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ORIGINAL ARTICLE

Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers

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ABSTRACT: *Immigrant and refugee populations experience life stressors due to difficult migration journeys and challenges in leaving one country and adapting to another. These life stressors result in adverse mental health outcomes when coupled with a lack of adequate support-enhancing resources. One area of support is access to and use of mental health services to prevent and address mental health concerns. Immigrant service providers in Canada support the integration and overall well-being of newcomers. This study focuses on immigrant service providers' perceptions of access to and use of mental health services for immigrants and refugees in Alberta. A qualitative descriptive design was used to collect and analyse the perspectives of 53 immigrant service providers recruited from nine immigrant serving agencies in Alberta between November 2016 and January 2017. Data were collected using a combination of individual interviews and focus groups, followed by thematic data analysis to identify relevant themes. Barriers to access and use of mental health services include language barriers, cultural interpretations of mental health, stigma around mental illness, and fear of negative repercussions when living with a mental illness. Strategies to improve mental health service delivery include developing community-based services, attending to financial barriers, training immigrant service providers on mental health, enhancing collaboration across sectors in mental health service delivery, and advancing the role of interpreters and cultural brokers. Overall, immigrant service providers present a nuanced view of the complex and inter-related barriers immigrants and refugees experience and identify potential approaches to enhancing mental health service delivery.*

KEY WORDS: *Canada, immigrant, mental health, service providers.*

INTRODUCTION

International migration is increasing as a result of globalization and advancements in transportation and communication technologies. Conflict, political unrest, and environmental disasters continue to create large episodic shifts in human populations across national borders. In 2015, 244 million people were living in a country other than their birth country with Canada having the 7th largest foreign-born population in the world (International Organization for Migration [IOM] 2018). Migrants are at risk for adverse mental health outcomes resulting from premigration and postmigration stressors and from difficult migration journeys (Bas-Sarmiento *et al.* 2017). Despite the resilience, resourcefulness, and adaptability of migrants in the face of adversity, poor mental health outcomes have been documented in migrant populations across the globe (Bourque *et al.* 2011). In Canada, immigrants on average arrive healthier than their Canadian-born counterparts with health declining as length of stay increases; a phenomenon dubbed the 'healthy immigrant effect' (Vang *et al.* 2017). The healthy immigrant

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effect holds for mental health with notable decline in mental well-being in subpopulations depending on contextually mediated stressors and availability of supportive resources (Hansson *et al.* 2012; Salami *et al.* 2017; Stafford *et al.* 2011).

Newly arrived immigrants contend with the stressors of learning a new language, finding employment, and navigating an alien cultural and social system (Robert & Gilkinson 2012). Refugees and immigrants with traumatic premigration experiences of war, persecution, or violence might live with persistent physical and mental health sequelae (Kanagaratnam *et al.* 2017). Vulnerable immigrants in Canada grapple with precarious or underemployment, fragmented social networks, and experiences of racism and discrimination (Edge & Newbold 2013; Premji 2018; Puyat 2013; Wang & Palacios 2017). Especially susceptible to negative mental health consequences are immigrants from visible minority groups, those with lower education, and those of lower socio-economic status. Youth (Hilario *et al.* 2015), women (O'Mahony 2011), and the elderly (Guruge *et al.* 2015) are particularly vulnerable subgroups within these categories. Despite the well-documented mental health risks for immigrants and refugees, there remain gaps in our understanding of barriers and facilitators of access to and use of mental health services for immigrants and refugees in Canada.

Immigrants and refugees from diverse ethnic backgrounds and with diverse migration histories have identified some similar barriers to accessing and utilizing mental health services. These barriers include migrants' lack of knowledge about mental health, stigma of mental illness in countries of origin and in receiving local communities, economic burden of accessing mental health services, and lack of appropriate mental health training for health and social service providers (Derr 2016; Donnelly *et al.* 2011; Sandhu *et al.* 2013; Wohler & Dantas 2017). Calls to address the mental health needs of Canadians at policy and practice levels continue, but with minimal incorporation of approaches to mental health service delivery that are specific to the needs of diverse populations, address known access barriers, and that are economically viable and sustainable (Hansson *et al.* 2010). To date, research is minimal on the role of immigrant service providers [ISPs] in supporting immigrants and refugees overcome these barriers. Immigrant service providers in Canada take a leading role in providing immigrant resettlement services and support for social, economic, and cultural integration into host societies (Kerman *et al.* 2017; Maximova & Krahn 2010). Alberta is a Canadian province with one of the fastest growing populations of foreign-born nationals; in 2013 and 2014 the proportion of immigrants preparing to settle in Alberta was 14.1% and 16.3%, respectively (Statistics Canada 2016). This article discusses study findings on barriers to accessing and utilizing mental health services and potential interventions and approaches to improving mental health service delivery from the perspective of ISPs.

STUDY DESIGN

A qualitative descriptive design was used for this study which allows for description and organization of data to reflect the original language and intent of participants (Sandelowski 2000). Ethics approval was obtained from the University of Alberta Research Ethics Board before commencement of research activities.

Recruitment

Participants were recruited from immigrant serving agencies in the province of Alberta, Canada. Immigrant serving agencies are nonprofit, community-based, and provide settlement, integration, and adaptation services to immigrants with the goal of facilitating adjustment to life in Canada. Recruitment was completed, initially, using convenience sampling by compiling a list of these agencies through online searches and then contacting representatives of those service providers. Individuals were, also, recruited from service agencies using snowball sampling to locate potential participants leveraging the authors' long-standing research partnerships within immigrant communities. Theoretical sampling was used at later stages of data collection to follow-up on emerging themes in the data. Inclusion criteria were being an ISP in the province of Alberta, over 18 years of age, and able to speak and understand English.

Data collection

Participants were given the choice of participating in individual interviews or focus groups. All interviews and focus groups were conducted in person at one of the immigrant serving agencies between November 2016 and January 2017. Forty-seven ISPs participated in one of six focus groups, while six ISPs participated in individual interviews. Each focus group included five to eight participants. All data collection was completed by the first author who is experienced with qualitative interviewing and group facilitation techniques. Detailed notes on context and nonverbal cues were kept by a research

assistant during all focus groups. The first author is an immigrant with years of experience studying immigrant populations. The research assistant was a recent refugee who had migrated to Canada within the last 2 years. Both kept reflexive memos to take into consideration the influence of their social locations on emerging data and to record immediate thoughts during data collection. Individual interviews lasted approximately 30 min to 1 hour, while focus groups lasted between 1 and 2 hours. Written informed consent was obtained from all participants. All interviews and focus groups followed a semi-structured format with the aid of an interview guide that included the following questions: '(a) What has been your experience with respect to access to and use of mental health services for immigrants in Alberta? (b) What feedback have you received from immigrants who are trying to access and use mental health services? (c) What challenges do immigrants in Alberta experience with access to and use of mental health services? and (d) What are the facilitators to access to and use of mental health services for immigrants in Alberta?' Data collection ended when data saturation was achieved; data saturation was defined as the repetition of thick descriptions with no new emerging themes.

Data analysis

Interviews and focus groups were audio-recorded and transcribed verbatim by a professional transcriptionist. Data analysis was completed using thematic analysis aided by NVivo 10 qualitative software. Thematic analysis is a method for identifying, analysing, and reporting repeated patterns of experiences and meaning across a data set (Braun & Clarke 2014). First, transcripts were read multiple times to become familiar with the data. Then, inductively, a list of preliminary codes were developed which were refined into categories and then refined, expanded, and condensed into themes. For the final analysis process, patterns were identified within and across thematic categories. All authors engaged in ongoing discussion around emerging themes and interpretations of data. Upon completion of data analysis, participants were provided with a preliminary report for verification.

FINDINGS

We recruited 53 ISPs for this project from nine immigrant serving agencies in Alberta. A total of 49 participants were immigrants themselves. Six participants were male, and the remaining 47 participants were females. Participants included both immigrant mental health practitioners and other immigrant service providers focused on housing, language, employment, and other integration needs. Five participants were counselling psychologists working at immigrant serving agencies in Alberta. The perspectives of ISPs revealed in this study highlight two main themes: (i) barriers persist to accessing and utilizing mental health services in Alberta and (ii) alternative strategies are needed to improve mental health service delivery.

Barriers to access and use of mental health services

Language and cultural barriers

Participants reported that many clients believed mental illness to be a Western concept used by healthcare professionals. Clients preferred going to family, friends, or spiritual leaders to address their concerns or receive support for life stressors and were uncomfortable talking with healthcare professionals about their problems. Often clients perceived symptoms of mental illness as a crisis of faith, personal weakness, or evil spirits that invade the body.

> Well for me mental health is predominantly, with my clients, it is predominantly a Western notion. They'd rather consider it as a spiritual crisis … they opt to go to a regiment of prayer rather than seek professional or medical help. (P6, FG 4)

Emotional or mental distress commonly manifested and was described by clients in terms of physical symptoms. Clients did not recognize symptoms of mental illness even when sensing a lack of overall well-being. Mental illness in some communities was associated with overt acts of aggression or stereotypical depictions of 'acting crazy'. Persistent sadness, anxiety, or psychosomatic symptoms were not seen as related to mental health.

> … our clients wouldn't even recognize that they are experiencing depression or experiencing isolation or experiencing all these kinds of mental health concerns. They don't have a definition of mental health and they don't even know that they are grappling with the intensity of all these situations … (P8, FG3)

Language barriers were one of the biggest impediments to accessing and utilizing mental health services seen across immigrant serving agencies. Many immigrant and refugee clients lacked English language fluency skills and needed interpreters to communicate with mental health professionals:

> … Many mental health programs, service providers, don't speak the language of newcomers and that is a big issue. When newcomers finally acknowledge that they have an issue and they want to see a psychiatrist or a psychologist somebody else has to go with them to translate and then you have to wait for that somebody to be available … (P3, FG2)

Certain groups were especially vulnerable to the impact of language barriers. For example, immigrant women were more likely to have lower English language skills due to lack of employment outside the home and decreased opportunities for language learning.

Persistence of stigma

Participants recognized the stigma attached to the label of mental illness and reported searching for more culturally appropriate language to begin a discussion with clients who were experiencing mental health difficulties. Stigma was often internalized by clients as a devalued sense of self where they presented with feelings of shame and failure. Many immigrants and refugee clients felt a personal responsibility to manage life stressors, keep going, and 'deal with it'. External stigma was, also, noted in local ethnic communities and in the broader Canadian context leading to experiences of discrimination and social exclusion. Overall, stigma meant that those suffering from significant symptoms concealed the issue from family members and extended support networks, increasing their isolation and exacerbating their mental illness.

> … even if they acknowledge they have a problem they will not seek mental health support because they feel ashamed doing that … they still feel that people who go to ask for mental health services or treatment are kind of crazy. They don't want to acknowledge that. Even if they do, it is still in secret. They don't mention it even in front of their family members. (P4, FG 3)

When family members became aware of a mental health problem, they felt the need to conceal this from their ethnic community to avoid stigmatization. Having a family member with a mental illness could mean loss of social status, social exclusion, and discrimination.

> … the family members are actually ashamed to address the issues, so what they do is just say: 'Oh you know he's sick, he has back pain, he has some chronic disease but it's not a mental health issue.' So it's kind of hard to address that, especially when they do come here to Canada in a Western society where mental health is actually a big part of health and it needs to be addressed. (P1, FG 4)

The lack of discussion and recognition of mental illness in immigrant and refugee communities meant individuals and families often suffered in silence, unable or unwilling to access available mental health supports.

> … what I find difficult is *(clients)* understanding that help is available and understanding that help is ok and that it's ok to accept help … the problem is to motivate them to accept help. I think to accept help is not easy anywhere. Mental health stigma is everywhere but help is available … (P7, FG4)

Fear of negative repercussions

When experiencing significant mental health symptoms or receiving a diagnosis of a mental illness, participants described clients' fears of negative repercussions from Canadian society. Such negative repercussions included losing custody of children when parents were struggling with mental illness or imprisonment of spouses in cases of family violence. One participant gave an example of working with a family accessing mental health services.

> … So there is a perception that there is something wrong with your child and maybe that your child might be taken away from you. That's actually a common concern, that if they're working with a psychologist they're more at risk of losing their kids. So, I think that can deter a lot of parents… (P39, Interview)

Immigrant and refugee clients, also, feared deportation back to country of origin or termination of employment. One service provider summarizes the challenges experienced in supporting clients with recognizing and addressing a mental health concern.

> … the fear of being deported or somehow that my immigration status would be compromised if I am diagnosed with mental illness … Especially in the hospitals and the health system, you go and then the information would be entered. So, they feel like once it's entered it's everywhere. (P14, Interview)

Participants who came in contact with clients struggling with mental health needs described tensions where ISPs were seen as gatekeepers to much needed resources and clients felt their mental health issues would result in denied access to those resources.

> I think that some of our clients feel that if they admit they have a mental issue, even depression, that somehow they are going to lose other resources …. So let's pretend and then at least I have access to these

> resources, the minute I don't pretend I lose all of this. (P4, FG4)

Presence of systemic access barriers

Clients experienced tangible barriers to accessing and utilizing mainstream mental health services, such as high financial costs of accessing counselling services, transportation barriers, and lack of childcare for families attending therapy sessions. Some of these barriers were particularly limiting for women who were primary caregivers, could not drive, and/or had limited socioeconomic resources in Canada.

> . . . if we want to work with a mother that's often near impossible. A lot of the fathers we work with don't think that it's their role to stay home with the children, so accessing mothers is very difficult in that way. . . if there were somewhere that could provide some childcare services for parents who were seeking therapy that would also improve access. (P39, Interview)

Community-based mainstream mental health services are expensive and not always covered by public health insurance. Free services are either limited or not flexible enough to meet the complex needs of immigrants and refugees. Few evening or weekend services are available. Taking time away from work was difficult for many clients who were primary bread winners with low-pay or precarious employment.

> But one of the things that I wanted to add is the income issue. One of the reasons why clients don't seek help and I have had this conversation with a lot of clients is 'we don't have the time'. We need to pay the bills. We need to pay the rent. (P3, FG3)

> . . . lots of clients are not willing to pay $200.00 per hour to talk to a stranger. No thank you, unless it is covered by their insurance. Here basic health insurance won't cover for counseling or a psychologist. (P10, FG1)

The combination of these barriers for immigrants and refugees unfamiliar with mainstream mental health services meant significant delays in recognizing mental health needs and receiving support.

Strategies to improve mental health service delivery

Community-based delivery models

Participants identified successful features of mental health initiatives in the communities they serve that could enhance the delivery of future mental health services. Community-based mental health services needed to be flexible, address complex needs beyond immediate mental health concerns, and be situated within communities with outreach capacity.

> Any kind of wellness promotion has to have a service model that has people going out to the communities instead of expecting people to come to the desk. (P4, FG 3)

> I think that more community-based mental health services would be very beneficial . . .. A community model address barriers such as language, such as economic barriers, such as adjustment to this country.(P38, Interview)

Service providers highlighted the need for a delivery model that incorporated holistic approaches, addressing the broad range of social, economic, and integration challenges experienced by immigrants, while avoiding the stigmatized label of being a mental health service. Another important feature involved taking a prevention approach versus a crisis management approach in mental health service delivery. Participants frequently supported clients who were experiencing a crisis; something that could be better addressed by developing proactive initiatives to raise awareness, identify common sources of crisis, and develop targeted strategies for support.

> Holistic, proactive, and preventative right. I think those are the features well before the crisis or trying to avert crisis states . . . So, recognizing that there are risks to the migration process . . . (P2, FG 6)

Parenting programmes were a given as an example of an effective holistic delivery model where families were able to develop social networks, increase engagement in their community, and learn about wellness and parenting.

> There is a program called Parenting and Literacy Program here and that's offered for moms . . . by coming here they are exposed to new information, there are people who come to speak about legal issues, health issues . . . it doesn't necessarily have to be called mental health, it doesn't have that label on it . . .. because the stigma comes from that label . . . (P14, Interview)

Needs of immigrant service providers

Participants played an important role in identifying clients who were struggling with mental health issues, supporting clients towards mental well-being, and connecting clients to mainstream mental health services. Many of these service providers felt unequipped to

deal with the mental health needs that arose during client interactions. The desire for increased mental health training for ISPs on identifying client needs, referring clients to specialized mental health services, and supporting clients in crisis were unanimously addressed as priority areas.

> They need to provide training for the frontline worker to deal with mental health, because quite a lot of people they may know that they want to do supportive counseling but they really don't know about mental health issues ... (P8, FG 5)

> ... our ability as an institution and as employees who serve these clients to actually recognize signs and symptoms *(of mental health needs)* and to differentiate between different cases... I don't have those skills ... about 90% of our clients they come here because they don't have a job or because they are having some difficulties and they usually need help particularly with employment ... it's how to differentiate and how to recognize red flags ... (P9, FG4)

Participants found the referral system for accessing mainstream mental health services cumbersome and time-consuming due to lengthy wait times, complex eligibility criteria, and fragmented service delivery. On the other hand, participants who were counselling psychologists working in immigrant serving agencies described frustration as they in turn experienced increased client referrals from mainstream healthcare services.

> We get referrals from everywhere ... in the last 10 years our problem has been that we have more referrals than we can serve ... now we are seven therapists and we still have a waitlist of 6 weeks ... which of course is really not good for refugees and immigrants ... (P13, interview)

Participants were aware of the mental health needs of their clients but were entrenched in a system that provided minimal mental health training and little support tailored to the needs of ISPs navigating mainstream mental health services.

Role of interpreters and cultural brokers

Service providers reported discrepancies in expectations between clients and mental health professionals around the purpose of therapy sessions. Clients went to therapy to receive a cure for their symptoms or to be given a solution to problems believed to cause their symptoms. Cultural brokers had an important role in providing education and cultural translation for clients and mental health professionals on the differing perceptions of mental health and mental illness treatment:

> The feedback that I have from my client is say that the way of counseling is not what they expect ... when they come back, they always say that the counselors don't teach me what to do. They *(counselors)* expect me to talk about my story, talk about my feelings but don't teach me. They *(counselors)* don't tell me what I should do ... (P1, FG 5)

Participants, also, identified the need for well-trained interpreters who knew their roles within counselling sessions, developed rapport with clients, and understood medical terminology. Often family, especially children, adopted the roles of interpretors which came with many challenges, such as loss of confidentiality and increased burden on family members. The importance of having in-person interpreters was emphasized for improving access to mental health services but was seen as deficient in the current healthcare system.

> ... So if there were interpreters readily available and clients knew that they could speak to someone in their own language that would be a really good start .... In-person. Over the phone, I'm sorry, but therapy with somebody helping over the phone would take too long... (P48, interview)

Participants reported evaluating the fit of a cultural broker or interpreter with a particular client; a process often neglected by mainstream mental health services. Cultural brokers and interpreters who shared the language of a client could differ along religious, class, and political lines, resulting in mutual distrust and tension. Cultural brokers or interpreters from the same ethnic communities as clients could jeopardize confidentiality due to the close knit nature of these communities.

> You don't even want to go to someone who could interpret your language because it's more embarrassing ...
> I don't want to go speak to anybody who does know my language if they might be from my community ... (P4, FG 4)

DISCUSSION

We identify in this study the perspectives of ISPs on immigrant and refugee access and utilization of mental health services in Alberta. Two major insights that come from the findings are, first, that ISPs are at the front lines of initiating conversations about mental health in immigrant communities and provide multiple

supports for mental well-being. Secondly, current mainstream mental health services present significant challenges for vulnerable immigrants and refugees. We will discuss below the need to further address the multidirectional and counter-influencing impact of language, culture, and stigma and the continued importance of advancing community-based mental health initiatives.

Addressing the triple barriers of stigma, language, and culture

Immigrant service providers discussed three major barriers to accessing and utilizing mental health services: mental health stigma, cultural interpretations of mental illness, and language barriers. Beliefs and perceptions of mental illness included not recognizing mental illness as a valid condition or interpreting mental illness in ways that conflicted with Western biomedical views. Mental health stigma was, also, a prevalent concern. Stigma and lack of knowledge about mental illness is well documented in the literature on immigrant populations from various cultural and linguistic traditions (Chaze *et al.* 2015; Guruge *et al.* 2015; Nadeau *et al.* 2017). However, the complex challenge of eliminating stigma around mental illness is not limited to immigrant populations (Szeto *et al.* 2013). There remains little evidence of successful approaches to addressing stigma, especially in culturally and linguistically diverse groups, both self-stigma that relates to internalizing negative perceptions of self and public stigma that relates to discrimination and the tangible impacts on a persons' life (Guruge *et al.* 2017). Immigrant service providers can navigate barriers and create awareness around mental health within communities. In this study, ISPs discuss using culturally appropriate terminology to refer to mental health, honouring confidentiality, and building trust with clients. Meeting parallel needs, such as housing and employment, sets the ground work for addressing more taboo topics like mental health. These strategies not only provide useful insight for other healthcare professionals working with immigrant communities but point to the potential for utilizing ISPs' positions within these communities to promote mental well-being.

Using interpreting services and cultural brokers, although deemed necessary, results in challenges because of the minimal training provided in these roles, lack of funding for full-time positions, client concerns around confidentiality, and personal values and beliefs of these mediators being imposed on conversations with clients (Brisset *et al.* 2013, 2014). Immigrant service providers called for improvements in training cultural brokers and interpreters working within immigrant serving agencies and within the mainstream healthcare system. A lack of relevant training and feelings of inadequacy were, also, voiced by ISPs working with clients who require mental health support or who are in mental health crises. Considering ways to support and train ISPs, interpreters, and cultural brokers to discuss mental health with clients, identify mental health crises, and navigate the mainstream healthcare system is paramount to advancing mental well-being in immigrant and refugee populations.

Advancing community-based mental health initiatives

Mainstream healthcare service barriers in Alberta include lengthy waitlists to access services, high costs of counselling services, and lack of culturally and linguistically appropriate services. These barriers, coupled with the challenges vulnerable immigrants and refugees face in their daily lives related to housing insecurity, lack of and underemployment, and transportation barriers, create significant deterrents to benefiting from formal avenues of mental health support. Attending to mental health in immigrant and refugee populations must simultaneously incorporate attention to the social determinants of health across premigration, migration, and postmigration contexts (Kanagaratnam *et al.* 2017; McKenzie 2015). Immigrant service providers argued for community-based mental health initiatives that integrate with other social services accessed by immigrants and refugees. The use of case managers and community navigators who serve as community liaisons continues to show promising results (Hartley 2017; Hochhausen *et al.* 2011; Shommu *et al.* 2016). Outreach programmes were identified, in this study, as one approach for meeting the needs of the most vulnerable clients who experience complex barriers with locating and using mainstream mental health services. In Canada, inequities in mental health outcomes persist due in part to public health insurance limiting coverage for many forms of mental health service delivery (Slaunwhite 2015). The impact of high costs for uninsured community mental health services needs to be further discussed in the Alberta context.

There remains a need to, also, train healthcare professionals to identify the unique mental health stressors experienced by immigrants and to refer for support to

relevant immigrant serving agencies (Kirmayer *et al.* 2011; Thomson *et al.* 2015). Creating spaces for collaboration between mainstream healthcare professionals and ISPs might address the knowledge deficits and training needs of these different groups. Positive mental health outcomes are shown when collaboration occurs between mental health specialists and other healthcare professionals (Mulvale *et al.* 2008; Wener & Woodgate 2017). Immigrant service providers can be valuable partners in informing approaches to care and improving client health outcomes in vulnerable immigrant and refugee groups. Immigrant service providers reveal a nuanced awareness of the cultural, linguistic, and systemic challenges experienced by clients. There remains a need to recognize and incorporate the expertise of ISPs in collaborative interdisciplinary health service delivery models. Locating mental health professionals within immigrant service agencies may, also, help address barriers and normalize the inclusion of mental health support in the range of provided immigrant services (Alaggia *et al.* 2017; Hochhausen *et al.* 2011). Funding more mental health programmes that are colocated within immigrant serving agencies is a potential strategy to improve mental health outcomes and increase mental health service access and utilization.

STRENGTHS AND LIMITATIONS

Our study looked at the experiences of ISPs in supporting the mental well-being of immigrant and refugee clients. We recruited a large and diverse sample of ISPs to enrich our understanding of mental health barriers and possible strategies to address these barriers. Adding the perspective of mainstream mental health professionals would have strengthened the study by providing a multifaceted view of these barriers and resulting recommendations. ISPs, in this study, draw from their experiences in Alberta and transferability of findings to other Canadian and non-Canadian contexts is dependent on the realities of mental health and social service sectors in those contexts. We suspect, however, that many of the experiences identified by ISPs provide valuable insights for mental health service delivery to diverse populations in other settings. Future research must incorporate the perspectives of immigrants in accessing and utilizing mental health services in Alberta while recognizing the diverse migration histories, social positioning, and postmigration influences that shape these experiences. Also, there remains the need to better understand the barriers experienced by mental health professionals who provide mainstream healthcare services to immigrant populations.

CONCLUSION

Immigrants and refugees in Alberta continue to experience challenges with accessing and utilizing healthcare services. These challenges include language barriers, stigma of mental illness, and distrust of and lack of familiarity with mainstream mental health services. Investment in mental health service delivery models that build on collaboration between mainstream mental health services and immigrant serving agencies is needed in Alberta. These services must be flexible, affordable, accessible, and culturally and linguistically appropriate; this necessitates further research on delivery models that meet such requirements. Increasing the pool of service providers, cultural brokers, and interpreters equipped with mental health training will have positive implications for mental health service delivery. Overall, this study presents possible strategies for improving the mental health outcomes in immigrant and refugee communities.

RELEVANCE TO CLINICAL PRACTICE

Immigrants arrive to Canada with many strengths but, also, vulnerable to adverse mental health outcomes due to the many stressors of settling in a new country. Nurses and other healthcare professionals must be required to routinely assess for mental well-being, especially during early postmigration and resettlement. Attending to cultural references of mental health and eliminating language barriers will allow healthcare professionals to initiate conversations around mental well-being with diverse populations. Further training of healthcare professionals on immigrant and refugee mental health experiences and fostering opportunities for collaboration with ISPs in service delivery are paramount strategies to improve immigrants' access and use of mental health services.

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