Role of Cultural Beliefs, Religion, and Spirituality in Mental Health and/or Service Utilization among Immigrants in Canada: A Scoping Review

Ferzana Chaze
Sheridan College

Mary Susan Thomson, Usha George, and Sepali Guruge
Ryerson University

ABSTRACT

This paper uses Arksey and O'Malley's (2005) framework for conducting scoping reviews to examine 25 years of Canadian literature to understand the importance of cultural beliefs, religion, and spirituality in the context of immigrant mental health and/or service utilization. A review of 24 selected articles revealed 4 broad areas relative to the role of religion, spirituality, and culture in these contexts. Based on the findings the authors suggest that in increasingly diverse societies like Canada there is an urgent need for mental health professionals to take into account in their practice their service users' cultural, religious, and spiritual beliefs.

Keywords: mental health, culture, religion, spirituality, immigrants, Canada

RÉSUMÉ

Cet article utilise le cadre d'examen de la portée d'Arksey et O'Malley (2005) pour résumer 25 années de la littérature canadienne afin de comprendre l'importance des croyances culturelles, de la religion et de la spiritualité dans le contexte de la santé mentale et/ou de l'utilisation des services par les immigrants et immigrantes. Un examen de 24 articles a révélé 4 grands domaines relatifs au rôle de la religion, de la spiritualité et de la culture dans le contexte de la santé mentale des immigrants et immigrantes. Sur la base

Ferzana Chaze, Faculty of Applied Health and Community Studies, Sheridan College; Mary Susan Thomson, Faculty of Community Services, Ryerson University; Usha George, Faculty of Community Services, Ryerson University; Sepali Guruge, Daphne Cockwell School of Nursing, Faculty of Community Services, Ryerson University.

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Correspondence concerning the article should be addressed to Ferzana Chaze, Faculty of Applied Health and Community Studies, Sheridan College, 7899 McLaughlin Road, Brampton, Ontario, L6Y 5H9. Email: ferzana.chaze@sheridancollege.ca.

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des résultats, les auteures suggèrent que dans des sociétés de plus en plus diverses telles que le Canada, les professionnels et professionnelles de la santé mentale doivent urgemment prendre en compte les croyances culturelles, religieuses et spirituelles de leurs utilisateurs et utilisatrices de services dans leur pratique.

Mots clés : santé mentale, culture, religion, spiritualité, immigrants et immigrantes, Canada

In this paper we review the literature on cultural beliefs, religion, and spirituality in the context of immigrant mental health in Canada. Culture refers to the values, beliefs, ideas, customs, traditions, and behaviours associated with a particular group of people (Sullivan, 2009). Religion can be defined as an organized system, or set of beliefs, that provides answers to questions about life through sacred texts, rituals, and practices (Ameling & Povilonis, 2001; Blanch, 2007). Spirituality understood as "meaning making" helps individuals to make meaning of life and circumstances (Ameling & Povilonis, 2001, p. 16). We suggest that in increasingly diverse societies like Canada there is an urgent need for mental health professionals to take into account in their practice their service users' cultural, religious, and spiritual beliefs. Two major phenomena frame the backdrop of this paper: the growing immigrant diversity in Canada and an increasing awareness of the limitations of the Western medical model of mental health intervention in addressing the needs of diverse populations.

Canada's demographic profile is undergoing a slow but steady change. Each year over 200,000 new immigrants make Canada their home (Citizenship and Immigration Canada, 2013). Although Canada has a long history of immigration, it has been less than 50 years since the country opened its doors to non-European groups. Since the introduction of the points system in the late 1960s, the majority of persons immigrating to Canada have arrived from non-European countries. Accompanying this increasing ethno-racial diversity is a growing awareness about the limitations of the Western bio-medical model of intervention in serving diverse populations who might have varied conceptions of mental health (Donnelly et al., 2011; Chiu, Ganesan, Clark, & Morrow, 2005), or believe in other solutions for mental health issues (Chiu et al., 2005; Acharya & Northcott, 2007). In particular, there is recognition that religion and spirituality might play a role in dealing with mental health issues and in mental health service utilization. Analysis of the Ethnic Diversity Survey (EDS) shows that attendance at religious services has decreased over the past few decades; however, the number of religious activities that Canadian adults engage in on their own remains high (Clark & Schellenberg, 2006). The EDS found that 40% of persons who immigrated to Canada between 1982 and 2004 had a high degree of religiosity (Clark & Schellenberg, 2006).

Culture, Religion, Spirituality and Canadian Immigrants' Mental Health and Service Utilization

Many immigrants come to Canada from countries where religion and spirituality are important components of health and healing. Once in Canada, however, they encounter a healthcare system that often does not recognize the role of spirituality in health or treatment (Collins & Guruge, 2008). This can be a serious barrier to their mental health service utilization. Countries in East Asia and South East Asia have long recognized the relationship between spirituality and health (Blanch, 2007). The importance of culture in relation

to immigrant mental health and mental health service utilization has been well established and supported by research, and the importance of religion and/or spirituality has recently been given growing attention in Western health care systems (Ameling & Povilonis, 2001; Koenig, 2010; Blanch, 2007). There is a call for mental health professionals to increase competencies in relation to religion and/or spirituality (Grabovac & Ganesan, 2003) as well as to explore the possibilities of using these in therapeutic treatments (Koenig, 2010).

Immigrants' mental health and mental health service utilization. Research has established the vulnerabilities of immigrants in relation to mental health (Dean & Wilson, 2009; Jafari, Baharlou, & Mathias, 2010; Tang, Oatley, & Toner, 2007). Although immigrants enter the country with high levels of health, their health advantage over Canadian-born persons slowly declines over time (Kennedy, McDonald, & Biddle, 2006). Possible reasons for this are acculturation stress (Matheson, Jorden, & Anisman, 2008), difficulties in finding suitable work in Canada (George, Chaze, Fuller-Thomson, & Brennenstuhl, 2012; Reitz, 2005), loss of traditional sources of social support (Ahmed et al., 2008; Donnelly, 2002), and experiences of discrimination (Simich, Maiter, & Ochocka, 2009).

Immigrants are also likely to underutilize mental health services (Fenta, Hyman, & Noh, 2006; Sadavoy, Meier, & Ong, 2004; Whitley, Kirmayer, & Groleau, 2006), often because of a lack of awareness about mental health issues (Chow et al., 2010) or available services (Reitmanova & Gustafson, 2009a; Donnelly et al., 2011; Sadavoy et al., 2004; Ahmed et al., 2008). Research also shows cultural beliefs and practices as barriers to mental health service utilization (O'Mahony & Donnelly, 2007; Donnelly et al., 2011). Culture influences the understanding of mental health and health behaviours as well as of health care utilization (Simich et al., 2009). The manner in which cultural, religious, and spiritual beliefs affect mental health and mental health service utilization is an under-explored area of research.

Although religion is often experienced within a community, spirituality can be experienced within or outside of religion, and with community or individually. Koenig (2009) states that religious beliefs can provide a sense of meaning and purpose in times of difficulty; it provides an optimistic world view and positive role models that help the acceptance of suffering and offer communities of support. Spirituality is important especially at times of illness (O'Reilly, 2004). Research has identified the many benefits of spirituality and religiosity, relating it to better coping with illness, improved recovery, survivorship, and better health and quality of life (Koenig, 2010; J. A. Schreiber & Brockopp, 2012; Ameling & Povilonis, 2001). Many health practitioners can be reluctant to incorporate spirituality into their practice because of the historical belief that religion and spirituality are antithetical to science (Ameling & Povilonis, 2001; Blanch, 2007). Other reasons could be the ambiguity in their understandings of spirituality and lack of training in implementing spirituality in patient/client care (Ameling & Povilonis, 2001). There is also evidence that the health practitioners' own religious beliefs could impact the provision of services (Curlin, Nwodim, Vance, Chin, & Lantos, 2008; Griggs & Brown, 2007).

This paper reviews the literature on culture, religion, and/or spirituality in relation to immigrants' mental health and/or service utilization. The authors recognize that culture, spirituality, and religion are intersecting concepts that cannot be neatly separated from each other. Specifically the authors sought to understand what the existing literature informs us about the role of cultural beliefs, religion, and spirituality on immigrants' mental health and service utilization in Canada. A Canadian-specific search was considered especially important keeping in mind the strategic directions of the Mental Health Strategy for Canada (Mental Health

Commission of Canada, 2012) and its commitment to reduce disparities in risk factors, and strengthen responses to the needs of diverse populations.

METHOD

This paper uses Arksey and O'Malley's (2005) framework for conducting scoping reviews to examine over two decades of relevant Canadian literature. A scoping review allows for a rapid review of "key concepts underpinning a research area and the main sources and types of evidence available" (p. 5). Search criteria for the review included peer-reviewed articles written in English and published between January 1990 and January 2015. While ethno-racially diverse immigrants have been entering the country in significant numbers since the 1970s, the research on immigrant mental health prior to 1990 is very sparse. A 25-year span of literature review was considered adequate to capture a vast majority of the literature on immigrant mental health in Canada.

Online databases Medline, CINAHL, PsycINFO, Embase, and Healthstar were searched using the following key words: culture/cultural/ multicultural; race/racial/racism/racialization; diversity/diverse; religious/ religion/spirituality; ethnic/ethno/minority/ethno-cultural; health/health beliefs/ mental health/diseases/ chronic conditions; immigrant/emigrant/migrant/immigration/refugee/newcomer/non-status/precarious; and Canada. The scoping review was limited to the Canadian literature because it arose from a larger Canadian study related to mental health in the context of Canadian immigrants. This paper is one of a series of four papers that emerged from this larger study. Figure 1 describes the method of selecting the relevant articles for the review. Full texts of 486 articles identified from the search criteria were reviewed. Articles were selected that focused on how cultural beliefs, along with religion and/or spirituality, affect the mental health and/or service utilization of immigrants in Canada. Table 1 provides details about the study characteristics of the selected articles.

FINDINGS

The scoping review reveals four broad areas in relation to the role of religion, spirituality, and culture in the context of immigrants' mental health and service utilization: varying conceptions of mental health and treatments, the reliance on spirituality and/or religion, the role of stigma, and the need for linguistically and culturally appropriate services.

Conceptions about Mental Health, Mental Illness and Treatments

Some immigrants may not be familiar with "Western ideas" of mental health and mental illness, or with "Western services" for treatment (Donnelly et al., 2011). Mental illness may be conceptualized differently by immigrant groups. Some South and East Asian immigrant women, for example, have conceptualized mental health as "peace with oneself and a tenable and maintainable goal in life" and mental illness as "a bad spirit" residing within oneself (Chiu et al., 2005, p. 645).

Some immigrants are more likely to use informal support systems such as family and friends than formal services to deal with mental health problems (Donnelly et al., 2011). In a study of West Indian immigrant

Figure 1

Flow Chart: Literature Search and Selection

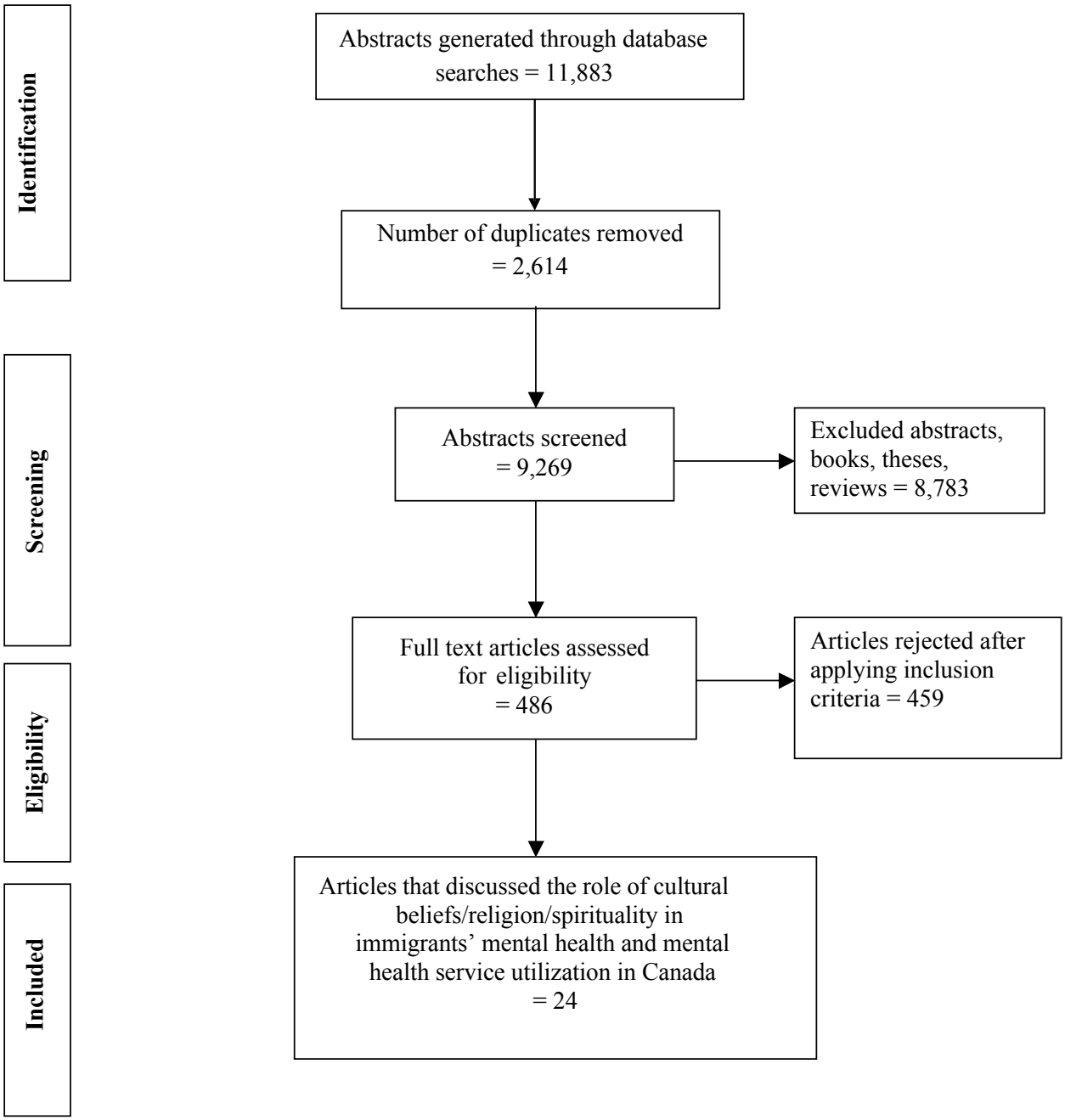

Table 1

Data Extraction Table

No.	Author Information	Sample Information: Ethnicity or Country/Continent of Origin, Age, Gender, Sample Size and Location	Research Design
1	Acharya & Northcott (2007)	South Asian (India) 60–74 years Female *n* = 21 Alberta	Qualitative Cross-sectional
2	Ali & Toner (2001)	Trinidad, Jamaica, Barbados, Guyana, Caribbean 19–64 years Female *n* = 40 Toronto, Ontario	Quantitative Cross-sectional
3	Bottorff et al. (2001)	South Asian Women (India, Pakistan, Bangladesh, Fiji) East Africa 20–80 years Female *n* = 80 British Columbia	Qualitative Cross-sectional
4	Chappell & Lai (1998)	Chinese 65+ years Male & Female British Columbia	Qualitative Cross-sectional
5	Chiu, Ganesan, Clark, & Morrow (2005)	South and East Asians (India, Mainland China, Taiwan, Vietnam, Hong Kong, Brunei) 26–67 years Female *n* = 30 British Columbia	Qualitative Cross-sectional
6	Donnelly et al. (2011)	China and Sudan Female *n* = 10 Alberta	Qualitative Cross-sectional
7	Dossa (2002)	Iranians Range = n/a Female *n* = 40 British Columbia	Qualitative Cross-sectional
8	Etowa Keddy, Egbeyemi, & Eghan (2007)	African Canadian 40–65 years Female *n* = 113 Nova Scotia	Mixed Cross-sectional

Table 1
(Continued)

No.	Author Information	Sample Information: Ethnicity or Country/Continent of Origin, Age, Gender, Sample Size and Location	Research Design
9	Fenta, Hyman, & Noh (2006)	Ethiopia 18+ years Male & Female *n* = 342 Toronto, Ontario	Quantitative Cross-sectional
10	Haque (2010)	South East Asians (Chinese & Indians) Male & Female Canada (more than one province)	Qualitative Cross-sectional
11	Hynie, Crooks, & Barragan (2011)	Colombia, El Salvador, Jamaica, Ecuador, Trinidad, Caribbean islands, Portugal, Brazil, Azores, Mexico, Angola, Costa Rica, Cuba, Pakistan and Afghanistan 19–50 years Female *n* = 87 Toronto, Ontario	Qualitative Cross-sectional
12	Jarvis, Kirmayer, Weinfeld, & Lasry (2005)	Anglophone Canadian-born, Francophone Canadian-born, Afro-Caribbean, Vietnamese and Filipino immigrants 18–75 years Male & Female *n* = 2,246 Montreal, Quebec	Quantitative Cross-sectional
13	Lai & Surood (2013)	South Asian 55+ years Male & Female *n* = 220 Alberta	Quantitative Cross-sectional
14	O'Mahony, Donnelly, Bouchal, & Este (2013)	Mexico, South America (Brazil, Colombia), Central America (Costa Rica), South East Asia (Philippines), South Asia (India, Pakistan), China, Middle East, Africa 18+ years Female *n* = 30 Alberta	Qualitative Cross-sectional
15	O'Mahony & Donnelly (2007)	Chinese, South East Asian, Caucasian health care providers n/a *n* = 7 Male & Female Calgary, Alberta	Qualitative Cross-sectional
16	Reitmanova & Gustafson (2009a)	n/a 30–45 years Female *n* = 8 Newfoundland	Qualitative Cross-sectional

Table 1
(Continued)

No.	Author Information	Sample Information: Ethnicity or Country/Continent of Origin, Age, Gender, Sample Size and Location	Research Design
17	Reitmanova & Gustafson (2009b)	n/a 30–45 years Female *n* = 8 Newfoundland	Qualitative Cross-sectional
18	Reitmanova & Gustafson (2008)	n/a 30–45 years Female *n* = 6 Newfoundland	Qualitative Cross-sectional
19	Rousseau et al. (2011)	Arabs & Haitians 18–65 years Male & Female *n* = 1,216 Montreal, Quebec	Quantitative Cross-sectional
20	Sadavoy, Meier, & Ong (2004)	Chinese & Tamil 55–65 years Male & Female 17 groups Toronto, Ontario	Qualitative Cross-sectional
21	Schreiber, Stern, & Wilson (1998)	Black West Indian Average = 39 years Female *n* = 11 Toronto, Ontario	Qualitative Cross-sectional
22	Whitley & Green (2008)	Black women n/a Female *n* = 12 Montreal, Quebec	Qualitative Cross-sectional
23	Whitley, Kirmayer, & Groleau (2006)	Euro Canadian and Anglophone, Afro Caribbean 20–30 years Female *n* = 15 Montreal, Quebec	Qualitative Cross-sectional
24	Wong & Tsang (2004)	Korea, Hong Kong, Mainland China, Taiwan and Vietnam 39 years Female *n* = 102 Toronto, Ontario	Qualitative Cross-sectional

women, for example (R. Schreiber, Stern, & Wilson, 1998), participants noted that depression was not a problem in their country of origin, that growing up in Jamaica they had never heard about depression, and that "no one goes to see a psychiatrist back home" (p. 514). Similarly, in a study with immigrant women experiencing post-partum depression (PPD) (O'Mahony, Donnelly, Bouchal, & Este, 2013), the women shared that in countries like the Philippines people may not call PPD "depression" and that "other countries are not as focused about depression" (p. 306).

Some immigrants might have a mistrust of Western biomedical models of treatment and/ or may prefer to rely on alternate treatments (Donnelly et al., 2011). In a study of older immigrant Indian women (Acharya & Northcott, 2007), participants reported that they relied on "staying busy doing one's duties" (p. 619) as a way to maximize control over the inner self and to avoid mental distress. Other alternate treatments reported in the literature included "foods/diets, herbs (e.g., tonics/teas), Chi-gong or Tai chi practices, acupressure, acupuncture, and cupping" as well as "chiropractic, naturopathy, and massage therapy"(Chiu et al., 2005, p. 646); following a cultural imperative of "being strong" (R. Schreiber et al., 1998); reliance on herbal remedies or healing practices that "restore balance" and "take bad spirit out" (Chiu et al., 2005, p. 645). Religious beliefs may have an impact on how mental health issues are perceived as well as on service utilization. For example, Fenta et al. (2006) inform us that in some religious groups, such as the Coptic Orthodox Church, mental illness is thought to result from possession by evil spirits, and treatment involves "priests and monks using prayer, holy water, and even exorcism" (p. 353).

Reliance on Spirituality and Religion

Religion and spirituality have been found to be important for many immigrants in making meaning of life (Wong & Tsang, 2004); in accepting one's illness and managing it (R. Schreiber et al., 1998); and in coping with it (O'Mahony et al., 2013). In a study of depression among Black immigrant women in Ontario, for example (R. Schreiber et al., 1998), religion and spirituality were found to play an important role in accepting and managing depression. Participants in the study interpreted depression from a religious context and either "gave their troubles over" to God, seeking solace and comfort in prayer; or believed that God "gave them strength and faith to do what they needed to do in order to solve their problem" (p. 516).

Activities and practices such as worshipping/praying, spiritual reading, meditation, and repeating God's names are described by some immigrants as spiritual resources for mental health care (Chiu et al., 2005). Spirituality and religious beliefs were found to be strong facilitators of coping with PPD (O'Mahony et al., 2013). Este and Bernard (2006) found that spirituality was an important source of strength and a coping strategy in the face of racism and discrimination among African women from Nova Scotia.

Jarvis, Kirmayer, Weinfeld, and Lasry (2005) note that although there is a positive relationship between religious practice and mental health for diverse ethno-racial populations, this may vary across cultural groups and by gender. Chappell and Lai (1998) studied the service utilization of older Chinese immigrants in British Columbia and found that participants preferred Western- over Chinese-medicine-based care although they did prefer to use the services of Chinese practitioners. Approximately half the older Chinese immigrants in their study also engaged in traditional Chinese care alongside Western medicine, however. Their findings suggest that religious beliefs can also be a predictor for the use of traditional medicine. A study by Whitley et al. (2006)

of West Indian immigrants in Quebec found that the participants believed both in non-medical interventions such as the power of God, and to a lesser extent, in traditional medical practices. These non-medical beliefs were important factors related to the non-utilization of mental health services.

Stigma

Stigma has been recognized by the World Health Organization (2001) as a serious problem for persons living with mental illness in all communities, but the level of stigma may vary between communities. In many immigrant communities stigma acts as a barrier to the utilization of mental health services (Donnelly et al., 2011; R. Schreiber et al., 1998; O'Mahony et al., 2013**;** Sadavoy et al., 2004; Teng, Robertson, & Stewart, 2007; O'Mahony & Donnelly, 2007, 2011; Etowa, Keddy, Egbeyemi, & Eghan, 2007; Chiu et al., 2005; Whitley et al., 2006; Ahmed et al., 2008). In their study of Black immigrant women, for example, R. Schreiber et al. (1998) found that mental illness carries a strong stigma in West Indian cultures, and that an individual living with mental illness is likely to suffer social isolation and social sanctions. Shibre et al. (2001) inform us that in some cultures, mental illness can affect not only the person who is ill but other members of the extended family as well. Similarly, Bottorff et al. (2001) reported that South Asian immigrant women might be unwilling to talk about health concerns for fear that information about their "weakness" (p. 396) would not be held in confidence. Stigma and the pressure to "save face" (O'Mahony et al., 2013, p. 307) might lead to somatization of the ailment, and some immigrant communities might prefer that their problems are seen as physical health issues rather than mental ones (O'Mahony et al., 2013; Fenta, Hyman, & Noh, 2007; Kirmayer & Young, 1998).

The Need for Linguistically and Culturally-Appropriate Services

The need for linguistically and culturally appropriate services that take into account the cultural world-views, beliefs, and practices of immigrants is a recurring theme in the literature. The inability to communicate in English or French can pose serious challenges to immigrants seeking access to health services in Canada **(**Taylor, Taylor-Henley, & Doan, 2005; Lai & Surood, 2013; Lai, 2005; Etowa et al., 2007; Lai & Surood, 2008; Simich et al., 2009; Sadavoy et al., 2004; Schaffer et al., 2009). When "mainstream" mental health services do not provide linguistically appropriate services, immigrants with low English-language proficiency may be forced to turn to ethno-specific agencies for health-related services. These agencies are not adequately equipped to meet these needs (Sadavoy et al., 2004). Lack of culturally sensitive services may make it difficult for immigrants to access existing services (Reitmanova & Gustafson, 2009a; 2009b). Healthcare providers may not be aware or trained in the needs of diverse clients, posing an additional barrier to immigrants' access to service (Donnelly et al., 2011; Lai & Surood, 2008; Sadavoy et al., 2004). Cultural brokers or interpreters may be used to assist in providing services to diverse ethno-racial clients (Kirmayer et al., 2003; 2011).

DISCUSSION

This scoping review emerged from acknowledgment in the literature that Western bio-medical models of mental health intervention are not always suitable to meet the needs of the growing number of immigrants of diverse ethnicities and cultures in Canada. The Canadian Mental Health Strategy (2012) recognizes the

vulnerability of racialized immigrants in relation to mental health and mental health service utilization and makes improving health services to immigrants and racialized groups a priority focus. This scoping review makes an important contribution to the literature by consolidating existing knowledge on this understudied area in the Canadian context. A quick search of the literature in the USA and UK, moreover, indicates no comparable review that focuses on all four variables: culture, religion, spirituality, and immigrant mental health.

This paper revealed four broad areas in relation to the role of religion, spirituality, and culture in the context of immigrants' mental health and/or service utilization. First, immigrants from different parts of the world may hold varying conceptions of mental health and mental illness, along with what mental health treatment looks like. Second, spirituality and religion can be important dimensions of a person's reality and identity that mental health practitioners need to take into consideration. Third, cultural stigma related to mental illness can be a barrier to service utilization; and fourth, there is a need for linguistically and culturally appropriate services in mental health settings. None of these findings are surprising given the centrality of religion and culture to many immigrants and because of the strong social networks that play an important role in many racialized communities.

The authors of this paper join others (Chow et al., 2010; Pepler & Lessa, 1993; Jafari et al., 2010) in reiterating the need for culturally and linguistically appropriate services. Cultural brokers and interpreters can be important to help in effective communication between the service providers and users (Kirmayer et al., 2003). At the same time, the authors propose that there is a need to understand the role of religion, culture, and spirituality in the person's life without essentializing the person or fixing into place stereotypes about cultural groups. Drawing on an integrated cross-cultural model of social work practice (Tsang & George, 1998), we suggest that although a basic understanding of different cultural systems can be helpful, it is important for the practitioner to understand how the individual service user has internalized these cultural elements and what impact this has on his/her mental health and/or service utilization. Such a guideline should also take into account the factors related to acculturation and mental health utilization. There is also a need to work on culturally and linguistically appropriate public education strategies that promote awareness of mental health and mental health services, and that fight stigma (Ahmed et al., 2008; Chow et al., 2010; Sadavoy et al., 2004). Moreover, practitioners should strive to build upon the immigrants' cultural beliefs and practices (Lai, 2005).

There is a need to further explore and incorporate culturally relevant therapies with immigrant groups. Culturally adapted Cognitive Behaviour Therapy has been found effective with traumatized Latino and South East Asian refugees (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012), with African American women (Kohn, Oden, Muñoz, Robinson, & Leavitt, 2002), and with persons with a diagnosis of depression in Pakistan (Naeem et al., 2015). Culturally adapted therapy strategies include unique approaches to exposure (Hinton et al., 2012); involvement of family members in completing the homework required of the participants and in the initial session (Naeem et al., 2015); focusing initially on physical symptoms (Naeem et al., 2015); incorporating culturally relevant terminology and imagery (Hinton et al., 2012, Naeem et al., 2015; Kohn et al., 2002) and culturally prescribed techniques, rituals, or healing rites (Hinton et al., 2012); and incorporating relevant folk stories and/or culturally relevant examples (Naeem et al., 2015; Kohn et al., 2002). Mindfulness-based interventions in mental health also appear to have potential (Shapiro, Carlson, Astin, &

Freedman, 2006; Carmody, Baer, Lykins, & Oledzki, 2009; Centre for Addiction and Mental Health, 2014) and can be further explored for effectiveness with diverse communities.

One of the limitations of the review is that it includes only peer-reviewed Canadian studies published in English. The grey literature was not reviewed. In addition, the quality of the selected articles was not assessed. A majority of the articles used qualitative research and had very small sample sizes. Of the articles reviewed none were longitudinal, making it difficult to understand changes in perceptions of mental health and/or service utilization over time. There is an urgent need for larger quantitative studies that test for the findings that emerge from the qualitative studies, and for longitudinal studies that track changes in immigrant mental health and/or service utilization over time.

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