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Canadian Labour Market as a Dispiriting Phenomenon on Skilled Migrants: Mental Health Consequences on Immigrant Canadians

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Abstract

The main purpose of the 2003 first Minister on Health Care Renewal Accord was to ensure that Canadians received accessible, sustainable and portable healthcare. In spite of these provisions, the health of immigrants in Canada living in various provinces continues to fall through the cracks. How does the labor market situation of unemployment and underemployment affect the mental health conditions of immigrants and their access to healthcare? What role do gender, race, and income play in getting access to quality and specialized health care in the provinces? This paper examines the impact of unemployment, underemployment and Term employment on the mental health of immigrants in Canada. The paper uses the author-ethnographic narrative, Spirituality and Healthcare model, anti-racist and anti-colonial theories to foreground immigrants' experiences in Canada. It concludes that the difficulty of navigating through and penetrating the Canadian labor market for immigrants with foreign training especially the minority groups, grossly limits their integration into the economic mainstream and consequently, their optimal productivity to the society. Failure to secure decent jobs after retraining, with the hope of being accepted by Canadian employers, often leads to depression and other health issues.

Keywords

Unemployment, Underemployment, Low Income, Stressor, Depression Hyperthyroidism

1. Introducing Spirituality and the Persona

Holistic view of one's personality is crucial to map the individual's journey through life. Bailey and Peoples (2002: p. 8) argue that to gain a holistic know-

ledge of a subject is to attempt to understand all the factors that influence it and to interpret it in the context of all those factors. Therefore one's knowledge of the self will be no cheaper task. It will amount to searching for connections and interrelations between things, and trying to "understand parts in the context of the whole" (p. 9). One would ask, why search for an understanding of holistic self? The answer comes instinctively in Dei (2002), "to destroy the self/other dichotomy, rendering the self as not autonomous but connecting to a larger collective" (p. 4). In other words, the various components of self-spiritual, intellectual, psychological, physical and emotional—not related within Western world views are incorporated in a spirituality-based transformative education (Frazer, 2004: p. 4). In my journey so far, I have also come to the realization that the spirituality that will effect transformation in education must necessarily be divorced from specificities of religious affiliation.

Both in my journey in African traditional religion and those undertaken in other institutions what continues to resonate with my understanding of spirituality remains the concept of "inner personality", or the authentic self as is held in African world views (which may as well be shared by other indigenous peoples). This is the self that is both an embodiment of the past and the present. The Maoris for instance believe that a living person is an embodiment of both the living and the dead community members, "yeah, in the spiritual world … you're carrying them with you, you're taking them with you into the future and not forgetting about them" (Frazer, 2004: p. 6). Some African communities believe in dual terrestrial habitation. Mbiti (1975) argues "the next world is in fact geographically here being separated from this only by virtue of being invisible to human beings" (p. 159). Consisting of several dimensions, the self is both individualistic and collective (Dei, 2002). Also Robbins (2001: p. 170) reasons that it is after learning who we are that we step into that position of self or being, whence we begin to learn how we stand in relation to others (including beings other than human. My interpolation); then we learn how to relate with others and in a specific capacity. I will like to hint at this juncture that religion is as much a measure of spirituality as being religious which is a predictor of spiritual maturity. I have encountered people who were religious in so many manifestations but hardly attained appreciable level of spiritual maturity.

2. Racism and Anti-Colonial Theories in Understanding Canadian Primary Health Care System: Author Experiential Narrative

Racism is viewed in this paper as an act of social representation and construction of difference aimed at positioning the dominant social group to enjoy certain exclusive privileges that are girded around by socio-political power imbalances and barricaded from the subordinate "Other" with taboos of normativity. It is difficult to talk about race without looking into power relationships which is where the 19th century neo-liberal vestiges of Western colonization and present

neo-colonial structures and processes play critical roles. Anti-racism informs the need for a move to an inclusive race-based analysis of colonial relations with the understanding that representation is not only about subject identities and identifications but also about fundamental issues of economic, material and structural manifestations in existing human conditions (Dei, 2011). On the other hand anti-colonial framework is a perspective that challenges all manifestations of hegemony and imposition of ideas and practices of cultural and socio-political domination. In other words, exercise that seeks to re-invent social equilibrium must challenge or disrupt existing social dynamics of power imbalances.

Situating the discourses of anti-racism and neo-colonial practices in my Canadian experiences as a new immigrant, I will invoke conversations around immigrants' marginalization within the dynamics of medical and socio-economic interventions in host societies. Specifically I will contextualize the repressive experiences of minority immigrants within the complexities that Canadian HealthCare system represents. In this context, the realities of lopsided power relationship in the Canadian healthcare praxis wielded upon marginalized immigrant minorities at the periphery begins to emerge. The healthcare delivery system I experienced was designed to identify and repress signifiers of racialized bodies or their representation. Spaces such as the Canadian primary healthcare system have the tendency to reproduce hegemony, dominance and privilege because such spaces also come with specific histories and impressions. Therefore the experiences of the racialized bodies of African migrant minorities in accessing required healthcare cannot be fully grasped in discourses of split binaries of landed migrants or refugees, legal and illegal migrants, because we are not unaware of the aphorism that occupying certain spaces comes with meanings and politics. The discourse of meritocracy functions to marginalize certain groups of people by allowing Caucasians to direct attention away from their own privileges and to ignore larger patterns of racial injustices in their societies. The neo-liberal self-centered assumption that achievement is a function of one's socio-economic input runs against the grains of migrants' epistemic realities. In other words, the basis for drawing a link between people's success and their socio-economic efforts, although is reified, normalized, and validated in most western societies, yet might find repudiation in other socio-cultural settings—within which it is taken up as devoid of sound premises—hence counter progressive, parochial, and anti-public practice. In our lopsidedly bipolarized world that is monitored and girded with neo-colonial vestiges that globalization multi-ethnicity symbolized it is not uncommon to be lost in the repressive crater created by essentialization, under-valorization of signifiers of otherness and willful denial of difference at the spaces of appropriation. The process was therefore set to conceal how social, cultural, and in this context economic, and healthcare privileges facilitate the success of some groups of people but not others. It allows the privileged to see themselves as innocent spectators rather than accomplices in a system that creates, maintains and reproduces social inequities and injustice.

3. Mental Health and Newcomers: Definition of Terms

Mental health has been defined by the World Health Organization "as a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community" (CAMH, 2009). Every individual possesses certain psychological and social capacities that influence each person's ability to achieve the best possible mental health and well-being. "Mental health problems and illnesses are clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering, or impairment in one or more areas such as school, work, social and family interactions, or the ability to live independently" (CAMH, 2009). According to Statistics Canada, average life expectancy at birth in 1999 was 79.0 years. A breakdown by sex shows that women had an average life expectancy of 81.7 years, while men had an average life expectancy of 76.3 years (Pederson, Raphael, & Johnson, 2010). This work also noted that women also have higher prevalence of chronic diseases especially during later parts of their life. I was eventually diagnosed with Graves Hyperthyroidism. Hyperthyroidism was associated with "exhaustion psychoses" and delirium before effective treatments were discovered. Currently, it has been noted with less severe manifestations of nervous dysfunction that has been described as "consisting of various mental symptoms and signs (anxiety, depression, euphoria and cognitive dysfunction or as discrete non-psychotic psychiatric disorders" (Bunevicius & Prange, 2006: p. 899).

Jadresic (1990) details its attributes as a situation that results when there is "an excess of unbounded thyroid hormones. Its clinical manifestations depended upon the severity of the disease, the age of the patient, and the presence of other diseases. The cardiovascular, metabolic and nervous system manifestations of thyrotoxicosis are similar to those of increased adrenergic activity, or excess catecholamines, like tachycardia, increased cardiac output, increased glycogen and lipid mobilization, enhanced thermogenesis, hyperkinetic behaviour, tremor, and sweating" (p. 605). Graves disease or hyperthyroidism is also associated with Graves' orbitopathy or ophthalmopathy (GO) which "is an invalidating and disfiguring disease affecting appearance and functioning of the eyes and profoundly impairing the quality of life of affected individual" (Bartalena 2011: p. 592). According to Luigi Bartalena (2011), "Graves disease is an autoimmune disorder, but its precise pathogenic mechanisms are not fully unravelled" (p. 592). It is assumed that Graves's disease is caused by certain "complex interplay between still undefined genetic factors and environmental factors" (p. 593). "Hyperthyroidism and Hypothyroidism, but not euthyroid (thyroid gland disease), is considered as a possible contributor to psychiatric disorders." (Bunevicius & Prange, 2006: p. 899). Psychiatric disorder caused by hyperthyroidism is considered to be secondary to the endocrine state, because it acts as a trigger to the main psychiatric condition. I was therefore lucky that I did not fall through the cracks as almost all of the extant studies confirmed the symptoms I had, which accounted

for my perception of my physical and mental health as deteriorating progressively at the pick of my health crisis. This also informed my increased anxiety, need for and use of family doctors. The symptoms I also presented to specialist physicians who though understood their underlying etiology, but failed to accurately communicate their diagnosis and cause of my ill-health to either my family doctors or me. This action is contrary to the *First Ministers Accord* on healthcare renewal that stipulates that all Canadians have the right to:

- Have timely access to diagnostic procedures and treatments;
- Do not have to repeat their health histories or undergo the same tests for every provider they see;
- Are able to access quality care no matter where they live; and
- see their health care system as efficient, responsive and adapting to their changing needs, and those of their families and communities now, and in the future (First Ministers' p. 2).

Regehr and Glancy (2010) added a cardinal value of Canada's Health and Mental Healthcare system, which includes "Informed Choice—involving the ability of all Canadians to choose health options based on best available information". Mitchell (2008) who encountered immigrant and refugee women from Somali, Sudan, Ethiopia, Liberian, Nigeria, Latin America, the Caribbean and Vietnam in her practice observed that the clients may require health counselling, psychotherapy and/or medication for Thyroid, postpartum depression (PPD), bipolar disorder, major depression and posttraumatic stress syndrome (PTSD). This study is pivotal to my analysis of immigrant mental health issues, because, it not only recognizes the fact that socio-economic and cultural changes might have negative effect on immigrant mental health, but that acculturation challenges could be complicated by hormonal and biochemical changes during a woman's life and reproductive cycle. Bailey (2016) defined stress as "our body's reaction to people and events and to our own thoughts. Some level of stress is normal, such as before a test. But too much stress can have physical and psychological effects that can interfere with health and well-being" (p. 10). Bailey (2016) further defined stress as "an organism's total response to environmental demands or pressures" (p. 8). Going by the strength of this definition, I experienced so much stress owing to the demand for Canadian experience and the apparent under-valorization of my credentials—the fact that my credentials though assessed as Canadian equivalent—was not recognized by Canadian employers—was a big blow. Most of the places I applied for employment neither acknowledged receipt of the applications nor responded to any of them, and the only place that responded, could not (at least in writing) consider my experience relevant to their overall job description.

Beiser (2005: p. 532) asserts that expending a great deal of effort to select people to become part of Canada and more or less ignoring them once they are here is short-sightedness. Resettlement experiences exert enormous influence on the eventual health of immigrants and on the likelihood that their human capital will fulfill its promise (Beiser, 2005). The study on immigrants' health holds that

immigrants are on the average, in better health than native born Canadians, and have lower mortality rates. However, shortcomings in immigration and resettlement policy jeopardize immigrants' health advantage (Beiser, 2005). This health gain is because Canada selects immigrants on the basis of attributes such as education, job skills, age, all of which are grouped under the rubric of human capital (Jafari, Baharlou, & Mathias, 2008). Screening helps ensure that they are healthy as well. After immigrants enter the country, responsibility for assuring they stay healthy devolves to the Provinces. However, aside from defining a mandatory waiting period before becoming eligible for health-care coverage as in my case, and arranging surveillance for immigrants with a history of tuberculosis, provincial health policies have little to say about immigrants' early life in Canada. Bauder (2003) frames his theoretical analysis around Pierre Bourdieu's notion of institutionalized cultural capital and his concept of the educational system as a site of social reproduction. Using data from interviews with instructional administrators and employers in Greater Vancouver that employed immigrants from South Asia and the former Yugoslavia, his findings support the view that many professional and skilled immigrants to Canada suffer from de-skilling and non-recognition of their foreign credentials and experiences. As a result they fail to get the higher paying jobs, which unfortunately and contrary to esteemed expectations are reserved for their Canadian born counterparts who may not be better qualified or be better skilled than these new immigrants. It is exaggeration to insist that Canadian government; particularly the conservative government waddled between opinions as a result of immigrant complaints of unemployment and underemployment that it engaged a policy of outsourcing employees (see Selley, 2013). This policy involves recruiting temporary workers from overseas for job skills that could be filled by Canadians so that while Canadians, particularly immigrants (who could be paid more) were laid off, new short term migrants were recruited and paid less. This approach to addressing a fundamental socio-economic problem is illogical, myopic and counter-productive. It also goes to confirm my earlier argument that immigrants were not less qualified or lower skilled than their Canada born counterparts. For if technical skills could be outsourced on temporary basis it is an evidence that foreign trained professionals are as skillful if not more skillful than Canadian born citizens.

There is a distinction between unemployment and being out of the labour force. To be counted as unemployed, an individual must be actively looking for work. Those without paid employment who are not actively seeking a job are considered out of the labour force or "inactive". Some studies refer to the combination of the unemployed and the inactive as the "non-employed". Because many new immigrants, who actively want to work, but fail to find jobs in their fields or anything similar might get discouraged and stop active job search, these comprise the category of unemployed since they could easily work if they have the opportunity. These include "those who hold part-time jobs but are available for full-time work and those who are working full-time but are considered overqualified for their jobs" (Discussion Paper 1996). Term positions are offered

to most immigrants in certain provinces which imply that such individuals, male and female alike are hired to work full time hours on their jobs, for very short duration, sometimes shorter than stipulated. In some offices they are given superficial support in the workplace to help them perform their duties, but effectively denied essential tools for optimal performance and success, an inbuilt vestige of tokenism, labelling and racialization. Management, in this case government representatives who in the first instance set up the system often surround the staff with older staff specially assigned to trump charges both related and unrelated to work issues simply to pull down the immigrant often minority staff. These charges are taken as "truth" and never investigated for more clarity. They become the judge and jury, a situation that is extremely stressful. This situation often gives rise to depression for male and female immigrants. The arguments go to substantiate my own experiences, which might serve as a sort of resistance to systemic imbalances and injustices as seen by those who live it daily, as I did then, and still do, which is why I chose to retrain in another field, irrespective of how challenging the choice might be. Yet five years after, I have not secured full time, permanent employment in my field of training as a Masters Degree holder in Social Work, and registered Social Worker in Ontario, at first and later, Saskatchewan.

Chen, Smith, & Mustard (2010), using the longitudinal survey of immigrants to Canada examined the "association between over-qualification and decline in general and mental health among new immigrants to Canada over a four-year period, with three conceptually different measures of over qualification, based on education, pervious work experience, and expected employment" (p. 612). "Based on this study, 51.6% of immigrants studied were over-qualified for their jobs based on their education levels, with a lesser extent over-qualified based on experience (44.4%) or expectations (42.8%)" (p. 612), about 58% of immigrants in the study sample who had post-secondary education were employed in occupations that were below their educational qualifications. This number is "25% higher than the proportion of over-qualification previously reported for all post secondary graduates in Canada" (p. 612). Their findings bear on previous studies that "sub-optimal labour market experiences play in declining health among immigrants to Canada." It also provides "evidence that inadequate employment, as assessed by three different aspects of over-qualification, impacts immigrants' mental health, in addition to unemployment and lack of income …" (p. 612). Similarly, Roxana Salehi's (2010) work made a connection between "income and health. Her research shows that immigrants who have been in Canada for less than 10 years are more likely to live in lower-income families than those who have been in Canada for 10 years or more or those who are Canadian born." Her cross-cultural comparison points to the fact that "on average, members of European ethno-racial groups (immigrants or Canadian born) have better jobs, higher family income and a much lower rate of poverty—a difference "that is diminished only slightly by excluding groups suffering extreme disadvantage" (p.

793). Dean, & Wilson's (2009), collaborative in-depth research interviews examined the experiences of employment and perceptions of subsequent health impacts among 22 recent immigrants. The findings identified mental health issues due to a lack of income, loss of employment-related skills, loss of social status and family pressure as enormous challenges to their mental and physical well-being. These health concerns are also extended to their family members. In addition, Aycan and Berry (1996) examined the process of acculturation with specific emphasis on the impact of economic integration on psychological well-being and adaptation of new immigrants to Canada. The research applied a survey questionnaire to 110 Turkish immigrants; and found that despite high educational attainment, two-thirds of the samples were either unemployed or underemployed. All the participants perceived both mental and physical health to be negatively impacted by under/unemployment. Most frequently mentioned mental health issues identified were stress, anxiety, depression, unhappiness, worry, tension, irritation, and frustration, all of which the new immigrants attributed to the difficulties encountered in finding a secure employment in their field in Canada. These immigrants noted three main ways in which employment circumstances affected them, namely: lack of income, loss of employment-related skills and loss of social status.

I found that all these experiences were not unique to me as I had confronted them within the first 2 years of our arrival. The attendant anxiety that followed our settlement process and the need to have a family of our own with low income resulted in poor access to healthcare within a specialized field not covered by Canada's Medical Insurance. Low income in my case led to accessing healthcare specialists who were prepared to withhold information vital to my well-being despite the *First Ministers Accord's* recommendation that every Canadian should be able to "have timely access to diagnostic procedures and treatments." The specialist denied me access to diagnostic procedures and treatment related to thyroid, which in turn affected my man-hour-performance and ability to gain meaningful employment. Despite the recognition by the Accord that "the core building blocks of an effective primary healthcare system are improved continuity and coordination of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to ensure that new approaches to care are swiftly adopted …" (First Ministers, 2003: p. 3); the specialist physicians played on my ignorance and those of the family physicians about the implication of a high TSH (Thyroid Stimulating Hormone) and its pervasive action when abnormal in a patient's body. This attitude earnestly begs for a structural reform in the healthcare system concerning the protection of patients' right to information. It also calls for a coordinated primary healthcare inter-professional team that either works together or in different locations, and an electronic database that gives access to patients' healthcare records to any consulting physician. Other studies identified work-related problems and low socio-economic status to be associated with depressive symptoms and stress in

various groups such as Mexican, South Indian, Korean immigrants (Aycan & Berry, 1996). Similarly, Noh & Avison (1996) examined the interplay among stressors, psychological and social resources, and psychological distress among a large sample of Korean immigrants living in Toronto by using the Stress process formulation. Data from a longitudinal study of over 600 respondents indicated that social and psychological resources have important deterrent effects on the experiences of stressors and their subsequent distressful consequences. They also identified ethnic social support and mastery as being critical factors in this process.

4. New Immigrants and Access to Healthcare

Lebrun & Dubay (2010), in their analysis used logistic regression models to assess the effect of immigrant status and country of residence on access to care in Canada and the United States. Their finding proved their hypothesis that immigrants living in Canada would have better access to care compared to those living in the United States. Immigrants in the two countries who gained access to care reported similar satisfaction with care and perceived quality of care. Their finding suggest that "although there are disparities in access to care across countries, once immigrants in each country achieve access they are equally content with their overall health care experiences" (p. 1708). This could be attributable to income disparities between immigrants who have access to care being endowed with better resources compared to those without access.

Better resources would be Key to obtaining higher and even timely quality healthcare, a situation that was grossly missing in my case. I had neither the requisite income nor resource base, while seeking access to quality and specialized care. Little wonder those two gynaecologists denied me access to information that would have earned me free Medicare; a decision that benefited another specialized healthcare provider, and left them with only their consultation services. They realized that the consulting endocrinologist they would refer my case to have his services covered by the government Medical insurance policy, but reproductive health was not. This situation also makes the argument for Primary healthcare reform envisaged by the First Ministers in *Rekindling Reform*, for a strategy that incorporates a team of specialized healthcare professionals working together. *Rekindling Reform* lamented that "Primary healthcare was to be a cornerstone of health care renewal …". Accordingly the Health Council of Canada insisted that:

"*Transition Fund* (*established in* 2000) *represented a common commitment to reform primary healthcare*, *most jurisdictions used the funds to implement small initiatives rather than invest in long-term*, *sustainable change*. *Adopting team-based care continues to be a challenge for a number of reasons*, *including misgivings and misconceptions among the different professionals about one another's roles and responsibilities in a team environment*" (Health Council Canada, 2008: p. 17).

Definitely, had an endocrinologist been among a team of physicians at the primary care level examining my health record, I am convinced that I would have received timely access to diagnostic procedures and treatments, and could have been spared much misery, and Ontario government would have saved so much cost from repeated health tests. Another interesting finding of Lebrun & Dubay (2010) is that "immigrants in Canada were less likely to have a timely Pap test than immigrants in the United States, indicating that barriers to care remain for Canadian immigrants despite the country's universal coverage" (p. 1709). The explanation offered for this trend is that the United States has embarked upon a preventive method of care in ensuring that "targeted efforts at increasing cancer screening among minority and low income populations" are systematic and successfully reaching immigrants that tend to fit the high prevalence socio-odemographic profiles. Whereas in Canada, cervical cancer screening is "ad hoc" or opportunistic, rather than through an organized screening program" and in provinces where the screening program has been implemented, does not seem to target underserved populations" (p. 1709). On the other hand, K. Bruce Newbold (2005) carried out a longitudinal National Population Health Survey using a logistic analysis and found that "the native-born were not more or less likely to rank their health as poor relative to the foreign-born, controlling for other effects". In other words "health status was not significantly different between the foreign—and native-born. Rather, individuals who were younger, those with higher income adequacy, non-smokers, married, and workers were less likely to rank their health as 'unhealthy,' results that reflect the determinants of health framework" (p. 1366). Conversely, Newbold and Danforth (2003), utilized the "1998-99 NPHS cycle and various measures of health status, "the finding of this study are consistent with previous research into determinants of health and health status within the immigrants population. The results indicate that individuals with lower levels of education and income, and those who are not in the labour force or are older, were more likely to be 'unhealthy,' whether measured by self assessed health or by Health Utility Index—Mark (HUI3)" (p. 1992).

The findings of these studies are consistent with my own personal experiences of stress arising from low income that was itself, a result of unemployment and under-employment. If new immigrants to Canada would have immediate access to gainful employment, the number of new immigrants who develop mental health and other illnesses would greatly reduce, thereby optimizing Canada's per capita income. The fact that more new immigrants develop health issues less than two years after their arrival has obvious implication for hospital utilization and need. Newbold, Eyles, and Birch (1995) analyzed variations in the incidence and quantity of utilization of hospital services within Canada. They made methodological changes to reduce bias in the representativeness of population of users within the sample. They found "significant changes in the utilization of family physicians (14.45%)." This analysis also emphasized the necessity of "looking beyond simple use income or use-need relationships and broadens the explanation of differences in hospital utilization". Their finding about hospital

utilization is comparable to other researches in this area, and indicates that "hospital utilization is positively related to the level of need, proxied by self-assessed health status; decreasing self-assessed health status increases the likelihood of hospital utilization" (p. 1190). My experiential narrative above lends credibility to this research, in that my self-assessment of my health as decreasing led to increased hospital utilization, and increased use of family physician services. From November 2007 to August 2008, I paid an average of one weekly hospital visit to the family physician. And from May 20, 2009 to August 2009, I paid one visit daily for five days a week, and from September, I paid one or two visits a week till June, 2010. These regular visits to family physician were prompted by decreasing self-assessment of health status, leading to increased hospital utilizations, including hospitalization.

Newbold (2009) used the 1994/95-2000/01 National Population Health Survey to evaluate "the use of healthcare facilities by the Canadian immigrant population. Given the context of rapid decline in health status after arrival, as measured by chronic conditions or other health markers, and widely reported in literature", he questions whether "increased need for care corresponds to an increase in the use of healthcare facilities?" (p. 558). His evidence "represents increased need, greater awareness of service availability, and potentially, the use of physicians who share cultural origins, or racial background with their patients, easing access by providing culturally sensitive care". He noted that the number of immigrants that reported use of a family doctor or GP often exceeded the number for the Canadian-born. Gaining access to and use of family doctors only represents initial contact with the larger healthcare system, and hospital use may represent deeper penetration into the system. Consequently immigrant men and women (Caucasian and ethnic minorities) tend to report better access to regular doctors than did the Canadian-born individuals in a longitudinal research sample of 12 year period; with access increasing with duration of stay in Canada for all immigrants. This research suggests that "having a regular doctor may be considered a measure of potential healthcare access" i.e., those who have a regular doctor may be more likely to access care (Setia, Quesnel-Vallee, & Abrahamowicz, 2011: p. 75).

5. Mental Health Needs of Immigrants

Both education and trust in the Canadian system, cultural competency of services and co-operation between service providers may decrease barriers to care. Ethno-specific health promotion and diversity of services including alternative approaches have been shown to facilitate access to care in some communities. There exist some connections between a range of social factors and mental health problems and illnesses. The impacts of social determinants of health can be complex, for instance discrimination has a direct impact on individual's psychology, physiology, and through its links to other social determinants of health at a group level. Therefore healthcare workers should adopt an anti-oppressive

and empowerment approach to their practice while working with various populations of immigrants. They could challenge dominant discourses that are disempowering to newcomers through language. Larson (2008) has suggested that although language is a discourse that constructs and reinforces oppression, language is also a site for deconstructing and challenging oppressive discourses such as the medical model that pathologies persons with mental disability by addressing them as patients, clients or even by the category of the disease such as the Thyroid patient as I was addressed by health personnel in Healthcare Clinics. Healthcare workers need to support advocacy in sensitizing community consciousness against all forms of stigmatizing labels against individuals suffering from mental illness and give voice to clients and ensure that they have opportunity to express their opinion in matters affecting their own care and recovery. They also need to educate new immigrant and refugee members in communities that mental disorder is like any other sickness and sufferers should not be viewed as dangerous or feared. Access is facilitated by information; healthcare workers need to be conversant with healthcare services, social services agencies, and mental health agencies in their communities, and be prepared to disseminate such information to newcomers.

6. Discussion and Conclusion

From my experiential narrative, and current scholarship on immigrant health and mental health, it is evident that factors such as lack of awareness of services, stigma, socio-economic factors, perceived discrimination and language are potential barriers to care for new immigrants. Mental health institutions lack approved and trained interpreter services which can mean that children or non-medical staff will act as interpreters. In addition, structural barriers, such as institutionalized racism, mean that recent immigrant groups are less likely to get the care they need (CAMH, 2009). Stress is a response to a situation that a person feels is beyond her/his ability to manage. It is a feeling of "undue pressure" because of all the things one has to do or worry about. I experienced stress both physically and psychologically. If one does not get enough sleep or has a poor diet, one can feel physically stressed. Stress can also be mental, by worrying too much and feeling uneasy. If stress is not dealt with properly, it can cause a breakdown in mental health and can affect one's overall mental health. Some people can stay calm and balanced in the most stressful situations, while others cannot stand the least stress (Regehr & Glancy, 2010: p. 108). I withstood these very stressful times by holding on to my Spirituality. Some of the stressors I experienced corresponding to stressors identified by the Canadian Public Health Association (1996) that affect new immigrants include: Not being able to do the work they used to do; Feeling that they are not welcome in Canada; Experiencing racism and discrimination; Learning that Canada does not value their skills and education; Not being able to speak English in Canadian accent and Not having the support of the people from their community.

7. Micro Level: Meaning of Work

I also realized that underemployment that results when a trained professional is unable to work at the level for which s/he is trained is also a potential risk to psychological well-being. New immigrants are often told that they are not qualified to work in their profession while on the other hand they are told that they are overqualified for entry level positions, leaving them with no option but to accept any precarious jobs offered in order to support their families. This causes mental distress on a new immigrant who is dissatisfied with his/her job status and wages. The findings of this study show that work as a major Social Determinant of Health has other functions than providing income. Work provides a purpose to life; it defines status and identity, and enables individuals to establish relationships with others in the society. The latter function is critical for immigrants, because adaptation is facilitated by social interactions. The more one interacts with the groups in the larger society, the faster one acquires skills to manage everyday life. The implication for immigrants who are underemployed /unemployed is both a decline in psychological well-being and a delay in integration and adaptation (Raphael & Dennis, 2008: pp. 3-18; Aycan & Berry, 1996). Hence many of us immigrants sought reintegration into Canada by acquiring a "Canadian experience" through undertaking further education. Despite the struggles, our perception that we were getting better integrated and hope that the odds of resettlement would soon be over was soon skewed by inability to get a job interview for many years. When interviews were granted the offers were deliberately made for term positions that lacked proper support for staff training in skills tailored to meet their job description requirement for optimal input—a grand plan hatched by senior civil servants at the echelon of government affairs. This is where spirituality as an innate power of the persona kicks in as a fortification against stress and trauma experienced due to systemic racism and the resulting disappointments to realization of migrants' dreams in Canada.

8. Impact of Unemployment on Families and the Mental Health of Newcomers

For new immigrants, income loss could imply a depletion of a person's assets, a loss/lack of employment benefits and the loss/depletion of the income/assets of family members due to resettlement and its demands. Income loss due to unemployment generates new waves of anxiety for new immigrants due to uncertainty about future income and continuous drop in standard of living. Underemployment and insecure work conditions cause anxiety. Those who are economically insecure due to underemployment or unemployment have lower morale. Unemployment leads to a drop in status among family and friends and in the community at large. This can lead to a loss of self-esteem. The loss of a job typically means a disconnection with work colleagues and a reduction of social networks. That loss of engagement and social capital can bring about a decline in personal

well-being. The enormity of the effects of unemployment might vary with age and gender. Mental illness is debilitating on the individual and family as a whole. For new immigrants, mental illness may also mean a loss of income and the spending of the already depleted family savings on medication and cure that is not readily available. Where the affected individual is the family provider, that household would be on the threshold of homelessness creating a social problem. In some cases reluctance to seeking help due to fear of stigma or ignorance of services that are available and in my case undisclosed diagnosis and untimely treatment of Grave's Disease or Hyperthyroidism—a hormonal disorder capable of triggering other health and mental health issues, may mean deterioration in the individual's condition. This in turn leads to a decline in the standard of living of the individual or household, thereby affecting the well-being of the entire family which in turn affects the community. The larger picture is that the Province ended up spending more on healthcare than was necessary if government policy on immigration had been humane enough to provide for adequate employment and affordable housing or Medicare; and had balanced support for a culture of reproductive healthcare. If reproductive health had the same support as chronic diseases, specialist gynecologists would not have to embark on a culture of lying and cover-ups to survive in their practice.

This paper brings to mind Fook's (1999), critical reflectivity—a sense of responsibility, of agency, an appreciation of how each player can act upon to influence a situation. This could be viewed as an ability to interweave analysis with action, to engage in a process of inductive and creative thinking, so that specific personal experiences act as a springboard to broaden understanding. Thus, a capacity to question, to tolerate uncertainty, and to utilize this as a catalyst for active change, develops. The capacity for questioning and change emerges as a hopeful theme, so does the glimmer of uncertainty. Similarly, Coll, Cook-Nobles, & Surrey (1997), challenge my ways of seeing and knowing, by sensitizing me to consider how I labour and interact with others. What views, prejudices, and assumptions I bring into my analysis, and how I consider people other than myself. Their words raised crucial questions and issues that I reflected on during my period of struggling with Graves's Disease and the realization that two specialist physicians had colluded to withhold information so critical to my survival and well-being. Could recourse to legal action have resolved the problem? I agree with *Rekindling Reform* that litigation by patients who have been hurt by careless actions of their healthcare providers, like I was, is not the best way to resolving this type of problem. Although it may satisfy the compensatory aspect of an inquiry, it certainly "focuses on finding fault, rather than learning from the mistakes. It inhibits healthcare providers from disclosing problems and creates an adversarial relationship between provider and patient …" (Health Council Canada, 2008: p. 24). I realized that an adversarial action may also affect the disposition of my current healthcare providers toward me, and they may not inform me if they made a mistake. After all we are all human being, and similar

and different in specific ways.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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