Taking action on health equity and diversity: Responding to the mental health needs of children, youth and families new to Canada

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Executive summary

This policy paper is intended to help policy leaders and decision-makers better understand and respond to the mental health needs of newcomer children, youth and families in their local communities. It brings together the latest evidence from research as well as the experiences of service providers and service users.

This paper is guided by several key research questions:

• What are the mental health needs of children, youth and families from newcomer communities?
• How do newcomer families currently experience the child and youth mental health system?
• What are the barriers or gaps in addressing the needs of newcomer children, youth and families?
• What current models are working well abroad, in Canada and in Ontario to meet the needs of newcomer children, youth and families? What are existing strengths in Ontario? What can we build on?

Nationally and internationally, organizations, communities, health authorities and governments are recognizing the importance of diversity, equity and inclusion in health care, specifically in mental health care. Regardless of a person’s identity or social, economic or cultural position, access to quality mental health care that is inclusive and free from discrimination is a fundamental human right (United Nations, 2006). The WHO Commission on the Social Determinants of Health (2008) recommends that national and local governments take action to close the gaps in health (and mental health) equity in three main ways:

• improve daily life conditions
• address the inequitable distribution of power, money and resources
• measure and understand the problem, and assess the impact of action

Using the social determinants of health lens, we can point to a number of risk and protective factors that can affect the mental health of newcomer children, youth and families. Risk factors may increase the probability of developing a mental illness, while protective factors are resources and strengths that can decrease the chances of developing mental health challenges. While there is no direct cause-and-effect relationship between these variables, there are correlations between specific factors and mental health outcomes. It is critical then, to assess risk and protective factors for newcomer children and youth at individual, family and community/environmental levels, especially given their high rates of poverty and challenges with adjustment during the settlement process (Pottie et al., 2015).

Research suggests that despite their increased risk for experiencing mental health difficulties, newcomers to Canada are less likely to access and use mental health services across the life span when compared to the Canadian-born population (Fenta, Hyman, Noh, 2006; Hyman, 2001; Measham et al., 2001). Newcomer youth do so with even less frequency (Ellis, Miller, Baldwin & Abdi, 2011; Kilbride et al., 2000). In the broader newcomer population, a lack of understanding and information about services, unclear pathways to care, cultural mistrust, communication challenges and economic constraints can prevent newcomer families from getting the mental health supports they need (Beiser, 2005). For youth, these challenges are exacerbated by the stigma of mental health services, different views of mental health and wellness between mainstream and ethno-cultural communities, agreement about what constitutes appropriate support.
(e.g. religious organizations or extended kinship networks over support from a mental health organization), logistical barriers (e.g. distance from services or cost of transportation), a general distrust in mental health systems and the lack of flexibility in services to address their unique preferences and needs (Ellis et al., 2011; Khanlou, Shakya & Gonsalves, 2011; Kilbride et al., 2000; Shakya et al., 2010).

The Ontario Federation of Community Mental Health and Addictions Programs, now Addictions and Mental Health Ontario (2009) identified several challenges that mental health agencies confront when working to tailor services to meet the needs of their diverse communities. At the service provider level, there is often a lack of relevant skills, knowledge and confidence to support newcomer youth. Further, organizations struggle to conceptualize and implement an overall approach to service delivery in a consistent manner (e.g. incorporating diversity into agency mission statements, diversifying their staff complement and gaining general buy-in to prioritize diversity as a core organizational value).

Through the Moving on Mental Health (MOMH) initiative, the Ministry of Children and Youth Services (MCYS) has made a commitment to support the unique needs of all children, youth and families in Ontario. Newcomer children, youth and families are an integral part of our communities and supporting their mental health is critical. The following is a set of actionable recommendations to enhance supports for Ontario’s newcomer children, youth and families.

Recommendation 1: Consider the impact of social determinants on the mental health of newcomer children, youth and families.
- Develop coordinated responses to service delivery gaps across sectors (e.g. health, employment, education, etc.) that consider the unique social and contextual circumstances of newcomer children, youth and families.
- Target mental health programming to newcomer children as early as possible to prevent the onset of mental health challenges.
- Create clear pathways and access to services for refugee children, youth and families that recognize the complexity of the pre- and post-migration risk factors and protective factors and offer strengths-based care.
- Create appropriate interventions and enable access to supports for LGBTQ+ newcomers as they face multiple forms of marginalization that increase their risk for mental health challenges.
- Consider the structural barriers to mental health care for newcomer children and youth with special needs across ministries to ensure systems of care effectively respond to their needs throughout the resettlement process.
- Conduct needs assessments and collect local data related to the diversity of communities and the experiences of newcomers. This data can be used to increase awareness of cultural diversity, population’s needs and strengths and provide a rationale for a flexible set of services that are adapted to diverse cultural, religious, ethnic and linguistic experiences.
Recommendation 2: Address barriers to care and deliver culturally-responsive and culturally-specific mental health services that are tailored to the needs of newcomer families.

- Consider and respond to the barriers that can prevent newcomer families from getting the mental health supports they need, including but not limited to: lack of information about services, unclear pathways to care, cultural mistrust, communication challenges, economic constraints, etc.
- Use a holistic approach to the mental health care of newcomer youth by adopting a social determinants lens, and understanding the cultural belief systems and social/contextual circumstances of newcomer families.
- Engage newcomer communities and develop targeted initiatives to increase mental health awareness, reduce stigma and reach out to specific ethno-cultural communities to promote mental wellness.

Recommendation 3: Identify and adopt specific approaches, standards, tools and priorities for child and youth mental health agencies that will guide service delivery for newcomer youth and ensure they are tailored to each community’s unique needs and context.

Recommendation 4: Ensure the processes involved in service delivery are structured to produce meaningful and relevant supports tailored to the specific needs of newcomer children, youth and families.

- Offer a range of options in mental health care that include both mainstream and traditional supports.
- Foster connections with ethnic communities and incorporate diverse cultural, spiritual and religious beliefs/practices in care.
- Reduce isolation and minimize barriers to care for newcomer children, youth and families.
- Help newcomer families navigate and understand the mental health system and identify available resources that can minimize the migration-related stressors.
- Increase trauma awareness and deliver strength-based interventions to newcomer families accessing mental health support.

Recommendation 5: Use principles of mental health promotion and a strengths-based approach to support newcomer child and youth mental health.

- Engage newcomer communities as partners in decision-making to collaboratively develop organizational and system level policy and determine local priorities.
- Use a whole-community approach to promote resilience. Consider school-based mental health promotion and prevention as an effective way to reach newcomer children, youth and families.
- Identify newcomers’ first points of access in times of need and the barriers they face when accessing mental health care. Collaborate with primary care providers to develop clear pathways to care to culturally responsive mental health services.
- Collect information on the linguistic make-up of children, youth and families accessing services and offer trained cultural interpreters and/or cultural brokers to facilitate mental health service delivery for newcomer families.
- Promote the integration of a diversity of value and belief systems, linguistic competencies and social and contextual realities into mental health systems as reflected in funding, policies, partnerships and hiring practices.
Introduction

The Ontario child and youth mental health sector is changing. The goal is a system where all children, youth and families can access the right services, where and when they need them most.

Within this transitioned system, lead agencies will be responsible for planning and ensuring the quality of child and youth mental health services in their service area. The Ministry of Children and Youth Services (MCYS) will provide funding and oversee the work of lead agencies, and service agencies will receive funding from and be accountable to lead agencies. As a result of these changes, children, youth and families can expect a core set of mental health services (core services) are available in every community. They can also expect a clear and direct path to accessing mental health services.

MCYS along with the ministries of Education, Health and Long-Term Care, as well as Training, Colleges and Universities are working together to improve access to care, service coordination and integration. Within this context, there is an opportunity for policy- and decision-makers across ministries and sectors to consider the unique mental health and support needs of a number of ethno-culturally diverse populations within their communities. This paper is intended to help this group better understand and respond to the mental health needs of newcomer children, youth and families in their local communities.

Guiding questions

While the content of this paper is relevant to a number of stakeholder groups (e.g. families, youth, community partners), the primary audiences for this paper are policy makers from various government ministries as well as organizational decision-makers within child and youth mental health agencies in Ontario. Our guiding questions for this work are:

- What are the mental health needs of children, youth and families from newcomer communities?
- How do newcomer families currently experience the child and youth mental health system?
- What are the barriers or gaps in addressing the needs of newcomer children, youth and families?
- What current models are working well abroad, in Canada and in Ontario to meet the needs of newcomer children, youth and families? What are existing strengths in Ontario? What can we build on?

Defining newcomer

There is no single definition of newcomer that can capture the range of experiences and contexts of children, youth and families who migrate to Canada. Statistics Canada (2006) defines recent immigrants or newcomers as permanent residents who have arrived in Canada within the last five years. In some cases, the number of years in Canada is extended to up to 10 years to ensure eligibility for services, such as within the Federal Internship for Newcomers Program offered through Citizenship and Immigration Canada (CIC).

1 Refer to the Glossary of terms (Appendix 1) for a range of definitions such as “immigrants”, “refugees”, “refugee claimants”, “precarious status”, “second generation” etc.
In this policy paper, we use the term newcomer to reflect the broad range of immigration categories to which new Canadians are assigned (immigrants, refugees, refugee claimants and precarious status). We do this acknowledging that diverse terminology exists.

**Methodology**

This paper was co-developed by a policy paper advisory committee (PPAC) with a range of personal and professional interests and experiences within a newcomer context in child and youth mental health. This group was convened by staff from the Ontario Centre of Excellence for Child and Youth Mental Health (the Centre). It included two youth, a family member, several Centre staff with relevant content knowledge, as well as interdisciplinary professionals with subject matter expertise on this topic. The PPAC collaboratively guided the Centre to identify a clear focus for the paper, offered their knowledge of potential leading models or best practice examples in Ontario and beyond. They reviewed the themes, outlines and drafts of this paper and supported the Centre in refining and validating policy recommendations.

To inform the development of this paper, we held targeted consultations with a diverse range of service providers, researchers, experts and policy-makers across sectors (including education and health care). Centre authors, reviewed and assembled relevant research and grey literature, policy documents and models addressing newcomer child and youth mental health. We also used this information to develop a draft set of policy recommendations grounded in current knowledge in this area. Findings and recommendations were reviewed by PPAC members and their comments helped guide refinements towards the final version. While input was sought from PPAC and others who were directly engaged in the development of the policy paper, widespread consultation did not occur beyond the environmental scan.

**Purpose**

Taking action on health equity and diversity

Nationally and internationally, organizations, communities, health authorities and governments are recognizing the importance of diversity, equity and inclusion in health care, specifically in mental health care. Regardless of a person’s identity or social, economic or cultural position, access to quality mental health care that is inclusive and free from discrimination is a fundamental human right (United Nations, 2006). The WHO Commission on the Social Determinants of Health (2008) recommends that national and local governments take action to close the gaps in health (and mental health) equity in three main ways:

- improve daily life conditions
- address the inequitable distribution of power, money and resources
- measure and understand the problem, and assess the impact of action
A health equity lens recognizes the growing evidence that people belonging to certain groups experience inequities in their health status, access to services and quality of care due to marginalization and oppression (The WHO Commission on Social Determinants of Health, 2008). Extending this view to a mental health context, the Centre for Addiction and Mental Health (CAMH, 2012) defines health equity as “creating equal opportunities for good health for all and reducing avoidable and unjust differences in health among population groups.” We adopt this lens throughout our paper to ground the literature and related policy recommendations. Our work has been guided by several assumptions that should be used to contextualize the findings and recommendations found in this document:

1. **Social and health inequities influence individual mental health outcomes**
   A social determinant of health framework links the wide health inequities experienced by certain groups of individuals in Canada as directly related to the conditions in which people live (Mikkonen & Raphael, 2010). Experiences of marginalization based on age, gender, status, ethnicity, race, sexual orientation and so on, are not individual problems, but rather rooted in inequities in society. These can result in poor mental health outcomes.

2. **Newcomer groups are diverse**
   Throughout the literature, migration experiences are presented as similar within defined categories or groups, such as refugees or immigrants or particular ethno-cultural groups. There are however, important differences both within and between groups that can impact health and influence mental health outcomes. Given the diversity of experiences, we highlight relevant risk and protective factors at a general level to increase awareness and responsiveness to the needs of newcomer children, youth and families. We do caution however, that individual and group differences must be taken into account when applying this information in practice.

3. **Culture is dynamic and multidimensional**
   Systems of mental health care can create barriers for members of newcomer communities by viewing culture as static and unidimensional (Williams, 2010). Approaches to mental health care that fail to acknowledge how a person’s cultural practices and experiences evolve over time and across different contexts are limited in their effectiveness, and can perpetuate stereotypes and biases within an organization (Sundar et al., 2012).

4. **Newcomer families experience a number of barriers to accessing mental health support**
   A number of factors can keep newcomer children, youth and families from reaching out for mental health supports in the first place. These factors include, but are not limited to, the stigma of mental health and mental illness (e.g. using terms such as *crazy* or *sick* to describe mental illness) and different conceptualizations of mental health and wellness across newcomer communities when compared to those who use mainstream mental health services. It is critical to ensure that the diverse voices of newcomer families are meaningfully engaged in the development and implementation of agency, community and provincial priorities focused on re-shaping services to meet unique needs and strengths of these groups.
5. Access to and experiences with mental health and health systems are linked to identity
People identify themselves in a number of ways simultaneously which can provide them with advantages in certain situations and present as barriers in others. A person’s access to and experience with appropriate and quality mental health care is influenced by an intersection between their identities (e.g. gender, race, ethnicity, sexual orientation, income and education, etc. (Mikkonen & Raphael, 2010). For example, someone who identifies as male, homosexual, with mental health challenges and who has recently arrived in Canada can face barriers to accessing mental health care resulting from language issues, fear of racism/discrimination and a lack of available services for lesbian, gay, bisexual, transgender or queer (LGBTQ+) newcomers. In this case, any advantage that comes from being male (traditionally the most powerful gender group) is likely offset by the lack of facility with the dominant language, stigma as it relates to diverse gender group, etc. The notion of intersectionality allows for a more inclusive view of identity, which can capture the complex ways newcomers identify and provide entry points for improving the quality of care and service that they receive.

Newcomer children, youth and families in Canada and Ontario

<table>
<thead>
<tr>
<th>Highlights</th>
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<tbody>
<tr>
<td>• The newcomer population is diverse and changing from year to year.</td>
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<tr>
<td>• Most people new to Canada come from parts of Asia. This is a shift from predominantly European countries of origin from the 1970s and earlier.</td>
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<tr>
<td>• About 20% of permanent resident newcomers to Canada are children when they arrive.</td>
</tr>
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<td>• Children and youth identify as either: first generation (they are immigrants), second generation (their parents were newcomers) and third generation immigrants/refugees.</td>
</tr>
<tr>
<td>• Ontario receives the greatest number of newcomer families with almost 30% being foreign-born.</td>
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<tr>
<td>• Approximately 75% of Toronto’s population consists of people who are foreign-born or have at least one parent in the family born outside Canada.</td>
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Canada has one of the highest immigration rates in world with approximately 250,000 people arriving here each year (Statistics Canada, 2011). Statistics Canada (2011) estimates that about one in five people in Canada is foreign-born and that newcomer populations are generally younger (at an average of 31.7 years of age) when compared with their Canadian-born counterparts (at 37.3 years of age). About 20% of permanent resident newcomers are younger than age 15, similar to the overall child population (Statistics Canada, 2011). In 2013, more than 48,000 newcomer youth from 0 to 14 years of age and 30,000 from 15 to 24 years of age became permanent residents (CIC, 2014).

Newcomers to Canada are grouped into three main categories: economic class immigrants, family class immigrants and refugees (CIC, Glossary). Economic class immigrants are selected for their skills and ability to contribute to Canada’s economy (this designation applies to both adult applicants and the children accompanying them). Family class typically includes those sponsored to come to Canada by relatives who are Canadian citizens or permanent residents. Refugee is
a broad term that covers a number of statuses someone may hold while abroad or resettling in Canada (e.g. refugee claimant, precarious status, government-assisted refugees). Canada’s definition of refugee refers to someone who is outside of their home country and cannot return due to a well-founded fear of persecution based on race, religion, political opinion, nationality or membership in a particular social group. In 2012, 66% of children and youth ages 0 to 24 who were permanent residents were economic class immigrants, 18% were family class, 13% were refugees and 3% were in the category of other immigrants (CIC, 2012). Kids New to Canada (developed by the Canadian Pediatric Society) provides an overview of demographic information related to immigrant and refugee children and youth in Canada.

Children and youth new to Canada represent more than 200 ethno-cultural groups (Statistics Canada, 2011). Most newcomer youth who are permanent residents arrive to Canada from Asian countries, as shown in the table below. In 2013, the number of refugee claimants arriving in Canada dropped to almost half from 20,469 to 10,350 however their countries of origin remain very diverse with most refugee claimants arriving from the People’s Republic China, Pakistan, Colombia and Syria (CIC, 2014).

Table 1: Newcomer youth (ages 0-14 and 15-24) who arrived to Canada as permanent residents in 2013 by country of origin (CIC, 2014)

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>0-14 years</th>
<th>15-24 years</th>
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<tbody>
<tr>
<td>Asia and Pacific (not including the Middle East)</td>
<td>46.6%</td>
<td>49.6%</td>
</tr>
<tr>
<td>Africa and the Middle East</td>
<td>29.4%</td>
<td>25.7%</td>
</tr>
<tr>
<td>South and Central America</td>
<td>9.2%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Europe and United Kingdom</td>
<td>9.5%</td>
<td>9.2%</td>
</tr>
<tr>
<td>United States</td>
<td>5.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Source area not stated</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Ontario receives more new arrivals per year than any other province with over 100,000 newcomers welcomed in 2013 (40% of Canada’s newcomers) (CIC, 2014). Newcomers are attracted to the central location of Ontario and the diverse economy that provides opportunities in a number of industries (Government of Ontario, 2009). In general, almost 30% of Ontario’s population is foreign-born (Statistics Canada, 2013). In 2011, the three most common countries of origin among foreign-born populations living in Ontario were India (8.6%), United Kingdom (8.1%) and China (7.4%) (Statistics Canada, 2013). The primary language of new arrivals to Ontario is diverse. In 2013, 37% of permanent residents arriving to Ontario did not speak either French or English, Canada’s two official languages. In 2011, the three most common non-official languages in Ontario were Cantonese (3.9%), Chinese (3.4%) and Punjabi (3.2%).

A high percentage of newcomer families and second generation immigrants reside in large metropolitan areas. In 2011, 75.8% of Toronto’s population consisted of people who were foreign-born or who had at least one parent who was born outside Canada. Toronto has the largest proportion of second generation youth of all 33 census metropolitan areas, with this group accounting for 28.0% of Toronto’s population in 2011. Within Toronto, the municipality of Vaughan has the
highest proportion of second generation immigrants (35.4%), only slightly higher than Mississauga (27%) and Brampton (31.3%).

**Mental health needs of newcomer families**

**A scan of the literature**

To situate the recommendations we offer later on, this section summarizes relevant literature focusing on the mental health needs of newcomer families. Some studies attempt to understand the lives of all children and youth, with a secondary focus on the newcomer experience, while others take a deliberate, focused look at the experiences, strengths and needs of newcomer children and youth in particular. There are two national databases primarily used to examine the health, mental health and development of newcomer children and youth specifically: The National Longitudinal Survey of Children and Youth (NLSCY) and the New Canadian Child and Youth Study (NCCYS). While the NLSCY is a longitudinal study that looks at a national sample of 23,000 children and youth, it has been critiqued on the basis that particular factors rooted specifically in the migration experience for immigrant and refugee children are ignored (Beiser, Armstrong, Ogilvie, Oxman-Martinez & Rummens, 2005). Despite this limitation, the NLSCY offers opportunities for comparisons across population groups. For example, Beiser and colleagues (2002) have used this data to examine the link between mental health and poverty among foreign born, second generation and Canadian-born youth.

Given the limits of the NLSCY, four Metropolis centers launched the New Canadian Child and Youth Study (NCCYS) in 2001 to help address the lack of representation of immigrant and refugee children and youth in the NLSCY and the general research gap on the mental health and development of newcomer children, youth and families (Beiser, et al. 2005). The NCCYS is a longitudinal study of a nationally representative sample of approximately 4,000 newcomer children and youth between the ages of 4-6 and 11-13 from 16 ethno-cultural communities across Canada. The database is used to understand the specific challenges immigrant and refugee children face, how these affect their physical and mental health and how policy and practice can better support them toward healthy development.

A recent study used this database to look at the influence of an inclusive school environment, social/psychological isolation and perceived discrimination by peers and teachers on the psychosocial and academic adjustment of 515 children between 11-13 years of age from three different ethnic groups (Oxman & Choi, 2014). They found that all of these factors have significant negative effects on the abilities of newcomer children to positively adjust to their new environments, regardless of socio-demographic background. Findings such as these provide valuable information that can be used to develop policies and programs that build positive support systems around newcomer children and youth (Oxman & Choi, 2014). A list of publications and projects can be found on their website.

Despite recent progress towards understanding the mental health needs of newcomer families, the Canadian literature on rates of mental illness in newcomers across the range of ethnicities, cultures and racial groups is not comprehensive, and is even less rigorous for children and youth (Hansson, Tuck, Lurie & McKenzie., 2012). Most reports of mental health problems in newcomers come from three provinces, and more specifically from three major cities (Vancouver, Toronto...
and Montréal). This is problematic given that a considerable number of newcomers live in rural communities (Hansson et al., 2012). This body of work is also plagued by methodological limitations, including the lack of acknowledgement of within and between group differences (e.g. many studies focus on mental illness in the overarching origin group (Asian or African) rather than subgroups within these very broad categories) (Hansson et al, 2012), and the use of tools that are not validated cross-culturally. These limitations result in a skewed perception of both the causes and consequences of mental illness in newcomer groups.

While most studies rarely report on social and contextual risk factors (e.g. low income neighbourhoods, lack of access to healthcare), there are a few notable exceptions. For example, Beiser et al. (2010) have looked at how factors affecting mental health outcomes of the general youth population (age, gender, family and neighbourhood characteristics) compare with the influence of migration-specific factors (ethnic background, acculturative stress, prejudice and the region of resettlement within Canada) on mental health outcomes of newcomer children from Mainland China, the Philippines and Hong Kong. Their findings overall show that very similar factors influence the mental health of newcomer children compared to children in general however, certain factors such as low income can impact newcomer children in different ways. Newcomer children had lower distress due to poverty. The authors suggest this may be attributed to less family dysfunction and fewer single parent families among newcomer families in poverty compared to Canadian-born families. The study also shows that migration-specific factors can lead to significantly different mental health outcomes across newcomer groups. In particular, settling in Toronto was associated with the greatest mental health risk, highlighting the importance of region of resettlement. As well, children from Mainland China had lower risk of developing problems compared to those from the Philippines and Hong Kong, possibly associated with different migration stressors among ethnic groups. Clearly, the influence of migration-specific factors on mental health compounds risk factors that are known to affect children in general.

Other studies have investigated the influence of immigration status and the amount of time since migration on mental health outcomes, finding that these differ between newcomers and Canadian-born youth, vary from childhood to adolescence and change depending on length of time in Canada. (i.e. emotional or behavioural) (Adlaf, Hamilton & Noh, 2009; Alati, Najman, Shuttlewood, Williams & Bor, 2003; Beiser et al., 2010; Georgiades, Boyle & Duku, 2007; Rousseau, Hassan, Measham & Lashley, 2008). In particular, children born outside of Canada exhibit fewer behavioural and emotional problems compared to their Canadian-born peers (Georgiades et al., 2007). During adolescence, foreign-born youth report more psychological distress but still show lower levels of behavioural problems (such as substance use) than their Canadian-born peers (Adlaf et al., 2009; Rousseau et al., 2008). However, studies also show that problem substance use and delinquency patterns increase in frequency among second and third generations (Adlaf et al., 2009; Georgiades et al., 2007). These findings point to the importance of considering the environmental context pre- and post-migration, since this can have impact mental health.

There is a growing body of Canadian research that has looked specifically at diagnoses of mental health issues among newcomer children and youth. Data from the 2011-2012 Canadian Community Health Survey (CCHS) show that almost 11% of newcomer youth between the ages of 15 and 24 have been diagnosed with a mood disorder (Pottie et al., 2015). Recent analyses of mental health outcome data from across Ontario have found that immigrant and refugee children
and youth have similar issues with mood as the general youth population but tend to have lower rates of substance use issues and delinquency, similar to the findings described above (Institute for Clinical and Evaluate Services [ICES], 2015). As a sub-group, refugees appear to experience more diagnoses of schizophrenia, with the prevalence greatly increasing among those living in the lowest-income neighbourhoods (ICES, 2015). Higher rates of post-traumatic stress disorder (PTSD), depression and anxiety have been found among refugee children in Canada (Crowley, 2009) and internationally (Bronstein & Montgomery, 2011; Fazel, Wheeler & Danesh, 2005). In Quebec, higher rates of major depression and dysthymia were found among refugee youth in Quebec, higher rates of suicide attempts among refugee girls compared to youth born in Quebec, and higher rates of diagnosed conduct disorder across refugee youth when compared to the general youth population (Rousseau et al., 2008; Tousignant et al., 1999).

In trying to understand findings like those described above, researchers generally draw on one of three typical explanations:

- The morbidity-mortality hypothesis which suggests that newcomers have worse health than the general population (Hyman, 2004; Alati et al., 2003). This means that regardless of their health status prior to migration, one can expect that when compared to their mainstream counterparts, newcomers are generally less healthy.
- The healthy immigration effect or immigration paradox theorizes that newcomers have better health than the general population (Hyman, 2004; Hyman, 2007; Flores & Brotanek, 2005).
- The transitional effect states that their positive health upon arrival declines the longer they live in the host country and their health begin to mirror that of Canadian-born individuals (Alati et al., 2003; Hyman, 2007).

Recent reviews of the literature describing the health and mental health trajectory for newcomer families show growing support for the healthy immigration effect however, our understanding of how this plays out specifically in children and youth is unclear (i.e. why this effect occurs, whether the health advantage persists over time and what the differences are between groups) (Hyman, 2007; Pottie et al., 2015). A number of studies are showing that this health advantage may decline over time (Hyman, 2007; Pottie et al., 2015), possibly due to inadequate policies and services to support the health of immigrants during settlement, their higher rates of unemployment, poverty and barriers in access to care (e.g. language barriers) and exposure over time to similar stressors (Beiser, 2005). Research also shows that refugees in particular tend to be less likely to have the same measure of good health when arriving to Canada since they often experience poorer living conditions, limited access to health care and challenges meeting basic needs both before and after migration (Pottie et al., 2015). Clearly, this area requires deeper study with attention to both between and within group differences/similarities (Khanlou, 2009), as well as the different factors that place newcomer children and youth at risk for developing mental health challenges (Beiser, 2005).

**Newcomer families and the social determinants of health**

A social determinants of health framework focuses on how people’s living conditions can impact their health (Mikkonen & Raphael, 2010). The social determinants of health are the key social, environmental, political and economic factors that shape health, such as barriers to affordable education, poor quality of housing or exposure to community violence (Khanlou, 2003). This lens is useful for understanding the wide health and mental health inequities that exist among
Canadians given that certain groups of individuals (including newcomers) face marginalization and oppression in various spheres (Khanlou, 2003; Mikkonen & Raphael, 2010). For example, research shows that a lack of access to employment, language and communication barriers, stress related to migration and settlement and discrimination/exclusion are some of the greatest factors that impact on mental health for newcomer children, youth and families in Canada (see Hansson et al., 2010; Shakya, Khanlou & Gonsalves, 2010). The Mental Health Commission of Canada (MHCC) argues that among the 12 social determinants of health produced by the Public Health Agency of Canada (PHAC) applicable to the general population), seven are particularly relevant to immigrant and refugee groups (Hansson et al., 2010):

- income and social status
- social support networks
- education and literacy
- employment/ working conditions
- social environments
- physical environments
- healthy child development

Using the social determinants of health lens, we can point to a number of risk and protective factors that can affect the mental health of newcomer children, youth and families. Risk factors may increase the probability of developing a mental illness, while protective factors are resources and strengths that can decrease the chances of developing mental health challenges. While there is no direct cause-and-effect relationship between these variables, there are correlations between specific factors and mental health outcomes.

Risk and protective factors exist within the pre-migration, migration and post-migration contexts of newcomer children, youth and families (Crowley, 2009; Kirmayer et al., 2011). Pre-migration, migration and post-migration experiences impact each child and youth differently, however certain factors have been shown to have a greater impact on the mental health of certain groups (such as refugees), and are more frequently associated with mental health outcomes in the post-migration context. While we acknowledge the importance of these factors throughout the entire migration experience, we focus primarily on post-migration factors that have been shown to significantly influence mental health outcomes since these are considered to be the most significant social determinants of health that can impact mental health outcomes for newcomer families (Crowley, 2009; Meadows, Thurston & Melton, 2001; Porter & Haslam, 2005). During the settlement process, language barriers, parents’ unemployment, adjusting to the new school system and related challenges and discrimination/exclusion are considered critical risk factors that can lead to mental health challenges in newcomer children and youth (Shakya et al., 2010).

Unemployment is a major source of stress and places considerable pressure on newcomer youth and their families as this can lead to housing issues and food insecurity (Shakya et al., 2010; Islam, Khanlou & Tamim, 2014). Beiser et al., 2002 found that newcomer children and youth are twice as likely to live below the poverty line when compared to their Canadian-born counterparts, but they still remain quite resilient in the face of these circumstances. The presence of risk factors like unemployment and poverty can exacerbate developmental challenges (e.g. increased stress, low self-
estem, worry, and sadness) that many children and youth experience during this life stage (Anisef & Kilbride, 2008; Georgiades et al., 2007; Kilbride, Anisef, Baichman-Anisef & Khattar, 2000).

Protective factors at various levels of intervention can help mediate some of the challenges faced by newcomer children and youth. Protective factors exist at the individual level (e.g. facility and comfort with the language, connection to cultural identity, positive social skills, etc.), the family or community level (e.g. strong family support, positive well-being in the family, strong extended networks of friends, etc.) and/or the broad environmental level (e.g. access to health care, a positive school environment) (Fazel et al., 2012). For example, children and youth with refugee status who have histories of trauma, fostering social connections with the broader community and incorporating cultural practices into mental health treatment programs support general well-being and self-healing (Blanch, 2008).

Family stressors (particularly those experienced by parents) have been shown to impact newcomer child and youth mental health (Khanlou & Crawford, 2006). These stressors are often rooted in structural barriers that exist in their social and environmental contexts such as barriers to education and relevant, meaningful employment (Portes & Rumbaut, 2005). Cultural differences between generations have also been reported by ethno-cultural communities as a major stressor between youth and their parents (Islam, 2012), since children and youth are growing up in vastly different contexts than those in which their parents were raised. Children with parents who have adapted well to Canada while simultaneously maintaining traditional beliefs and practices tend to have better outcomes than children with parents who have assimilated to the new country (Hyman, Beiser & Vu, 1996).

As a part of Ontario’s 10-year Comprehensive Mental Health and Addictions Strategy, the Ontario Ministry of Health and Long-Term Care recently tasked the Institute for Clinical and Evaluative Sciences (ICES) with developing a baseline scorecard for child and youth mental health in Ontario. The scorecard provides an overview of the contexts of at-risk populations, service delivery processes in child and youth mental health and important mental health and addiction outcomes. It acts as the starting point from which ongoing monitoring of child and youth mental health indicators can be assessed over time. Findings from the scorecard show that certain social and contextual factors tend to moderate negative mental health outcomes, including the availability and location of services, region of living and living in low-income neighbourhoods. Children and youth living in the lowest income neighbourhoods were found to have the highest suicide rates and rates of emergency department visits and hospitalizations for mental health issues. Those with refugee status in particular had higher emergency department visits for self-harm. These findings demonstrate the importance of assessing risk and protective factors for newcomer children and youth, especially given their high rates of poverty and challenges with adjustment during the settlement process (Pottie et al., 2015). Research has looked specifically at certain dimensions of newcomer children, youth and family identity that have been found to either significantly increase risk for mental health issues or act as protective factors.

Age

The migration experiences of children and youth can make them vulnerable to stress and life events that may impact their emotional, cognitive and social development. This can increase their risk for experiencing mental health challenges (Fazel, Reed, Panter-Brick & Stein, 2012). Studies show that the age at which a young person migrates can significantly
impact mental health outcomes with effects that last into adulthood (Patterson, Kyu, Georgiades, 2013; Wu & Schimmelle, 2005). For example, those who immigrate to Canada before 18 years of age have a higher risk of depression. This lends some support to an age of immigration effect (Wu & Schimmelle, 2005).

Patterson, Kyu and Georgiades (2013) examined the association between age at migration (less than 6 years, between 6 and 17 years, or 18 years and above) and risk for mood, anxiety and substance use disorders among a large sample of adult immigrants in Canada. They found that those who arrived prior to age 6 years tend to be at increased risk for developing mood and anxiety disorders in adulthood compared to other age groups. That the risk was significantly greater compared to those who immigrated after 18 years of age. Their findings also confirm that the longer newcomers reside in Canada, the higher their rates of depression and alcohol dependence. Studies show that the increased risk for mental illness for newcomer children can originate from the process of acculturation and acculturative stress2, whereby young newcomers’ connections to their culture of origin are replaced by cultural aspects of their new home. As this happens, the health of newcomer youth begins to mirror the health of Canadian-born individuals. At the same time, they can however, struggle with peer and familial pressure when developing an identity within multiple cultures (Beiser et al., 2010; Hyman, Beiser & Vu, 1996; Khanlou et al., 2002). Developing social connections within the ethnic community or embracing traditional cultural practices can support positive acculturation since cultural identity is then balanced with the values of the new society (Berry, 2008; Hyman et al., 1996; Khanlou et al., 2002). Given that settling in Canada during childhood can increase the risk for mental illness, there is a need to target mental health programming to newcomer children as early as possible to prevent the onset of mental health challenges as time progresses (Islam et al., 2014).

Refugee status

While many of the risk and protective factors for refugee children and youth are similar to those with immigrant status, refugee children typically have unique pre-migration, migration and post-migration circumstances that can impact their mental health (Fazel et al., 2012; Porter & Haslam, 2005).

In the pre-migration context, refugees can experience serious traumatic events that can affect their well-being while resettling into a new country, including forced relocation, violence, persecution, familial separation, social disruption and poverty (Rubenstein & Kohli, 2010). Factors that can impact the mental health of refugees are different for each individual, but may include:

- individual and sociocultural factors (age, gender, personality)
- nature of the traumatic event that prompted relocation
- number of traumatic events and length
- availability of support or resources before, during and after migration

For children and youth, exposure to violence and the general insecurity of relocation can have a negative impact on their ability to positively adapt to developmental challenges and their new environments (American Psychological Association

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2 Refer to the glossary in Appendix 1 for definitions of “acculturation” and “acculturative stress”. 
Unaccompanied minors\(^3\) are particularly vulnerable to mental health challenges as a result of their dual status as both minors and as refugee claimants (Montgomery, 2002). Members of this group experience similar settlement challenges as youth in other newcomer groups, but they also share experiences that are unique to refugee youth (e.g. difficulties securing paid employment due to immigration status, barriers to accessing affordable housing) (Montgomery, 2002).

Despite their increased risk to traumatic and adverse events, child and youth refugees demonstrate strengths and resilience that help them overcome difficult circumstances and adapt to new environments (Khanlou et al., 2002; Khanlou & Crawford, 2006; Mollica, Cui, McInnes & Massaqli, 2002). Drawing on these strengths and resilience factors are essential elements of mental health support for child and youth refugees and their families (Blanch, 2008). Specifically, a response that attends to the ongoing interaction of factors at multiple levels as they influence mental health outcomes in the resettlement context (e.g. refugee status, education and socio-economic status before and after migration, acculturative stress) is key (Porter & Haslam, 2005). Attempts to minimize risk factors and build on protective factors at individual, family and community levels are most successful when working to support the mental health needs of child and youth refugees (see table below) (Fazel et al., 2012).

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
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<tr>
<td><strong>Individual factors</strong></td>
<td><strong>fluency in language of adopted county</strong>&lt;br&gt;- high self-esteem and self-concept&lt;br&gt;- high cognitive ability&lt;br&gt;- positive previous educational experiences&lt;br&gt;- connection and commitment to original culture&lt;br&gt;- skills in empathy&lt;br&gt;- skills in positive thinking&lt;br&gt;- positive and adaptive social skills</td>
</tr>
<tr>
<td>• exposure to violence in country of origin&lt;br&gt;• pre-existing physical, developmental or mental health disorders&lt;br&gt;• exposure to post-immigration violence&lt;br&gt;• impulsivity&lt;br&gt;• history of engaging in risk behaviours (e.g. substance use)&lt;br&gt;• genetic vulnerability to mental illness</td>
<td>&lt;br&gt;<strong>Family factors</strong></td>
</tr>
<tr>
<td>• being unaccompanied by caring adults when entering Canada&lt;br&gt;• separation from immediate family&lt;br&gt;• residing in a single-parent household&lt;br&gt;• presence of mental or physical illness in parent(s)&lt;br&gt;• financial stressors (e.g. unemployment, underemployment)</td>
<td>&lt;br&gt;<strong>Environmental</strong></td>
</tr>
<tr>
<td>• perceived discrimination</td>
<td>&lt;br&gt;<strong>Environmental</strong>&lt;br&gt;- support from friends</td>
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\(^3\) Youth under 18 who have been separated from parents in their home countries and who arrive in Canada without a legal guardian.
Table 2: Risk and protective factors among refugee children and youth at individual, family and environmental/community levels

Despite acknowledgement of these factors, precarious or insecure immigration status (which many refugee families hold upon arriving to Canada) results in limited or no access to health and mental health care services (Oxman-Martinez et al., 2005; Rousseau et al., 2008). While the Interim Federal Health Program (IFHP) offers basic health care for resettled refugees, refugee claimants and certain other non-citizens who are not eligible for provincial or territorial health insurance, specialized supports (like psychological services) are typically unavailable (Canadian Council for Refugees, 2013). This is particularly problematic for those who have experienced torture, trauma and abuse in their home countries, and adds to the stress of an already complex migration process (McGuire & Georges, 2003; Oxman-Martinez et al., 2005). The Ministry of Health and Long-Term Care (MoHLTC) recently began implementation of the Ontario Temporary Health Program for Refugee Claimants to respond to gaps in health care coverage for refugee claimants and certain other refugees, but the ongoing sustainability of this program is unclear.

Gender and sexual identity

Research focused on the intersection between children and youth with different gender/sexual identities and other social determinants of health is limited despite a general agreement that impact on mental health outcomes is a concern (Blanch, 2008; Guruge, et al., 2010; Coker, Austin & Schuster, 2010; Khanlou & Guruge, 2000; MHCC Task Group on Diversity, 2009; Reading & Rubin, 2011; Shidlo & Ahola, 2013). For example, research shows that female newcomers face unique challenges following migration to Canada that can affect their experiences of distress and their ability to access mental health care for themselves and/or their children (Guruge, et al., 2010; Islam et al., 2014). Newcomer women can experience persistent stressors related to their social and environmental contexts, especially when they are single or primary caretakers of their children (e.g. a lack of social support for raising children or disproportionate poverty compared to male counterparts) (Guruge et al., 2010). In the post-migration context, female newcomers often hold a more precarious immigration status and are likely to be dependent on male relatives. This can limit their access to resources, their ability to influence their own health care decisions and can increase their vulnerability to violence resulting from their isolation and dependence on their sponsors (Guruge et al., 2010). These stressors and the identified barriers to mental health care can prevent newcomer women from accessing appropriate mental health care. Given they are often the primary caretakers this can lead to lower family functioning and increased stressors for their children (McNaughton et al., 2004).

LGBTQ+ youth in general are at greater risk for mental health and substance use challenges than their non-LGBTQ+ peers due to victimization and stigma related to these identities (Coker et al., 2010). LGBTQ+ newcomers are exposed to the same challenges but in many cases their sexual or gender identity may be the reason they have been forced to
relocate. LGBTQ+ asylum seekers report high levels of multiple traumatic events that may begin at a young age, including gender and sexuality-based violence and abuse, discrimination, harassment and bullying (Shidlo & Ahola, 2013). Their migration experiences are unique in that families in their country of origin can contribute to the persecution or abuse, which then adds to their social isolation (Shidlo & Ahola, 2013). LGBTQ+ asylum seekers can experience re-traumatization and intense distress, shame and fear as they’re forced to produce evidence in a short amount of time about their identities and re-tell stories of trauma related to their reasons for seeking asylum (Reading & Rubin, 2011; Shidlo & Ahola, 2013). Added to the general risk and protective factors that refugees face, LGBTQ+ newcomers face multiple forms of marginalization that increase their risk for mental health challenges. This requires targeted intervention and improved access to appropriate support (Coker et al., 2010; Reading & Rubin, 2011).

Special needs
Children, youth and families who access special needs services in Ontario experience barriers related to physical disabilities, developmental disabilities, mental health or behavioural issues and/or chronic medical conditions. Ontario’s Special Needs Strategy is currently being implemented by the Ministries of Children and Youth Services, Health and Long Term Care, Education and Community and Social Services in order to respond to the challenges faced by families of children and youth with special needs in accessing and receiving services. To improve service delivery and enhance outcomes for all children and youth, they will focus on three key areas:

- identifying and bridging access to care as soon as possible
- improving service coordination
- integrating services to deliver a seamless system of support

A recommendations report from the previous Parliamentary Assistant to the Minister for Children and Youth Services identified four key opportunities to improve service delivery based on an engagement process with provincial family and provider associations as well as regional families and providers. These include: access to information and services, assessment, transitions between services and to adult services and respite.

Families, associations and providers identified that addressing language and cultural barriers and, in some regions, providing services that reflected the cultural diversity of the community are important priorities on which to focus in order to improve difficulties navigating complex systems to attain services. Recent research has focused on the unique context of newcomer families who have children or youth with special needs. There are major structural barriers during resettlement that hinder access to services for newcomer families with children and youth with special needs, and a growing body of study that works to explain these experiences in order to identify ways to better support well-being throughout migration (Jennings, Khanlou & Su, 2014; Khanlou, Haque, Sheehan, & Jones, 2014; Mirza & Heinemann, 2012). For example, Khanlou and colleagues (2014) found that service providers in Toronto serving newcomer families with special needs are aware of and understand these issues, however barriers that hamper access to services (e.g. language and communication barriers, the complexity of navigating the system, gaps in professional training) can prevent newcomer families from getting appropriate mental health support. Understanding the nature and origin of these barriers to mental health care for newcomer families with special needs will be a priority across multiple governments to ensure systems of care effectively respond to their needs throughout the migration process.
The child and youth mental health sector will need to consider the needs, strengths and circumstances of children and youth with a variety of immigration statuses, gender and sexual identities, special needs and social and contextual circumstances. Newcomer children, youth and families interact with a unique set of individual, family and environmental factors from a broad range of social determinants of mental health that will require integrated responses from across sectors. Service areas and communities should assess needs and collect local data related to the diversity of communities and the experiences of newcomers. This data can be used to increase awareness of cultural diversity, population’s needs and strengths, and provide a rationale for a flexible set of services that are adapted to diverse cultural, religious, ethnic and linguistic experiences. The development of baseline and ongoing scorecards for child and youth mental health in Ontario developed by ICES is a promising method of addressing this gap in data collection. Some avenues for collecting data at the local level include gathering demographic information from local municipalities, and information from organizations that can show who is and who isn’t accessing services.

Recommendation 1: Consider the impact of social determinants on the mental health of newcomer children, youth and families and:

- Develop coordinated responses to service delivery gaps across sectors (e.g. health, employment, education, etc.) that consider the unique social and contextual circumstances of newcomer children, youth and families.
- Target mental health programming to newcomer children as early as possible to prevent the onset of mental health challenges.
- Create clear pathways and access to services for refugee children, youth and families that recognize the complexity of the pre- and post-migration risk factors and protective factors and offer strengths-based care.
- Create appropriate interventions and enable access to supports for LGBTQ+ newcomers as they face multiple forms of marginalization that increase their risk for mental health challenges.
- Consider the structural barriers to mental health care for newcomer children and youth with special needs across ministries to ensure systems of care effectively respond to their needs throughout the resettlement process.
- Conduct needs assessments and collect local data related to the diversity of communities and the experiences of newcomers. This data can be used to increase awareness of cultural diversity, population’s needs and strengths and provide a rationale for a flexible set of services that are adapted to diverse cultural, religious, ethnic and linguistic experiences.
Newcomer families’ experience of the mental health system

Research suggests that despite their increased risk for experiencing mental health difficulties, newcomers to Canada are less likely to access and use mental health services across the life span when compared to the Canadian-born population (Fenta, Hyman, Noh, 2006; Hyman, 2001; Measham et al., 2001). Newcomer youth do so with even less frequency (Ellis, Miller, Baldwin & Abdi, 2011; Kilbride et al., 2000). In the broader newcomer population, a lack of understanding and information about services, unclear pathways to care, cultural mistrust, communication challenges and economic constraints can prevent newcomer families from getting the mental health supports they need (Beiser, 2005). For youth, these challenges are exacerbated by the stigma of mental health services, different views of mental health and wellness between mainstream and ethno-cultural communities, agreement about what constitutes appropriate support (e.g. religious organizations or extended kinship networks over support from a mental health organization), logistical barriers (e.g. distance from services or cost of transportation), a general distrust in mental health systems, and the lack of flexibility in services to address their unique preferences and needs (Ellis et al., 2011; Khanlou, Shakya & Gonsalves, 2011; Kilbride et al., 2000; Shakya et al., 2010).

In response to identified barriers, communities in Ontario are beginning to establish processes to assess the needs and address mental health equity gaps of newcomer populations. As part of Ontario’s Comprehensive Mental Health and Addictions Strategy, 18 Mental Health Service Collaboratives have been introduced as a systemic response to tackling service and equity gaps for vulnerable children and youth. Service Collaboratives identify, plan and implement interventions unique to their communities, and in some cases the focus for these services is based on addressing the needs of particular newcomer groups. For example, the Scarborough-East York (SEY) Service Collaborative conducted a Needs Validation process where they engaged with the community to identify service gaps. This led to the development of a walk-in clinic for youth with mental health and substance use problems. Through this initiative, several key issues relevant to newcomer populations are being addressed (including ensuring culturally-appropriate services, addressing language barriers and differences in understanding mental health and addictions across family generations and service relationships). There are deliberate attempts to align different approaches across agencies in the community.

Cultural variations in understanding and responding to mental health

For newcomer families, the priority is often to focus on pressing and basic needs (like housing, employment, etc.) rather than seeking/accessing mental health care (Davies & Webb, 2000). As well, many newcomers may not fully understand the nature of local mental health services, believing that they should only be accessed during a time of crisis (Davis & Webb, 2000). In instances where newcomers do attempt to access and use mental health services, there are often cultural differences between diverse groups and mainstream service providers in understanding and responding to mental health challenges.

While culturally-responsive and culturally-specific mental health services are best practices to promoting positive mental health outcomes, current models of service delivery for newcomer families tend to be based on western bio-medical
evidence and related approaches (Este, 2007; Measham, Rousseau, & Nadeau, 2005; Thomas Bernard & Moriah, 2007). Most models for diagnosis and treatment still focus largely on identifying pathology and contributing factors at an individual level, along with responding with interventions aimed directly at the young person without consideration of natural supports in the family and/or community (Rousseau et al., 2005). Even in cases where families are able to access services, newcomer youth are less likely to attend follow-up sessions (Nadeau & Measham, 2006), likely because many supports are geared towards mainstream populations and are not developed with attention to contextual factors that are present in the lives of newcomer youth (DesMeules et al., 2004; Ellis et al., 2011; Khanlou et al., 2011; Newbold, 2005; Whitley, Kirmayer & Groleau, 2006). To understand perspectives on the barriers newcomers face when accessing mental health treatment, Whitley and colleagues (2006) interviewed a sample of West Indian immigrants in Montreal around their experiences with psychiatric care. In general, participants shared that psychiatrists tend not to be holistic in their approach, do not take time for deep one-on-one interaction and rely too heavily on medication as a solution to presenting issues (Whitley et al., 2006).

There are also cross-cultural variations in presentations of symptoms and how individuals express distress (APA, 2013). For example, among Portuguese Canadians, studies have shown culture-specific understandings, descriptions and symptom presentations of agonias, or anxiety and/or depression (James, Navara, Lomotey & Clarke, 2006). Mainstream clinicians need to be aware of relevant contextual information within an individual’s culture, while considering other critical aspects like age, ethnicity and religion when making diagnoses and providing support. Historically, cultural influences were referred to within the scope of a culture-bound syndrome. More recently, contextual considerations have been included in the DSM-5 (APA, 2013). Mental health services should be tailored to newcomer families by incorporating one’s cultural belief systems and responding to social and contextual circumstances from a broad range of social determinants of health. This is consistent with a holistic approach to mental health.

Stigma of mental health and illness among newcomer communities

Stigma associated with mental health and illness among newcomer communities is a major barrier to reaching out for help and accessing mental health services (Ellis et al., 2011; Kinzie et al., 2006; Lustig et al., 2004; Simich, Maiter, Moorlag & Ochocka, 2009). The relationship between culture, mental illness/health and stigma is complex given the diversity of newcomer families who hold a variety of belief systems, values and cultural views on mental health (Simich et al., 2009). This speaks to the importance of targeting mental health awareness, stigma reduction and outreach efforts for specific ethno-cultural communities and their sub-populations.

A potential first step in engaging newcomer communities around mental health and illness is to address the stigma that can prevent them from seeking or accessing mental health services in the first place (Hansson et al., 2010). For many newcomers to Canada, the concepts of mental health and mental illness can have very different meanings and manifestations compared to those within the mainstream western culture. What western practitioners might identify as depression or psychosis, can for some be referred to as crazy or mad within their ethno-cultural group (Khanlou et al., 2011; Simich et al., 2009). A youth consulted indicated that in their culture, mental illness has no direct translation. Rather words like sick, sad or crazy are used to describe these experiences. Some members of ethno-cultural
communities can also respond to the presence of mental health issues with denial and avoidance due to embarrassment or shame (Simich et al., 2009).

The ethno-cultural youth advisory committee (EYAC) at the Youth Services Bureau of Ottawa is an example of a structure that draws on the expertise and knowledge of newcomer youth by providing opportunities for them to lead community engagement, outreach, awareness-building and education initiatives to a range of community members and partners (including youth, families, service providers, school boards etc.). Here are some examples of their initiatives:

- Deliver workshops on diversity and intergenerational conflict to youth and parents separately, and hold forums with both youth and parents to facilitate perspective-taking and collaboration.
- Help newcomer families address stigma of mental health and illness within their communities.
- Offer information to families on the intersection between migration and mental health and common mental health experiences for newcomer families.
- Help overcome barriers to employment through the immigrant youth employment program. Youth can become involved in workshops, receive support in understanding Canadian workplaces and learn to engage in volunteerism, and employers receive education around the needs of newcomers.

**Recommendation 2: Address barriers to care and deliver culturally-responsive and culturally-specific mental health services tailored to the needs of newcomer families.**

- Consider and respond to the barriers that can prevent newcomer families from getting the mental health supports they need, including but not limited to: lack of information about services, unclear pathways to care, cultural mistrust, communication challenges, economic constraints, etc.
- Use a holistic approach to the mental health care of newcomer youth by adopting a social determinants lens, and understanding the cultural belief systems and social/contextual circumstances of newcomer families.
- Engage newcomer communities and develop targeted initiatives to increase mental health awareness, reduce stigma and reach out to specific ethno-cultural communities to promote mental wellness.
Approaches to supporting mental health of newcomer families

The Ontario Federation of Community Mental Health and Addictions Programs, now Addictions and Mental Health Ontario (2009) identified several challenges that mental health agencies confront when working to tailor services to meet the needs of their diverse communities. At the service provider level, there is often a lack of relevant skills, knowledge and confidence to support newcomer youth. Further, organizations struggle to conceptualize and implement an overall approach to service delivery in a consistent manner (e.g. incorporating diversity into agency mission statements, diversifying their staff complement and gaining general buy-in to prioritize diversity as a core organizational value). Predominant ways of addressing cultural competence through cross-cultural education can sometimes even reinforce biases and structural barriers, since this typically happens without an explicit focus on how social, economic and other environmental factors work in combination with culture to prevent access to mental health care and produce negative mental health outcomes.

Despite the barriers and issues described above, there are a varied number of approaches that work well in meeting the mental health needs of newcomer families in Canada (Kirmayer et al., 2001). For example, some organizations introduce concrete solutions to barriers (e.g. using cultural interpreters when providing service), while others develop specialized, ethno-specific supports to meet the needs of priority populations (e.g. a support group for South Asian youth). In other cases, agencies adopt and communicate a wholesale, equity-focused philosophy that is embedded in all elements of the service experience from the physical appearance of the office to the services that are rooted in anti-racist or culturally sensitive approaches to care. Others draw on the knowledge and resources available from people within cultural communities (such as traditional interventions used by faith leaders), and use this in practice with families.

Decisions to adapt services for newcomer populations are often informed by the research evidence, understood within equity-based philosophies and focus on the unique needs of particular ethno-cultural populations. For example, the Winnipeg Regional Health Authority’s (WRHA) Immigrant and Refugee Mental Health Working Group recently developed an Immigrant & Refugee Mental Health Wellbeing Stepped Care Service Model. The model is based on a conceptual framework that strives to understand the mental health and wellbeing of immigrants and refugees and offers a comprehensive approach (with specific action areas) to address the needs of their newcomer population. It recognizes that all service delivery should use evidence-based/informed practices that are culturally relevant. The Stepped Care Service Model features a continuum of services based on mental wellness promotion and capacity building (e.g. outreach to ethnic communities and training in culturally-responsive care) and focuses on cross-sector work and collaboration.

Hong Fook Mental Health Association is a well-known example in Ontario of a mental health organization that offers culture-specific mental health services, support and outreach education to Cambodian, Chinese, Korean and Vietnamese communities in Scarborough, North York and downtown Toronto and in East and Southeast Ontario. Their services include helping people who experience linguistic or cultural barriers to access mental health services by providing counselling, case management, consultation, advocacy, psycho-education workshops, English as second language classes, housing services and support groups.
Even while mental health agencies implement and adapt services to address equity and meet the mental health needs of newcomer families, there is still a lack of research evidence that provides clear and definitive implementation guidelines and evaluation findings related to these approaches that strive to improve mental health outcomes (Horvat et al., 2014; Ontario Federation of Community Mental Health and Addictions Programs, 2009). With a range of models available to child and youth mental health agencies and the challenges that agencies face in implementing such models, it will be essential to use a planned implementation approach to identifying and integrating models that fit both the organizational and community context. It will also be important to evaluate both the process of shifts in service delivery and the outcomes for newcomer families. Below is a review of well-known and emerging approaches in child and youth mental health that are being implemented with newcomer communities to support equity and diversity.

Cultural competence

*Cultural competence* is “a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system and agency staff to work effectively in cross-cultural situations” (Cross et al., 1989). Within an organization, cultural competence evolves over time. Staff and leadership strive to address diversity and equal access in service provision by acquiring relevant awareness, knowledge and skills to approach diversity. The National Center for Cultural Competence has developed organizational guidelines based on Cross et al.’s (1989) framework to ensure organizational accountability to support cultural competence in practice. Such agencies should:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- Have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge and adapt to diversity and the cultural contexts of communities they serve.
- Incorporate elements listed above in all aspects of policy-making, administration, practice and service delivery. They should systematically involve consumers, families and communities in planning, programming and delivery (e.g. engaging communities as full partners in determining their own needs and ensuring children and their families are decision-makers in the care they receive).

Over the last two decades, cultural competence has been the prevalent approach to addressing cultural diversity in mental health service provision (Hansson et al., 2010; Ontario Federation of Community Mental Health and Addictions Programs, 2009). Despite its widespread adoption, there are several criticisms related to the way cultural competence has been defined and operationalized in the mental health system (Este, 2007; Ontario Federation of Community Mental Health and Addictions Programs, 2009; Sundar et al., 2012; Williams, 2010). For example:

- Cultural content contained within the cultural competence training curriculum often draws on static representations of culture that reinforce stereotypes or dominant group experiences.
- The most common definition implies that by acquiring a set of defined skills, knowledge and competencies and using them in practice, an individual will reach a level of competence while working cross-culturally. This is a difficult goal to attain.
Cultural competence frameworks can reinforce the practice of viewing marginalized groups as different from dominant groups. This can promote exclusion and an us vs. them dynamic that ignores the marginalized groups’ experiences of racialization and oppression both within and outside of the mental health care system.

There is a lack of research that assesses the effectiveness of cultural competence in improving health and mental health outcomes in service delivery.

A recent systematic review assessed whether cultural competence training (improving cultural awareness, knowledge and/or skills) for health professionals would lead to improved outcomes for service users and organizations (Horvat et al., 2014). Overall, findings show that short training courses for health professionals do not lead to better client outcomes and that there is a need for consensus on the core components of cultural competence. Williams (2010) proposes that cultural competence can be improved in three ways: using dynamic, multidimensional definitions of culture, incorporating cultural safety as a primary approach and investing in cultural adaptations of evidence-based practices. There is an overall consensus that moving toward cultural competence in mental health service provision to address the mental health needs of newcomer populations requires action at both individual (e.g. reflection on attitudes toward cultural beliefs) and organizational/systemic levels (e.g. diversifying staff, ongoing training) (Hansson et al., 2010).

Culturally-responsive services
Sundar and colleagues (2012) propose a culturally-responsive approach to mental health service provision. This approach shifts the focus from the goal of acquiring a set of professional competencies, to focusing deep attention on the therapeutic alliance. Central to this approach is the relationship between the service user and service provider, and the context within which each lives and works. The service relationship (and not the acquisition of competencies) is the focus in this approach and important social and contextual factors rooted in ethnicity, age, race and gender are considered in mental health intervention. Changes can come from analyzing one’s own identities that impact the service relationship and how we interact within our organization to move toward inclusiveness and equity. Cultural-responsiveness offers a complementary approach to the dominant practice of cultural competence and can be integrated into existing diversity strategies in mental health.

Mental Health in Multicultural Australia (MHiMA), funded by the Australian Government, is a national mental health support organization for people from culturally and linguistically diverse backgrounds developed in response Australia’s cultural diversity and the need for relevant, appropriate mental health services. MHiMA offers an organizational and system-level framework to cultural responsiveness in which staff work toward good partnerships with the culturally diverse communities they serve, address access issues by reducing barriers and improve equity through responsive service delivery. The framework requires organizational commitment and leadership that supports cultural responsiveness and recognizes that it is an ongoing process rather than a series of activities with determined end points. The framework uses a continuum that incorporates assessment (using a tool to assess the organization’s current state), planning (developing individualized action plans), implementation (developing outcome areas, indicators and strategies) and evaluation (on-going monitoring). This ensures that individuals and the organization are working together in a long-term and sustainable process.
Anti-oppressive practice

The anti-oppressive practice (AOP) framework is also gaining popularity as an approach to providing mental health care for newcomer youth (Corneau & Stergiopolous, 2012; Strier & Binyamin, 2010). AOP shifts many of the predominant assumptions held in mainstream organizations in which mental health problems are individualized, problem-based and addressed through hierarchical service relationships (Karabonow, 2004). Instead, this approach works to recognize existing social inequalities and power imbalances (including those that exist between practitioner and client), and attempts to reduce them through meaningful engagement and collaboration with children, youth, families and service providers in all levels of decision-making. Anti-oppressive practice requires that we become aware of the power imbalance between dominant and marginalized groups in order to provide the best possible care (Dumbrill, 2003; Strier, 2006).

Karabonow (2004) describes the key overarching tenets of organizations that have adopted an AOP approach to working with vulnerable youth broadly:

- awareness of mechanisms of oppression, domination and injustice
- acknowledgement of the structural elements at play in human behaviour
- acceptance of diversity and difference
- recognition of the complexity of power
- necessity for action

For newcomer youth and their families, AOP offers a more holistic and strengths-based way of supporting mental health since it requires a deep understanding of and attention to the barriers in social and environmental conditions that create inequalities such as poverty, racism and discrimination (Corneau & Stergiopolous, 2012; Strier & Binyamin, 2010). For example, Strier and Binyamin (2010) argue that AOP works as an approach with vulnerable populations living with low socioeconomic status since they experience multiple layers of oppression that require combined interventions at micro (individual) and macro (system) practice levels. Rather than ignoring the influences of racism and marginalization on the mental health of newcomers, these concepts become an essential aspect of mental health practice and its guiding frameworks. This allows for an intersectional approach to addressing the inequities result from cultural, ethnic, gender and class differences at all practice levels (i.e. power dynamics in the service relationship to systemic barriers at policy levels).

Research on the effectiveness and implementation of using an AOP framework in mental health care organizations is less extensive than for cultural competence. There is, however, a growing body of work that supports its use in social service organizations working with newcomer populations (Karabonow, 2004; Sarang et al., 2009; Stergiopolous et al., 2012). For example, in recent years, Ontario’s child welfare system has been moving away from a cultural competence approach and has adopted the use of an AOP framework to respond to the overrepresentation of certain population groups in the child welfare system (Wong & Yee, 2010). The Ontario Association of Children’s Aid Societies (OACAS) led an extensive consultation process and developed an organizational change process to support the implementation and evaluation of the AOP framework at individual, group and institutional levels. Ontario’s child and youth mental health system may have an opportunity to learn from and build on this system change using a mental health equity lens.
Cultural safety

Ensuring cultural safety is increasing in popularity as an organizational imperative when providing mental health supports for diverse groups. This approach was developed in the 1980s by a group of Indigenous Maori nurses working in New Zealand (National Aboriginal Health Organization, 2006). Since then, cultural safety has gained wide-spread acceptance by national organizations as a framework for health care that encourages respect of diversity, acknowledges historical oppression and the impact of power on building trust, and emphasizes empowerment and cultural identity. The Mental Health Commission of Canada promotes cultural safety and asks mental health service providers to consider social, political, linguistic and spiritual factors when addressing the mental health needs of First Nations, Inuit and Métis (FNIM) groups. As a practice approach for newcomer youth and their families, cultural safety incorporates a social and contextual understanding of mental health, marginalization and inequities into mental health service provision.

A system-level approach

Addressing disparities in health (and mental health) requires a focus on equity in mental health care that is built into all planning, programming and service delivery. Since disparities can be understood within a social determinants of health framework, a wide-ranging and diverse group of stakeholders from across sectors should be involved in improving health equity for newcomer groups. Such efforts require collaborative planning, evaluation and a planned approach to implementing changes to ensure the best possible social and economic impact for newcomer children, youth and families from diverse backgrounds (Gold, 2010). At a system level, having clear approaches, sets of standards and priorities for child and youth mental health organizations to address health equity will be important in moving towards health equity in a way that reflects the needs of newcomer families in Ontario’s diverse communities. A systems approach can serve as a way to understand and address the multiple layers and intersecting factors as rooted within a social determinants of health framework. This approach takes into account individual (e.g. age, gender and ethnicity), family/community (e.g. social support and acculturation) and system (e.g. economic barriers and responsive services) level factors. A systems approach can help assess risk and protective factors that influence mental health and the barriers and facilitators to culturally-responsive services so that policies and practices can be shaped around the needs of newcomer families (Khanlou, 2009).

Ontario’s Ministry of Health and Long Term Care (MOHLTC) in collaboration with the Local Health Integration Networks (LHINs) have developed the Healthy Equity Impact Assessment (HEIA) tool which is a decision support tool to help agencies identify how a specific program, policy or initiative impacts diverse groups and works to improve targeting of health care investments at the system-level. This tool was designed to ensure health equity, reduce avoidable health disparities between population groups and improve targeted health care investments to ensure timely, accessible and coordinated care. The HEIA has been internationally recognized and endorsed by the World Health Organization.

While tools such as these can support a health equity framework, comprehensive strategies to address barriers to equity in the mental health care system are largely lacking. In 2009, The Mental Health Commission of Canada (MHCC) contacted all provinces and territories to better understand how communities respond to the mental health needs of newcomer groups and found that no province, territory or region had a comprehensive strategy for improving the mental health of immigrant, refugee, ethno-cultural or racialized populations (Hansson, Tuck, Lurie & McKenzie, 2010).
Recommendation 3: Identify and adopt specific approaches, standards, tools and priorities for child and youth mental health agencies that will guide service delivery for newcomer youth that are tailored to each community’s needs and context.

Despite the absence of a targeted response, research findings continue to show compelling evidence that suggests a need to invest in closing this health equity gap.
Potential responses

There are several process-focused and structural elements of practice that must be considered in mental health service provision for newcomer youth. These potential responses are grounded in both the research literature, as well as knowledge gleaned from consultation with the advisory committee involved in guiding this paper.

Process-focused supports

Support natural support networks

Fostering a connection to a person’s ethnic community can help with positive identity development, especially during adolescence (Berry, 2008), and can increase resilience toward mental health challenges for refugee children and youth (Betancourt & Khan, 2008). The social determinants of health include attention to a young person’s level of perceived social support, as this is an important factor in the mental health of newcomer children and youth (Kilbride et al., 2000; Simich et al., 2005). Extended family members are often primary sources of support, and in some cases families have been separated during the migration process (Kilbride et al., 2000). The Transcultural Psychiatry model in Montréal works with the child, youth and their family to connect with family in other cities or countries if the child or youth considers this relationship important to promoting their mental health (Measham et al., 2005; Nadeau & Measham, 2006). It is important to reduce isolation and barriers to care for caregivers who are working to cope with the stigma of mental illness, as well as the lack of access to appropriate models of care that support their family’s unique needs (Mirza & Heinemann, 2012; Khanlou et al., 2014). A case management model that can help newcomer families navigate and understand the health and mental health systems and identify available resources would help to reduce some of the stress and barriers to accessing support during and following the migration process (Khanlou et al., 2014).

Pay attention to cultural, spiritual and religious beliefs

Attending to the diverse cultural, spiritual and religious beliefs of newcomer families produces meaningful support and can help with the management of mental health and illness. At the present time, most services don’t adequately address the diverse cultural, spiritual or religious beliefs of newcomer families (James & Prilleltensky, 2002; Collins, 2008). Religion, spirituality and traditional healing practices are important sources of support and help to manage mental health and mental illness for newcomers (MHCC Task Group on Diversity, 2009; Shakya et al., 2010). For example, one family member we consulted spoke about the importance of connecting with a mosque in their ethnic community and that the fact that the practitioner facilitated this type of link during service provision had enormous positive consequences for care. A youth we spoke with shared how different gender role perceptions or views on age appropriate behaviours can impact access to care. For example, it may be culturally inappropriate for young people and young women in particular to be out of the home after dark so offering services only in the evening may limit access for youth in these circumstances.

Ethno-cultural communities and mental health agencies are growing their capacity to respond to diverse cultural, spiritual and religious beliefs. A family member we spoke with who works with a Somali community-based organization described using an expert panel that included both cultural and mental health leaders to provide education around mental health, crisis management, information about where to go for help and knowledge about when it might be most
appropriate to reach out for professional support rather than rely exclusively on faith as healing. At the start of their outreach to ethno-cultural communities, Peel Children’s Centre (http://www.peelcc.org/) connected with community-based services and went to cultural events to share knowledge about mental health and provide information about the availability of their services. During outreach, differences between mainstream and cultural interpretations and terminology used to describe mental health or illness can be a major barrier to engaging in a culturally-appropriate way with ethno-cultural communities. This organization emphasized the importance of being aware of how the cultural community understands and refers to mental health and working to meet families where they are at. These examples demonstrate the importance of flexibility in service provision in terms of adopting a holistic lens when engaging with newcomer families, offering a range of options in mental health and traditional supports and engaging in meaningful, two-way communication that can result in more appropriate and relevant services.

Enhancing resilience and strengths

Enhancing resilience, protective factors and strengths in newcomer children, youth and families can help them face adversity and adapt to a new life. These can in turn improve mental health outcomes throughout the settlement process (Beiser et al., 2010; Georgiades et al., 2007). Research has shown that refugees in particular have a very high resilience and abilities to adapt (Blanch, 2008; Guyot, 2007; Vasileyska & Simich, 2010). Rather than being passive victims of trauma, refugees typically play active roles in their survival, especially during their adaptation to new environments (Guyot, 2007; Vasilevska et al., 2010).

At the practice level, a strengths-based approach to practice supports the development of a strong relationship and trust within the therapeutic alliance. This is particularly important for working with refugee children and youth who have histories of trauma (Measham et al., 2005; Vasilevska et al., 2010). A trauma-informed approach is an evidence-informed practice for working with refugee children and youth with complex mental health challenges, especially when there are known histories of trauma (Blanch, 2008). Visit the National Traumatic Stress Network (NCTSN) for more information about implementing trauma-informed services. Trauma-informed services are based on principles of trauma awareness, safety, trustworthiness, choice, collaboration and building strengths and skills (Blanch, 2008). These services are implemented at the client, staff, agency and system levels to ensure all of a young person’s interactions with mental health services, from outreach education to initial assessment to treatment programs, are trauma-informed. Services across sectors coordinate and collaborate to improve trauma awareness and deliver appropriate interventions to all populations accessing mental health support.

Recommendation 4: Ensure that the processes involved in service delivery are structured to produce meaningful and relevant supports tailored to the specific needs of newcomer children, youth and families.

- Offer a range of options in mental health care that include both mainstream and traditional supports.
- Foster connections with ethnic communities and incorporate diverse cultural, spiritual and religious beliefs/practices in care.
- Reduce isolation and minimize barriers to care for newcomer children, youth and families.
- Help newcomer families to navigate and understand the mental health system and identify available resources that can minimize the migration-related stressors.
- Increase trauma awareness and deliver strength-based interventions to newcomer families accessing mental health support.
Structural elements

Work toward mental health promotion and cross-sectoral collaboration

Responding to inequity in mental health care requires the adoption of a mental health promotion approach and collaboration with a diverse range of stakeholders among government and non-government organizations (including community-based advocates and newcomer communities), in order to attend to the diverse and complex social determinants of newcomer families’ health (Gold, 2010; Hansson et al., 2010; National Center for Cultural Competence, n.d.).

Mental health promotion involves targeting the risk and protective factors across the range of the social determinants of health that contribute to mental health inequities for newcomer populations. Service users are encouraged to participate in decision-making processes that affect their health to enhance their capacity to take control of their own well-being (CAMH, 2012; Canadian Mental Health Association, 2012; Khanlou, 2003; Khanlou, 2009). This approach requires cross-sectoral collaboration between government, health care, education, justice, environment, housing and prevention and treatment programs (Canadian Mental Health Association, 2008; CAMH, 2012).

Cross-sectoral/cross-community collaboration and partnerships can address the variety of process and structural factors that impact access and experiences of mental health care for newcomer families (Hansson et al., 2010). While developing organizational and system level policies to respond to the needs of newcomer families, it is important to draw upon youth, family and community engagement principles (MHCC Task Group on Diversity, 2009) which include a focus on collaboration and social inclusion and the involvement of diverse sectors and a diverse range of people (Tamarack Institute for Community Engagement, n.d.). At the heart of this process is that community members are full partners in decision-making processes and collaboratively determine local priorities to achieve a shared vision.

Mental health promotion and cross-sectoral collaboration fit well with a social determinants of health and health equity lens as they:

- identify and address risk and protective factors
- support increased resilience
- identify and address barriers to positive mental health
- focus specifically on reducing inequities by providing culturally-responsive care

Mental health promotion in schools can be particularly effective in reaching newcomer youth (Anisef & Kilbride, 2008; Hodes, 2000; Rousseau & Guzder, 2008). Studies suggest that models that target the whole-school environment are so useful since they are designed to consider cultural and migratory contexts (with an emphasis on parent-school interactions) in shaping mental health promotion initiatives (Rousseau & Guzder, 2008). A recent review of the literature on child and youth resilience promotion interventions reveals that a whole community, ecological approach can target the mental health equity gap (Khanlou & Wray, 2014). This framework bridges partnerships and collaboration across and within family, community and school environments.
Table 3: A whole community approach for promoting resilience (Khanlou & Wray, 2010)

<table>
<thead>
<tr>
<th>Overlapping strategies to support a whole community approach</th>
<th>Families</th>
<th>School environment</th>
<th>Communities</th>
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<tbody>
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<td>+ parenting support programs</td>
<td>• whole school policy</td>
<td>• community involvement in whole school governance</td>
<td></td>
</tr>
<tr>
<td>+ parent involvement</td>
<td>• social emotional curriculum</td>
<td>• community use of facilities</td>
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<td></td>
<td>• professional development</td>
<td>• community based resilience initiatives</td>
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<td></td>
<td>• interactive teaching</td>
<td>• service continuum with health, mental health and social services</td>
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<td>• staff health and welfare</td>
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The Peel Service Collaborative (PSC) used a whole community approach as they developed an intervention geared toward their multicultural community that required consultation with a broad range of stakeholders across sectors. This Service Collaborative involved diverse youth, faith leaders, as well as schools boards, hospitals, multicultural and health community centres and community crisis providers working together and using relevant research to develop two specific initiatives to implement:

1. **Holistic Crisis Planning (HCP):** A holistic-strength-based and youth/family-centred guide to crisis planning for children and youth with mental health and addictions
2. **Mental Health First Aid (MHFA):** An evidence-based program developed by the Mental Health Commission of Canada to support people in the community to recognize and respond to mental health crises. Using a train-the-trainer approach, the Peel Service Collaborative trains key support systems that families in their region turn to during crisis, such as leaders in the faith community at no cost.

**Collaborate to develop clear pathways to care**

Newcomer families often draw on informal support systems (like ethnic community groups or religious organizations) rather than formal support systems when a mental health need emerges. These organizations may provide support such as legal advice, employment skills and explanations around cultural difference (Khanlou et al., 2011). Those who access formal supports tend to approach teachers, English as a Second Language (ESL) staff or youth-focused programs at school (Shakya et al., 2010). Possible referrals to secondary care providers such as psychiatrists, may follow (Hansson, Tuck, Lurie, & McKenzie, 2009), however family physicians can find it difficult to locate culturally appropriate services to refer to (MHCC Task Group on Diversity, 2009). To ensure a clear pathway to care, it is essential that we improve knowledge and awareness of the range of formal supports that newcomer youth can access in times of need and address the barriers they face when accessing mental health supports.

A Montreal-based study found that immigrant and refugee children, youth and their families identify primary care providers as their first points of contact in initiating access to mental health services (Measham et al., 2001). Family
doctors, pediatricians, followed by social workers and schoolteachers were the most common sources of referral for families accessing mental health services, with a small number of self-referrals (Measham et al., 2001). The Transcultural Psychiatry services (see Appendix 2 for more details) have moved their consultation services so they are closer to schools and community-based services where diverse communities work, live and play in order to facilitate the connection to specialized mental health services.

The modes and outlets for communicating about services can also be a barrier to care. Mainstream mechanisms for promoting services might not reach newcomer communities as effectively as reaching out through ethnic community media or connecting in-person (Khanlou, et al., 2011). Those that are promoted in a limited number of languages (i.e. only English and French), can also understandably pose barriers to engaging communities to seek supports.

**Address language and communication challenges**

Practices and processes that address language and communication barriers are critical to enhancing service use and ensuring high-quality supports for newcomer families. Language difficulties are perhaps the most pervasive challenge for newcomer youth and their families who are adjusting to Canadian society (Anisef & Kilbride, 2008; Kilbride et al., 2000). Newcomer children may experience more distress if parents speak languages other than English or French (Beiser et al., 2010), and those who do not master Canada’s official languages also have difficulties receiving mental health services (Li & Browne, 2000; Simich, 2010). Language barriers can result in lower use of prevention services, lower quality of services, lower adherence to treatment and differences in the use of prescribed medications (Bowen, 2001). For example, one family member we consulted referred to a situation when a translator misinterpreted symptoms being described by a person new to Canada and then misrepresented the illness to a doctor. Service providers have also identified that there are cases where children and youth who are more fluent in English and French than their parents become the cultural translator/liaison for the family (Khanlou et al., 2011). This can be helpful but can also place unreasonable pressure on the young person to act as the ambassador for the family.

Child and youth mental health organizations can assess disparities in care by collecting information on the linguistic make-up of the youth and families accessing services, the overall picture in the community and the linguistic competencies of staff. Organizations may also need to gather knowledge on the availability of translation services in the community in order to offer this support to children, youth and families or connect them to these where required. The use of trained cultural interpreters and/or cultural brokers in mental health service delivery for newcomer families is emerging as an evidence-informed practice with promising results (Kirmayer et al., 2011). This requires collaboration with interpretation services to develop a system or strategy that allows for improved access to quality mental health care for newcomer families. The Toronto Central LHIN has developed a model for **Centralized Integrated Interpretation Services (CIIS)** as a part of their strategy to address health equity by improving language access. The model provides a pathway to services through centralized access to a pool of interpreters using one booking system and assigned health service providers at several host organizations across Toronto.
Work to reduce prejudice, racism and discrimination
Promoting inclusion of diversity in mental health services and responding to experiences of discrimination at individual, community and institutional levels can help address the racism and discrimination that newcomer youth and families experience. Perceived racism and discrimination/exclusion are major sources of stress for newcomer youth and their families (Anisef & Kilbride, 2008; McKenzie, 2006; Shakya et al., 2010). Studies have shown that the perception of racial discrimination is a barrier to care that reduces service use (Li & Browne, 2000; Whitley et al., 2006). Perceived discrimination can also contribute to a general distrust in services (Hansson et al., 2010; Vasilevska et al., 2010).

Institutionalized discrimination comes from systems of mental health care that offer poor access and treatment options to newcomers (Hansson et al., 2010), and does not consider their diverse values and beliefs systems in care. In other words, a mainstream one-size-fits-all approach does not take into account the unique strengths, preferences and needs of newcomer youth in care (Georgiades et al., 2007).

Recommendation 5: Use principles of mental health promotion and a strengths-based approach to support newcomer child and youth mental health.

- Engage newcomer communities as partners in decision-making to collaboratively develop organizational and system level policy and determine local priorities.
- Use a whole-community approach to promote resilience. Consider school-based mental health promotion and prevention as an effective way to reach newcomer children, youth and families.
- Identify newcomers’ first points of access in times of need and the barriers they face when accessing mental health care. Collaborate with primary care providers to develop clear pathways to care to culturally responsive mental health services.
- Collect information on the linguistic make-up of children, youth and families accessing services and offer trained cultural interpreters and/or cultural brokers to facilitate mental health service delivery for newcomer families.
- Promote the integration of a diversity of value and belief systems, linguistic competencies and social and contextual realities into mental health systems as reflected in funding, policies, partnerships and hiring practices.
Conclusion and recommendations

Through the Moving on Mental Health initiative, the province of Ontario has made a commitment to support the unique needs of all children, youth and families. Newcomer children, youth and families are an important part of our communities, and supporting their mental health is critical. Our goal in this policy paper has been to bring together the latest evidence (from research as well as the experiences of service providers and service users) in order to provide a set of actionable recommendations to enhance supports for Ontario’s newcomer children, youth and families:

Recommendation 1: Consider the impact of social determinants on the mental health of newcomer children, youth and families.
- Develop coordinated responses to service delivery gaps across sectors (e.g. health, employment, education, etc.) that consider the unique social and contextual circumstances of newcomer children, youth and families.
- Target mental health programming to newcomer children as early as possible to prevent the onset of mental health challenges.
- Create clear pathways and access to services for refugee children, youth and families that recognize the complexity of the pre- and post-migration risk factors and protective factors and offer strengths-based care.
- Create appropriate interventions and enable access to supports for LGBTQ+ newcomers as they face multiple forms of marginalization that increase their risk for mental health challenges.
- Consider the structural barriers to mental health care for newcomer children and youth with special needs across ministries to ensure systems of care effectively respond to their needs throughout the resettlement process.
- Conduct needs assessments and collect local data related to the diversity of communities and the experiences of newcomers. This data can be used to increase awareness of cultural diversity, population’s needs and strengths and provide a rationale for a flexible set of services that are adapted to diverse cultural, religious, ethnic and linguistic experiences.

Recommendation 2: Address barriers to care and deliver culturally-responsive and culturally-specific mental health services that are tailored to the needs of newcomer families.
- Consider and respond to the barriers that can prevent newcomer families from getting the mental health supports they need, including but not limited to: lack of information about services, unclear pathways to care, cultural mistrust, communication challenges, economic constraints, etc.
- Use a holistic approach to the mental health care of newcomer youth by adopting a social determinants lens, and understanding the cultural belief systems and social/contextual circumstances of newcomer families.
- Engage newcomer communities and develop targeted initiatives to increase mental health awareness, reduce stigma and reach out to specific ethno-cultural communities to promote mental wellness.

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Recommendation 3: Identify and adopt specific approaches, standards, tools and priorities for child and youth mental health agencies that will guide service delivery for newcomer youth and ensure they are tailored to each community’s unique needs and context.

Recommendation 4: Ensure the processes involved in service delivery are structured to produce meaningful and relevant supports tailored to the specific needs of newcomer children, youth and families.

- Offer a range of options in mental health care that include both mainstream and traditional supports.
- Foster connections with ethnic communities and incorporate diverse cultural, spiritual and religious beliefs/practices in care.
- Reduce isolation and minimize barriers to care for newcomer children, youth and families.
- Help newcomer families navigate and understand the mental health system and identify available resources that can minimize the migration-related stressors.
- Increase trauma awareness and deliver strength-based interventions to newcomer families accessing mental health support.

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- Identify newcomers’ first points of access in times of need and the barriers they face when accessing mental health care. Collaborate with primary care providers to develop clear pathways to care to culturally responsive mental health services.
- Collect information on the linguistic make-up of children, youth and families accessing services and offer trained cultural interpreters and/or cultural brokers to facilitate mental health service delivery for newcomer families.
- Promote the integration of a diversity of value and belief systems, linguistic competencies and social and contextual realities into mental health systems as reflected in funding, policies, partnerships and hiring practices.
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Appendix I: Glossary of terms

**Acculturation:** “...the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members” (Berry, 2005, p. 698). Changes occur at the group level through social structures, institutions and cultural practices, and at the individual level through a person’s set of behaviours.

**Acculturative stress:** “...stress reaction in response to life events that are rooted in the experience of acculturation” (Berry, 2005, p. 708).

**Assimilation:** An interactive process where “the newcomers move out of formal and informal ethnic associations and other social institutions and into the host society’s non-ethnic ones” (Gans, 1999, p. 162). This is viewed as the extreme to acculturation.

**Anti-oppression:** A way of working that recognizes existing social inequalities and power imbalances and reduces them through meaningful engagement and collaboration with children, youth, families and service providers in all levels of decision-making.

**Anti-racism:** The active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably (Calgary Anti-Racism Education, University of Calgary).

**Culture:** A set of patterns that are used to guide people’s behaviours, thoughts, artifacts, ceremonies, speech, values, ethics etc. in the context of their societies, histories and environments. It is dynamic and multidimensional rather than static or fixed (Lopez, Kopelwicz & Canive, 2002). Our language in particular, how we describe, label and discuss things, is a major product of how our culture impacts our point of view.

**Cultural competence:** There are a variety of definitions used that have evolved over time. However, in the context of this paper we use the American Evaluation Association (AEA) definition of “A stance taken toward culture, not a discrete status or simply mastery of particular knowledge and skills. Cultural competence is a ‘process’ or a sensibility cultivated throughout a lifetime. It requires awareness of self, reflection on one’s own cultural position, awareness of others’ positions, and the ability to interact genuinely and respectfully with others” (AEA, 2011).

**Dependent child:** A child who depends on their parent for financial or other support. The child must be under 19 years of age with no spouse or partners, or 19 years old and over and has largely depended on parent’s financial support before the age of 19 due to physical or mental conditions (Citizen and Immigration Canada [CIC]).

**Diversity:** The variety of differences among people. This includes language, education, cultural traditions and work experiences among many others (Ontario Healthy Communities Coalition, 2004). There are differences between cultures around the world as well as within them.

**Ethnic origin:** Refers to a person’s roots or ancestors (usually more distant than a grandparent) and differs from citizenship, nationality, language or place of birth (Statistics Canada, 2011).
**Ethno-cultural group**: This refers to a group of people or community that shares recognized characteristics, such as cultural traditions, language, national identity or physical traits, and often refers to groups who experience marginalization (MHCC Task Group on Diversity, 2009). The term also encompasses ethno-racial and racialized which are used to make it more explicit that marginalization comes from systemic discrimination and exclusion based on skin colour.

**Exclusion/inclusion**: The World Health Organization (WHO) Commission on Social Determinants of Health (2008) considers social inclusion and exclusion as existing on continuums that are “characterized by unequal access to resources, capabilities and rights which leads to health inequalities”.

**Generation status**: “Refers to whether a person or their parents were born in Canada” (Statistics Canada, 2011). Waves of immigration that have settled in Canada over time and the number of generations people have lived in Canada create a picture of Canada’s diverse population.

- **First generation**: People born outside of Canada.
- **Second generation**: Individuals born in Canada with at least one parent born outside of Canada.
- **Third generation or more**: Individuals born in Canada with both parents born in Canada – for example, their grandparents were born outside of Canada (Statistics Canada, 2011).

**Government-assisted refugees (GAR)**: A person who is outside Canada and has been determined a Convention refugee. They are chosen from applicants referred by the United Nations High Commissioner for Refugees (UNHCR) and other referral organizations and receive a range of supports from the federal government (Citizenship and Immigration Canada [CIC]: http://www.cic.gc.ca/english/helpcentre/glossary.asp).

**Health equity**: Creating equal opportunities for good health for all and reducing avoidable and unjust differences in health among population groups (Centre for Addiction and Mental Health [CAMH], 2012).

**Immigrant**: This term often refers to a broad range of migrant groups and experiences, such as refugees who have been in a new country for several years. In this paper, immigrant will refer to permanent residents who have voluntarily migrated to Canada as family, business or economic class immigrants (Khanlou, 2009).

**LGBTQ+ (also GLBT)**: LGBTQ refers to individuals of diverse sexual orientations and/or gender identities, including those who identify as lesbian, gay, bisexual, trans, two-spirited, queer and questioning. Another common variation of the acronym is LGBTQIA to include intersex and allies. The plus (+) is included to be inclusive of all identities that identify with LGBTQ communities.

**Mental health/wellbeing**: The capacity to feel, think and act in ways that enhance one’s ability to enjoy life and deal with challenges (Public Health Agency of Canada [PHAC], 2014).

**Mental health promotion**: Strategies applied to specific groups and the general population that aim to strengthen mental health. These strategies enhance individuals’ capacity to take control of life and health, promote resilience and are strengths-based and intersectoral (Canadian Mental Health Association [CMHA], 2008).

**Migrant**: Individuals who leave their country of origin and relocate to a new country regardless of the reason (UNHCR, n.d.). In the context of this paper, we use this term to refer to the experience of migration for all newcomers.
Newcomer: There are a range of definitions and variations of the term “newcomer”. Statistics Canada (2006) defines “recent immigrants” or “newcomers” as permanent residents who have arrived in Canada within the last 5 years. In some cases definitions range up to 10 years. This term can counter the stigma associated to the terms “immigrant or “refugee” (Sadiq, 2004).

Permanent residents: Individuals granted permanent resident status in Canada. Upon gaining this status, they have lived in Canada for at least two years within a five-year period, have all the rights guaranteed under the Canadian Charter of Rights and Freedoms but do not have the right to vote in elections and may apply for citizenship after living in Canada for 3 years (Caring for Kids New to Canada, 2014).

Precarious status: Describes the situation of all non-permanent residents, whether they are authorized or unauthorized to reside in Canada (Goldring & Landolt, 2012). Under the Immigration and Refugee Act, those who are sponsored family members, temporary residents or live-in caregivers can also hold this status (Oxman-Martizen et al., 2005).

Racialization: The process of social construction of race “by which societies construct races as real, different and unequal that matter to economic, political and social life” (Ontario Human Rights Commission [OHRC], n.d.). The OHRC uses the terms “racialized population” or “racialized individual” rather than “visible minority”, “non-White”, “person of colour” or “racial minority” to acknowledge that race is a social construct creating experiences of systemic racism and marginalization based on skin colour.

Refugee: Someone is outside of their home country and cannot return due to a well-founded fear of persecution based on race, religion, political opinion, nationality or membership in a particular social group (Citizenship and Immigration Canada [CIC]: http://www.cic.gc.ca/english/refugees/outside/index.asp).

Refugee claimant: A person who has applied for refugee protection status while in Canada and is waiting on their claim from the Immigration and Refugee Board of Canada (Citizenship and Immigration Canada [CIC]: http://www.cic.gc.ca/english/helpcentre/glossary.asp).

Social determinants of health: The social, political, economic and environmental factors that can affect an individual’s or group’s health and wellbeing (Khanlou, 2003).

Systems approach: An approach to health that “considers multiple levels of influence on a particular phenomenon: the micro (individual), meso (intermediate), and macro (systems) levels” (Khanlou, 2009, p. 4).

Temporary residents: Foreign nationals living lawfully in Canada on a temporary basis under a work permit, study permit, temporary resident permit or a visitor record (Caring for Kids New to Canada, 2014). This also includes individuals seeking asylum upon or after their arrival in Canada. Categories include: refugee claimants, foreign students, temporary foreign workers and other humanitarian cases.
Appendix 2: Examples of models

In addition to the examples presented throughout the paper, below are a number of models that governments, health authorities and organizations implement to address the needs of specific newcomer population groups and general diversity in their communities. The models offer opportunities to build on, adapt or learn from in order to develop a system of care that responds to the mental health needs of newcomer children, youth and families.

International scan

Internationally, several European countries who receive high numbers of migrant populations are similarly moving towards health equity and diversity strategies to improve accessibility and quality of care for multicultural populations. Studies show however that in countries such as Sweden and Germany, there has still been little evaluation of the effectiveness of cross-cultural mental health training (Bäärnhielm & Mösko, 2012). Countries employ a variety of strategies and approaches toward health equity and diversity:

- **In Sweden, a Transcultural Centre** developed based on principles of Transcultural Psychiatry offers supervision and consultation on a range of health services, as well as training, education and a link to health communicators who provide services in the native language of newcomers.
- In Germany, strategies toward equity are based on a principle of intercultural opening. This focuses on long-term organizational development and accountability through structure, processes and results to ensure equal access and quality of services for all migrants groups (Bäärnhielm & Mösko, 2012)
- **In the United Kingdom, an Equality and Diversity Strategy** focuses on systemic equity policies in access to health and employment which has allowed for more efficient data monitoring, increased collaboration across sectors and greater numbers of diversity in leadership positions.

Caring Across Communities: Addressing mental health needs of diverse children and youth

**Caring Across Communities supported by the Robert Wood Johnson Foundation (RWJF)** in the United States focuses on improving the mental health of immigrant and refugee families through school-based initiatives and their key community partners. Between 2007 and 2010, schools and communities across the Unites States developed mental health programs ranging from school-wide mental health promotion to culturally-based counselling with individuals or groups. **Some of their key outcomes from results** show that there are four components of mental health services for immigrant and refugee children that begin with family engagement:

- engaging with families
- meeting their basic needs
- supporting their efforts to adapt to a new culture
- providing emotional and behavioural support
National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards)

The U.S. Department of Health & Human Services has developed 15 standards to address health disparities and improve the quality of services. Their principal standard is to: “provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.” The remaining standards fit into three overarching domains:

- governance, leadership and workforce
- communication and language assistance
- engagement, continuous improvement and accountability

Jurisdictional scan

Health equity and diversity have been prioritized by health authorities and organizations across Canada, such as the Regional Diversity Advisory Committee in Calgary, Vancouver Coastal Health (one of six British Columbia Health Regions) and the Toronto and Central LHINs in Ontario, with an emphasis on linking equity, cultural competence, strategy and outcomes.

Evergreen: A child and youth mental health framework for Canada

The Mental Health Commission of Canada (MHCC) is a resource for service providers, caretakers and decision-makers involved with child and youth mental health policy, planning, programs and services. The framework is based on a set of values to guide the development of child and youth mental health initiatives and inform all policies, planning, programming and services across Canada. The MHCC recommends the framework to address the mental health needs of diverse communities since it offers options for decision- makers and service providers to select from that depend on local contexts and needs.

The framework embeds cultural diversity as a core component of initiatives throughout the framework:

- Prevention: Includes the availability and promotion of culturally-specific activities to support communities to reconnect with or maintain connection to cultural traditions. These are particularly relevant for Aboriginal youth and newcomers.
- Intervention and ongoing care: Includes the establishment and delivery of appropriate cultural diversity training programs for all child and youth mental health providers.
- Research and evaluation: Includes the promotion of research into groups of people traditionally excluded or under-represented in child and youth mental health system.

Transcultural Child Psychiatry Service in Montréal – Cultural Consultation

Transcultural Psychiatry based in Montréal at McGill University is a leading approach worldwide that seeks to understand the associations between mental health and culture and effectively respond to diversity in mental health care. Multi-disciplinary and collaborative care are at the core of this approach (http://www.mcgill.ca/culturalconsultation/; http://www.mcgill.ca/tcpsych/files/tcpsych/Report11.pdf). Three hospitals
implement a specialized cultural consultation model which integrates the diverse perspectives of psychiatrists, physicians, psychologists, art therapists, schools, counsellors, social workers and others based on the needs of the child and their family.

At Montréal Children’s Hospital they emphasize a pluralistic and flexible approach to working with immigrant and refugee children. Research results analyzing 239 cases between 1996 and 2000 show a decrease in drop out rates (15%) which usually happen before the initial meeting.

- **Assessment process:**
  - A multidisciplinary team completes the evaluation of the presenting problem with a professional interpreter and cultural broker and the team’s culturally diverse multidisciplinary team (multiple professional backgrounds and identities)

- **Treatment:**
  - Standard western psychotherapy and pharmacotherapy techniques are offered to children and families along with treatment techniques that have been specifically developed to meet the needs of their client demographic (e.g. sand play therapies, storytelling therapy, art and drama therapy)
  - The team explores including other modes of care that are being practiced by the family, such as traditional or religious care, which become central, complementary or parallel treatment modalities
  - Team members consult and mediate with institutions, including schools, health and social service providers, and immigration and legal services

**Communities That Care (CTC)**

CTC supports communities through a five phase process based on prevention science and risk and protective factors. The prevention process aims to promote healthy youth development, improve youth outcomes and reduce common youth challenges (substance use, violence, school drop-out, mental health challenges etc.). Establishing the CTC system in a community brings about multi-level and multi-sectoral prevention planning as well as the implementation of evidence-based programs that fit the make-up of the community. The five phases include: community readiness assessment, community mobilization, risk, protection and resource assessment, strategic planning and implementation and evaluation.

The Public Health Agency of Canada rate the CTC program as a best practice for supporting communities in collecting local data on risk and protective factors for youth and improving community capacity to effectively respond to their own needs [http://cbpp-pcpe.phac-aspc.gc.ca/interventions/communities-care/](http://cbpp-pcpe.phac-aspc.gc.ca/interventions/communities-care/). The model is currently being used in three urban Aboriginal communities in British Colombia through CMHA, BC Division and the BC Association of Aboriginal Friendship Centres: [http://www.cmha.bc.ca/how-we-can-help/aboriginal-families/connectingthedots](http://www.cmha.bc.ca/how-we-can-help/aboriginal-families/connectingthedots).
Provincial scan

East Metro Youth Services

East Metro Youth Services (EMYS) is an accredited adolescent mental health and addictions centre in East Toronto and is an example of an organization that, given the ethno-cultural diversity in their region, commit to access, equity and anti-racism as founding principles of their organization. Their Newcomer Youth Program serves youth from 12-21 years of age who are permanent residents or conventional refugees and have been living in Canada for less than five years. The program helps orient youth in the new culture and throughout the settlement process, educates around stigma, migration and mental health and trains them and their families on skills for employment, school and building social networks.

Community Health Centres of Ontario

The Network of Ontario’s Community Health Centres and Aboriginal Access Centres all work from the same Model of Health and Wellbeing that recognizes health equity, people- and community-centred and community vitality and belonging as central to their service delivery: http://aohc.org/model-health-and-wellbeing.

Attributes of the model include:

- anti-oppressive and culturally safe
- accessible
- interprofessional, integrated and coordinated
- community-governed
- based on the social determinants of health
- grounded in a community development approach
- population and needs-based
- accountable and efficient

Across Boundaries

Across Boundaries is a mental health centre in the Greater Toronto area that provides support and services to people of colour/racialized communities with severe mental health challenges. The organization uses a holistic approach to care and operates within an anti-racism framework to address the unique needs, histories and context of racialized populations in their community. This approach considers the influence of emotional, mental, physical and spiritual dimensions of health as well as the intersection of mental health with social, economic, cultural, linguistic and environmental aspects of individuals. The organization offers a range of programs and intervention options, such as art therapy, community outreach, support groups and alternative or complementary therapies. The anti-racism framework ensures service providers learn cultural competence. They focus on the importance of community development, collaboration and partnership to draw upon their own expertise and others in meeting the needs communities of colour.
Appendix 3: Tools and initiatives to support policy recommendations

Understanding the community: Needs assessments and research initiatives

Ontario Common Assessment of Need (OCAN) of the Community Mental Health Common Assessment Project (CMH CAP)

The OCAN is a standardized decision-making tool that uses a collaborative and holistic approach to understanding the needs of service users and identifying gaps in services. The OCAN is used at both individual care planning levels in mental health recovery and at the system-level to support a streamlined assessment process and support informed-decision-making. Agencies can also translate the OCAN tool using resources from the CMH CAP. CMHA Toronto and Across Boundaries have led the translation of the tool into a variety of languages:
https://www.ccim.on.ca/CMHA/OCAN/Private/Pages/OCAN_Translation_v2.aspx

Mapping the mental health system in Peel region: Challenges and opportunities

United Way of Peel Region identified mental health as a priority in their 2013 investment strategy. They commissioned a community research project that focusses on how people in their community, particularly ethnocultural communities, access and navigate services. Their goal was to identify common challenges and gaps as well as promising practices and opportunities for improvement. They consulted with community members and a large range of organizations that expanded beyond mainstream mental health services to reflect the make-up of their community. These included social and health services such as newcomer settlement, youth transitions and family neighbourhood services. This resulted in five different interactive online maps that cross sectors showcasing the pathway people take to access mental health services and recommendations to respond to the identified system challenges. Some of the recommendations include improving collaboration across sectors, increasing flexibility of services and building capacity of family, neighbourhood and ethnocultural service organizations to meet the mental health needs of people they serve.


Morton Beiser at St Michael’s Hospital, Toronto, along with a team of researchers are working to better understand the specific experiences and implications of post-traumatic stress disorder (PTSD) among refugee children and youth in Canada. Identified as a priority population, this study will include approximately 300 refugee children and youth ages 7 to 18 years (https://www.clinicaltrials.gov/ct2/show/NCT02334566).

The purpose of the study is to “address the needs of this at-risk population through pilot testing of the feasibility of providing a PTSD intervention (Narrative Exposure Therapy [NET or KIDNET]) within two-school based primary health care programs and an inner city youth shelter in Toronto.” It is hoped that these results will be used to assess the feasibility of using this model of intervention across Ontario and Canada to prevent mental health challenges and enhance adjustment to Canadian society.
The Metropolis Project

The Metropolis Project in an international network that focuses on comparative research and developing public policy on migration, diversity and immigrant integration in Canadian communities and around the globe.

Health Profile on Immigrant and Refugee Children and Youth in Canada

A recent initiative of the Canadian Institute of Child Health (CICH) evaluates and summarizes data on the health and well-being of immigrant and refugee children and youth up to 24 years of age in Canada in an interactive online module format. Pottie et al. (2015) display recent research literature and data using graphs and tables to illustrate the general health status of immigrant children and youth, the priority health conditions among this population and the causes and consequences of cultural discordance. They describe cultural discordance as the perceived conflict between a child or youth’s culture of origin and the new culture in Canada. Their findings highlight the importance of risk and protective factors within the social and environmental conditions that newcomer children and youth experience migration. This recent review of the research literature also highlights the need for increased data collection, access to statistics and dissemination of information on the mental health needs and strengths of newcomer children, youth and families.

Integrating diversity and equity into mental health services

Task Force on Migrant-Friendly and Culturally Competent Health Care (TF MFCCH): Equity standards in health care organizations

The TF MFCCH supports the work of the International Network of Health Promoting Hospitals and Health Services (HPH) and the World Health Organization. They aim to facilitate partnerships and disseminate policies and experiences, foster alliances between healthcare organizations and networks, and support health care organizations in becoming more migrant-friendly and culturally competent. The Task Force recently developed and piloted a set of equity standards that aim to help organizations monitor, measure, and enhance equity for migrants and vulnerable groups they serve.

Opening Doors Project by the Canadian Mental Health Association (CMHA) of Toronto

In partnership with Access Alliance and Across Boundaries, CMHA Toronto provides a free workshop series for newcomer communities, mental health services, agencies and institutions about migration and mental health. The project acknowledges the impact of discrimination and stigma on the mental health of newcomer communities. The series of 10 workshops aim to increase literacy in communities across Ontario on mental health, anti-racism and anti-discrimination, support participation of newcomers with mental health challenges and create more inclusive environments for newcomers.

Diversity in Action: Adapting mental health services for newcomer families

Diversity in Action (DIA) is a mental health promotion initiative of Scarborough to respond to the needs of their large newcomer population. In partnership with a range of agencies who provide support to newcomers in the region, the Psychology Foundation of Canada lead the DIAS project to connect newcomers to mainstream mental health services and work with ethno-cultural groups to develop new approaches to serving newcomer children and families. An e-
learning module provides an overview of the needs of newcomers in mental health services, a picture of the DIAS project and the components of their logic model.

The Central West LHIN prioritizes diversity and equity in their Integrated Health Service Plan (IHSP) to ensure responsiveness of cultural diversity in local health systems. Their major activities include ensuring a Health Equity Plan for organizations that will identify key strategies and implementation plans focused on improving equity of access to care. One of their guidelines for organizations includes adopting a consistent Language Interpretation model.

Avenues for improving cross-sector collaboration and coordination

The Racialized Populations and Mental Health and Addictions Community of Interest (CoI), an initiative of the Evidence Exchange Network (EENet) for Mental Health and Addictions, is a provincial forum for knowledge exchange and collaboration to leverage promising evidence that will improve mental health and addictions program planning for racialized communities. Meetings with individuals from across sectors identified several opportunities and promising practices:

- Prevent emergency department use by going beyond the health sector to leverage existing community and social service supports.
- Improve the collection and coordination of socio-demographic data using accessible, standardized questions at health systems levels in hospital planning. Using the HEIA and Community Health Links at the LHIN level or investing in peer support navigator positions.
- Use promising practices in collaboration to improve hospital-community collaboration, particularly in the involvement of police services in planning and decision-making.
- Prioritize health equity and the needs of marginalized populations in planning ED services to improve continuity of care and aspects of service delivery.

The Youth Outreach Worker (YOW) Program of Ontario’s Youth Opportunities Strategy

The Youth Outreach Worker (YOW) program of Ontario’s Youth Opportunities Strategy (MCYS 2013-2018 Strategic Plan) and a part of Ontario’s Poverty Reduction Strategy is a recent, multi-agency outreach initiative for the most vulnerable and marginalized youth in underserved neighbourhoods, including those with special needs, LGBTQ+, newcomer, racialized and ethno-cultural communities. As mentioned, facilitating outreach and community engagement are key strategies to understand the needs of diverse communities and connect them with appropriate services. YOWs meet youth in places where they spend their time and aim to help youth and their families better navigate and connect with services and supports in their communities so they can take action on their own well-being. In mental health promotion, this initiative can help bridge gaps in coordination and collaboration across sectors to improve access to care and health inequities for newcomer communities.
Addressing language and communication barriers to improve health equity

The Health Equity Office of the Centre for Addiction and Mental Health (CAMH) in Toronto has developed standardized guidelines for working with cultural interpreters.

Let’s Talk: An interpretation toolkit for service providers working with immigrants in Ontario
Developed by Citizen and Immigration Canada, Ontario Region, this toolkit supports organizations in improving services to newcomers with limited English language proficiency.