

Transformation Through Collective Action:

Best Practices in Migration,
HIV and Mental Health



Committee for
Accessible
AIDS Treatment

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HIV and Mental Health

Improving Access to Mental
Health Services for Immigrants,
Refugees and Non-Status
People Living With HIV/AIDS in
the Greater Toronto Area

Summary Report
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The Committee for Accessible AIDS Treatment

The Committee for Accessible AIDS Treatment (CAAT) is a coalition of people and agencies who provide health, social and legal services to immigrants, refugees, and non-status people living with HIV/AIDS (IRN-PHAs). CAAT also contains many people who are themselves, IRN-PHAs.

CAAT is governed by a steering committee elected by its membership. The coalition was formed in 1999 to address the many barriers that many IRN-PHAs face in accessing essential services and HIV treatment. CAAT's primary objectives are:

- To serve as a forum for information exchange, problem solving and skill building amongst service providers and affected populations; and,
- To identify and facilitate the implementation of creative solutions to these access barriers.

CAAT continues to address its objectives through PHA capacity building, research, knowledge transfer and exchange, coalition building, and advocacy.

The Committee for Accessible AIDS Treatment (CAAT)

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Executive Summary

This summary report presents the highlights of the action research project, *Improving Access to Mental Health Services for Immigrants, Refugees and Non-status People Living with HIV/AIDS in the Greater Toronto Area*, conducted by the Committee for Accessible AIDS Treatment. This study followed up on the needs identified in previous research and community consultation projects.

Background of the Study

Many immigrants, refugees and non-status people living with HIV (IRN-PHAs) face significant problems in accessing the health care services and treatments they need. Addressing these challenges was one of CAAT's earliest and largest concerns.

As a first step toward addressing these kinds of challenges, they need to be investigated and documented as accurately as possible. In 2001, the Committee for Accessible AIDS Treatment (CAAT) completed a community action research project that documented access barriers faced by IRN-PHAs when seeking HIV care as well as legal services¹. This study focused on the health services, treatment and legal needs of IRN-PHAs. However, in the course of the study, mental health emerged as a critical issue that needed further investigation.

In 2004, CAAT proceeded with a pilot study on IRN-PHA mental health issues. This included a literature review, a scan of available programs, and two focus groups – one in which we spoke to IRN-PHAs, and in the other, to relevant service providers. Results from this pilot project helped us to outline the kind of information that was missing from current literature – and therefore, the kind of information that we needed to gather with a larger study of our own. We realized that we needed to collect stories and information about the life experiences of IRN-PHAs, and how the stresses they face daily affect their mental health. We also needed to begin forming effective strategies for service providers, so that they could begin to address these mental health issues.

In 2005 CAAT formed a research partnership amongst five ethno-specific AIDS service organizations in Toronto:

- Africans in Partnership Against AIDS,
- Alliance for South Asian AIDS Prevention,
- Asian Community AIDS Services,
- Black Coalition for AIDS Prevention, and
- the Centre for Spanish-Speaking Peoples.

Together, we developed a research team to explore and address these mental health issues. In particular, we wanted to look at the barriers that often prevent IRN-PHAs from getting mental health support.

The investigating team was soon expanded to include practitioners in the mental health field, other community-based researchers, and academic researchers from McMaster University, the University of Toronto, St. Michael's Hospital and the University Health Network. The research study was funded by the Ontario HIV Treatment Network and the Wellesley Institute, with additional funding for translation provided by the AIDS Bureau of Ontario Ministry of Health and Long Term Care. The study received ethics approval from Research Ethics Boards at the University of Toronto, McMaster University, and the University Health Network.

Who the study was concerned with:

The study was concerned with two major groups – firstly, **IRN-PHAs**, that is, immigrants, refugees, and people without legal status in Canada, who are living with HIV/AIDS. For the purpose of this study, we looked at first-generation IRN-PHAs, currently residing in the Greater Toronto Area, who migrated from any of five regions: Africa, the Caribbean, South Asia, East and Southeast Asia, and Spanish-speaking countries in Central/South America.

The study was also concerned with **service providers** – people who provide professional health, legal, or social services to IRN-PHAs in the Greater Toronto Area.

How the Mental Health study was conducted:

As an action research project, the goal of this study was not only to address knowledge gaps but also to work toward improved mental health service access and enhanced quality of life for IRN-PHAs. In order to achieve this goal, the research team designed a research framework consisting of six interconnected research and action components (see Figure 1). This report reports on Phase I – that is, the completed first three components of the framework). In this phase of the study, we spoke with IRN-PHAs and their service providers to gather their perspectives on:

- The effects of HIV/AIDS and migration on the mental health of IRN-PHAs,
- Mental health needs of IRN-PHAs,
- The capacity of existing service providers and organizations to meet these needs, and
- Solutions to improve mental health services and support for IRN-PHAs.

GIPA Principles in Action: How IRN-PHAs were involved in this study

CAAT's research efforts are aimed at helping a specific population – immigrants, refugees, and non-status persons living with HIV/AIDS (IRN-PHAs). From its inception, CAAT has always put a high value on involving IRN-PHAs in all aspects of its work, rather than creating an “us and them” scenario. This principle is often called, “the Greater Involvement of People Living with HIV/AIDS (GIPA)”.

In this study, five research assistants from the target communities were hired to participate in recruitment, data collection, and analysis. In addition, twenty one PHAs were recruited to undergo capacity building activities, and served as equal team members in developing the best practice framework and recommendations.

In the knowledge transfer and exchange phase of the research study, we further engaged twenty PHAs from the target communities who were trained as “knowledge transfer and exchange ambassadors”. These ambassadors worked with the research team to develop knowledge transfer/exchange tools for disseminating the findings and recommendations to different target group audiences.

* See the Action Research Report: Improving Access to Legal Services & Health-Care For People Living With HIV/AIDS Who are Immigrants, Refugees or Without Status. The report is available on CAAT's website at <http://www.hivimmigration.ca>.

HIV, Immigration, and Mental Health

Over the last few decades, the Canadian population has become increasingly diverse, with immigrants coming from all over the world. Of the one million immigrants that arrived in Ontario between 1991 and 2001, 80% came from Asia, the Americas, and Africa. Over three-quarters of immigrants to Ontario have chosen to settle in the Greater Toronto Area, making Toronto one of the most diverse metropolitan centres in the world.

As Canadian society becomes more diverse, the face of those living with HIV and AIDS in this country has also changed. The burden of HIV/AIDS has become disproportionate among immigrants, refugees and non-status people who migrated from countries where HIV rates are high. For instance, HIV-positive tests among newcomers born in these endemic countries rose from 2.9% of all HIV positive tests between 1981 and 1995, to 14% of all positive results in 1997 and 1998 alone.

Mandatory HIV testing for all Canadian immigrant and refugee applicants was instituted in June 2002. Until the end of 2005, approximately 2000 individuals had tested HIV positive during their application process - 668 of these in 2005 alone. The majority (67%) of these people were from Africa & the Middle East, 23% from the Americas and 9% from Asia. According to Citizenship and Immigration Canada statistics, the majority of these applicants were eventually accepted into Canada.

What did we already know about *HIV and mental health*?

The nature of HIV/AIDS as an illness has also changed. HIV/AIDS has always been a disease with profound physical and mental health impact. With recent advances in care, people living with HIV/AIDS (PHAs) are now likely to live longer and have better health prospects. Good news though this is, it also means that PHAs now face additional burdens on their mental health due to adverse side effects of antiretroviral medications, fluctuations in their health condition (Clay, 2000), and HIV/AIDS-related discrimination (Kang, Rapkin & DeAlmeida, 2006).

Studies have found that **depression, anxiety, reduced neurological functioning**, and other **neuropsychiatric conditions** are common among PHAs (Kalichman et al., 2000; Zinkernagel et al., 2001; Cook et al., 2004; Berg, Mimiaga & Safren, 2004). Relative to the general population, researchers have found the rates of depression among PHAs to be twice as high (Constantine et al., 1996). Clinically significant anxiety and depression have been shown to affect as many as 40% of women living with HIV/AIDS (Kaplan, Marks & Mertens, 1997), and post traumatic stress disorder affects 62% of female PHAs (Kimerling et al., 1999). A few studies have demonstrated an association between mental health symptoms and HIV disease progression (Ickovic et al., 2001; Kimerling et al., 1999).

Depression and other mental health conditions can also make it difficult for PHAs to take their medications properly (i.e., interfere with **medication adherence**). This can lead to **treatment resistance** (Murphy et al., 2004). Clearly, mental health services are critical to providing treatment and care to people with HIV/AIDS.

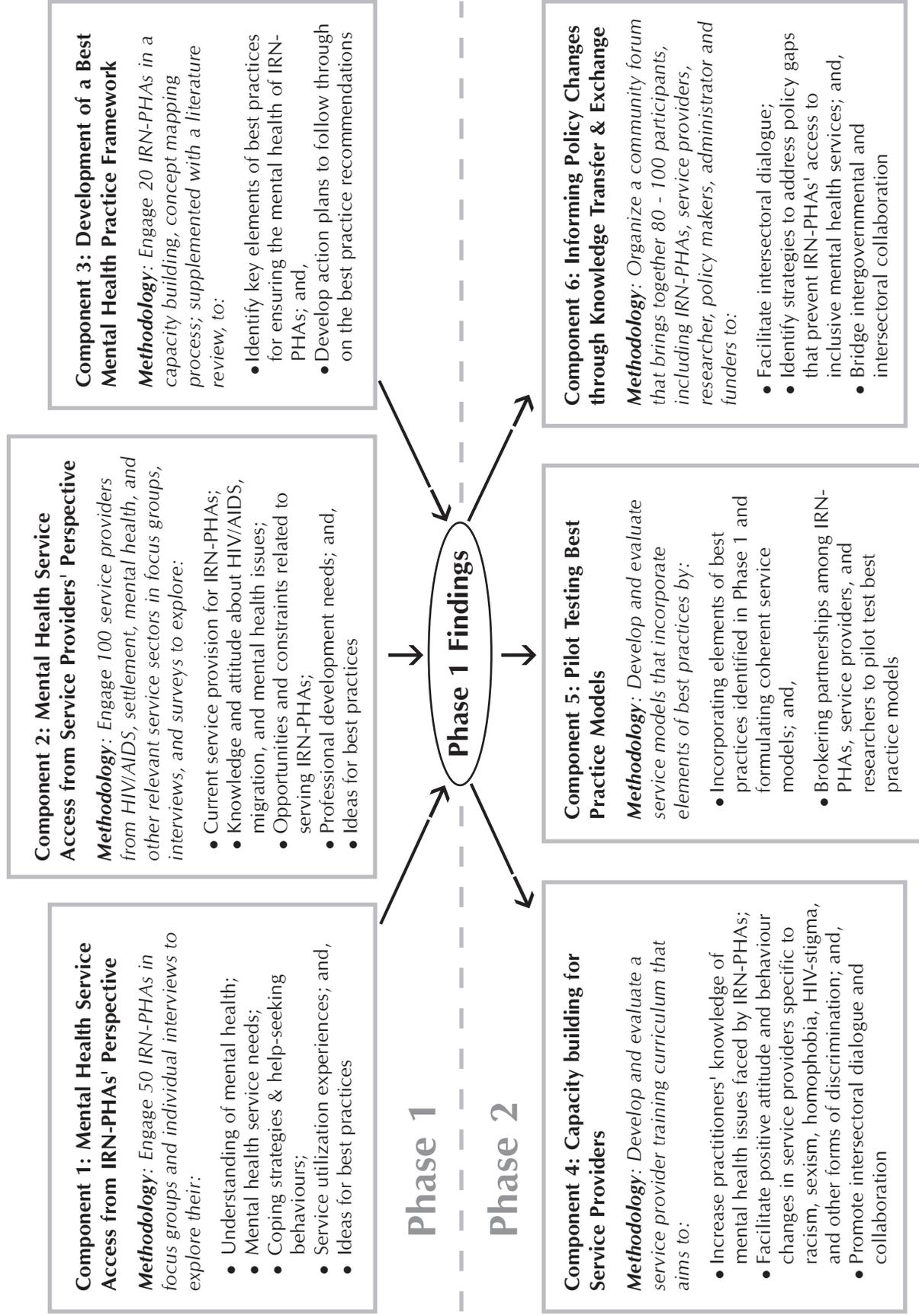
What did we already know about *HIV, immigration and mental health?*

When PHAs are also immigrants, refugees, or do not have legal status, they must cope with the experience of immigration, adding an additional layer of stresses to their lives. Immigrants and refugees, regardless of health status, experience a great deal of settlement stress resulting from **discrimination** (Noh & Kaspar, 2003), **institutional racism** (Karlsen and Nazroo, 2002) and **social exclusion** in the form of **under-employment/unemployment**, **financial strains**, and **social isolation** (Papillon, 2002; Nesdale, Rooney & Smith, 1997). Unemployment and poor social supports are known to lead to **greater symptoms of depression and anxiety** (Zinkernagel et al., 2001; Serovich et al., 2001).

Unfortunately, when IRN-PHAs seek help from the HIV/AIDS community and their own ethno-cultural communities, they often find themselves rejected by both. IRN-PHAs may have to keep their HIV status secret in some ethnic communities where AIDS-phobia is prevalent. Meanwhile, the HIV/AIDS community has for a long time neglected the needs of PHAs from diverse ethnoracial backgrounds, leaving these PHAs feeling out of place. As a result, IRN-PHAs may often "fall between the cracks" when trying to access services and support.

Published research on the mental health of IRN-PHAs is still scarce (Wong et al, 2004). Published literature on HIV and mental health is mostly US-based and mostly about gay white males. This CAAT study was intended to fill these gaps in research related to mental health of IRN-PHAs. It was intended to describe the lived experiences of IRN-PHAs, to pay special attention to the Canadian context and to not only identify challenges faced by IRN-PHAs, but begin to develop strategies to ensure their mental well-being.

Figure 1: Structure of the Mental Health Study



Guiding Principles and Values

As in CAAT's previous research projects, we sought guidance from the philosophy of community-based research (CBR – sometimes called "community based participatory action research" or CBPAR). CBR puts research capabilities in the hands of the "studied" communities themselves, actively involving them in the research process rather than treating them as passive subjects. CBR seeks to meaningfully engage community members and their representatives in every aspect of the research process, so that they use its benefits to advance their lives. The CBR paradigm embraced by the research team as a commitment to the Greater Involvement of People with HIV/AIDS (GIPA) principle, which has been used by the HIV/AIDS movement to embody the ideal of community empowerment and capacity building.

The strategies used to involve IRN-PHAs in this study included:

- A Research Advisory Committee consisting of IRN-PHAs, service providers, and academic researchers, established at the start of the project to provide strategic directions.
- Building research capacity of the IRN-PHA community through paid positions. The investigating team explicitly invited applications from IRN-PHAs on the postings for all paid and volunteer positions. As a result, this study employed a coordinator and a team of five peer research assistants (RAs) from targeted IRN-PHA communities to perform recruitment, data collection, and analysis.
- Involving IRN-PHAs as community co-investigators in data analysis. The third component of this study engaged 20 IRN-PHAs in developing a best practice framework for addressing the mental health issues of IRN-PHAs.

By engaging PHAs in research and subsequent action steps, this study aimed to promote greater PHA involvement – not only in research, but also in program planning and policy development. By playing an active role in research and ensuring that scientific inquiries stay relevant to their lives, PHAs may now have opportunities to table their own agenda.

Component 1:

The Stories Of Immigrant, Refugee and Non-status PHAs On Migration, HIV & Mental Health

Component 1 – The Stories and Perspectives of IRN-PHAs

In this part of the study we spoke to people who were:

- Over the age of 16,
- Living with HIV/AIDS,
- First-generation immigrants, refugees, or individuals who have experienced the migration process but currently without legal status in Canada,
- Originally from Africa, the Caribbean, South Asia, Southeast/East Asia, or Spanish-speaking countries in Latin America, and
- Currently residing in the Greater Toronto Area.

We advertised the study in places that IRN-PHAs frequently visit, including AIDS service organizations, sexual health clinics, community health centres, hospitals, immigration lawyers' offices and community centres. The peer research assistants (RAs) who helped with recruitment were, themselves, from the target ethnoracial communities. We hoped that this would help build trust and encourage participants to come forward. Overall, we made sure we reached as diverse a group as possible, including young people, transgendered/transsexual people, and sex workers.

A total of 47 IRN-PHAs participated in Component 1. Their demographics are described in the full study report, and key details are listed in Appendix B. Some of the main characteristics are as follows.

- Participant **age** ranged from 17 to 53 years old, and was 36 years on average.
- Just over two-thirds were **male**, just under a third were **female**, and one participant was male-to-female **transgendered**.
- **Ethnoracial identity** was nearly evenly divided among the study's five target groups.
- Participants reflected a wide range in terms of **citizenship status**, **length of time in Canada**, **educational level**, and **sexual orientation**.
- Most relied on **social assistance** as their main source of income.
- The length of **time since HIV diagnosis** ranged widely, from 2 months to 22 years.
- Most were on antiretroviral medications; there was a wide range of **CD4 counts** and overall **health status**.

What we asked

We asked the IRN-PHA participants about:

1. their **health beliefs**,
2. their **mental health needs** and **challenges**,
3. their **coping strategies**, and
4. their **experiences** using services.

People could participate in individual interview or a focus group, according to their own preference. Prior to each focus group or interview, participants were asked to complete an anonymous demographics form (results above).

We conducted 17 one-on-one interviews and 6 focus groups (of 3 to 11 participants), reaching 47 IRN-PHAs in total; three of the focus group participants were invited back for individual interviews. All focus groups and interviews were audio taped with participants' consent. All identifying information was removed from the transcripts.

Three **focus groups** were conducted in English, one in Spanish, one in Cantonese, and one was specific to South Asian IRN-PHAs. All focus groups were moderated collaboratively by the research coordinator, an RA, and an additional seasoned facilitator.

The **individual interviews** were conducted by the RAs in person. Most interviews were in English, six were in Spanish, one in Ugandan and one in Thai.

What "Mental Health" meant to participants

Our participants had diverse ideas of what the term “mental health” means. Many spoke about social factors that influenced their mental health, while others saw mental health as something connected to their body and spirituality. These external and internal factors mutually influenced one another.

I think, for me personally, good mental health means security. I mean ... financial security or personal security or housing, these are the basic kinds of necessities which we all need and I'm very lucky to have them, so right now I'm very much stabilized.

(South Asian man)

External Factors

For many IRN-PHAs, mental health is closely connected with their **immigration status**, their access to **basic necessities for survival** (including food and housing), **employment**, and a sense of physical, psychological and social **safety**. Employment was important, not only as a source of income, but often to provide a meaningful focus in life.

Safety takes on special meaning especially for participants who had experienced trauma back in their country of origin. In some cases, unexpected events and incidents involving law enforcement in their current living environment rouse a heightened sense of threat and insecurity:

They call the police and then they come on all floors and they knock on my door, they knock, they knock, they knock! I said, 'who is this?' I open. When I open my door, they point the gun on me. *(participant in a mixed group)*

Social supports from family members, friends, or the community, both practical (e.g., childcare help was specifically mentioned) and emotional, were important, particularly for people who have been separated from their loved ones and having difficulty acculturating.

Our mental health is affected by many different factors – emotional factors, family factors and even friendship related factors as well. When you first come to this country, you found different customs. This influences a lot your health. *(Spanish-speaking participant)*

Internal Factors

For many participants, mental health is associated with the **absence of unwanted symptoms**, including physical (e.g. insomnia and physical discomfort) and psychological symptoms (e.g. depressed mood, anxiety, and worries). This focus on identifiable, specific "pathologies" of mental health is often used by mental health providers (see next section), and some of the IRN-PHA participants made deliberate attempts to align their understanding of mental health with the medicalized, psychiatric perspective and language:

For me, it was really important to know what a panic attack is, to know what depression is, to talk about it. I didn't know anything about those things. I had to learn, I had to include those words in my vocabulary, and I had to learn the meaning of those words in order to be able to express my feelings. *(Spanish-speaking participant)*

Some defined mental health as a particular **"positive" state of being**; for example, having positive thoughts, emotions and attitudes, self-confidence and self-esteem. Some discussed mental health in terms of **specific mental capacities**. This included the capacity to deal with stress and adversity (e.g. coping skills or ability to accept things); basic cognitive capacities (e.g. good memory and concentration); or the capacity to regulate or control emotions.

For me, mental health is the ability to think, to talk, to have a good conversation. Sometimes when somebody is talking to me I am very distracted, I am in my own world. I easily lose the interest in a topic or in a conversation... I believe this has to do with mental health. *(Spanish-speaking participant)*

This sometimes meant attending to the present, and not constantly relating one's situation back to having HIV. However, participants often discussed the importance of **coping with and/or acceptance of HIV** as well.

To me mental health is coming to terms with the situation you're in, and feeling comfortable with what you have, like your (HIV) status. That's good mental health. Basically feeling good in your skin. *(South Asian participant)*

Some participants described **successful functioning**, in terms of observable outcomes in life rather than abstract underlying mental capacities. This included being able to maintain a regular lifestyle (e.g. eating, sleeping, exercising, etc.), secure a job, or maintain social relationships in the context of concern for HIV.

Sometimes because of our health problem, how you live or what you eat becomes one of the primary concerns in your life. *(Cantonese-speaking participant)*

Spirituality was often discussed as an important part of mental health. Some participants explained their holistic views on a mind-body connection.

You cannot separate the brain from the heart. Everything goes together. You can have an excellent sexual health, or mental health, or physical health; all are interconnected. *(Spanish-speaking participant)*

I understand mental health as having stability, such as safe housing, where your next meal is going to come from, get to work, and also in the spiritual way. *(African woman)*

Challenges to Mental Health

Participants described several major sources of stress and challenge to their mental health, including the **migration and settlement process; living with HIV; stigma and discrimination; social isolation, and difficulties in accessing services.** People often had to deal with stress from many of these sources at once.

The Journey of Migration

The **migration process** for immigrants and refugees typically follows several distinct stages – pre-migration, departure, arrival in the host country, obtaining legal status, and settlement – and each of these stages can present stresses. A number of participants revealed experiences of war, abuse, and sexual assault in their country of origin or during the journey of migration.

In my country we went through genocide. We have two tribes and then we had a civil war. Because I don't belong to either tribal group, they got angry and I got HIV from this person who was seeking revenge. As a woman living with HIV, it is quite hard to get married. And, being single in my country, you don't have value. They just ignore you. You are nothing. I can't have a biological child and that makes me feel sad about life. (*African woman*)

Most participants who disclosed traumatic experiences had not sought assistance, and these experiences continued to have lingering effects on their mental well-being. The journey of migration and settlement was complex and at times contradictory. While some participants were elated by the prospects of a better life, they were also distressed by the uncertainty of their future.

It's extremely stressful leaving your family. The journey was also stressful and not easy to handle. After I left Africa, I went to [a country in Europe] where I spent almost a month before coming to Canada. I had to go to immigration three times to get the visa. It was a very gruesome experience going and not coming back with all the documents. Also, facing new people and new culture, it's been challenging coping. (*African man*)

Making a New Life in Canada

Upon arrival in Canada, participants often faced multiple setbacks and challenges manoeuvring through the immigrant/refugee system, which sometimes lasted for years.

When I submitted my refugee claim, it was rejected. I had a bad lawyer who didn't know to provide much evidence and didn't tell me what was required ahead of the hearing. I went for a second hearing with another lawyer, but the decision was still negative. It increased my fears and later I applied to stay in Canada on humanitarian and compassionate grounds. During that time, I had nightmares that kept occurring, constant headaches, and frustrations. (*Caribbean woman*)

In addition, many participants described the hurdles they had to overcome in a new country: adjusting to the environment, learning a new language, securing suitable housing, and finding appropriate employment. Many had trouble finding jobs that were equivalent to their employment in the country of origin.

Before coming to Canada, I worked in sales and in research and development. Since I have been here in Canada, I have been working in very low-end jobs, which I don't like.

(Southeast/East Asian man)

For non-status PHAs, not having full legal status limited participants' ability to fully settle and plan for a future.

When I sleep at night I have anxiety attacks. There are a lot of things on my mind such as my HIV status and my financial status. If you don't have legal status you really have to pay everything out of your own pocket. I just go day by day. I don't really think about what's going to happen tomorrow. *(Southeast/East Asian man)*

Many participants also expressed the feeling of loneliness and worry related to being separated from their family and friends as a result of migrating to Canada.

I consider my mental health right now to be quite poor because I am always depending on someone else to be okay. It is very hard to be far away from my family. Back home, I would have family support. It has been very hard without that closeness, that warmth. *(Spanish-speaking man)*

Living with HIV/AIDS

For IRN-PHAs, the processes of coping with the diagnosis, dealing with uncertainty about the future, and adjusting to HIV medications represented another major source of stress,.

You don't know what to do, so you get more stressed. If I get sick do I call the paramedics? Do I go to the hospital and tell them that I am positive? If I get thrown out of the place where I'm living, what do I do? How should I explain to people why I am not working although I am young? I get stressed just trying to figure these things out. *(Caribbean woman)*

Many participants who underwent mandatory HIV testing reported that they did not receive pre- and post-test counselling or referrals to support services.

I received a phone call from the immigration doctor's office saying: 'Please come to the office. Did you know you are HIV positive? Please talk to the receptionist for the referral to the HIV specialist.' Fortunately I had some information about HIV before that, but in other circumstances I would have jumped over a streetcar, or I might have been crying for weeks. I think these people should be sensitized about HIV issues. *(Spanish-speaking man)*

Medication, or the concern about having to be on medications, was often a large source of concern.

Sometimes in the morning I have to come back home from work because I have forgotten my pills. Sometimes that stresses me. Sometimes this stress makes me lose the balance in life. Sometimes it feels bad to be taking medication all the time. Although I know I have to do it, there are mixed feelings about it.

Stigma and Discrimination: HIV and Being a Newcomer

Participants described **fears of disclosure** of HIV status that were related to the fear of **stigma and discrimination**. Many participants, although diagnosed for years, still found it challenging to tell others (including close friends and relatives) about their HIV status.

I very much worried and feared about revealing my HIV status to anyone, and I felt this was leading to my mental health being unstable. I feared revealing to people my HIV status, so I didn't have many people that I associated with. *(Spanish-speaking man)*

For some participants, their encounters with people who openly expressed **prejudice against PHAs** made it difficult to disclose their status.

I met a man and I asked him, 'what do you think about people living with HIV/AIDS?' He said, 'well, I don't think they should have sex; they should stay by themselves.' I was so upset that I couldn't continue the conversation. I was so mad. *(Caribbean man)*

Many participants also reported facing a combined form of discrimination based on both their HIV status and their immigration status. Underlying such discrimination is an assumption that immigrants, refugees and people without status who have HIV/AIDS, are **bringing HIV/AIDS to Canada** and spreading it. One participant described overhearing, "those fucking infected immigrants." Related to this, some participants described an awareness of stereotypes, which equated HIV/AIDS with people from Africa.

In addition to stigma and discrimination related to HIV, our participants also described **multiple other forms of discrimination** including racism, sexism, homophobia, and transphobia, creating an overall environment of discrimination. These social oppressions were reported to impact on self-image and mental well-being, as explained by a South Asian participant:

In Canada, I always knew that I was linguistically different, racially different, ethnically different, religiously different, and sexually different. It is like you just got banged against the wall. So, I experienced discrimination from different levels, from all these different perspectives and it took me to a point where I lacked self-confidence. I developed low self-image and that contributed to me having mental problems. *(South Asian man)*

Related to the recent trend to **criminalize HIV transmission**, many participants in the study therefore expressed feeling distressed as they were forced to either not disclose and risk breaking the law, or disclose and risk losing potential mates. Some participants described feeling isolated as a result of not disclosing:

It's better to die alone than to tell them that you have the disease.
(East/South Asian participant)

Finally, participants also expressed concern that their **family and friends** would experience stress after they disclosed to them due to stigma and discrimination.

Coping Strategies

Our participants described an array of **coping strategies** that included **formal health and social services**, as well as **informal and spiritual support**.

Although expressed in different ways, all participants spoke of a strong desire to restore their mental balance. Those with an outgoing personality and an extensive social network were able to **actively seek support from their peers**, family and friends in Canada and abroad. Those with limited social connections or difficulties making friends turned to **private, calming activities** such as listening to music, reading, exercising, meditating, and gardening.

Spirituality was an important part of the coping strategies for many participants, regardless of their religious affiliation. They spoke of seeking solace in faith-related activities, ranging from reading religious books, prayer, meditation, to actively going to church or temple, and joining faith related study groups.

My heart relaxes when I go to church. Some of the people there know that I am HIV positive and they are very supportive. That gives me good feeling to know that there are people that care about me. *(South Asian man)*

Many participants felt that **contributing** and **giving back to the community** helped their own mental health.

I do some volunteer work at [an AIDS service organization]. I do haircuts. I enjoy giving some happiness to others. I enjoy when they feel happy about their haircut. *(Spanish-speaking transgendered woman)*

Some participants relied on '**active denial**' as a way of coping, while realizing its shortcomings.

I just try to ignore it. I try not to think about my HIV status, but at the same time it keeps coming back like the anxiety attacks in the middle of the night. And sometimes when I am working, people who I work with tell me that I get very moody. *(Southeast/East Asian man)*

Some participants identified **alcohol and drug use** as a key way for them to cope with stress and unresolved conflict. This was sometimes related to cultural expectations of a masculine role:

I grew up with all this ideas about masculinity – men don't get depressed, men have to be aggressive, men don't have nervous breakdowns, men don't suffer from anxiety. To be a man is to be invincible. I started using drugs and alcohol ... when I don't want to talk to people, when I am isolated, when I feel afraid of expressing my fears. Having to keep my feelings inside myself leads me to this self-destruction. *(Spanish-speaking man)*

Many participants sought support from a variety of service providers to meet their mental health needs. These included:

Formal mental health professionals such as psychiatrists:

Right now, I'm very much stabilized. I am on anti-depressants, and I am also on antipsychotic drugs. I am currently seeing a psychiatrist, too. As a result, I am handling my situation much more effectively now. *(South Asian man)*

Counselling services through hospitals, AIDS service organizations, and peer-based groups:

My friend told me about this support group so I attended. Hearing other people's stories made me feel that I was not alone, and if other people had won the battle I would do it as well. *(Spanish-speaking man)*

Complementary and alternative therapies or a **mixture of strategies**:

I decided Tuesdays are the days for taking care of myself. Tuesday mornings I go to the counsellor, then to the naturopathic clinic, and in the afternoon I go to the support group. And after that, I do something that I like, usually going to a film... I have gotten a lot of benefits from taking vitamins and acupuncture. *(Spanish-speaking man)*

Many participants identified **ASO services**, including **ASO retreats**, as one of the few safe places where they could connect with their peers, talk openly about their HIV status, share ideas on coping, and spend time on self-care. **PHA support workers** played an important role for many clients, as well as other resources such as **food banks**, **clothes banks**, **employment services**, **legal services** and other programs.

Having my PHA support worker, who has compassion, who can walk me out of the HIV closet and give me that little extra push, really helps. It really uplifts you. It gives you a feeling that there are people who care. *(South Asian man)*

Barriers to Service

As just described, "mental health services" were taken to include a wide array of programs and supports that go beyond the conventional understanding of mental health care. Participants described many **barriers** that tended to prevent them from utilizing mental health services. These included:

- stigma and discrimination,
- lack of communication and follow-up from service providers,
- language difficulties,
- differences in the idea of what "mental health" was,
- long wait times, and
- limited service availability.

Stigma and discrimination are common experiences. When service providers perpetrated these acts of discrimination – either consciously or unintentionally – they not only added to IRN-PHAs' stress but deterred them from accessing service in the future.

There should be more psychiatrists or mental health workers that understand HIV. I had a problem you know I had to explain to the psychiatrists every time I saw them about how I got HIV. It was like there was something in my body that they were afraid of. *(African man)*

On occasions, participants reported being denied services because of their HIV status.

When I went to see this housing staff, she said to me, 'No, I can't give you a room here because it is shared accommodation and you are HIV positive. We don't want people run out of this building because of you.' *(African woman)*

Participants also mentioned having encountered other forms of discrimination from service providers, including racism, sexism, homophobia, and transphobia, which could take a more covert form than the often-blatant stigma around HIV.

At some of the places, they don't treat you very well. Like the social worker that I first had, for two months we never met and each time we would communicate through phone instead of face-to-face. I realized that was because of race ... we later found out that other black people were treated like that, too. (*African woman*)

Participants sometimes found their right to be in Canada called into question, were seen as burdens rather than contributors to society, and/or were seen as actively importing HIV/AIDS to Canada.

Every time I deal with my nurse, she is always negative. The first time I went there, the question she asked me was, 'I hope you are not sleeping around here. I hope you are not giving Canadian citizens HIV.' (*African woman*)

A **lack of communication** between service providers and IRN-PHAs often took the form of **poor follow-up**. Participants often described feeling neglected by their service providers and therefore decided not to return for support in the future. There was also a frequent **lack of sensitivity** around their HIV status (failure to provide pre- and post-test counselling, lack of proper referrals, having test results displayed openly).

Language barriers were also frequently cited. Participants who had difficulties with either English or French often found it challenging to locate services in their language.

I haven't accessed many services. Most of the services are in English. I do speak English but not my partner, and he feels very isolated. So, I feel bad accessing help and leaving him behind, very depressed and lonely. (*Spanish-speaking woman*)

Most often, participants relied on interpreters to communicate with service providers. However, interpreters were not always well-versed in medical terminology, HIV/AIDS, or the needed cultural competency.

Three times I heard the interpreters translating 'AIDS' instead of 'HIV positive'. I always had to clarify that I am HIV positive, not with AIDS. I think they are not doing their work properly just because of lack of education. Or, when I said 'my boyfriend' they translated by default to 'girlfriend'. So, I had to clarify, 'Yes, I said boyfriend.' This kind of thing could be very embarrassing. (*Spanish-speaking man*)

The **manner in which services are organized** in Canada sometimes confused participants. Many participants were unfamiliar with the types of services available, and often described feeling overwhelmed.

Initially it was like there was this mass of information and I didn't even know where to start. The information doesn't come in a package. It is all like here and there, like the internet. So it was difficult navigating through all that. (*South Asian man*)

As described earlier, participants expressed **diverse perceptions of what mental health meant** to them. When their perceptions were different from the ideas and concepts of Western medicine, this could present challenges. For instance, several IRN-PHAs felt that their counsellors did not offer the concrete solutions they had expected.

I didn't find psychiatrists helpful. I find it a waste of my time actually. I mean those couple hours in the session just brought back all the bad memories. It made me miserable and I had to cry. It was like they digging up dirt but offered no solutions. So, I just stopped going back. (*Southeast/East Asian man*)

A few participants mentioned that they would not seek help from psychiatrists because of their **hesitation to take more medications** such as antidepressants. One participant described feeling “overdrugged”.

Long wait lists and **limited service availability** were also identified as barriers.

Once you finally get the health services it is good, but it is the long wait, the long process of getting there that is tiring. That process can sometimes kill people in my opinion. I had to wait for two months before I finally got to see my counsellor. (*South Asian man*)

Many services that are perceived as more HIV-friendly are in the downtown Toronto area, while newcomers to Canada often live in the outskirts of the Greater Toronto Area. Many participants said that the time and costs associated with traveling often stopped them from accessing services they needed.

In summary, IRN-PHAs reported multiple barriers when seeking formal mental health support. These barriers were sometimes a result of negative attitudes and behaviours from service providers, and sometimes they arose from the structure of healthcare and social services. Some of these obstacles, such as the language barriers, long wait times and limited service availability, might be addressed by general, non-IRN-PHA-specific initiatives. Others – such as stigma, discrimination, and differences in how “mental health” is understood – call for service providers to re-examine their practices and develop a set of specific protocols for working with IRN-PHAs.

Best Practice Recommendations

Our respondents were asked to put forward suggestions for improving services that can benefit their mental health. Their recommendations can be broadly grouped into six categories:

Creating more opportunities for IRN-PHAs to enhance their capacity in dealing with challenges in life:

Many of our respondents saw self-empowerment as a key component of attaining good mental health. Suggestions for achieving this goal included: skills-building training initiatives around treatment literacy, leadership, problem solving, peer support, employment-seeking and service access advocacy, life skills training and skills building around disclosure. A key recommendation was to advocate for more resources on culturally and linguistically sensitive PHA capacity building programs.

Peer based support to promote mental wellness:

Learning from someone who had experienced and overcome similar challenges led to an enhanced sense of empathy and had a positive role-modeling impact. This could include informal sharing at PHA socials and retreats, language-specific support groups, and formal case management provided by peer support workers. Ideas for enhanced peer support included: more formalized ways to provide peer based support, especially in language specific settings; an e-group amongst peers to discuss mental health issues; more peer based social and health related group activities such as yoga, self defence, stress reduction and physical activities.

Addressing stigma and discrimination through education:

Participants believed that concerted efforts to educate and mobilize ethno-racial leaders from faith based organizations, ethnic media, settlement workers and cultural interpreters, were key strategies to combat ignorance and stigma against ethno-racial PHAs.

Improving quality and access of services for PHAs during the immigration and settlement processes:

Recommendations included cultural competency training for refugee shelter staff, Citizenship and Immigration Canada officials and designated medical practitioners (DMP) to sensitize them to IRN-PHA issues, and working closely with settlement agencies and shelters to ensure information on HIV related legal, health and social support services is distributed to all newcomers.

Culturally competent initiatives to bridge current gaps:

Overall, participants wished for more holistic support services from providers who are sensitive to their social and cultural realities, and services that could address their significant others and support network.

Improving service integration and coordination:

A more integrated and coordinated approach to mental health-related support delivery was seen as crucial. This included holistic case management support delivered at a primary care level, addressing practical issues as well as support related to the immigration/refugee application processes, mental health care support integrated with the delivery of physical and spiritual support, and preferably including access to complementary therapies such as acupuncture, massage and naturopathic medicine.

Component 2:

The Perspectives and Opinions Of Service Providers

Component 2 – Talking to service providers

Component 2 of this study explored current mental health service provision for IRN-PHAs from the perspective of service providers. The target population of this component was defined as:

- frontline workers, administrators, funders, or policy makers,
- who were actively involved in two of the following service fields: HIV/AIDS, immigration and settlement, and/or mental health,
- with a geographic catchment area that included at least parts of the Greater Toronto Area.

Service providers were reached through focus groups, individual interviews, and a web-based survey. A total of four focus groups and nine semi-structured individual interviews were conducted, reaching 28 and 9 service providers respectively (a total of 37).

Service provider participants in the focus groups and interviews:

- Most (just over half) were in social work and social services. Others included a range of professionals (including nurses, physicians, psychologists, etc.) in both frontline and managerial positions.
- Were roughly two-thirds female and one-third male.
- Just under half were Caucasian.
- Just over half were themselves immigrants, refugees, PHAs, and/or users of mental health services.

The participants represented agencies including: AIDS service organizations, mental health agencies and programs, hospitals, community health centres, settlement agencies, legal services, lesbian/gay/bisexual/transgendered/transsexual/questioning/queer/intersexed (LGBTQQI) organizations, and community centres.

The demographics of the 66 service providers who responded to the web survey were roughly similar to those of the focus group/interview participants.

Full demographic details are available in the full research report; selected key details are provided in Appendix C.

What "Mental Health" meant to service providers

In many ways, the ways that IRN-PHA participants and service providers spoke about mental health reflected quite different understandings and points of view. While IRN-PHA participants tended to talk about their difficult life circumstances creating stress that threatened their mental health and coping abilities, service providers were more likely to talk about mental health in medical terms.

I've always kind of looked at mental health as a scale where you may have people who have a very episodic type of depression, like a reaction depression, something's going on in their life at that very time and needs intervention ... To the group where their mental health is starting to impair their day to day activities... clinically diagnosable like a DSM criteria, mental illness, you know, schizophrenia, obsessive compulsive disorder, bipolar, whatever. *(hospital clinic, female)*

When service providers embody the use of medical labels, they may be distracted from questioning the social, economic and political context of mental health problems experienced by IRN-PHAs. As an example, while IRN-PHAs often said that they experienced HIV-related stigma and discrimination which kept them from seeking services from their own ethnocultural communities, some service providers saw this hesitancy as 'paranoia':

The other thing that I see sometimes happening is definitely paranoia and it's usually the fear that somebody within their community knows their diagnosis or will find out about their diagnosis, to the point where they want to separate themselves from their community and yet that can be the community that supports them the most. *(hospital clinic, female)*

However, it is equally important to note that some providers are well aware that individual stresses are associated with the social contexts one lives in:

I think we often underestimate some of the stress that immigration means in general. Never mind that people are coming from traumatic backgrounds, just the simple fact of immigrating is unbelievably difficult you are uprooted, you've lost your contacts, you've lost your identity to some extent. And so, I think that training in general for all of us [service providers] needs to include looking at the impact of immigration as such. *(community health services, female)*

Mental Health Needs of IRN-PHA Clients

Both the IRN-PHA and service provider participants identified a similar set of mental health needs for IRN-PHAs. These often have to do with the **traumas, migration and settlement stressors** and **anxiety related to HIV disclosure** that IRN-PHAs face.

We tend to see a lot of post-traumatic stress particularly for refugees coming from war-torn countries. We also see a lot of adjustment kinds of disorders where it's sort of culture shock as people are just getting to know the system and the society. *(manager, mental health services, female)*

I remember a client who was experiencing some kind of depression and it was mostly triggered by public stigma around HIV, particularly exhibited by his close relatives and friends. *(FG participant, hospital clinic, female)*

Furthermore, the mental health needs of IRN/PHAs can also come from overlapping experiences of racism and HIV related stigma:

We had a case where a student lawyer went with one of our clients to the immigration hearing and the immigration staff was saying stuff like, 'oh, you guys come here and bring your sickness and your disease' and the lawyer didn't stop the officer. It's really traumatic for our client. She came out of the hearing bawling. *(FG participant, community health services, female)*

Providing Mental Health Services for IRN-PHA Clients

Service providers in our study identified a range of services they provide for IRN-PHAs who experience mental health issues. These included:

1. assessing clients' psychosocial needs,
2. support from social workers, therapists, and spiritual counsellors,
3. pharmaceutical prescriptions from psychiatrists,
4. psychiatric nursing support,
5. support groups and social activities,
6. practical assistance (e.g., food, clothes, financial support, etc.),
7. providing legal, medical, and financial information, and
8. referrals to other appropriate services.

The types and extent of services varied according to the mandates and resources of each organization. Some felt that mental health service provision could be influenced a great deal by an organization's vision, commitment and practice culture, as one manager explained:

In HIV and AIDS we do have quite a few clients who also have a mental health diagnosis. So our philosophy is meeting people where they're at, treating people respectfully, and personally we do the same thing too, recognize that it is an illness and individuals need to get the appropriate care to basically be effective. (*hospital clinic, female*)

Some providers have found practical strategies to reorient their programs and interventions.

We've taken an initiative to offer more cultural staples in our food bank, so we offer more things like beans and rice instead of pasta. Those things are a cost, so we really rely on donations. But, we are looking into ways we can fund raise to partner with other organizations that could offer cultural food boxes for our clients. (*mainstream ASO, female*)

However, others took a more passive stance, implying that the responsibility of overcoming stigma-related barriers rests with the clients themselves.

I think it is a patience game. ...If IRN-PHAs cannot overcome the barrier related to stigma themselves, no matter how good the service you have, they are not going to come in and get it. (*hospital clinic, female*)

Service providers who shared similar social conditions as the IRN-PHAs (e.g. being racialized, experiencing migration and settlement, living with HIV, etc.), and who worked in non-mainstream organizations, were more likely to describe specific strategies for enhancing care.

I mean ... developing stronger partnerships, strengthening referrals, even staff training to better assess mental health issues. Those are all things that absolutely could fit in with what we do right now... right now it definitely would be outside of our mandate to provide counseling [for] mental health issues or clinical assessment, because we really don't do any specific counseling. (*mainstream ASO, male*)

Others reported external referrals as the most common course of action, particularly in community-based agencies with limited resources to deal with mental health needs.

...if we can't necessarily provide the best counselling, we have to pass clients onto someone else who potentially has more knowledge about mental health. So, we usually refer clients to the mental health clinic at [a hospital], [a mainstream counselling service], or [a mainstream AIDS service organization]. (*ethno-specific ASO, male*)

Nevertheless, competency in making appropriate referrals is not 'naturally acquired' or 'guaranteed'. Numerous service provider participants were unsure of the types of mental health services that were available.

I'm not aware of any specific mental health agency for newcomers, I mean I know there's [X, Y and Z] and there's long term facilities. But in terms of what their mental health services are specifically, like counseling or yeah, we wouldn't really know. (*mainstream ASO, female*)

Barriers to Providing Services for IRN-PHAs

Many service providers described challenges in making effective referrals and collaborations due to complexities in the existing health and social service systems. Our participants identified a number of service provision barriers that fall under several main categories: **stigma, lack of appropriate training, lack of coordination, and lack of resources.**

The central barrier of **stigma** was not only attached to HIV/AIDS, but also to mental health issues. In some communities, mental health problems may be seen a sign of weakness, to not require professional care, or to even be a taboo. There may also be a shame associated with using services, or being a "burden".

It's an added barrier because some of the communities in their culture ... don't recognize mental health. So, we had discussions around depression, for example, and that's just not a part of the language of some cultures. It's not a reality or it's not something that they acknowledge. (*hospital clinic, female*)

It's probably more acceptable in Canada to understand that counselling is very much a part of our social fabric but I would not necessarily assume that from folks from other countries. It's a very western idea, the idea of counselling and going into therapy. (*hospital clinic, female*)

Gender norms also play an important role.

It's hard, especially for men of African and Caribbean descent to really talk, to put this mental health stuff out there. They refuse to show any type of vulnerability because society sees men as 'okay, men must be men', 'men don't cry', 'men don't complain'. (*ethno-specific ASO, female*)

Our female clients generally don't feel the need to get help for depression. They often think that's just a norm of life and don't want to talk about it. They don't know they can actually get help for it. (*community health services, female*)

Another barrier identified by our service providers relates to their **lack of training** to deal with complex issues relating to both HIV infection and mental health issues.

Not all the trained professionals would automatically accept people living with HIV/AIDS and that's another huge barrier. My colleagues, I can tell you, the majority of them do not have enough knowledge about AIDS and HIV. They probably would have some biases towards people's sexual orientation. Do you think that all my colleagues can work with IRN-PHAs? No way, not yet. *(mental health services, male)*

Service providers spoke of the **language barrier** experienced by some IRN-PHAs who do not communicate well in English or French and the need for more resources to provide a wider range of cultural interpretation.

Here at the clinic we can get an interpreter for any language. But, particularly when dealing with mental health issues, you don't know what you are getting back. I think there's a huge need for cultural interpreters with specific mental health training. *(hospital clinic, female)*

Service provision is often **fragmented and uncoordinated**. Service providers often work in distinct areas, and have little or no contact with professionals in other fields of service. IRN-PHAs with mental health needs often get caught between AIDS service organizations and mental health providers, both of which consider themselves ill-equipped to deal with problems in areas outside of their expertise.

I have never seen somebody coming into an AIDS organization only wanting to deal with HIV, because PHAs all have layers of issues. So when you say that 'oh, we are an AIDS organization and we don't deal with immigration or we don't deal with mental health, we just want to deal with HIV,' it's problematic. *(ethno-specific ASO, male)*

These separate areas or "silos" exist not only between professional groups, but within disciplines.

We could get our clients to see psychiatrists here but I don't know if they were the right professionals or if they have the right expertise. A few times we had clients that we felt were experiencing post-traumatic stress but when we approached the psychiatrists here, they said 'well, that's not really an area that I have a lot of experience in'. *(hospital clinic)*

Service organizations are bound by the parameters set by their funding sources, and our participants recognized that funding arrangements reinforce this fragmented system of service delivery:

The Ministry of Health doesn't really look at holistic health. It doesn't look at the person as a person. Instead, they look at you as 'you suffer from cancer', 'you live with mental illness'... what they want to do is to deal with the illness and not work with the whole person. We are only beginning to switch it into that direction in the past few years, but it has been a struggle because the funders are still not buying it. *(mental health services, male)*

Service providers in our study cited **shortage of resources**, in particular for serving people without health coverage.

People who don't have health coverage are not generally seen in this service because all of our doctors bill OHIP. There is nothing in place right now for people without status. *(MH hospital, female)*

Aware of this problem, some community health centres and hospitals have designated resources to serve non-status patients. Unfortunately, many service providers described these allocations as inadequate:

In an acute care setting, the cost for someone who has no coverage, which is a fairly regular occurrence, is unbelievable. We bring folks in who need blood work and that sort of thing, and the pot of resources is empty by January, never mind getting through to December. (*hospital clinic, female*)

A lack of resources often leads to long **waiting lists** for mental health services.

The waiting periods are just very long to get people into. In some cases you've got such a small window where IRN-PHAs are willing to accept 'I need help' or that they'll say 'yeas, I will go and see somebody' and we have got everything ready in place, and then we are told 'well, we can see your clients in six weeks.' It's very frustrating. (*hospital clinic, female*)

Lastly, service providers in our study talked about the effects of limited resources on **service availability** in term of **hours of operation** or **location**.

A lot of HIV services are downtown when you have probably most of your immigrants and refugees living outside of downtown Toronto. ... We also struggle with ... people going back to work. How are they supposed to work and go to doctors' appointments? (*community health services, female*)

Service providers in the downtown area often have limited knowledge of resources available to IRN-PHAs in their local neighbourhoods:

Immigration populations usually reside at the fringe of the city and yet, the services are downtown. Like those of us here at the table, we work downtown and we have our own networking, so at least we can pick up the phone and say, 'do you have any ideas?' But, I don't know a lot of physicians or nurses who are working in the peripheral area. (*hospital clinic, female*)

Service Provider Survey

Service providers were also invited to participate in a web-based survey, which sought to explore their understanding of, comfort with, knowledge of, and attitude towards individuals with mental illness and HIV disease, and potential challenges they saw in working with such clients. The inclusion criteria were that respondents had to be actively involved in providing services in at least two of: HIV/AIDS, immigration & settlement, and/or mental health. The characteristics of the respondents are briefly described in Appendix C.

The survey involved two hypothetical case scenarios involving I/R/N-PHAs, with practice-related questions directly related to the cases. The first case scenario depicted a transgendered Asian PHA experiencing symptoms of depression. The second depicted a couple from Africa, both PHAs, whose refugee claims were both rejected. The husband displayed symptoms of psychosis and his wife showed symptoms of depression.

How Respondents Interpreted the Cases

Survey respondents were asked to consider possible contributing factors for each case presentation. Their responses took various possible contributing factors into account, suggesting that they were open to both biomedical, psychological, social and cultural understandings of the clients' symptoms.

However, significant numbers of respondents did not diagnose the psychiatric syndromes (psychosis and depression) that the symptoms, as described, were intended to reveal. For instance, less than half of the respondents considered psychosis as one of the "top three likely causes" of the symptoms (delusions) experienced by one of the characters in the case scenarios. This suggests that further training to support service providers in early recognition of common psychiatric syndromes is critical.

Service Providers' Challenges in Working with Clients

Service providers in the survey identified three key areas of challenges in working with the clients described in the case scenarios:

1. Having adequate knowledge:

Many respondents were not confident that they had enough knowledge to be able to help these clients, especially around HIV and mental health co-morbidity, and how to support transgendered clients.

2. Clients' help-seeking and treatment adherence:

Many respondents identified 'reluctance to seek help', 'treatment non-adherence' and 'difficulty in building trust' as key challenges in working with these clients. This suggests that expanded knowledge and skills through training would support service providers in helping their clients with treatment adherence and help-seeking.

3. Psychosocial factors influencing clients' mental health:

Many respondents considered a number of psychosocial factors as challenges in working with these clients. These included social isolation, language barriers, lack of citizenship status and family/marital difficulties.

Given the attention given to systemic and social factors, stigma, and lack of culturally appropriate services, we were surprised that so few survey respondents identified these important challenges to providing services in these case scenarios. This requires further investigation to better understand service provider's perceptions.

A complete description of this component of the study can be found in the study report.

Best Practice Recommendations

Service providers in our study put forth a number of practice recommendations:

1. to address stigma and discrimination through public education,
2. to bridge the different understandings of mental health between clients and practitioners;
3. to improve the accountability of the service delivery system;
4. to foster coordinated services by reducing silos in practice and developing an effective referral system.

They also highlighted the importance to take a **strength-based approach** and facilitate **peer-based support** amongst IRN-PHAs.

Anti-Stigma and Anti-Discrimination

Like the IRN-PHA participants, service providers said that public education was needed to combat stigma and discrimination. Service providers, however, spoke of the need to develop **leadership within the IRN-PHA community** to raise awareness and challenge the existing service gaps:

I think we need PHA leaders... it's those early pioneers who admitted that they were survivors of the mental health service industry and came forward and really challenged us and other social service organizations to develop. I really feel strongly that there needs to be leaders in the IRN-PHA community who come forth. It's an unfortunate burden that they have to bear, it's not very equitable, but I think that's important. (*ethno-specific ASO, male*)

Some service providers suggested that **a cultural difference in how mental health is conceptualized contributes** to the stigma attached to mental health issues. They spoke of the need to bridge such differences between IRN-PHAs, service providers and the Canadian mental health system, by (a) reaching out to IRN-PHAs by moving their services to community settings; and (b) reorienting Western medical-based notions of mental health to better match clients' more holistic ideas of interconnected mental/physical/social health.

Stigma and taboo around mental health will likely disperse if we make mental health a part of our overall health.

Some participants felt that clients may be more inclined to seek formal support if mental health interventions are framed as **wellness promotion** and **recovery** rather than a treatment for pathologies.

What we had to do to get clients coming to mental health services was to frame HIV as a traumatic event itself. When we did that, our clients were able to pinpoint exactly, 'oh yah, I am at this stage of coping right now'. Otherwise, our clients don't find mental health therapists useful. (*community health services, female*)

Some participants recommended that mental health practitioners explain their way of framing mental health to clients from the beginning so that IRN-PHAs may develop clearer understandings and expectations.

Basically at the first meeting with clients I'm going to tell them what the limits of confidentiality are going to be, what my approach is, and also what my credentials are so that they are aware... The reality is why should anyone be forced to be in a treatment that is based solely on the therapists' belief? The client should be able to decide 'I want this and I want that'... The [professional association] ethical guidelines clearly state that the clients should be given the opportunity to consent and have full knowledge of the [intended] treatment. (*community health services, female*)

Accountability of organizations and service providers

Many service providers believed that we cannot rely on public education alone to reduce stigma and discrimination. Some felt strongly that service providers and organizations must be held accountable to ensure that discriminatory, stigmatizing practices are not tolerated.

We mentioned that people are really reluctant to seek services because of the stigma. So, all our broad based efforts have been on trying to reduce stigma through education campaigns and stuff. The flip side of that is the culture of confidentiality. In [a recent study] that I've been involved in, we couldn't believe how much people talked about the lack of confidentiality on the community level. So, it wasn't just the fear of you're going to be disclosed or stigmatized, because the reality is that it goes on. (*ethno-specific ASO, female*)

Several other participants also recommended that organizations adopt or augment diversity policies that clearly prohibit any acts of discrimination from staff or clients.

[There needs to be] some type of mechanism in place ... to monitor any abuse against IRN-PHAs so that we can call on these practitioners and say that we are not referring clients to them anymore. (*ethno-specific ASO, female*)

In summary, service providers in our study highlighted the importance of going beyond public awareness campaigns by attempting to bridge differences in understanding between practitioners and IRN-PHAs, as well as designing strategies to improve service providers' accountability for their quality of services.

Enhanced Service Coordination

All of our participants – both IRN-PHAs and service providers – believed that the existing service delivery system is fragmented. Service providers in our study emphasized the need to improve coordination among practitioners in various disciplines (primary health physicians, psychiatrists, nurses, social workers, etc.) and across service sectors (e.g. AIDS service organizations, mental health agencies, settlement services, healthcare providers, immigration lawyers, etc.).

Cross staff training is important. I am sure we can share quite a bit of mental illness and mental health kind of thing with AIDS service organizations, and then they can share more with us about knowledge on AIDS or to the broader sense the gay and lesbian issues. We need to cross-fertilize on our knowledge and our experience. (*mental health service, male*)

They also proposed forming an **intersectoral network** among frontline practitioners, which could be a venue for ongoing dialogue and information sharing – including a consultation partnership between primary health care providers and mental health specialists.

What would be helpful is if there is some kind of at least telephone consultation for acute care so that if there's something happening and you just need to bounce something off with a psychiatrist or a psychologist you can do that or even to just get some information or some possible treatment plan, things like that. This way, at least access goes a little faster. *(community health services, female)*

Several participants mentioned a 'case management' approach as a potential model.

If we service providers don't communicate consistently, all sorts of things get missed from our clients. And so, it is really a question about keeping each other informed to have a clear sense of who is clients' care team, who are the different players that are supporting the clients and keeping them informed. *(hospital clinic, female)*

Other participants added that communication needed to occur, not just among frontline practitioners, but organizational leaders at a program level.

We started meeting with the heads of some of the organizations to be able to say, 'okay, how can there be a seamless transfer?' We also are looking at other organizations' missions, mandates, and what they do... The key thing is keeping the client in the centre. *(community health services, female)*

Lastly, participants also spoke of improving service coordination by **strengthening the current referral system**. They suggested compiling a comprehensive list of services with specific information such as languages spoken, whether practitioners are willing to take on clients without health coverage, areas of specialization, etc. The idea was to provide IRN-PHAs with "a menu of services" from which the clients can choose the most appropriate types of support.

In short, effective mental health support for IRN-PHAs entails improved coordination among service providers, which may be achieved through regular dialogues and knowledge exchange, partnerships and linkages, client-centred case management, and developing of a comprehensive resource listing and referral mechanism.

Peer-Based Support

As discussed previously, many professional mental health services are resource-limited and short-term focused. Service providers in our study suggested that increasing community involvement and facilitating peer-based support systems might be key solutions to these barriers. This type of peer-based support could be regarded as complementary to formal mental health interventions.

I have noticed that among some of our women [PHA] clients there's a certain network that has developed on its own. So, I think that if we can harness this kind of organic organizing... there's a certain comfort level and a bond is established with their peers because they are both in the same position and face the same issues. *(ethno-specific ASO, female)*

Component 3:

Defining and Developing Best Practices

Literature review: What was known about best mental health practices?

Our review of literature on mental health issues faced by IRN-PHAs revealed few studies on this topic. Research that examined mental health service provision for IRN-PHAs was even more limited. Therefore, we also drew on literature related to mental health practices with PHAs and ethnoracial communities in general.

Studies in the areas of HIV mental health and cross-cultural mental health practices suggested that a comprehensive mental health service framework targeting the needs of IRN-PHAs should encompass:

- Fulfillment of basic necessities, such as food, housing, safety and financial security,
- Social support from family and friends,
- Attention to religious and existential well-being,
- Coordinated services and referral processes, possibly through a case management model,
- Culturally competent, HIV-aware mental health interventions,
- Reorientation of the value base of the mental health system by moving away from a medical model,
- Education for service providers as well as professionals in training,
- Anti-stigma and anti-discrimination campaigns, and,
- Enhanced service provider accountability through changes in funding structure and policies.

We identified several gaps in the existing literature. Firstly, only a handful of Canadian-based studies explore best practices in HIV-related mental health. Mental health services for IRN-PHAs in Canada need to take into consideration factors such as the Canadian health care structure, immigration and refugee policies, social service policies and programs, and the principles of multiculturalism. Some of the best practices outlined in this review may not apply to the Canadian context.

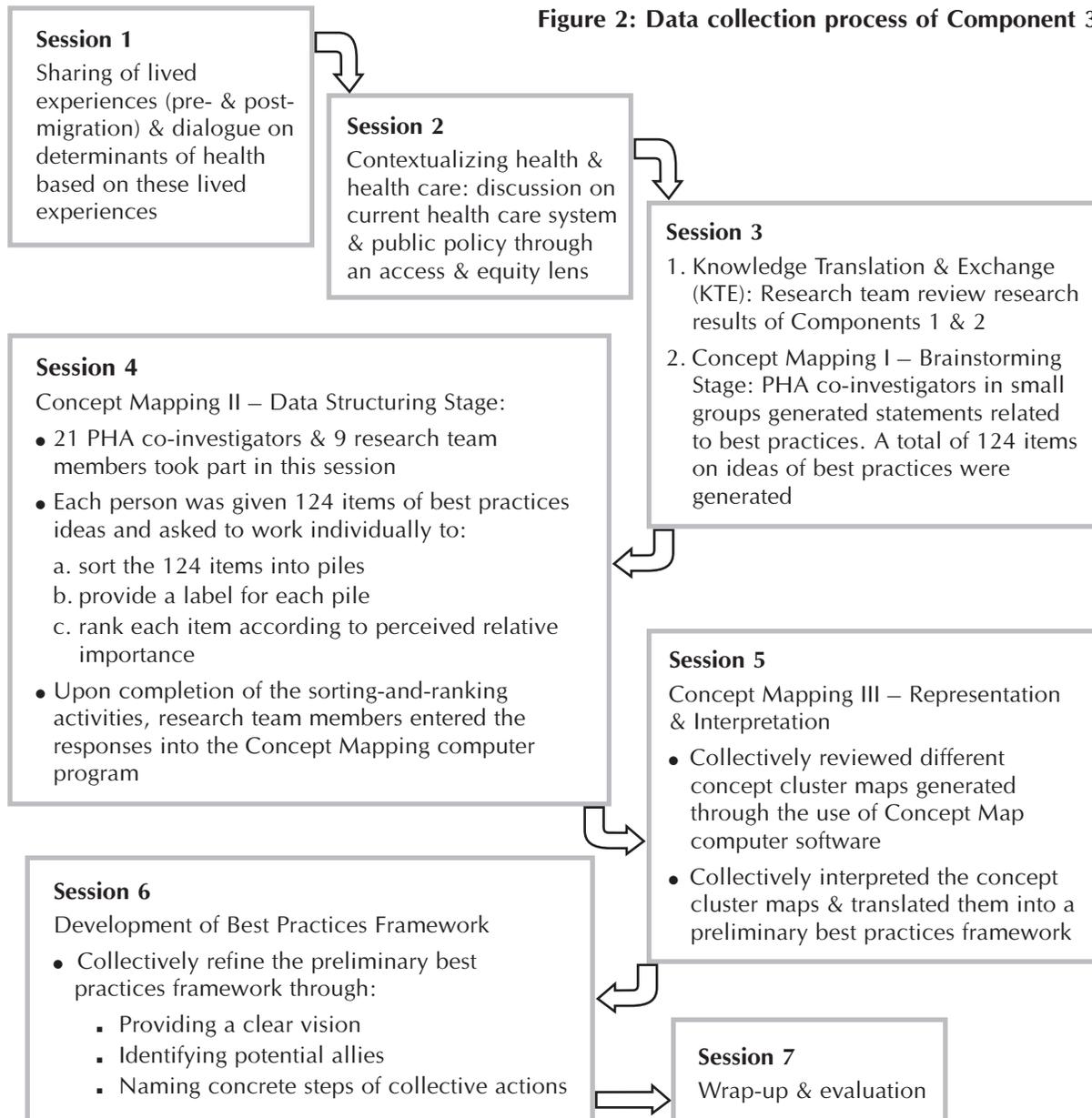
Due to the limited number of studies available, the inner workings of the mental health of IRN-PHAs and their service needs have not been fully explored. Without this information, recommendations for best practices will likely not be comprehensive.

Lastly, most of the best practice recommendations outlined in this literature review were described by service providers or by researchers, not by IRN-PHA community members. More community-based research is needed to identify service provision guidelines for IRN-PHAs in Canadian settings.

Developing the Best Practice Recommendations

In this component of the study, we engaged 21 PHA co-investigators and 9 members of the research team, providing a good demographic representation of the IRN-PHAs that were the focus of this study. This combined team took part in a series of five full-day and two half-day "think tank" sessions. All sessions were co-facilitated by four members of the research team with support from the research assistants on a rotating basis. (See *Figure 2.*)

Figure 2: Data collection process of Component 3



During the introductory sessions, PHA co-investigators first of all shared their own experiences of immigration and settlement and how these experiences have affected them as individuals living with HIV/AIDS. The session participants then discussed key issues related to health and health care, and its economic, social, cultural, and political contexts.

In the main working sessions, the team collaboratively worked with the information gathered in the earlier components of the study. Working in groups, participants reflected on this information, and generated a list of "best practices" – suggestions for service provision that would help to improve the mental well-being of IRN-PHAs. The suggestions in the list thus developed were then sorted and ranked by priority and grouped into common groups, or "domains". Taken together, this set of ideas constituted a structured framework for best practices. The working group also identified concrete action steps and potential partners who could work to realize the intended outcomes.

The original list of 124 ideas on "best practices" generated by the group were clustered into seven distinct yet interrelated "best practice domains".

Domain 1 - PHA Capacity Building

PHA capacity building is the core of our recommendations. Our group believes that, with increased capacity and skills, IRN-PHAs will be better able to make informed choices to improve their physical and mental health, and be able to become active contributors to society and community. Several PHA capacity building programs are currently offered by various ASOs in Toronto, but are not coordinated with each other, and are not always accessible to IRN-PHAs.

Participants proposed ways to build a holistic and coordinated capacity building training curriculum that will build on the successes and strengths of current programs. The proposed curriculum will include training in several areas: practical life skills, health and treatment information, peer support skills, employment skills, media and advocacy skills, leadership and group skills. There are opportunities to link this effort with other planning processes currently underway, such as the Toronto Community Planning Initiatives and the follow up work of the Living and Serving 2 Study.

Domain 2 - Intensifying Social Support

Participants noted that there are only a limited number of social supports for IRN-PHAs. More culturally, linguistically and sexually diverse space is needed where IRN-PHAs and their significant others can get psychosocial support.

Proposed strategies include developing support groups for serodiscordant couples, heterosexual men and women PHAs, victims of domestic violence, women who have sex with women, and language-specific groups for Hindi, Swahili and Nepalese-speaking PHAs. Information on health and legal services also needs to be developed in various languages and made available.

There is also an urgent need to improve availability of shelters for PHAs. Proposed solutions include targeted services in shelters for PHAs, training for shelter staff, and exploring the possibility of special shelters for homeless and IRN-PHAs.

Domain 3 - Service Provider Training

Health and social service providers need to have improved knowledge of the barriers and challenges experienced by immigrants and refugees, awareness of locally available resources, and service eligibility for IRN-PHAs. Providers need to better understand how cultural beliefs, social location, stigma and discrimination and limited service access affect the physical and mental well-being of IRN-PHAs.

Proposed strategies involve building on existing training models provided by the Committee for Accessible AIDS Treatment, Toronto Public Health, the Canadian AIDS Treatment and Information Exchange, the Ontario AIDS Network, and the Canadian AIDS Society. It would also be useful to augment attention to IRN-PHA issues in these existing training opportunities. Linkages can be built with professional associations and professional education programs such as the Ontario Medical Association and Ontario Nurses' Association. IRN-PHAs should play a key role in the design and implementation of training initiatives for service providers.

Domain 4 - Enhancing service delivery and coordination

Most newcomers rely on information from Citizenship & Immigration Canada when they first come to Canada, which does not discuss services related to HIV/AIDS for specific ethno-racial populations. Although a number of guides on services and resources exist, they are not accessible to newcomers with language barriers and who may not know where to start looking for information. Improving service access and coordination requires long-term commitment and buy-in from partners.

Short term strategies can be initiated immediately to facilitate service access, such as developing a multi-language resource guide for IRN-PHAs, including information on a wide range of relevant services. This resource guide should be made available in various formats and needs to be available at primary access points. Collaborative partnerships need to be developed with service providers including settlement services, health care services, housing, AIDS service organizations, ESL school boards, and faith organizations.

Domain 5 - Reducing stigma and discrimination through public education:

Stigma and discrimination negatively impact the physical, emotional and mental health of IRN-PHAs and their families and significant others, compound social exclusion, and often lead to increased use of negative coping mechanisms. Stigma and discrimination are often related to race, citizenship status and HIV status. Anti-stigma and anti-discrimination education campaigns can dispel myths about HIV/AIDS and lead to better understanding of issues faced by IRN-PHAs, helping to foster a healthier social environment and better access to support.

Proposed strategies include engaging members of specific organizations (e.g. hospitals/health centres, faith/religious groups, schools/school boards, immigration/refugee board, law enforcement/police, professional councils/colleges, etc.) and the public as collaborators in developing anti-stigma campaigns. Resources could be developed to assist decision makers of key organizations in establishing mandatory training programs. Campaign and training materials must address the ethics of care and reflect the strengths and contributions of IRN-PHAs.

Domain 6 - Addressing Inequities and Improving Accountability

Currently, there is no clearly defined standard of practice to ensure that culturally competent care and services are available and accessible to IRN-PHAs. Many sectors serving PHAs have no accountability measures or antidiscrimination policies, and there are few resources to support PHAs to advocate for their rights.

There is a need for a provincial body with representatives from different marginalized PHA groups to address complaints from PHAs regarding poor quality services or discrimination. This body could also develop practice guidelines and standards to advocate for human rights and protection of vulnerable PHA groups. The HIV sector needs to learn from other sectors such as mental health consumer survivors, who have developed effective models, such as the client empowerment council at the Centre for Addiction and Mental Health.

Domain 7 - Bridging gaps in healthcare coverage and improving policies

Key priorities identified in this theme include following up on the recommendations of the CAAT policy research study, *Status, Access and Health Disparities*. Target areas include getting health care coverage for PHAs who do not have it, and changing criteria in the immigration evaluation process which might excessively restrict PHA immigration. Other policy priorities include: working with government departments to improve processing time for immigration/refugee processes and claims, and instituting better coordination, communication and accountability amongst government ministries. Other specific policy recommendations are discussed in the earlier policy research study.

Strategies include advocating to hospitals to establish standardized policies for treating patients without health coverage, advocating for more dedicated resources for providing health care to people without full legal status in Canada, and developing multiple entry points to services to reduce waiting time. Finally, we recommend that mental health staff should become an integral part of patient health care team to ensure that PHA psychosocial needs are effectively addressed.

Summary and Recommendations

Immigrant, refugee and non-status people living with HIV/AIDS (IRN-PHAs) live in a reality of multiple layers of oppression that can have a serious impact on their mental health. As newcomers to Canada, many IRN-PHAs endure trauma and abuse prior to and during their migration journey, and experience losses in their personal life including loss of identity, property and supports. Most PHAs identify the process of negotiating the immigration and refugee system in Canada as another major mental stressor. IRN-PHAs must deal with complex and confusing policies and procedures, long waiting times, the possibility of rejection and deportation, and prolonged periods of uncertainty about the future. The challenges of adapting to a new culture, language and service access barriers, racism and xenophobia, barriers in finding employment, housing and community support, all create further stress and can jeopardize IRN-PHAs' health. In addition to the challenges experienced by most newcomers, IRN-PHAs also face the stigma and discrimination associated with HIV/AIDS. Study participants reported negative attitudes, discriminatory practices, breaches of confidentiality, and lack of sensitivity from many sectors of service providers. The fear of losing confidentiality has led many IRN-PHAs to further isolate themselves and shy away from accessing support and services.

The fragmentation of services in the HIV/AIDS, legal, health care and settlement sectors present additional challenges. There is no coordinated case management approach, resources to ensure mental health and HIV/AIDS treatment literacy are inadequate, and there is little accountability to ensure culturally competent services. Services continue to be fragmented into "silos", and IRN-PHAs' needs remain largely unmet.

In the face of this multiplicity of barriers and challenges, many IRN-PHAs display incredible strength and resilience. They use innovative strategies to solve problems, support each other through adversities, and strive to make inspiring contributions to their larger communities. It is clear that effective strategies to improve the mental health of IRN-PHAs must be built on lessons learned from these inspiring examples. Different levels of the service systems, including individual service providers, organizations and public policies that govern and fund these services, must also collaborate in a coordinated manner to create a more compassionate, equitable and healthy society for all.

Recommendations:

To better understand the complex realities and barriers faced by IRN-PHAs, our research study collected data related to mental health service access for PHAs from East Asian, South Asian, African, Caribbean and Spanish-speaking communities in Toronto from 47 IRN-PHAs and 103 service providers. In addition, 22 IRN-PHAs were engaged to work collaboratively with the research team members to develop a best practice framework based on ideas generated by the participants. Seven key domains were identified to comprise the best practice framework:

- capacity building for IRN-PHAs,
- intensifying social support,
- addressing service inequities and improving accountabilities,
- reducing stigma and discrimination through public education,
- promoting service providers' cultural competency,
- enhancing service delivery and coordination, and
- improving policies & bridging gaps in health care coverage.

The study team held community strategic planning sessions to engage diverse community and government stakeholders, to identify key priorities within the best practice framework, and to develop concrete recommendations. The research team then recruited and trained 25 IRN-PHAs as knowledge transfer exchange ambassadors to prioritize and refine the recommendations. The ambassadors also developed tailored knowledge transfer tools to disseminate the findings and recommendations to the community, and to engage them in dialogue about the findings. The following recommendations represent a summary of the key strategic recommendations that emerged from these collective community processes. Central to all the recommendations is the call for the development of a comprehensive HIV/AIDS immigrant strategy to be led by IRN-PHAs working in partnership with other relevant community, government and professional stakeholders.

Recommendations for all stakeholders:

1. The Committee for Accessible AIDS Treatment (CAAT), African & Caribbean Council on HIV/AIDS of Ontario (ACCHO), Ethno-racial Treatment Support Network (ETSN) and partners from all three levels of government work together towards the development of a comprehensive HIV immigration strategy to address prevention, treatment, support, capacity building, research & policy needs of IRN-PHAs
2. Develop a multi-sectoral network of PHAs, service providers, policy makers and researchers to design, implement and evaluate interventions that will identify and build on the strength and resiliency of IRN-PHAs to address social determinants of health
3. Develop campaigns and interventions to mobilize ethno-racial community leaders from media, faith-based, settlement and social justice sectors to engage in anti-HIV stigma education.

Recommendations for Policy Makers & Funders:

1. Provide needed funding for:
 - a. Successfully-piloted **PHA capacity building programs targeting IRN-PHAs** (e.g., the ETSN Peer treatment counselor training program, CAAT's HIV & immigration service access training program and the Women's Health In Women's Hands PHA Health Promotion program).
 - b. **Mentorship initiatives** that support and enable PHAs to apply skills learned through training programs in the HIV and other related sectors.
 - c. **Intersectoral collaboration** in training, research, and development of service delivery models that are inclusive of the needs of IRN-PHAs.
2. Develop and enact policies to ensure that:
 - a. All sectors, including professional organizations, are accountable for safeguarding **confidentiality** and ensuring **access** and **quality** of services for all PHAs.
 - b. Public services develop skills in serving diverse IRN-PHA communities, and adopt a "**Don't Ask, Don't tell**" policy such that service users would not be asked about their citizenship status when accessing emergency services.

3. Specific initiatives with policy implications:

- a. AIDS Bureau to take a leadership role through its Living & Serving Working Group to work with relevant community partners to:
 - i. Improve **coordination** of PHA capacity building programs,
 - ii. Explore **accreditation** of PHA capacity building programs, and
 - iii. Enhance **access** to adequate employment for PHAs.
- b. Strike a Federal-Provincial taskforce to develop policies and program to ensure **equitable access to healthcare for PHAs without health coverage**.
- c. Strike a Federal inter-ministerial taskforce to review policies and programs to ensure **equitable access to healthcare, employment and other prerequisites for health by IRN-PHAs**.

Recommendations for service organizations:

1. Organizational Policies:

- a. Establish **inclusive hiring practices** that recognize transferable skills and training credentials obtained through evaluated PHA capacity building programs.
- b. Establish and implement organizational policy and procedures to **safeguard confidentiality** and to **ensure access and quality of services**.
- c. Establish guidelines and protocols that ensure service delivery in **languages** accessible to target client population.
- d. Increase **PHA representation in leadership positions** within the organizations. Ensure all **program development** processes include PHA input and participation.

2. PHA Capacity Building Programs:

- a. Develop more PHA capacity building programs including, but not limited to, programs on **life skills** and **treatment literacy** and programs to **address social determinants of health**.
- b. Establish partnerships with learning institutions to coordinate a **centrally planned, publicized, and accredited** curriculum of PHA capacity building programs.

3. Service Delivery:

- a. Increase utilization of **peer-based service delivery models**, including peer treatment counselors and peer service advocates.
- b. Improve collaboration and coordination through a **client-centred case management approach**.

4. Staff Training:

- a. Improve **cross-sector empowerment training** (i.e., anti-HIV stigma and anti-oppression) and collaboration to break down silos amongst different disciplines in service provision.
- b. Ensure **equitable participation of IRN-PHAs** in the development and implementation of **empowerment anti-oppression training** to all relevant staff and volunteers of the organization.

Recommendations for individual service providers:

1. Practice Principles & Values: Service providers commit to practices that are grounded in the principles of **social justice, anti-oppression** and **social inclusion**.
2. Training:
 - a. Health care, settlement, legal & HIV/AIDS service providers participate in **anti-oppression and cross cultural communication training** to improve their sensitivity and competency in working with PHAs with diverse cultural backgrounds.
 - b. Service providers working with IRN-PHAs attend **HIV & Immigration Service Access Training** to improve their awareness of issues affecting IRN-PHAs and services available to IRN-PHAs.
3. Enhanced Service Delivery:
 - a. Collaborate to develop a **standardized resource kit** that includes all relevant service information for IRN-PHAs to be distributed online and to all relevant service providers to increase their awareness of available resources.
 - b. Use a **client-centred service model** that supports clients in accessing the full range of options to address their needs in a manner respectful of their **culture, language, and identity**.
4. Anti-stigma: Actively promote **anti-HIV stigma messages** through a variety of strategies such as dialogue amongst colleagues, display and distribution of public education materials.

Recommendations for Researchers and Research Funders:

1. Increase the use of community-based participatory action research that promotes the Greater Involvement of People with HIV/AIDS (GIPA).
2. The Ontario HIV Treatment Network to take leadership in setting up a peer research training initiative to facilitate research capacity building and meaningful involvement of PHAs in research.
3. Establish an institute of researchers and relevant community partners that will address issues related to HIV, migration and health.

Appendix A: Glossary

Action research – Research that is intended to bring about social change.

ASO – AIDS Service Organization

Community-based research (CBR) - a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings.

Endemic countries – Countries in which HIV infection is widespread.

Ethno-specific – Dedicated to serving members of a specific ethnoracial community.

GIPA – Greater Involvement of People living with or affected by AIDS.

IRN-PHAs – Immigrant/refugee/non-status persons living with HIV/AIDS.

Knowledge transfer & exchange (KTE) – Collaborative problem-solving between investigators and other stakeholders.

PHA – Person living with HIV/AIDS.

Pilot study – A small, precursor study that paves the way for larger investigations.

Stigma – Severe social judgment and disapproval.

Appendix B: Demographics of IRN-PHA Participants

A total of 47 IRN-PHAs participated in Component 1. Detailed demographics are described in the full research report; *Table 1* below is a summary of some of the key characteristics.

Table 1:
Demographics of the
IRN-PHAs in the study

Demographics		Total
Age	Under 30 years	6 (12.8%)
	30 - 39 years	26 (55.3%)
	40 - 49 years	12 (25.5%)
	50 years or over	3 (6.4%)
Gender	Female	14 (29.8%)
	Male	32 (68.1%)
	Transgender/Transsexual	1 (2.1%)
Ethnoracial Identity	African	11 (23.4%)
	Caribbean	8 (17.0%)
	South Asian	8 (17.0%)
	Southeast/East Asian	8 (17.0%)
	Spanish-speaking	12 (25.5%)
Sexual Orientation	Heterosexual/Straight	23 (48.9%)
	Gay/Lesbian	17 (36.2%)
	Bisexual	6 (12.8%)
	Questioning/Unsure	1 (2.1%)
Years in Canada	Less than 1 year	5 (10.6%)
	1 - 4 years	15 (31.9%)
	5 - 9 years	12 (25.5%)
	10 years or over	15 (31.9%)
Citizenship Status	Citizen	16 (34.0%)
	Permanent resident	9 (19.1%)
	Refugee claimant	19 (40.4%)
	Holder of TRP	1 (2.1%)
	Non-status	2 (4.3%)
Employment Status	Full-time	3 (7%)
	Part-time	7 (15%)
	Unemployed, looking	15 (33%)
	Unemployed, not looking	6 (13%)
	Student	6 (13%)
Total		47

Appendix C: Demographics of Service Providers

In Component 2 of the study, a total of 28 service providers participated in the focus groups, and 9 in individual interviews. In the web-based survey, 85 questionnaires were returned, of which 66 were completed sufficiently to be usable. Detailed demographics of the service provider participants are provided in the full research report; some key characteristics are summarized in the following tables.

Table 2: Basic demographics of focus group/interview participants in Component 2

		Frequency ¹	Percentage
Gender Identity	Female	26	70.3%
	Male	11	29.7%
Age	Under 30 years	3	8.6%
	30 - 39 years	8	22.9%
	40 - 49 years	13	37.1%
	50 years or over	11	31.4%
Ethnoracial Identity	Black / African	2	5.4%
	Black / Caribbean	5	13.5%
	East / Southeast Asian	3	8.1%
	South Asian	3	8.1%
	West Asian	1	2.7%
	Latin American	3	8.1%
	White / Caucasian	18	48.6%
	Multiracial	2	5.4%
Professional Background	Medicine	5	13.5%
	Nursing	10	27.0%
	Social Work / Social Services	20	54.1%
	Psychology	3	8.1%
	Public Health	1	2.7%
	Pastoral Counselling	1	2.7%
	Other	3	8.1%

¹ Frequency does not always add up to 37 due to either missing values or the nature of multiple-answer questions.

Table 3: Characteristics of Component 2 focus group/interview participants' agencies

		Frequency ¹	Percentage
Nature of Organization	AIDS service organization	9	24.3%
	Mental health agency (excl. hospital)	3	8.1%
	Community health centre / hospital / clinic	19	51.4%
	Hospice	5	13.5%
	Settlement / newcomer service	1	2.7%
	Legal clinic	1	2.7%
Services Provided	Medical / dental / palliative care	18	48.6%
	Mental health services / counselling	30	81.1%
	HIV/AIDS and sexual health programs	9	24.3%
	Settlement / newcomer support	7	18.9%
	Instrumental support	15	40.5%
	Legal support / advocacy	1	2.7%

¹ Frequency does not always add up to 37 due to either missing values or the nature of multiple-answer questions.

Table 4: Demographics and Background of Service Providers in the Survey Sample

		Frequency ¹	Percentage
Gender Identity	Female	36	54.5%
	Male	27	40.9%
	Transgender / Transsexual	3	4.5%
Age	Under 25 years	1	1.5%
	25 - 44 years	44	66.7%
	45 - 65 years	21	31.8%
Ethnoracial Identity	White / Caucasian	43	65.20%
	East / Southeast Asian	5	7.60%
	Black / African	4	6.10%
	South Asian	4	6.10%
	Latin American	4	6.10%
	Black / Caribbean	3	4.50%
	West Asian	2	3.00%
	Multiracial	1	1.5%
Professional Background *	Social Work / Social Services	31	47.00%
	Medicine	15	22.70%
	Nursing	12	18.18%
	Law	3	4.50%
	Public Policy	2	3.00%
	Business	1	1.50%
	Other:		
	Psychology	3	4.50%
	Anthropology	1	1.50%
	Dietetics	1	1.50%
	Pharmacy	1	1.50%
Customer Service	1	1.50%	

¹ Frequency does not always add up to 66 due to missing values.

* Percentages may not add up to 100% since respondents can choose more than one category.

Table 5: Characteristics of survey participants' agencies

		Frequency ¹	Percentage
Nature of Organization *	Health Clinic or Hospital	34	51.52%
	AIDS Service Organization	18	27.27%
	Mental Health Organization (excl. hospital)	11	16.67%
	Settlement / Newcomer Services	4	6.06%
	Other		
	Legal Clinic	2	3.0%
	Community Centre	1	1.5%
	Public Health Unit	1	1.5%
Services Provided *	Medical / dental care	31	47.0%
	Mental health services / counselling	46	69.7%
	HIV/AIDS and sexual health programs	41	62.1%
	Settlement / newcomer support	9	13.6%
	Instrumental support	24	36.4%
	Other - Legal support / advocacy	3	4.6%

¹ Frequency does not always add up to 66 due to missing values.

* Percentages may not add up to 100% since respondents can choose more than one category.



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