, and intergenerational conflict, which are all mental health risk factors. Similarly, Beiser et al. (2002) study examining the relation between familial poverty and emotional and behavioural problems in immigrant children in Canada reveals that some immigrants stay poor. Further, like their poor non-immigrant counterparts, they become part of a chronically impoverished and psychosocially stressed underclass. Despite the stressors experienced by immigrant and refugee children, evidence suggests that children of recent immigrants have an observed resilience to mental health risk factors; however, this resiliency declines with time in Canada (Georgiades et al. 2007). In addition, Procter (2005) notes that the detention of detained asylum seekers in Scotland provides a re-traumatizing environment, which may contribute to their mental health problems. There are increased levels of psychological morbidity among refugee children in immigration detention facilities, especially post-traumatic stress disorder, depression and anxiety disorders. Potential risk factors for mental suffering in children include: observing parental distress, helplessness and suffering; separation from parents; being interviewed and re-interviewed by immigration officials; witnessing violence and harm; and the length of time required for determination of claims for asylum (Procter 2005).

Between now and 2031, the foreign-born population of Canada is projected to increase approximately four times faster than the rest of the population (Statistics

Canada 2010). Thus, understanding the mental health needs and barriers to care for newcomers is essential for ensuring the overall well-being of this population. The discussed literature, which has generally investigated particular immigrant groups at a national scale, has provided valuable insight for developing initiatives to minimize stressors and improve access to services for distinct cultures. This paper, however, aims to address the adversities experienced by immigrants in one city, highlighting how local characteristics act as barriers to mental health care for newcomers. In identifying and understanding the barriers that are unique to one city or community, policy and practice can be adjusted to better complement that city's distinctive cultural makeup.

Methods

In order to consider the barriers to mental health care amongst new immigrant arrivals, we conducted a case study in Hamilton, Ontario. Located approximately 60 km west of Toronto, 24.4% of Hamilton's population was foreign-born in 2006 (Ontario Immigration 2005), giving it the third highest proportion of immigrants of Canadian cities, trailing only behind Toronto and Vancouver (Statistics Canada 2007a,b). With a total immigrant population of 126,485 in 2006 (Statistics Canada 2007b), Hamilton welcomes a diverse population of newcomers each year. Between 2001 and 2006, 20,800 immigrants arrived in the city, one-half of them born in Asia and the Middle East, while 23% were from Europe (Statistics Canada 2008). Available services in Hamilton include primary care, settlement, employment, and community health centres.

Despite Hamilton's continuing role as immigrant destination, evidence suggests that the provision of services is not consistent with a clear and well-established immigrant reception system (Newbold et al. 2007). Thus, policy implications derived from this study may provide Hamilton, along with other Canadian cities also experiencing growing immigrant populations, insight into strategies for making mental health services more accessible and appropriate. In more effectively addressing these needs Canadian cities can hopefully decrease pressure on the health care system and capitalize on the many skills that immigrants bring with them.

In-depth, semi-structured interviews were conducted with nurses and nurse educators working at a local hospital, social service workers and community advocates employed at community health centres, and coordinators working for local community immigrant settlement services. Interviews were conducted in the City of Hamilton, Ontario from December 2009 to February 2010. While it was the intent to gain insights from the provider perspective, some participants were themselves immigrants. After ethics approval was granted, recruitment emails were sent to service providers identified through a combination of contacts and inquiry at different agencies throughout Hamilton, including telephone calls to relevant organizations, emails to providers whose contact information was available online, and via referrals from previous interviewees. A total of 14 recruitment emails were sent to providers throughout the city. The email identified the purpose of the study, sketched out the interview process, explained the guidelines of confidentiality,

explained the right to withdraw as a participant, and included the contact information of the researchers. Service providers were selected if they identified having knowledge of or experience with immigrants seeking mental health services in Hamilton. Six of the contacted service providers did not participate because they did not have time, felt their experience was not relevant to the study, or never responded to recruitment emails. These individuals ranged from community health centre staff and nurses to social service workers and advocates.

Due to a limited pool from which to draw participants knowledgeable in the experience of immigrants specifically seeking mental health services, interviews were limited to eight. These interviews, resulting in approximately 6 h of transcription were conducted using open-ended questions aimed at understanding the mental health needs of Hamilton's newcomers, as well as the barriers faced while accessing care. Preliminary questions functioned as a means to understand the participants' role and length of experience in providing assistance to Hamilton's immigrant population. Subsequent questions addressed client demographics, the mental health needs of immigrants in Hamilton, issues around interpretation, barriers to accessing care, challenges faced by the provider, and potential actions for improvement.

With the consent of all participants, interviews were recorded and then transcribed verbatim. Transcripts were then coded by category and results were compared to establish common themes (Gorden 1992). Both authors independently reviewed the data and accompanying emergent themes for relevance and significance. As an exploratory study, the research did not attempt to test existing theories (Cope 2005; Esterberg 2002). Instead, a grounded theory approach was used during the coding process to facilitate understanding (Strauss and Corbin 1998). Common themes were identified through the coding process and further discussed by the authors for relevance and significance. Respondents were offered anonymity and quotes are identified by coded number only to ensure confidentiality given the comparatively small pool of potential respondents in the city who are familiar with the mental health needs of immigrants.

Findings

The results of the interviews reveal three main barriers to care including a lack of cultural sensitivity on the part of providers, stigma and shame, and limited resources. The most common forms of mental health problems experienced by immigrants according to the providers include depression, anxiety and post-traumatic stress disorder.

Cultural Sensitivity

As described by many providers, a lack of culturally competent services is perceived to be a prime barrier for immigrants' access to care. This issue appears to be exacerbated when newcomers are seeking help for mental health problems in particular, as cultural variations make it difficult for providers to understand the causes and experiences of the illness, while immigrants may not define an illness as

a mental health problem (i.e. Cook 1994; Deinard and Dunnigan 1987). Limited cultural sensitivity may discourage newcomers' use of health services, can make mental health care provision less effective and may prevent immigrants from going back for further help (Magoon 2005). As one respondent revealed:

> I think this is the population that it is more at risk, because the mental health care system in Canada is not prepared, there is no cultural competence, to understand how people from other cultures, and other countries see mental health. And, and so when people go to a psychiatrist or a mental health worker in the community they end up going there once and never going back…(#101)

One reason why immigrants who have accessed the mental health system may not return for future care is due to providers'—as well as the Canadian population in general—lack of knowledge of what newcomers need to maintain or improve health. For instance, it is assumed that depression or post-traumatic stress associated with experiences in the homeland should be treated with medication or traditional psychiatric therapy. However, as one respondent notes, perhaps this is not the solution:

> But if we look at refugees, who have gone through torture, people in North America have a way of thinking that they should deal with this issue, when a refugee might only want to have a job, not to talk about what happened in the past…And here we think that, 'oh, if something that devastating happened to you, you have to go to a counselor and talk, and talk, and talk'. And yeah, for some people, yes. But for a lot of people, in my experience…people want something to do that is meaningful to them. To put the food on the table for people. So, it's more the practical that people need help with. (#101)

Therefore, because the causes of anxiety and depression may not always be clinical, but rather situational, the methods used to treat immigrant patients must be reflective of their needs. This task however, may be hindered due to the more implicit intolerant attitudes of providers. Observed elsewhere in the literature, this lack of knowledge and discriminatory attitudes on the part of providers can result in insensitive and inappropriate care (Reitmanova and Gustafson 2008). In fact, one respondent felt that the attitude of many Canadians is that an immigrant with mental health problems should return to his or her country of origin, and not be a financial burden on Canada's health care system. This respondent also stated that:

> I think that is the attitude of a lot of providers. I would say probably about 25% of providers would feel that way, and that would probably be a conservative estimate, because I think a lot of providers would not admit to that, but they would feel that. (#107)

This may further dissuade newcomers from accessing the few services available (i.e. hospitals, a community health centre, the Canadian Mental Health Association) in Hamilton, and magnify a fear of authority that many immigrants and refugees developed from experiences in their home country. For the providers who genuinely

wish to treat newcomers, their efforts are impeded by their lack of knowledge about their patient's or client's culture, an important fact given that some cultures or groups may not necessarily associate mental health with overall health (i.e. Anderson 1987). This however, as one provider notes, is difficult because this requires spending a lot of time with the patient to understand his or her story:

> Really, it is through trying to get to know the person…meeting the family, if the family is available. If the family is not there, then, you know, what do they think would be useful, and being open to try different things. You have to be open-minded. You can't think within your own understanding of mental illness, because it could be understood differently by different cultures. (#106)

A provider may not be familiar with his or her client's experiences in their home country, which can sometimes lead to a false diagnosis of a mental illness. Spiritual practices that may reflect a cultural norm of a particular patient may be misinterpreted as a mental health problem. Likewise, immigrants may not consider mental health issues as important (Anderson 1987). Misdiagnosis can lead to the application of superfluous treatment, while simultaneously neglecting other concerns such as "access to food, access to housing, basic needs…and connect[ion] to community resources" (#102). One respondent described a client who experienced such barriers while accessing mental health care in Hamilton.

> Now, I saw many cases when the provider tried, actually, because the client started to talk about, "I am hearing voices" and stuff like that, so the provider ultimately was thinking about schizophren[ia]. Now, the client is just actually coming from [a] group, where to talk like this, it is a normal thing; it is a spiritual thing (#105).

Another provider reported a similar experience, which reveals that knowledge about the history of the country from which a client originates is vital in understanding his or her experience. This provider had a client claiming to be followed all of the time. This particular client, who was persecuted in his home country, had immigrated to Hamilton at the same time as his persecutor, and thus maintained an immense sense of fear and anxiety upon arrival. This provider contends that many Canadian mental health professionals would have diagnosed this individual with a mental illness, without considering that his fears are a result of very real experiences, and therefore, perhaps, requires alternative forms of support rather than medication. Once again, understanding the history and context of the client is vital to his or her diagnosis and care.

Stigma and Shame

According to participants, there is a stigma associated with mental illness that makes the task of acquiring help, as well as accepting a diagnosis, a distressing experience for an individual. The stigma attached to mental illness is independent of one's status in Canada; however, a recent immigrant faces a double burden because of the stigma attached by the newcomer and his family, as well as by health care providers and the

Canadian-born population. For instance, some physicians will not take on a new patient if they are aware of a pre-existing mental health problem. Also, organizations aiming to aid in the settlement process may not be comfortable helping a client with mental health problems. As one respondent notes:

> …I think that there are a lot of community agencies who themselves are not comfortable with dealing with people who have a mental illness. So, they will help you with your finances, they will help you with [your] housing, but they don't know how to deal with you when you have a mental illness. (#107)

These often unpronounced yet apparent notions can directly impact immigrants' decision to seek care. One provider reveals that the stigma that accompanies mental illness prevents people from going to the hospital in a timely manner. Consequently, when the individual eventually does arrive, it takes much longer to treat him or her.

> …whereas if you would catch them when they are just starting to slide, as opposed to hitting rock bottom, their hospitalization could be shorter, and they could be back doing that thing that they need to be doing and want to be doing more quickly. (#107)

This has significant implications for newcomers' overall ease of settlement, as individuals who have treated, or at minimum can manage their mental health problems, can focus more on ensuring other basic needs, such as appropriate housing, acquiring healthy food, and finding employment for them and their family.

Immigrants may also be hesitant to obtain help because of the shame attached to mental illness as expressed by the family and community to which the ill individual belongs. Family members will often hide someone suffering from a mental health problem for fear that others will discover a relative's shameful condition.

> And we know that there is a stigma in Canada and all over the world when it comes to mental health issues, and sometimes people, even family members will protect the person with a mental health issue because they don't want their community to know. They are ashamed of it. And in some cultures, they see it as a curse or some see it as a…it's like they see it as a punishment from God for something that they may have done wrong. (#101)

Therefore, mental health problems may not be addressed promptly, or at all, potentially resulting in the worsening of the condition and a decreased ability to successfully integrate into Canadian society. Not only does this mean that those suffering from mental health problems are not accessing the mainstream services available in Hamilton, but there is likely little support received from the family.

Inadequate Resources for Services and Financial Barriers for Immigrants

Resources required for maintaining or improving newcomers' mental health is limited in that facilities that offer mental health services often receive inadequate funding. Moreover, newcomers to Hamilton (particularly refugees) often have little monetary capital, so time and energy is devoted to other tasks, as opposed to ensuring good mental health.

> A person who is of refugee status, although they do have workers who are assigned to them, there seems to be, like, a wave of refugees where you have, like, many, many, many coming through at one period of time. So, the case workers are overworked, so they aren't getting all of that information out to the individual…A person who is a refugee is probably stripped of any wealth that they would have had, so they have no money coming into the country. They don't understand necessarily, unless somebody tells them, that the services can be provided to them. (#107)

Limited funding and resources available for mental health services is also reflected in the long wait times required to see a provider. In fact, the wait to get into a Hamilton hospital for mental health services, according to one provider, is around 6 months. This respondent also reveals that this is particularly problematic for an immigrant who does not speak the language: "If someone is going through a trauma right now, that didn't speak English, there wouldn't be much I could do" (#102). Several respondents note that there are not enough mental health services even for the regular population, so newly landed immigrants suffer a double burden of having limited access, as well as the inability to advocate for themselves in order to achieve access.

> People who have, for example…what is a good cause? Breast cancer. Look at the fabulous marketing ploys they have now. And yes, it took them a number of years to really become front and centre, and the pink ribbon and everything, but gosh, now you even see football players, hockey players, wearing pink socks or whatever…to celebrate breast cancer awareness month. We don't have that with mental health, because it is still taboo. And who are the people who are advocating for the patient? It is the family, if they haven't been burnt out… (#107)

There appears to be a cyclical chain of events whereby the stigma attached to mental illness limits social and political discourse about barriers to care, thereby hampering the distribution of adequate funding for this department of care. This is exacerbated by the limited extent to which those suffering from mental illness can advocate for themselves. Coupled with poor English abilities and access to mental health care for Hamilton's immigrants is exceptionally difficult to achieve.

Conclusions

Using in-depth, face-to-face interviews with mental health care providers in Hamilton, this study has examined how local conditions affect immigrant access to mental health care in the hopes of learning how to make entry into the system smoother, and interactions with providers more sensitive to cultural variations.

Much of the previous work on immigrants' mental health needs and access to services has used large-scale population data, such as the Canadian Community Health Survey (Halli and Anchan 2005). Despite the statistical significance and generalizable results these sources yield, the qualitative interviews used in this study have produced results pertaining to the complexities of the individual experience, a

dimension that Halli and Anchan (2005) acknowledged their study lacks. Previous research has also generally been conducted at a national scale, with little specification as to how certain cities or locales create differing experiences for immigrants. This study has identified some of the mental health needs, as well as issues of accessibility for newcomers in Hamilton, revealing how local characteristics implicate barriers to care. Hopefully, this research, coupled with established quantitative research will provide a more nuanced framework on which policy change can be based.

Results reveal three main barriers to mental health care for immigrants including a lack of cultural competence on the part of providers, stigma and shame, and inadequate resources for services and immigrants. Provision of care is not culturally sensitive on account of a lack of understanding of immigrants' needs, provider racism, and a lack of knowledge on clients' culture and experiences in their home country. Furthermore, the shame and stigma associated with mental health as identified by both professionals and immigrant communities' limits service use. Finally, limited resources in the form of funding for facilities as well as limited income obstruct successful access to care. Importantly, however, these are not exclusive themes. Shame and stigma are closely related to culturally competent care, for example, in that providers are required to be aware of different cultural interpretations of mental health. Conversely, limited funding and resources often means that visits to a provider for care are all too short, with the provider unable to probe clients deeply, rendering images of perfunctory, non-culturally appropriate care.

There are a number of potential changes to the system that may improve access to care. First, increased funding for mental health care and greater awareness of service opportunities are vital. As recommended in Immigrant Mental Health Policy Brief by Khanlou (2009), this could include support for intersectoral approaches to promoting migrant well-being across systems through developing, enhancing, and coordinating partnerships between sectors; support for community-based mental health services; and support for policies that remove barriers to economic and social integration of newcomers.

Second, cultural competency training though education of providers is also crucial. Education regarding the customs and ideologies of other cultures pertaining to mental illness, as well as training related to ensuring sensitive interactions with immigrant clients is necessary to improve accessibility. This is consistent with the work of Wynaden et al. (2005) who argue that it is imperative that service providers and professionals receive training in common cultural manifestations of mental illness in the particular immigrant population for which they care. Watters and Ingleby (2004) argue that key service providers in Europe, including those acting as gatekeepers, should receive training modules to develop their skills and awareness in dealing appropriately with refugees with mental health problems. Another approach may be to create, or perhaps mandate opportunities for providers to immerse themselves in different cultural or ethnic communities. One respondent argues that a provider would only learn so much from theoretical training and education and that true competence can only be learned from practical experience.

Furthermore, the necessity for providers to engage in more experiential learning of the cultures for which they provide care is necessary; however, this should take

place during a period of wellness, not a period of illness. "[Providers] need to be more proactive…as opposed to reactive" (#107). Cultural competence training, as well as immersion in ethnic or cultural communities should also be more intensive during medical school, according to several providers. It was suggested that universities educating doctors and psychiatrists incorporate more practical experience into their curriculum. Medical students should be required to undergo a placement in another country, where they can learn not only about the way other cultures regard mental illness, but also gain somewhat of an understanding of the challenges associated with being new to a country.

Third, improved language and interpretation to facilitate discussion between patients and providers can improve the quality of care. Concurrently, the hiring of mental health providers could be geared towards those who speak a different language or are immigrants themselves so that newcomers can be matched to a doctor who can effectively communicate with them. This is consistent with the results of research by Halli and Anchan (2005), Ornelas et al. (2009) and Hyman et al. (1996) whose works suggest that language is one of the greatest deterrents to appropriate health care. More broadly, the report from the Mental Health Commission of Canada (2009) recommends greater involvement of immigrant, refugee, ethno-cultural and racialized groups in the planning, decision-making, implementation, and evaluation of provincial and regional plans. To achieve this, health funders should require that service providers take steps to attract a more diverse workforce and that there is a monitoring of the workforce to assess how it reflects the communities being served (Mental Health Commission of Canada 2009).

While specific results are largely place and context specific, there are implications for other areas, at both the local and international scale. Other immigrant receiving countries or regions, including the United States, Europe, Australia and New Zealand are also grappling with the mental health needs of new immigrant and refugee arrivals. Calls for such things as culturally competent care (Pumariega et al. 2005), recognition of language needs (Ornelas et al. 2009), and knowledge of the system (Mclean et al. 2003) have been flagged elsewhere in the literature, with the results of the current paper of potential interest elsewhere. Consequently, future research should involve interviewing immigrants at the local level to gain a more direct perspective on barriers to mental health care, particularly for those who have not yet obtained service. In addition, qualitative research that utilizes the knowledge of leaders of ethnic communities is also necessary, as participants note that community leaders play a vital role as gatekeepers to local resources and services for new immigrants. Future research could also explore other communities to see if results are consistent, as well as exploring the efficacy of promising practices in how to overcome mental health barriers.

Finally, it is important to note the limitations of the current study. Although the authors did not intend to create a representative sample, the limited number of participants provides a rich understanding of this phenomenon in Hamilton. Furthermore, the researchers are not foreign-born and thus do not, and never can, fully appreciate the experiences of immigrants in any context. In addition, the results of this study were acquired based on the perspective of providers, so the findings and conclusions made are limited to this position and are not generalizable. Finally,

participants in this study are likely only exposed to those immigrants who have sought care and thus the findings reveal the barriers faced by newcomers who have in fact gained access to services. Still, the results reveal important dimensions and barriers to mental health care within this vulnerable population.

Acknowledgments This research was funded by a grant from the Canadian Institutes of Health Research (CIHR) No. 86517.

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