CFMS Position Paper on Immigrants, Refugees and Asylum Seekers

By:

Maham Bushra, University of Toronto

Shanza Hashmi, University of Ottawa

Arnav Agarwal, University of Toronto

Chloe Brown, University of Toronto

Helen Teklemariam, University of Manitoba

Fatemeh Bakhtiari, University of Manitoba

Sarah Mader, Dalhousie University

Jean Zhuo Wang, University of Ottawa

Introduction

Since 2015, there have been significant changes to the demographic landscape of Canada, particularly following the implementation of federal policies that support the influx of immigrants, refugees and asylum seekers. However, there have been few, if any, modifications made to undergraduate medical curricula in schools across Canada or to the training received by new medical graduates and practicing physicians to reflect these large, population-level developments. This paper hopes to convey that newcomers to Canada are a unique, heterogeneous population with specific, complex and challenging health concerns. They face numerous obstacles at the individual, local, systems and policy levels, all of which this paper will address.

Background of the problem

Canada's legal and logistical framework for providing care to newcomers

Canada, being a party to the 1951 Convention and 1967 Protocol relating to the Status of Refugees, places a federal obligation to provide protection for refugees. Canada's refugee system is regulated mainly by the Immigrant and Refugee Protection Act, which consists of the Refugee and Humanitarian Resettlement Program for refugees seeking protection, as well as the In-Canada Asylum Program for persons who make their claims from inside the country. Canada also works alongside the United Nations Refugee Agency (UNHCR) to provide support and identify and sponsor individuals.

Illegal crossings into Canada, which can be the case for many refugees or immigrants, will call for Canadian adherence to the principle of non-refoulement, where a protected person or a person recognized as a Convention refugee shall not be removed to a country where they are exposed to the following risks: "...race, religion, nationality, membership in a particular social group or political opinion or at risk of torture or cruel and unusual treatment or punishment".[1,2,3] All eligible refugee claimants wait on a decision from the Immigration and Refugees Board of Canada (IRB) for a hearing. In making this decision, the IRB determines if the claimant is in fact considered a Convention refugee. On 23 July 2015, the Federal Court of Canada rendered a decision allowing individuals the right to appeal a decision made by the IRB. The options include submitting a pre-removal risk assessment (PRRA), applying to the Federal Court for judicial review or applying for your case to hold footing under humanitarian and compassionate grounds.[3]

With the rapid resettlement of Syrian refugees, Canada's federal government implemented changes to resettle 25,000 refugees by February 2016, with a goal of 25,000 more refugees being settled by the end of 2016. There was some resistance to these changes following the Paris terrorist attacks in November 2015.[4] Global News revealed polling results showing 60% opposition against Justin Trudeau's election promise to relocate 25,000 people displaced by conflict in Syria.[4] This resistance resulted in higher rates of prejudice and discrimination against refugees and immigrants upon their resettlement in Canada.

Discomfort and tension in having an increased influx of newcomers into Canada leads to questions about their ability to integrate themselves into the country's way of living, without causing a shift in job opportunities, resources, and customs. They also face significant barriers in understanding and receiving healthcare services, despite the reinstatement of the Interim Federal Health Program, which is discussed below.

Reinstatement of the Interim Federal Health Program

Prior to 2012, the Interim Federal Health Program (IFHP) was available to provide health services to refugee and immigrant populations, who would not be eligible for coverage under provincial public health care insurance. Specific groups eligible for this program included rejected refugee claimants, resettled refugees, and those not meeting the criteria for public health coverage.[5] Basic coverage includes inpatient and outpatient hospital services, services from physicians, nurses and other healthcare professionals as well as laboratory, diagnostic and ambulatory services.[5] Supplemental coverage includes dental,

vision, home care, long term care, mental health professionals, allied health professionals and assistive devices and equipment.[5] Refugees that are being resettled in Canada may also be eligible for pre-departure medical services under the IFHP. The services covered under pre-departure services include immigration medical examinations, treatment for conditions that would make an individual otherwise ineligible for admission into Canada, immunization and treatment for infectious disease outbreaks in refugee camps, transit centres or temporary settlements.[5]

Cuts were made to this program in 2012 as a means to save on health care costs in Canada, that resulted in reduced healthcare accessibility for refugee populations in Canada. These changes resulted in public discourse, resulting in a legal challenge in February 2013, brought upon by the Canadian Doctors for Refugee Care and the Canadian Association for Refugee Lawyers. Their challenge was successfully appealed in the Federal Court and in November 4, 2014, the Federal Government of Canada announced the introduction of "Temporary Measures of the IFHP" which restored some key health services to refugees.[6]

Even with this reinstatement, there was still issues with the coverage being offered which led to a study from the Canadian Public Health Association, which analyzed perceptions from 23 stakeholders. These groups included policy-makers, government officials (from local, provincial, and national levels) in the field of refugee health, refugee-serving civil society organizations and refugees and refugee claimants (arrival 2012-2015).[7] This analysis wished to obtain insight into stakeholder positions, interests and influences regarding the 2014 reforms.[7] Across these stakeholder groups, four common areas of healthcare access were determined.

The first being a lack of awareness and miscommunication due to the federal government's poor dissemination of the reinstatement, asides from listing the coverage details on their website.[7] This resulted in a lack of understanding for both providers and patients. For example, only physicians that are registered as IFHP providers are eligible to provide care for patients with IFHP coverage. For a physician to be registered as an eligible provider, they must first become aware of the program and the process, then fill out an application form to become registered as a Medavie Blue Cross provider.[8] Each patient encounter must be preceded by checking for the coverage eligibility of the patient, as the physician will not be reimbursed by Blue Cross if the patient is covered under any other type of insurance, to any degree.[8] Physician billing remains in accordance to the fees associated with the province of practice and are required to bill IFHP directly; if there is a discrepancy between billing and what IFHP covers the physician cannot ask the patient to pay difference.

This may limit the care the physician is able to give without financial loss.[8] Thus, there were cases of physicians turning away patients due to uncertainty of coverage and difficulty in communicating with Medavie Blue Cross.[9] Patients also found it more difficult to understand their coverage, preventing them for adequately advocating and inquiring on their care.[9]

The changes also resulted in a lack of continuous and comprehensive care, as individuals who were in midst of their applications were not being provided care. This study also presented the theme of negative political discourse in more influential stakeholder groups (on a policy-level), from the stigma of refugee and immigrant populations accessing care over Canadian citizens.[7] Finally, changes following the reinstatement in 2014 brought upon increased costs of care. Patients being denied care from a lack of understanding of IFHP resulted in ER departments picking up more problematic health concerns that could have been avoided with early intervention.[9] According to the University Health Network, which includes Toronto General, Toronto Western and Princess Margaret hospitals, and Toronto Rehab Institute, there was an estimated bill of $800,000 for services delivered to the uninsured in its emergency department alone.[9]

With the election of the Liberal Government, health coverage was fully reinstated in 2017, with additional coverage being offered for medical examinations required for immigration, vaccinations, treatment of disease outbreaks in refugee camps, and medical support during travel to Canada.[10] Prescriptive medicine, vision care, and urgent dental care would also have coverage in provinces and territories.[10]

Systemic Barriers to Health Access:

Pre-arrival health care

Before arriving to Canada, many newcomers are screened for health issues if they qualify for pre-departure services under IFHP. However, there are barriers to receiving optimal healthcare in pre-arrival stages.[11] Some refugees and immigrants may not have received appropriate care in their home countries. More specifically, refugees who are fleeing persecution may have experienced trauma or healthcare deprivation in their homeland, not know their medical history, have incomplete records, and may not have been appropriately screened or vaccinated.[11]

Problems with eligibility and entitlement

Health coverage for refugees is a complex system that is often misunderstood and difficult to navigate While some refugees may be eligible for provincial coverage, others will

receive coverage through IFHP provided by the federal government. The local government is responsible for social welfare and public health. Given the number of programs provided by different levels of government and each having their own eligibility requirements, it can be very difficult for a newcomer to navigate through the healthcare system. While some Government Assisted Refugees may have support from an agency or resettlement worker, many have to complete the large amount of paperwork on arrival without guidance.[12] Individuals who may have coverage under these programs may be unaware of their coverage or how to apply to these programs.[12] The challenges are not limited to the individual, but also occur on the provider level. Health care providers need to be registered with the Medavie Blue Cross in order to receive reimbursement for services provided to IFHP beneficiaries, which can be a time-consuming process.[8] As such, many some providers, pharmacies and dentists may require refugees to pay for their services, generating more confusion about healthcare coverage.

Unfamiliarity with Canadian healthcare system

A challenge to newcomer access to to healthcare is a lack of familiarity with the Canadian healthcare system. For instance primary care practices being utilized on a general and preventative basis, may not be a well-understood to refugees and immigrants. In fact, it is a notable trend that newcomers frequently visit emergency rooms or walk-in clinics for pertinent healthcare needs.[13] A lack of understanding of the various resources available within healthcare allocations and the roles of specialites and departments,[13] can pose obstacles for refugees and immigrants in navigating through steps for good health. The difficulty in navigation weakens their sense of autonomy and ownership of their health. They face the added challenge of being versed in what's covered and what's not – with the added responsibility of advocating for their family's healthcare needs.

For non-status refugees, there may also be a fear of deportation with accessing the healthcare system placing them on record.[11] Some newcomers may also have negatives perceptions of government services due to their experiences from their home country, causing them to avoid the healthcare system.[14] This fear and mistrust of the government and its role within healthcare can pose imminent threats to refugee and immigrant health.

Culturally Competent Care:

Cultural and language barriers serve as some of the most significant challenges in access to health care.[11] Present within a practitioner's office to outside, within the community, these barriers pose significant obstacles to the integration of refugees and immigrants.

Research has demonstrated that poor English or French proficiency by healthcare providers is associated with worse self-reported health, due to miscommunication and lack of understanding within the patient-physician relationship.[12] Currently, the provincial health plan of many provinces across Canada does not cover the cost of translational services, thus social services and community health agencies must accommodate their budgets to arrange interpreter attendance to appointments with their clients.[11] These interpretation services are also limited to pre-arranged appointments, providing significant challenges in acute care situations for communication with patients who do not speak English.[11] As a result, many patients will utilize family and friends as interpreters, which can contribute to incorrect translations of medical terms, condensation of concepts, and filtered translations. Furthermore, differences in social norms or cultural practices may lead to reluctance in utilizing facets of the Canadian Healthcare system.[15] Many newcomers to Canada find it difficult to access culturally competent care, where health care providers are aware of their cultural lens and how that impacts their interaction with their patients.

A large systemic barrier facing refugees and immigrants accessing healthcare lies in healthcare providers themselves. This includes a lack of provider knowledge and skills in dealing with newcomer populations, along with limited access to physicians who do have these skills.[11] Training gaps of healthcare providers can impact professional understanding of refugee insurance and status, working with translators, as well as cultural safety practices more generally. Along with a lack of supply of adequately trained primary care physicians, there is sometimes a reluctance in accepting refugees and immigrants as patients, as they can be seen as having more of an administrative burden.[11,16]

Personal Barriers to Health Access:

Socioeconomic and employment barriers

Newcomer populations in Canada face additional financial and economic barriers that influence their health status and overall health outcomes. Many refugees come from regions with low health care and economic resources, and where the economic burden has often increased due to war, natural disasters or sociopolitical strife.[17] Many newcomers will lose material possessions, property, wealth, and status, and may be separated from their families in the process of fleeing their native country.[17] In addition, while settling in a new nation, refugees and immigrants face significant barriers to finding sustainable employment.[18] Unemployment due to language barriers, lack of experience in the Canadian workforce and inadequate recognition of education completed at international post-

secondary institutions is common among newcomers. Those who do attain employment often work in low paying or casual jobs, and are more likely to accept employment in hazardous conditions and long, irregular work hours.[18] These difficulties may make it hard for newcomers to find work that covers dental and vision insurance, leading to deteriorating health outcomes. Moreover, loss of income or threat of dismissal can result in reduced willingness to take time off from work to access health care for themselves and their families.[18] Unemployment can also add to the psychosocial stress experienced by the head of households, as they may harbour feelings of inadequacy and disappointment at being unable to provide economic support to their family. Precarious and low-income work plays into long-term social determinants of health in many newcomer populations, as the effects of this psychosocial stress, along with income, housing and food insecurity can lead to worse health outcome in the future.[18]

Mental health challenges for adults

An important neglected issue faced by immigrant and refugee populations over the resettlement period in Canada is the decline in their mental health status Mental health issues are even more prevalent in certain subpopulations, including immigrants and refugees from racialized groups or those with low socioeconomic backgrounds.[19] These negative changes reflect institutional challenges, such as a lack of accessibility to culturally competent and linguistically viable services, lack of health care provider training and knowledge, and difficulty understanding or navigating logistical and legal barriers within the healthcare system.[20] In addition, cultural barriers such as fear of stigmatization, a desire to deal with problems on one's own, and a lack of trust and familiarity with Western medical practices may be at play.[20] Thus, immigrants and refugees are less likely to seek out or be referred to mental health services than Canadian-born individuals, even when they experience similar levels of distress and trauma.[20] Moreover, unlike survivors of most traumatic events, refugees experience diverse stressors that accumulate over the pre-departure, flight, exile, and resettlement periods. Refugees face continual post-migration stress including marginalization, racism, isolation, socioeconomic disadvantage, acculturation difficulties and loss of social and financial support.[21]

Mental health challenges for children and youth

A complex network of individual, familial, and environmental factors underlie mental health challenges for immigrant and refugee children and youth. Exposure to violence in their country of origin or a foreign Canadian environment, pre-existing physical, developmental or mental disorders, an increased prevalence of risky behaviours such as substance use and impulsivity, and a genetic vulnerability to mental illness have been

identified as individual-level risk factors for mental health issues for this group in high-income countries.[11,22] Family-related factors such as independent travel into Canada without the support of any family member or friend, separation from family and friends in their country of origin, residing in a single-parent household, and parental struggles with financial burdens and their own mental and physical ailments may also contribute to mental health issues in this group.[11,22] Finally, perceived or explicit public discrimination, separation from their ethnocultural community and various systemic changes in a foreign environment represent environmental contributors to a sense of isolation with minimal support.[11,22]

Lack of social support and isolation

Social interactions with family, peers and professionals play an important role in assisting immigrants and refugees cope with health and other life-related challenges during transition to a new country, and to eventually become self-sustaining.[23] Communication and language-related barriers, cultural differences in understanding of disease, economic limitations, and barriers to obtaining timely permanent immigration status, employment and educational arrangements represent major barriers to adequate access to social support for immigrants and refugees.[23,24] A number of system-level barriers, including limited social support resources, long wait-lists, funding cutbacks and poor integration of policies and programs across different jurisdictions, further limit access to social support resources.[23,24]

Position Statement:

Increased efforts towards addressing needs of immigrant, refugee and asylum seeking populations within medical school curricula, medical trainee programs and informal education initiatives will translate to better provision of health care services upon arrival, and create medical graduates and future physicians who are well trained to provide healthcare for newcomer populations.

Key Principles:

The CFMS endorses the following principles in support of immigrants, refugees and asylum seekers:

1. Immigrants, refugees and asylum seekers have unique healthcare needs and requirements.
2. Since the reinstatement of the Interim Federal Health Program (IFHP) in 2016, physicians and other health care providers are eligible to provide care for patients who have received coverage. However, potential patients continue to be turned away

by providers because of uncertainty regarding coverage and perceived administrative burden.

3. Newcomer populations face significant system-level barriers in access to healthcare in Canada, including limited pre-arrival healthcare, issues with eligibility and entitlement and difficulty navigating a complex healthcare system
4. Newcomer populations face significant individual and societal barriers to success and optimal health, including unemployment, cultural and language challenges, mental health issues and social isolation
5. Canadian medical students can be better trained on the physical and psychosocial healthcare needs of immigrants, refugees and asylum seekers. Such education and training should be incorporated into Canadian medical curricula.

Recommendations

The CFMS recommends the following changes to Undergraduate Medical Education (UGME) across Canada:

1. Medical students should be taught a comprehensive, individualized and intersectional approach for immigrant and refugee populations within the UGME curricula which includes:
    - 1.1. IFHP registration and reimbursement procedures
    - 1.2. Access to, and knowledge of, interpreter services.
        - 1.2.1. To address the language barriers many refugees face accessing healthcare, it is important that medical school curricula focuses on training medical students on how to work with translators within a triadic interview structure, where there is communication between physicians, patients and an interpreter. This training should include questions on who best should act as interpreters, the interpreter's role in translating medical information, as well as the best ways for the physician to interact within this triad.
    - 1.3. Cultural sensitivity and safety training
        - 1.3.1. Adequate cultural sensitivity and safety training.
        - 1.3.2. Encourage training on holistic, cultural-specific concepts of health, illness and death.
        - 1.3.3. Consider culturally-responsive care, in consideration of the patient's immigration experience, and new integration and adaptation to the Canadian medical system and environment.
    - 1.4. Psychological support

1.5. Trauma care for refugees and asylum-seekers fleeing sociopolitical strife and war-torn countries

1.6. Infectious disease and public health screening measures

2. Medical students and trainees should be trained in addressing risk factors for mental health issues and promoting sustainable community integration and relationship-building skills.

2.1. Increase student knowledge of mental health issues faced by the immigrant and refugee health population.

2.2. Increase student knowledge of other social determinant of health components that influence mental health and community integration.

2.2.1. Living in a stable and supportive household environment which is pre-arranged prior to arrival to Canada has been associated with significantly lower risks of mental health, as have parental support and close contact with friends and community supports.[11,20]

2.3. Encourage efforts to reduce stigma around mental health with clear, supportive communication and collaborative treatment plans.

2.4. Incorporate at least one workshop such as SafeTALK, ASSIST, suicide to Hope or Mental Health First Aid, into Canadian medical school curricula

3. Include community immersion experiences for medical students as part of the curriculum on immigrant and refugee health

3.1. Increase opportunities for medical student interactions with clinics or community volunteer centers that serve newcomer and refugee populations.

3.2. Increase medical student awareness of healthcare and community resources that can help them broaden their understanding of the nuances of immigrant and refugee health.

4. Encourage student advocacy for immigrants and refugees to Canada, in addressing significant barriers to newcomer health

4.1. Increase medical student training on advocacy in connection to their responsibility to be future Health Advocates according to the CanMEDS roles.

4.1.1. Medical schools may incorporate at least one workshop on advocacy skills taught by physician leaders in the community within the UGME curricula

4.2. Encourage and provide support for anti-discrimination advocacy focused on acceptance of newcomer populations,

4.3. Encourage and provide support for advocacy focused on better financial and employment opportunities, housing, and mental health care for newcomers in order to secure better long term health outcomes.

5. Consider inviting immigrant and refugee patients to discuss their stories and experiences within the healthcare system, as well as focusing lectures and learning on global health issues common to newcomer populations.
6. The CFMS Global Health portfolio conduct a national, institutional scan of the work on immigrant and refugee health that already exists within UGME curricula. The results from this report could be used as an advocacy and evidence tool to bring to UGME deans and the AFMC and help advise future planning.

The CFMS recommends the following policy level changes to the Government of Canada, and medical licensing and regulatory bodies of Canada :

1. Establish a national refugee and immigrant health strategy tasked with the creation and implementation of recommendations for healthcare providers to ensure high quality, ethical and safe care for refugees and immigrants to Canada.
    1.1. Increase education and training in IFHP coverage and usage.
    1.2. Eliminate inefficiencies and barriers in providers accessing and using IFHP for their patients.
    1.3. Create and implement a streamlined and regularly analyzed process for provider application and reimbursement under IFHP.
2. Establish sufficient coverage of interpreter coverage across provinces.
3. Increase healthcare education opportunities for patients.
    3.1. Towards IFHP and non-IFHP coverage components.
    3.2. Preventative medicine education.
        3.2.2. Emphasis of usage of alternative forms of medicine.
        3.2.3. Education on use of primary health resources.
    3.3. Encourage education on healthy lifestyles in Canada.
        3.3.2. Increase awareness of available local community supports.

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