

Photovoice: Exploring Immigrants and Refugees' Perceptions and Access to Mental Health
Services in Winnipeg

by

Ogai Sherzoi

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Abstract

The deterioration of health status for immigrants and refugees is mostly observed after their arrival in Canada. Additionally, immigrant and refugee minorities are at a higher risk for mental health problems. Yet, refugees and immigrants in Canada, particularly those from non-European countries tend to underutilize community resources and mental health services. This study uses a participatory arts-based method of photovoice to gain deeper knowledge of the realities and lived experiences of immigrants and refugees who have or are dealing with mental health problems in Winnipeg. Additionally, it will shed light on the barriers faced by immigrant and refugee community, and the context in which they are unable to access services. Six immigrant and refugee individuals volunteered to participate in this photovoice project. The participants discussed structural barriers, non-recognition of non-Canadian credentials, underemployment/unemployment, poverty, discrimination, stigma, language barriers, lack of culturally inclusive services, inequality, lack of social network, and marginalization. The findings have implications for social work and future research is discussed.

Dedication

This thesis is dedicated to the six participants —Jason Cheung, Mesafint Hail, Khaled Al Kanaani, Yekaterina Kaplun, Ildiko Nova, and Mihret Tekie. Thank you for sharing your stories and perspectives. I learned so much from each one of these incredible individuals who used their voices to shed light on the barriers to accessing mental health services. Their strength, hope and resiliency continue to inspire me.

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CHAPTER 1 INTRODUCTION

Each year, Winnipeg, Manitoba welcomes over 11,000 immigrants, including refugees (Chartier, 2014). The deterioration of health status for immigrant and refugee groups is mostly observed after their arrival in Canada (Chadwick & Collins, 2015). Although mental health problems impact 1 in 5 Canadians, immigrant and refugee minorities have higher risks for mental health problems due to social causes of mental illness—often times referred to as social determinants. There are many community-based mental health care and services for individuals suffering from mental health problems and illnesses. Many studies have indicated that refugees and immigrants in Canada, particularly those from non-European countries tend to underutilize community resources and mental health services.

In the past ten years, there have been quite a few Canadian-based studies that have investigated mental health and mental illnesses/problems with immigrant and refugee groups. However, the majority of the studies and published research have been conducted and focused particularly in large cities such as Montreal, Toronto, and Vancouver. Medium sized cities like Winnipeg, which is the 6th highest-ranking city in Canada for immigration has nearly none. To my knowledge, there is no systematic research that has been conducted with immigrant and refugee population, which has investigated mental health problems and access to services in Winnipeg.

Significance of this Study

Barriers to accessibility of services have an impact on all Manitobans at some point in our lives or the lives of those around us. There is a broad range of disAbilities such as: visual impairment, hearing impairment, intellectual or developmental disAbilities, mental health issue(s), and chronic illness (The Legislative Assembly of Manitoba, 2014). In 2013, the

government of Manitoba introduced the Accessibility for Manitobans Act (Bill 26) (The Legislative Assembly of Manitoba, 2014). The purpose of this act is to remove barriers that prevent individuals disabled by barriers from full participation, and, by creating a more inclusive society, by the identification, prevention, and removal of barriers (The Legislative Assembly of Manitoba, 2014). Raising awareness in regards to barriers and accessibility is an integral part of making Manitoba an accessible province (The Legislative Assembly of Manitoba, 2014).

This community-based photovoice project —*Photovoice: Exploring Immigrants and Refugees' Perceptions and Access to Mental Health Services* was conducted in Winnipeg, in order to gain deeper knowledge of the realities and lived experiences of immigrant and refugee individuals who have or are dealing with mental health problems; to bring to light the barriers faced by immigrant and refugee communities, and the context in which they are unable to access mental health care. The purpose of the exhibition of the photographs was to raise awareness in the community.

Through the use of photovoice, immigrant and refugee individuals can utilize visual representations (pictures) to collaboratively create knowledge, and raise awareness of their needs (Wang, 1999). This arts-based method breaks down the language barriers, and gives immigrant and refugee individuals the opportunity to share their realities, needs, and perspectives. Additionally, photovoice projects are effective as they reveal real life stories, give voice to those most vulnerable in our communities, and empower marginalized community members by capturing their concerns and experiences, bringing them to the front. Utilizing photographs to share immigrant and refugee realities helps others in the wider community to see the world through their lenses and connect on a deeper level. The captured photos and stories can also be used as a tool to advocate for mental health improvements in the Winnipeg community.

Social Work Relevance

The social work profession has a long-standing history in the field of mental health and the role of social work in mental health was established early in Canada's history of service delivery (CASW, 2013). The knowledge and skills that social workers attain are ideally suited for practice in mental health, due to the focus on multilevel influences and multiple targets of intervention (Regehr & Glancy, 2014). Social work in mental health is unique as we are involved at the micro, mezzo, and macro levels in all sectors. As social workers we focus on social determinants and social dimensions of well-being and are mindful of opportunities and barriers in the environment. Additionally, we work across differences in class, gender, sexual orientation, culture, religion, ability, health, outlook on life and ideologies (Trevithick, 2011).

Many of the roles social workers carry out are common roles to all mental health disciplines. However, specific roles to the domain of social work are: building partnerships among professionals, caregivers and families; collaborating with the community; advocating for adequate resources; addressing poverty, employment, housing, social justice; and promoting development of preventive programs (CASW, 2013). Prevention is key in social work, and can be achieved by early intervention, individual and public education, advocacy and improving access to services and resources (CASW, 2013).

As social workers in mental health, we deliver professional services in the following ways: direct practice (counselling, advocacy, crisis intervention, therapy and coordination of resources); case management (organizing inter-disciplinary services specific to a client, group, or population); supervision and consultation (maintaining quality and management and audit and reviewing of other social workers involved in mental health services); program management/administration (overseeing mental health programs and/or service delivery;

organizational development); teaching; program/policy development; research evaluation; and social action (CASW, 2013). At any level, we may directly or indirectly provide mental health services for immigrant and refugee individuals. However, due to environmental and other factors, immigrant and refugee individuals underutilize mental health services.

The social work profession values equality and social justice and pays most attention to vulnerable, oppressed, and marginalized groups in our society. The Social Work Code of Ethics states “ Social workers promote social fairness and the equitable distribution of resources, and act to reduce barriers and expand choice for all persons, with special regard for those who are marginalized, disadvantaged, vulnerable, and/or have exceptional needs” (CASW, 2005, p. 5). This social work principle coincides with the Accessibility for Manitobans Act, which was previously mentioned. Both strive for inclusivity, reducing barriers, and increasing accessibility in order to meet the unique needs of individuals who are disadvantaged and marginalized in our society.

Immigrant and refugee groups are often marginalized and oppressed in our society. Additionally, immigrant and refugee individuals underutilize mental health services and resources in our community. Yet, to my knowledge there is limited arts-based social work research conducted with immigrant and refugee individuals in Winnipeg, which explores mental health and barriers to accessing services. This photovoice project was beneficial, as it brought the voices of immigrants and refugees from the margins to the centre. Additionally, the results of this study can be utilized to help others see the world through the lens of immigrant and refugee individuals dealing with mental health problems; and help social workers at all levels of mental health service delivery to gain deeper understanding of the immigrant and refugee individuals’ realities, perception of mental health, and the contextual factors that create barriers in accessing

services. The results of the study will be beneficial in providing a deeper understanding of what the barriers are for immigrant and refugees in accessing mental health services. This knowledge can be used to raise awareness and advocate for inclusive, culturally appropriate, and accessible mental health services.

Photovoice can support social work values of self-determination, empowerment, advocacy, social justice, and individuals' expertise in their own lives. Photovoice provides the tools and opportunity for individuals to use images to capture their own realities and share their knowledge. The process of taking photographs and discussing with others facing similar challenges and the possibility for participants to be a catalyst for change may serve to empower individuals (Molly, 2007). The action piece of the photovoice method brings the community together to start a dialogue, and raise awareness, which are the steps to advocacy. The self-determination of immigrant and refugee participants, empowerment through visual arts, and advocacy, all adhere to the social work profession's goals of social justice.

CHAPTER 2

LITERATURE REVIEW

Worldwide, Canada is known to be one of the most diverse countries. One out of five people in Canada are born outside of this country and many others are Canadian born to foreign-born parents (Bowen et al., 2010). According to the 2011, National Household Survey (NHS) Canada's foreign-born population totaled over 6.7 million people; comprising 20.6 % of the total Canadian population, the highest amongst the G8 countries (Statistics Canada, 2011). Additionally, each year, immigrants enter Canada by the hundreds of thousands (Hansson, Tuck, Laurie, & McKenzie, 2009). Between 2006-2011, it was estimated that over 1 million individuals immigrated to Canada, which means new immigrants represented 17.2 % of the foreign-born population and 3.5 % of the total population in Canada (Statistics Canada, 2011). Although there has been a slight increase of immigrants from the Caribbean, Africa, Central and South America, the largest source of immigrants since 2006 has been from Asia (including the Middle East) (Statistics Canada, 2011).

When considering immigration by refugee status, 8.9 % (23, 281 individuals include government assisted, privately sponsored refugee, refugees landed in Canada, and refugee dependents) arrived in Canada under refugee status, in 2014 (Manitoba Labour and Immigration, 2015). In 2013, the top six refugee claimants by source of country included, China, Pakistan, Colombia, Syria, Nigeria, and Afghanistan (Citizenship and Immigration Canada, 2014). Since 2015, the Government of Canada has welcomed more than 30,000 Syrian refugees, making Syria number one on the list (Immigration, Refugees and Citizenship Canada, 2016). Looking specifically at Manitoba, in 2014, the province welcomed 1,495 refugees, comprising of 9.2 % of total immigrants. (Manitoba Labour and Immigration, 2015). Again, this number will be higher, due to the re-settlement of Syrian refugees in Manitoba. From the total number of refugees who

settled in Manitoba, 6% consisted of Canada's government-assisted refugees (435), and 22 % (1, 004) comprised of privately sponsored refugees, the highest per capita in Canada (Manitoba Labour and Immigration, 2015). Approximately 57 % of government-assisted refugees came to Manitoba from Somalia, Iraq, Democratic Republic of Congo and Eritrea (Manitoba Labour and Immigration, 2015). Conversely, 92 % of privately sponsored refugees came from Eritrea, Somalia, Ethiopia, and Democratic Republic of Congo (Manitoba Labour and Immigration, 2015). As previously mentioned, these statistics will be changing in the upcoming year to reflect the number of Syrian refugees who will be resettled in Canada.

According to the 2011 NHS, increased shares of recent immigrants were of Muslim, Hindu, Sikh, and Buddhist faiths. Amongst these groups, Islam was the highest. In 2011, just over 1 million individuals identified themselves as Muslims (Statistics Canada, 2011). Upon arrival, a greater number of immigrants reside in the larger metropolitan cities in Canada. Toronto for example, receives the largest share of immigrants to Canada. In 2013, Toronto received approximately 81, 000 immigrants, followed by Montreal (43, 950), Vancouver (29, 450), Calgary (17, 505), Edmonton (12, 717) and then Winnipeg (11, 100) (Chartier, 2014; Citizenship and Immigration Canada, 2013). Winnipeg's immigration rate is the sixth highest of the Canadian cities since 2013, and it is continuing to grow (Chartier, 2014). Winnipeg is the top destination choice in the province of Manitoba, receiving 85 % of immigrants and refugees (Manitoba Labour and Immigration, 2015).

In Canada, nearly 6.3 million people identified themselves as belonging to a visible minority group; of these visible minorities, 65.1 % of individuals were born outside of the country and immigrated to Canada (Statistics Canada, 2011). The majority of immigrants who came to Canada are relatively young. In 2011, it was estimated that 58.65% of the immigrants

who came to Canada since 2006 were in the working group category (between the ages of 25-54) (Statistics Canada, 2011). It is important to highlight that immigrants arriving in Canada are not a homogeneous population, as they represent diverse countries, cultures, languages, age groups, sexual orientation, education, socioeconomic status, and experiences (Bowen et al., 2010). It is also important to be aware that significant diversity can exist within a group from a particular country (Bowen et al., 2010).

Although often the term refugee and immigrant are coupled together, it is important to highlight and clarify the distinction between the two. Immigrants are defined as individuals who have chosen to come to Canada to increase their opportunities for a better life (Bowen et al., 2010). On the other hand, refugees are individuals who have been forced to leave their country of origin to seek safety in Canada (Bowen et al., 2010).

Mental Health of Canadian Immigrants and Refugees

Mental health plays a major role in overall well-being. According to the World Health Organization (WHO) mental health is defined as a “State of well-being in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2014, para. 1). An individual’s mental health well-being can arise from interactions with their environment (Jackson & Khanlou, 2010). In other words, an individual’s level of mental health at any point may be influenced by multiple social, physiological, and biological factors (WHO, 2014). Mental health problems and illnesses are patterns of behaviors and emotions coupled with levels of distress and suffering, impacting one or more areas of a person’s life (school, work, family/friends, and social interactions) (Hansson et al., 2009). Mental health problems and

illnesses can range from common mental health problems such as anxiety and depression to less common problems such as schizophrenia and bipolar disorder (Bartram et al., 2012).

Recent immigrants report more optimal health status than immigrants who have been residing in Canada for longer periods of time and native-born Canadians (Bowen et al., 2010; Chadwick & Collins, 2015; Dean & Wilson, 2010; Hankivsky & De Leeuw, 2011; Kirmayer et al., 2011; Ministry of Industry, 2005; Simich, Beiser, Stewart, & Mwakarimba, 2005). Over time, the mental health status of immigrants decline, which is referred to as the “*healthy immigrant effect*” (Chadwick & Collins, 2015, p. 221). This so-called *healthy immigrant effect* is attributed to the self-selection effect where, younger, healthier, higher educated individuals self-select to the immigration process (Dean & Wilson, 2010). Additionally, government-screening programs disqualify anyone with serious medical conditions for entrance into Canada under the Immigration Act (Bowen et al., 2010; Hankivsky & De Leeuw, 2011). The *healthy immigrant effect* also extends to mental health outcomes, both in terms of perceived mental health and mental illness (Chadwick & Collins, 2015).

Mental health of immigrants and refugees are influenced by complex, interrelated and multifaceted factors (Jackson & Khanlou, 2010). Migration in itself is a particular stressor for immigrant groups (the reasons for migration, the process involved, and so on) (McKenzie & Hansson, 2009). For example, refugee groups are forced to leave their country of origin, and face pre-immigration stressors and trauma due to war, torture, rape, natural disasters, which in turn increases their risk for developing common mental health problems (anxiety and depression) as well as posttraumatic stress disorder (McKenzie & Hansson, 2009). Within the first few years of residing in Canada, immigrants and refugees are engaged in the process of integration, adaptation, adjustment, and settlement in a new environment (finding housing, school/education,

and employment). Through the settlement process, immigrants and refugees are at a higher risk for developing poor mental health outcomes due to multiple psychological stressors through the settlement process (Chadwick & Collins, 2015). Although mental health issues impact one in five Canadians, racialized immigrant minorities have twice the risk of schizophrenia and higher rates of psychological distress compared to non-immigrant groups; posttraumatic stress disorder and depression are more elevated in refugees (McKenzie & Hansson, 2009). Racialization is defined as “The process by which personality traits, behaviors, and social characteristics are ascribed to minority people because of their ‘race’, and seem permanent and inalterable” (James, 2011, p. 285). A racialized person is someone, other than Indigenous peoples, who is non-Caucasian, or non-white in colour, and often are denied opportunities and privileges based on the colour of their skin (Bartram et al., 2012). Not all immigrants face discrimination and marginalization, but for the most part, it is immigrants who are racialized. It is also important to mention that the majority of refugees (of countries previously mentioned) who settle in Canada belong to racialized groups.

Social Determinants of Mental Health

The underlying factors influencing an increased risk for mental health problems and illnesses include unemployment/underemployment, financial insecurity, poverty, limited social networks, powerlessness, racial discrimination, stigma, and substandard housing. Others, like pre-migration stress due to war, torture, rape and stress of migration, will only impact some (Hansson et al., 2010; McKenzie & Hansson, 2009; Sher & Vilens, 2010). Social causes of mental illness are often referred to as social determinants, as it is not a direct cause of mental illness, but rather, factors that contribute to a person’s vulnerability to mental illness (MHCC, 2009). The Public Health Agency of Canada has listed 12 determinants of health that are

applicable to the general population. The following determinants are particularly significant to immigrants, refugees and ethno-cultural groups, and thus discussed more in detail. *Income and Social Status*—there is a strong connection between low-income levels, income inequality, financial insecurity, poverty, and mental illness (McKenzie & Hansson, 2009; MHCC, 2009; Nazroo & Iley, 2011). All of these factors are more prevalent in racialized immigrants/refugees and this is true for all age groups. Racialized groups are more likely to be in a lower social class and have lower status jobs. It is estimated that it takes approximately 10-15 years for immigrants to be economically integrated, but even so, immigrants continue to lag behind (MHCC, 2009).

Social Networks—the majority of immigrants and refugees face significant problems when social support networks are broken, as a result of their migration. It takes considerable energy and time to re-establish these networks and though there are immigrant and refugee group organizations to provide supports, these supports are limited compared to the networks that have been left behind (Chadwick & Collins, 2015; McKenzie & Hansson, 2009). Research by Pyat (2013) found that immigrants with lower levels of social supports are significantly more likely to report mental health issues, than those with moderate or high levels of support.

Education and Literacy—almost 6 in 10 (58.3%) immigrants are born in Asian countries (including the Middle East), with higher education than the general Canadian population (The Canadian Chamber of Commerce, 2009). This would be expected to decrease rates of mental health problems and illnesses in these groups. However, many immigrant groups face tremendous barriers in getting their credentials recognized and generally face greater discrepancies in wages than their Canadian-born counterparts. One of the major factors for this is lack of recognition of non-Canadian credentials. Over 60% of immigrants working in Canada felt overqualified for their jobs, and over 50 % felt their credentials were not fairly recognized

(Elgersma, 2012). In 2006, 28% of recent immigrant men and 40% of recent immigrant women with university degrees worked in jobs with low educational requirements, compared to 10% of Canadian-born men and 12% of Canadian-born women (Elgersma, 2012). Highly educated immigrants are overrepresented in jobs with low educational requirements, even though they have been in Canada for more than 15 years (Elgersma, 2012; McKenzie & Hansson, 2009). These difficulties are not universal, as immigrants who obtain credentials from countries similar to Canada, will more likely work in a profession that aligns with their skills. Thus, immigrant groups are at a higher risk for mental health problems, as many are unable to work at the same level they previously held in their country of origin. Additionally, a change in social status, particularly going from higher status in the home country to a lower status in host country, can have a negative impact on one's mental health well-being (McKenzie & Hansson, 2009).

Employment and Working Conditions—unemployment is not only common for immigrants, but even more so for immigrants who are racialized (McKenzie & Hansson, 2009). According to the 2011 NHS the unemployment rate for visible minority population was 9.9 %, compared to 7.3 % for non-visible minority groups (Statistics Canada, 2014). For women, the rates were 10.6% compared to 6.7% for non-visible minority (Statistics Canada, 2014). Looking specifically at Manitoba, the unemployment rate for visible minority groups is 7.3%, compared 6.0% for non-visible minority groups (Statistics Canada, 2014). For women, the rates were 8.2 % and 5.7 % respectively (Statistics Canada, 2014). Unemployed individuals experience higher levels of depression than those who are employed (McKenzie & Hansson, 2009). Employment provides not only an income, but also a sense of purpose and personal growth. Among employed racialized populations, a constant fear of becoming unemployed is a specific stressor, as the

majority of the work they are employed in are often casual or term positions (McKenzie & Hansson, 2009).

Gender and Sexual Orientation—immigrant and refugee women, lesbian, gay, bisexual, transsexual, transgender, two-spirited, and queer (LGBTTTQ*) groups are marginalized within an already marginalized group. The intersection of gender, cultural background, and racialized status all adversely impact the social determinants of immigrant and refugee women's health compared to these of Canadian-born women. Immigrant and refugee women face compounded distress including acculturation stress related to loss of family and social networks, social isolation, shift in gender roles, racism, language barriers, cultural barriers, loss of employment and socioeconomic status, poverty, and so on (Fung & Wong, 2007; MacDonnell, Dastjerdi, Bokore, & Khanloul, 2012).

The 2011 NHS estimated that over 3.5 million immigrant women and girls residing in Canada, representing 21.2% of countries total female population (Hudon, 2015). In 2011, 60.6% of immigrant women and girls belonged to a visible minority group (Hudon, 2015). Immigrant women were more likely than Canadian-born women to have completed university certificate or degree at the bachelor's level or higher. However, immigrant women are more likely to be unemployed compared to Canadian-born women and immigrant men due to discrimination and lack of opportunities (Hudon, 2015). Within the core working age group, 8.8% of immigrant women were unemployed compared to 5.2% of Canadian-born women. In 2010, immigrant women and girls were more likely to live in low-income households compared to Canadian-born women (Hudon, 2015). In addition, social networks are comprised of connections with family, friends, and acquaintances. Immigrant women have fewer social connections compared to Canadian-born women and immigrant men (Hudon, 2015). Social support from family and

community is crucial, as it acts as buffer against the stress of migration and, resettlement, and promotes mental and physical health, and enables help seeking (Hudon, 2015).

Immigrant and refugee women are more likely to experience mental health problems such as anxiety and depression and are two to three times more at risk for post-partum depression compared to their Canadian-born counterparts (Durbin, Moineddin, Lin, Steel, & Glazier, 2015; Kirmayer, et al., 2011). According to the Mental Health Commission of Canada (2009) for instance, racialized immigrant women in Quebec were found to display higher depressive symptoms compared to Canadian-born women. Additionally suicide rates for immigrant women were approximately six times higher than The Canadian-born population (MHCC, 2009). Men in general have three to four times higher rates of suicide than women, as they face extreme forms of exclusion that may manifest in homelessness and severe substance abuse (Mikkonen & Raphael 2010). In 2011, 2781 men died by suicide (16.3 percent deaths per 1000) compared to 947 women (5.4 percent deaths per 1000) (Statistics Canada, 2014). It is important to mention that death by suicide reflects a small percentage of suicide attempts. For example, it is estimate that for every suicide there are as many as twenty attempts (Statistics Canada, 2012a). Although men are more likely to die from suicide, women are three to four times more likely to attempt it and one and a half times more frequently hospitalized for attempted suicide (Statistics Canada, 2012a). The discrepancy in part could be due to the method of ending their life. Men are more likely to use hanging or firearms to end their life, whereas women are more likely to use poisoning (Statistics Canada, 2012a).

The LGBTTTQ* immigrants and refugees face both problems as immigrants and refugees and as members of sexual minority groups. Homophobia may contribute to reasons for migration, but these attitudes may face them again when they arrive in a new country (Bhugra,

Gupta, Kalra, & Turner, 2011). LGBTTTQ* groups face stigma and discrimination in their everyday lives. Individuals in sexual minority groups are 2.47 % more likely to attempt suicide in their lifetime and more likely to have mental health problems (Bolton & Sareen, 2011).

Social Environment and Physical Environment—there is an understanding that social environment has an influence on one’s mental health; therefore it is important to highlight the contextual effects such as neighborhoods (Wang & Hu, 2013). Refugees and immigrants are more likely to live in poverty and live in areas that are poverty-stricken. The majority of racialized refugees and immigrants live in cities and in areas with low-cost, substandard housing, a high level of crime, and a diminished sense of community (McKenzie & Hansson, 2009). Residing in cities will increase the risk of a number of mental health problems and issues. This in part may be due to immigrants and refugees residing in low-cost housing neighbourhoods that they can afford and then, such neighbourhoods are labeled as “ethnic ghettos”; which furthers stigmatization and isolation. Often neighbourhoods and communities internalize such stigma (Pruegger & Tanasescu, 2007). Additionally, refugees and immigrants face greater stress due to secondary homelessness, which is living with friends, in insecure housing, in overcrowded conditions or in housing that does not meet standard conditions (Pruegger & Tanasescu, 2007). According to Mikkonen and Raphael (2010) suicide rates in the lowest income neighbourhoods were approximately twice those seen in the wealthiest neighborhoods.

Healthy Child Development— depends on time, community resources and money. Mental health issues in immigrant and refugee children and youth are associated with neighbourhood disadvantages and lack of accessible resources. Over a third of racialized immigrant minorities live in poverty in Canada (McKenzie & Hansson, 2009). As a result, children are exposed to a significant number of social and environmental risks that can negatively impact their

development and their mental health. If a child is separated from their family during the course of migration, they will be at an even greater risk for mental health problems and illnesses (McKenzie & Hansson, 2009). Furthermore, youth can feel overwhelmed when trying to fit in with their new culture, while maintaining components of their own, dealing with social isolation, racism, prejudice and discrimination. Additionally, loss of culture can create loss of identity, which in turn can impact their sense of belonging and sense of self (McKenzie & Hansson, 2009).

Racial Discrimination—racism can take three forms, and simultaneously can have a negative impact on the overall well-being of an individual. Institutionalized racism refers to structures of society such as policies, laws, and government inaction that segregate and marginalize certain groupings of people and their needs based on ethnicity (Mikkonen & Raphael, 2010). Personally mediated racism is an act of prejudice and discrimination such as lack of respect or devaluation, dehumanization of an individual belonging to a racial minority group (Mikkonen & Raphael, 2010). Internalized racism is when stigmatized individuals accept the messages about their own capabilities and intrinsic worth, leading to helplessness, and lack of hope (Mikkonen & Raphael, 2010). Racial discrimination is a risk factor for mental health problems that are more commonly experienced by refugees, racialized immigrant minorities, and ethno-cultural groups. This is a complex social problem that impacts at a number of different levels; from racial abuse or attack through to more subtle forms such as stereotypes in the media (McKenzie & Hansson, 2009). For example, in the 2015 Federal Election, the Niqab debate became central to the Conservative Party's campaign, compromising expression of one's religious beliefs and cultural practice. During the campaign, two Muslim women, one in Montréal and one in Toronto, were attacked by fellow Canadians due to their religious beliefs of

wearing the Niqab. Through this campaign process, Muslim women were discriminated against based on their religious beliefs and were further marginalized. Discrimination impacts mental health through direct effects on an individual's psychological and physical health. It is also linked to other social determinants of health (McKenzie & Hansson, 2009).

Access to Health Care Services by Immigrants and Refugees

There are many community-based services and treatment programs for individuals suffering from mental health problems and illnesses. However, many studies have indicated that refugees and immigrants in Canada, particularly those from non-European countries tend to underutilize community resources and mental health services. The studies have examined some of the underlying factors (Chen, 2010; Durbin et al., 2015; Fung and Wong, 2007; Kirmayer et al., 2007; Kirmayer et al., 2011; McKenzie & Hansson, 2009; MHCC, 2009; Saechao et al., 2012; Tiwari & Wang, 2008; Whitley, 2006; Wood & Newbold, 2012). Some of the barriers that impact utilization of services include shame and stigma; culture; discrimination; socio-economic constraints; lack of culturally competent services; and language. This list is not inclusive, as there might be other barriers and factors for the underutilization of services that are not discussed.

Shame and Social Stigma—is highlighted as one of the major barriers and challenges to accessing mental health services for immigrants and refugees (Chen, 2010; Krimayer et al, 2007; McKenzie & Hansson, 2009; MHCC, 2009; Saechao et al., 2012; Tiwari & Wang, 2008; Wood & Newbold, 2012). Stigma refers to the negative perception people have regarding mental health problems and illnesses. Historically, individuals suffering from mental health problems were often ostracized by their families and communities (McKenzie & Hansson, 2009). Many immigrant and refugee individuals who are in need of mental health services are hesitant to seek

out these services for the fear of being stigmatized and marginalized in their cultural communities (Amri & Bemak, 2013). Additionally, immigrants and refugees along with their families may isolate themselves for the fear of being labeled as different and viewed negatively by their community (Wood & Newbold, 2012). Racialized immigrants who are suffering from mental illnesses are not only faced with the stigma of mental health problems, but also that of racialized stigma. These individuals are facing double stigma, which decreases their chances of seeking care and treatment (McKenzie & Hansson, 2009).

Cultural Barriers—values and beliefs of the refugee and immigrant family and community can act as a barrier in seeking service (Kirmayer et al., 2011). In general, refugees and immigrants are less likely than their Canadian-born counterparts to seek out or be referred to mental health services, even though they are experiencing comparable levels of distress. This, in part, is due to structural and cultural barriers (Kirmayer et al., 2011). Immigrants and refugees in the host country may not seek care, as mental health is understood differently by diverse groups and is dependent on cultural differences and availability of mental health services in their country of origin (Saechoa et al., 2012). In many cultures, mental illness is highly stigmatized. For example, the study by Saechoa et al. (2012), found that amongst Chinese-American female immigrants, the cultural values placed on avoidance of shame acted as a barrier to utilizing mental health services. Additionally the study conducted by Durbin et al. (2015) found that there were common beliefs in the Korean and Chinese communities that “mental health disorders are a ‘Western problem’ and that it demonstrates weakness, therefore individuals may restrain expressions of illness and may not seek services” (p. 9). For Muslim immigrants, social stigma is particularly profound, as Islam is seen as a source of healing and strength and especially as it relates to mental health (Amri & Bemak, 2013). An Individual suffering from mental illness may

be viewed as ‘crazy’ and someone who has lost touch with God (Amri & Bemak, 2013). Muslim immigrants may also face barriers in seeking care, as some cultures may encourage individuals to ‘toughen-up’ and ‘deal’ with their mental health issues. This view is particularly true for men as they are viewed and expected to be strong and the providers for their families (Amri & Bemak, 2013). Unfortunately, many Muslim immigrants go without essential treatments (Amri & Bemak, 2013).

Discrimination— is another area that acts as a barrier to care. Institutionalized discrimination influences structural barriers to accessing mental health care by refugees, racialized minorities, and ethno-cultural groups (McKenzie & Hansson, 2009; MHCC, 2009). For example, it may not be practitioners directly and actively discriminating against particular groups, but the system of care that offers less access and lower quality treatments to these individuals. Our health care system is built on services offered through a Euro-Canadian lens. This one-size fits all services philosophy ignores the differential needs, presentations of problems, and desires of groups, which could lead to poorer outcomes (McKenzie & Hansson, 2009).

Socio-economic Constraints— can lead to barriers for refugees and immigrants in accessing services and improving their mental health. As mentioned, refugees and racialized immigrants are often faced with underemployment/unemployment, are below the low-income cutoff, and less likely to have access to benefits (McKenzie & Hansson, 2009; MHCC, 2009). Additionally, limited monetary funds can cause individuals to not be able to afford transportation costs or any or all of their medications, which may further prevent treatment (Krimayer, 2011; McKenzie & Hansson, 2009; MHCC, 2009). Most of the services are offered during office hours (Monday-Friday; 8:30- 4:30), this may act as a barrier for someone who works in a blue-collar

job and is unable to take time away from work (Krimayer, 2011; McKenzie & Hansson, 2009; MHCC, 2009).

Lack of Culturally Inclusive and Competent Services— can act as a barrier for immigrants and refugees in accessing mental health services. Wood and Newbold (2012) found in their study that the lack of culturally competent services was perceived to be the main barrier for immigrants in accessing care. In other words, cultural insensitivity may discourage immigrants' use of health services and community resources, can make mental health provisions less effective, and may deter immigrants from going back for further help (Wood & Newbold, 2012). In many countries, primary care is the main contact for mental services. Durbin et al. (2015) found in Ontario, that the initial contact with primary care was similar between immigrant groups and the Canadian-born population. Primary care physicians are the gatekeepers, as they are to ensure mental health care is available and are the ones to refer immigrants to other mental health services. However, continuation of using primary care was much lower amongst immigrant individuals compared to their Canadian counterpart (Durbin et al., 2015; Whitley, 2006). This may reflect that immigrants are more likely to become disengaged with western health services, in part due to culturally insensitive services, perceived over willingness of doctors to prescribe medications, lack of time, and dismissive attitudes of some physicians during interactions (Durbin et al., 2015; Whitley, 2006).

Language—was cited as a barrier to accessing services, but also for mental health promotion and illness prevention (McKenzie & Hansson, 2009; MHCC 2009; Tiwari & Wang, 2008). According to the 2011 Census, in Canada, 595,920, individuals spoke neither English nor French (Statistics Canada, 2012b). Looking more specifically, at Manitoba, 14,135 spoke neither English nor French (Statistics Canada, 2012b). Many immigrants/refugees, who are not fluent in

English or French, may not be able to convey how they are feeling to mental health care professionals. Although interpreter services are mandated in the court system, this is rarely the case in the health care systems (McKenzie & Hansson, 2009).

CHAPTER 3 RESEARCH METHODOLOGY

Location of Self

Reflexivity in research is critical, as it not only helps to deconstruct oneself as an individual and a researcher, but also impacts the research relationship. Each one of us has values, morals and beliefs that have an impact on our perceptions and concepts. In addition, our social location, real life and lived experiences shape the lens we view the world through, as well as how we perceive and understand events and situations in the world. It is important that I discuss my social location as it influences the research process in terms of the types of research questions asked or ignored, to the type of population I study and the paradigms and methods I choose (Hertz, 1997).

I was born in Kabul, Afghanistan, in a culture where the sex of an individual had a great impact on the person. In Afghanistan, the gender roles were specific to males and females. At a young age, I became aware that my membership in this social group would have a negative effect on the way I would be treated within the society I lived in. Although I was raised in an educated family - where for the most part men and women were treated equally - because I was a female, I would not get the same rights and privileges that males would in that same society. Due to the war, my family and I were forced to leave our home and escape to Pakistan with very few belongings. When I was nine years old, my mother, two siblings and I immigrated to Canada. We were fortunate to have family in Canada who privately sponsored us. I believed my family and I would have more and better opportunities in the land of “freedom”. However, to my surprise, I quickly learned through experience that my ethnicity was going to impact the way I would be treated. Additionally, my family and I were faced with culture shock, poverty, language barriers and marginalization.

We were fortunate to have extended family in Winnipeg, who provided us with financial support for a year and helped us navigate through our new environment. As an adult reflecting back, I now recognize the hardship and struggles my mom went through immigrating to Canada as an adult compared to me, who immigrated at a young age. My mom's non-Canadian credentials were not recognized, thus greatly impacting our family. My mom was able to find a job at a daycare, where she was paid minimum wage, and was overqualified for the position. This in turn created a lot of financial hardship, as it was difficult for a single mom on minimum wage to meet the needs of three kids. My mom tried very hard to go back to school. She worked during the day and took evening classes, but was unable to pursue her education, as she did not have the financial means. With very limited choices, she gave up her dream of being a teacher.

In adolescence, I quickly became mindful of how addictions, mental health, immigration, oppression, can impact a healthy family functioning. Through my own experiences of the struggles I encountered as a newcomer, I began to recognize the importance that support systems have on an individual and family level. Thus, I volunteered in the community with immigrant and refugee children through the *Newcomer Employment and Education Development Services*. My passion for human rights, activism, and social justice was the reason I pursued my education in the social services field—Child and Youth Care Diploma, Human Ecology-Family Social Sciences, and Bachelor of Social work (BSW).

It was through my professional experiences of working in the field that I became cognizant of how a segment of our population often is absent in accessing mental health services. That segment of the population was immigrant and refugee individuals. I became quite interested in exploring what the barriers are for immigrant and refugee individuals in accessing mental health services, and their perceptions of mental health and mental illness.

My status as a master's student and researcher granted me a certain amount of privilege and power. It was very important for me to choose a paradigm and research method that created an opportunity to share and balance the power with the participants. I chose community-based participatory research as my paradigm, and photovoice as my method with immigrants and refugees who have or are dealing with mental health problems.

Research Question

My interest in this study was to gain knowledge of the realities and lived experiences of immigrants and refugees who have or are dealing with mental health problems, and their perception of community-based mental health services. The research question for the photovoice project is “What are the barriers for immigrants and refugees in accessing mental health services in Winnipeg?” Built upon this research question, I articulated five interview questions listed below that helped to gain knowledge and understanding about the lived experiences of the participants and their perceptions about their access to mental health services. The interview questions number one and two were answered from the immigrant and refugee participants' perceptions; interview questions number three and four were answered with a focus on their experiences; and interview question number five was answered with a focus on what they wanted changed in their community.

1. What is your perception of mental health and mental illness?
2. What do you think others (family, friends, community) perceptions are regarding mental illness?
3. What are your experiences with mental health services offered in your community?
4. What are some barriers you experienced in accessing these services?
5. What would you like to see different with the mental health services being offered?

The participants were made aware that the research questions were just a guideline and the participatory nature of this project supported the participants' wishes to change, refine, add or

remove, any of the interview questions. The participants expressed their desire to respond to the above questions when taking their photographs.

Paradigm—Community-Based Participatory Research (CBPR)

Historically research in the communities was conducted without including community partners in a participatory way. This resulted in community members feeling that research has been conducted on them rather than with them (Hacker, 2013). According to Hacker (2013), CBPR aims to create balance where community members are equal participants, and research has direct benefits for the individuals involved. Hacker (2013) provides a general accepted definition of CBPR in the following:

Community-based participatory research is a collaborative research approach that is designed to ensure and establish structural for participation by communities affected by issue being studied, representative of organizations, and researcher in all aspects of the research process to improve health and well-being through taking action, including social change (p.1).

The goal of CBPR is to develop a process that improves population health and increases connections with members of underserved communities (Hacker, 2013). CBPR is a participatory process that requires the equal and collaborative involvement of the community members in the identification of their concerns, and in the search of solutions and actions to address the identified needs in order to improve their community and individual social conditions (Van de Sande & Schwartz, 2011). CBPR values the knowledge that communities attain, as they are the experts of their own lives and have a deeper understanding of the context in which issues arise and inequalities exist. Individual community members are empowered when they are engaged in the inquiry process, but also when contributing to their own knowledge (Hacker, 2013). In

addition, individuals working together can make a difference within their own communities through group action. Empowerment of the oppressed communities can result in community action for social change and social justice (Hacker, 2013).

CBPR was chosen as the research paradigm, as it values partnership, empowerment, social justice and social change (Becker, Resier, Lambert, & Covello, 2014; Hacker, 2013). The participatory aspect of CBPR allows for partnership and involvement of immigrant and refugee community members throughout the research process—partnership with community agencies, participants’ involvement in data collection process, and collaboration with participants in the data analysis for choosing photos and sharing their stories (Hacker, 2013; Hergenrather et al., 2009). Immigrant and refugee participants’ involvement in the research created an opportunity for their concerns within the community context, culture, and knowledge to be present throughout the research. In other words, the research was structured using the lens and voices of the immigrant and refugee community, rather than only the researcher’s perspective and views of the community. Additionally, CBPR incorporates knowledge and action through the lived experiences of the community members (Hergenrather et al., 2009). Therefore, lived experiences of immigrants and refugees who are faced with mental health problems and access to care can be brought to light.

Method— Photovoice

In the mid 1990’s, Dr. Caroline Wang and colleagues developed photovoice as a creative approach to participatory action research (Hergenrather, 2009; Molloy, 2007; Palbroda, Krieg, Murdock, & Havelock, 2009; Purcell, 2007). The theoretical foundation of photovoice is based on Freirian philosophy- popular education or education for critical consciousness, feminist theory, and documentary photography (Becker et al., 2014; Molloy, 2007). The goal of popular

education is to raise awareness or critical consciousness of shared common concerns, which is assumed to mobilize individuals to question their realities, social situations, and create change (Molloy, 2007). Therefore, photovoice uses images captured by the community members, which reflect the realities that influence individuals' lives (Molloy, 2007). Feminist theory emphasizes that power accumulates among those who have voice, write history, determine language use, and participate in decisions (Molloy, 2007). Additionally, feminist theory equally respects and acknowledges individuals' subjective experiences; in doing so, the power is balanced and distributed more evenly (Molloy, 2007). Photovoice utilizes feminist theory in practice. For example, photovoice gives power through photographs and dialogue to those most marginalized in our society and whose voices are often not heard or included in decisions (Molloy, 2007). Images have been used throughout history as a way for people to express themselves and their needs. Documentary photography has been used predominately to capture and depict the realities of oppressed people, including the social, political, and economic conditions faced on a daily basis (Molloy, 2007). Photovoice expands on this practice by incorporating themes of concerns and strengths of communities. Additionally, photovoice uses the power of visual images to make the marginalized and oppressed groups' voices visible, but also goes beyond to include individuals in the process to reflect their reality, which in turn has the power to influence social policy and move towards social action (Molloy, 2007).

The three main goals of photovoice are: 1) to enable people to record and reflect their community's strengths and concern; 2) to promote critical dialogue and knowledge about important community issues through large and small group discussions of photographs; and 3) to reach policy makers and others who can mobilize for change (Wang, Cash, & Powers, p. 82;

Wang & Burris, P.370). The process of photovoice entails use of photography in order to identify, present, and enhance their communities (Wang & Burris, 1997).

Concepts of Photovoice

Wang (1999) highlighted five key concepts of photovoice, which are: “1) images teach; 2) pictures can influence policy; 3) community people should participate in creating and defining images that shape healthful public policy; 4) the process requires planners to bring policymakers and other influential people to serve as an audience; and 5) there must be an emphasis on individual and community action” (pp. 86-87).

1) Images teach—the visual image is a site of learning that has the capability of strongly influencing an individual’s well being (Wang, 1999). The use of arts and images are universal across cultures, and have the potential of conveying more meaning, feeling, and connection than text. The images themselves are not as powerful as the meaning individuals attribute to the photograph (Wang, 1999). According to Wang (1999), images contribute to how we view and understand ourselves, how we relate to the world and our environment, and what we perceive as important or different.

2) Pictures can influence policy—Wang (1999) suggests that in order to understand the influence of images, we need to analyze the production of images; the reception of images and the meanings attributed to them by the audience; and the content of the images themselves. Policy is not shaped by images in a linear manner, but rather, images influence each individual’s worldview. Additionally by contributing to how we view the world and our place within it, images can influence community advocates, policymakers, and society as a whole (Wang, 1999).

3) Community members should participate in creating and defining the images that shape public policy— Wang (1999) points out that policies created to benefit underprivileged groups

are not necessarily based on what these groups need or want. Photovoice is more than just individuals taking photographs; it is about individuals defining their photographs and adding meaning and value to their stories and perspective. This provides context for understanding the realities and conditions of their everyday lives (Wang, 1999).

4) The process requires the planner to bring community advocates and other influential people to serve as an audience for community member's perspectives—photovoice can be utilized as a tool, which can influence policy when there is an exchange of knowledge through images amongst community members, health and social workers, and policy makers (Wang, 1999). It is important that these interactions are planned in order to mobilize change with those in positions of power. Additionally, it is imperative that community leaders, social services workers, researchers, community advocates, and funders serve as significant participants in dialogue with community members (Wang, 1999).

5) Photovoice emphasizes individual and community action—photovoice shares similar values to participatory action research (PAR), and incorporates a community approach to documentary photography, the production of social knowledge and social action (Wang, 1999). Photovoice is grounded in “the understanding that policies derived from the integration of local knowledge, skills, and resources within affected populations will more effectively contribute to healthful and public policy” (Wang, 1999, p. 187). The most beneficial and effective public policy stems from community collaboration and local knowledge of the issues to be addressed.

Photovoice Research Studies

Photovoice has been globally used and for a wide range of issues, across diverse cultures and age groups, and has addressed sexual orientation, health, ability, and gender (Coghlan & Brydon-Miller, 2014). The process of utilizing photovoice has been implemented to address a

variety of public health and social justice concerns ranging from sexual health issues and person with HIV/AIDS (Grosselink & Myllykangas, 2007; Mamary, McCright, & Roe, 2007; Rhodes, Hergenrather, Wilkin, & Jolly, 2008); to discrimination (Graziano, 2004); homeless adults (Morrell, 2007; Wang, Cash, & Powers, 2000); understanding barriers to mental health care (True, Rigg, & Butler, 2015); and immigrant population (Streng et al., 2004) Similarly, photovoice methods has been conducted with youth (Wilson et al., 2007) and older adults (Baker & Wang, 2006). Photovoice puts cameras in the hands of individuals, offering them the opportunity to be active participants in the research process, inviting them to voice their experiences, perspectives and analysis through photographs they capture (Coghlan & Brydon-Miller, 2014). Additionally, photovoice uses photography and group dialogue as a way for marginalized individuals to further their understandings of community issues and concerns (Palibroda et al., 2009). Photovoice provides a platform from which to engage the community to start dialogues regarding issues presented through photos; and mobilizes the community to take action.

Limitations of Photovoice

Although photovoice has many advantages, there are a few limitations that need to be highlighted. According to Wang, Burris, & Ping (1999) potential ethical implication concerns the unfair distribution of the burden of social change on less powerful groups. Thus, we need to be mindful and caution should be taken to avoid placing the burden to organize for change on less powerful groups in our society, rather on privileged groups who hold power and have the responsibility to restore equality (Wang, Burris, & Ping, 1999). Although photovoice creates an opportunity for participants to share their stories, and communicate their concerns to community advocates, it does not shift power to them to make policy changes (Wang, Burris, Ping, 1999).

Participants, from the start of photovoice research, should be made aware of this. Additionally, participants who are engaged and are motivated to create change may get a sense of hope, however, they may face a sense of hopelessness and/or powerless when their efforts do not match the change they were hoping for (Coghlan & Brydon-Miller, 2014; Molly, 2007).

A photovoice process does need time commitment, and may be exhausting for some individuals, as the project continues for several weeks or more (Palibroda, et al., 2009). Participants may face some challenges in presenting abstract and difficult realities through photographs (Palibroda, et al., 2009). Additionally there are costs to consider when conducting a photovoice project, such as cameras, transportation, developing photos, and use of interpreters (if required) (Palibroda, et al., 2009). Some individuals may not feel comfortable sharing their stories and experiences in a group setting. Therefore, requiring adaptation to the research method. No research method is perfect and despite the limitation photovoice has many strengths. It provides a way to gain knowledge from immigrant and refugee individuals on what the barriers are in accessing mental health services.

Research Procedures

Rationale

The purpose of this photovoice project is to bring the marginalized voices of refugees and immigrants to the centre of the research project. Through this study, the barriers faced by immigrant and refugee communities were brought to light, as was the context in which they were unable to access mental health care. Additionally, using the photographs taken by the participants raised awareness within their community through an exhibition. It was important to choose a methodology which would create an opportunity for immigrant and refugee individuals

who had or are dealing with mental health problems to express their concerns, and through this creative process they raise awareness with the potential for broader change.

Photovoice research has potential advantages for diverse groups and various participants involved (individuals who are oppressed and marginalized; individuals who hold power; and the community at large). Photovoice is appropriate method to use with immigrant and refugee populations, as it breaks down the language barriers, and empowers participants to acknowledge their expertise in understanding their experiences (Molloy, 2007). Immigrant and refugee individuals themselves are best able to articulate their own mental health needs. Thus photovoice creates an opportunity for immigrant and refugee individuals to share with others their experiences and perceptions (Molloy, 2007). The data can also be used as a way to advocate for improvements in community-based mental health services (Leavy, 2015). Photovoice projects are effective as they reveal real life stories, give voice to those most vulnerable in our communities and empower marginalized community members by capturing their concerns and experiences and bringing them to the centre (Palibroda et al., 2009).

Photovoice Process

I utilized the activities and sequences recommended by Wang and Burris (1999) as a guide. The photovoice process involved: 1) Identifying community and or groups within the community that expressed interest in improving one or more conditions in the community, funding, selecting a site, method, sampling and recruiting; 2) conducting photovoice training, initial themes for taking pictures, and taking the pictures; 3) group discussion, reflection, analysis (selection, contextualizing, and codifying); and 4) selecting photos and stories for presentation. Wang and Burris (1997) articulated that these techniques should be flexible and adaptable to meet the needs of individuals and their lifestyles. Thus, my own implementation of the

photovoice method with immigrant and refugee participants was designed in a flexible manner to meet the needs of the participants.

Community Partnerships

Artbeat Studio Inc., established in 2005, is a mental health consumer initiated, peer-directed, and recovery-oriented program. Located in the Exchange District of Winnipeg, this community-based studio accommodates artists whose mental health, social connections, and income make it difficult for them, individually, to acquire a workspace where they might advance their artistic techniques safely and securely. Through its projects, Artbeat Studio is committed to reaching out into communities to promote healing and empowerment through creativity (J. Nato, personal communication, January, 2016).

The urban arts centre Studio Central is a project of Artbeat Studio that aims to facilitate the creation of art as a means of inspiring personal passion, connecting individuals, bridging diverse groups, and creating a sense of community (J. Nato, personal communication, January, 2016). Located in a Manitoba Housing residence in the Central Park Neighbourhood, Studio Central is committed to reducing the stigma surrounding mental illness, and collaborating with local business and organizations on community projects (J. Nato, personal communication, January, 2016).

I was first introduced to Artbeat Studio through one of my university courses titled *Arts Based Qualitative Inquiry in the Community*. Prior to developing an arts-based qualitative research proposal, I volunteered at Artbeat Studio Inc, in order to gain a better understanding of the programs offered. Additionally, I spoke with the staff to hear their voices and perspectives on what the needs of the agency are. Through my own conversations, I learned that Artbeat Studio has low numbers of immigrants and refugees who access their services and resources. As part of

their outreach, Studio Central wants to engage immigrant and refugee individuals through community development and research to ensure they have access to the arts-based community programs. From my own experience of working in the social services field, I too have observed underutilization of services by immigrants and refugees. As a result, I partnered with Artbeat Studio to conduct a photovoice project to gain a deeper understanding of what the barriers are in accessing mental health services from the perspectives of immigrants and refugees.

Throughout this study my partnership with Studio Central was essential, as the agency provided a safe place for the meetings to take place; offered supports in the recruitment process (as they have a wide networks and established trusting relationships in the community); raised awareness in the community regarding this project; shared their expertise and techniques of ways to display the participants' stories and photographs to attract the audience; and assisted with the launch and exhibition.

Funding

I was granted funding for the photovoice project from the Social Work Endowment Fund at the University of Manitoba and Emerging Leaders Fellowship (ELF) fund through the Winnipeg Foundation. Upon accepting the grant through the Winnipeg Foundation, I had to withdraw from the offer from the Social Work Endowment Fund. Receiving funding in the amount of \$1853.10 from the Winnipeg Foundation provided the financial means to conduct this photovoice project.

Photography is an important part of photovoice research. Therefore the funding provided the means to purchase digital cameras for each participant so they could take photos in their community and voice their community needs and concerns. At the end of the project, the digital cameras were given to the participants as a souvenir to keep. The funding also provided bus

tickets to those participants who required transportation to and from the meetings. Refreshments were purchased for the participants at each group meeting, and musical entertainment and refreshments were provided at the lunch and exhibition at Studio Central. The participants had a good experience as their photographs and stories were framed and the exhibition was professionally done with the help of Studio Central. Frames for each participant's certificate were purchased, and finally a \$30 gift card from Wal-Mart was given to the participants as an honorarium for their time and participation.

Recruitment Process

Multiple methods and strategies of recruitment were implemented over a period of five weeks. The first recruitment strategy involved creating a poster that described eligibility criteria, tasks and time involved (please see Appendix A). My phone number was included in the poster as a way for the potential participants to contact me, if they were interested in participation, or acquire further information or clarification. The research poster was distributed to all community agencies, student groups at the University of Manitoba, Faculty of Social Work, Siloam Mission, Winnipeg Harvest, social media (Facebook), and everyone was asked to pass the poster to their social networks.

On-line methods were also used to recruit potential participants. I collaborated with Jan Nato (former Community Art Program Coordinator, at Studio Central) to utilize his community contacts to introduce me via email to individuals who provide services to immigrant and refugee individuals. Upon the email introduction, I was able to send a letter to each of the community agencies in Winnipeg (please see Appendix B) and attached to that email was a copy of the poster, and a recruitment letter to be forwarded to potential participants (please see Appendix C). Both of the letters for participants and agencies described the research study, its purpose,

eligibility, and contact information. The agencies that received emails included Winnipeg School Division, MOSAIC, IRCOM, Family Place, Family Dynamics, NEEDS Centre, Spence Neighbourhood Association, WRHA (Community Mental Health Program), West End Library, Knox United Church, Klinik, Red River College Counselling, YMCA/YWCA, Nor' West Community, Graffiti Art Programming, Art City, St. Matthew's Community Ministry, West Central Neighbourhood, Manitoba Islamic Association, Mount Carmel Clinic, Clubhouse of Winnipeg, Wolseley Family Place, and St. Vital Neighbourhood Immigrant Settlement Program.

Another approach involved meeting with agencies face-face and presenting information regarding the research (please see Appendix D- oral script for agencies). The Clubhouse of Winnipeg Inc. (drop in centre for individuals with mental health issues, to support their integration into the community) invited me to present information regarding this study to potential participants. Also, MOSIAC Newcomer Family Resource Network, which is a neighbourhood language-learning program and family resource centre, invited me to present to immigrants and refugees at the higher-level English classes. This allowed individuals to meet me in person and ask questions, thus allowing opportunity to build rapport and trust. A snowball technique was also utilized as a way to recruit individuals who were not accessing any community services. Potential participants were asked to share information with their networks and individuals who met the criteria and were interested.

Due to a well-planned strategic way of reaching community agencies and their support in sharing information regarding this study, Canadian Broadcasting Corporation (CBC) network came across the recruitment poster and was quite interested in this topic and wanted to help in the recruitment process. I was interviewed by CBC Radio, and information regarding this

research was posted on their website. The hope for the CBC interview was to raise awareness about to this issue and to extend the information to those who may not be accessing any services.

Purposive sampling was utilized amongst refugee and immigrant individuals residing in Winnipeg, Manitoba. I described the purpose of the study and their time commitment when the potential participants contacted me over the telephone. We also discussed their roles as a potential participant. It was important to clearly define the roles and expectations of the potential participants right from the onset of the project, so that the potential participants could make an informed decision about the participation. Each participant was expected to attend five group meetings; each meeting was of 90 minutes duration. The potential participants would also be involved in the research process, such as data collection (taking photographs in their community, attaching narratives or stories). Sharing their photos and stories in the group discussions. Potential participants would also be invited to partake in data analysis, if they were willing to participate (review, code, and select). For example, as a group the participants reviewed all material, searched for common and or uncommon threads, and summarized all contents into a display for the exhibition.

When a potential participant showed interest in participating, they were screened over the telephone, to ensure they met the criteria stated on the research poster. Those individuals who were eligible to participate had to meet the following criteria: 1) individuals who identified as an immigrant and/or refugee; 2) who have been residing in Canada for at least two years; 3) between the ages of 18-55; and 4) who have or are dealing with mental health problems.

During the recruitment process, a total of eight individuals contacted me and showed interest in the study. Out of those, two individuals did not meet the criteria, as they both were born in Canada. Additionally, prior to the first meeting one of the participants contacted me to

inform me that he no longer could be part of the study, due to an illness in the family. Another participant could no longer be part of the research, as she found it difficult to care for her child given the time commitment needed for the project.

The suggested number of participants for a photovoice project is between 5-10 participants (Becker et al., 2014; Palibroda et al., 2009). A group of 5-10 individuals is large enough to offer a variety of ideas and experiences, but also allows enough time for each participant to contribute in a meaningful way (Palibroda et al., 2009). Facilitation of a large group can be challenging and taxing for the participants (Becker et al., 2014). Prior to the start of the project, I had four participants. I was concerned that I would not have enough participants for this study. After experiencing difficulties with recruitment, my community partner continued to share information regarding this study with individuals who accessed services and/or volunteered at Studio Central. Subsequently, two more individuals contacted me and expressed interest excitement for the project. Both met the criteria and were recruited for the project. As a result, six individuals fully participated in the project from start to end.

Researcher's Role

My role as a researcher was to connect with community agencies (listed above) and build a partnership with Artbeat Studio. As a researcher, I was actively involved in recruiting potential participants for the photovoice project. Within the photovoice project, my role as a facilitator was to carry out this piece of research for my masters thesis (working closely with participants)— planning group meetings; preparing information to share with the group members (ethics, confidentiality, information on photovoice project, and safety protocols, etc.); ensuring meetings were structured effectively (a safe place to share photos and stories and where opinions of group members were treated with respect). As a facilitator I was mindful of maintaining

professional boundaries, and not adopting the role of a therapist and or social worker with the participants. As the researcher, I was responsible to ensure no photograph was taken without informed consent. My role also included, safely cataloguing photos and stories; taking charge of the data analysis and involving participants in the process for sharing photos and stories in the exhibit; and providing the participants with a summary of the data analysis results for feedback and member checking. In the consent form I indicated how the results of this project would be disseminated, but I also discussed the process with the group. As a researcher it was important to discuss the process so that each individual participant had a better understanding of how, where and with whom, the results would be shared. My role also included ensuring the dissemination of the stories were carried out in accordance with research ethics and confidentiality.

Implementation of Photovoice Project

The following methods have been adopted from Manitoba's Photovoice for Community Development Guide prepared by Manitoba Agriculture, Food and Rural Initiatives (MAFRI). The document is an excellent tool and a resource for community organizations. It provides step-by-step information of how to conduct and implement photovoice research within the community. The photovoice guide also contains forms and list of resources that can be adopted, changed or modified to meet the needs of the community organizations. It appears that no permission is needed to use the forms from the photovoice guide. I have modified two forms—one for photograph consent (please see Appendix E) and the other for photo logs (please see Appendix F).

Each group meeting was held at Studio Central, 444 Kennedy Street. The group meetings took place in a private room. The group meetings were held once a week, with the exception of the third meeting, which was held a week and a half later to give participants sufficient time to

take photographs. All meeting times were consistent and held at 6 pm, which was optimal for all members.

First Meeting – Participants Discover Photovoice (MAFRI, n.d.)

The first meeting took place at Studio Central. The allocated time for the meeting was approximately 90 minutes. The purpose of the first meeting was to bring participants together for the first time. At the beginning of the meeting, each participant received a file folder with a number on it, which they could use to keep pictures, notes and forms. The meeting consisted of the following items:

- 1) Conducted an icebreaker activity;
- 2) Introduced photovoice project concepts and methods;
- 3) Focus topic- mental health and access to care;
- 4) Research questions—discussed, asked group if they wanted to change and or modify;
- 5) Role of participants;
- 6) Consent forms (please see Appendix G) handed out, discussed, and signed;
- 7) Confidentiality;
- 8) Ethics;
- 9) Safety and precaution;
- 10) Practice of giving photographs back to the community as a way of expressing appreciation and respect; and
- 11) Highlight the tasks for the following meeting.

Icebreaker Activity— A picture speaks a thousand words (Powers, Freedman, & Pitner, 2012): printed pictures (e.g.: landscape, nature, local landmarks) were passed around the group, and each participant was asked to choose one photo and hold on to it. Once the photos were chosen, each participant took the opportunity to introduce him or herself by indicating why they chose the photo, and what it said about them (Powers, Freedman, & Pitner, 2012). This was a good way to start the project, as it created the opportunity for the participants to make the connection between photography and their voice. It also helped the participants begin to think about how photos can tell stories (Powers, Freedman, & Pitner, 2012).

Safety and Precautions

Sharing one's story carries with it the risk of experiencing psychological or emotional distress. For example, asking immigrant and refugee individuals to share their experiences of mental health issues and barriers to accessing services may cause participants to re-live painful experiences. With the possibility of inadvertently provoking strong emotional reactions, a list of counselling resources in Winnipeg was provided to participants in the first meeting (please see Appendix H). However through sharing their stories, no painful emotions surfaced.

Furthermore, safety and precautions was discussed with the participants prior to taking photographs. 1) Discussion around responsibility of participants when carrying a camera to respect the privacy and rights of others, (for example asking permission and consent), and 2) it was emphasized that no picture is worth taking if it brings any harm to participants and or to others (Palibroda et al., 2009).

Second Meeting—Camera Distribution (MAFRI, n.d.)

Digital cameras and logbooks were distributed to the participants, so they could start taking pictures. The goal of the second meeting was to collect the remaining consent forms and reiterate ethics and safety. Participants were notified that when taking photographs of people, it was important to have their permission. Also, the individuals need to be over the age of 18. Each participant was provided with consent forms, so that permission could be sought at the time the photographs were taken. If the individuals who were being photographed wished to have their names attached to their photo, they needed to provide permission to waive privacy and confidentiality by signing an additional waiver form (please see Appendix I). As a group, we reviewed permission to photograph consent forms; discussed timeframes and instructions on

when photo taking was to be completed; encouraged participants to take notes as they took the photos, so they could attach stories and give meaning to each photo.

Prior to ending the meeting, group discussion took place to determine how many pictures and stories each participant would be responsible for. As a group, it was decided that each participant would take at least one photo per question. In other words, there were six questions and each participant was responsible for taking a minimum of six pictures. Then at the next meeting, each participant shared each photo with a written corresponding story. Limiting the number of photos had advantages, as it caused the photographers to think more selectively of what they wanted to shoot and why; also was cost effective (MAFRI, n.d.).

Cataloguing the Pictures and Stories

Participants had 10 days to take their photographs. As the researcher, I was responsible to safely print, copy, sort, and file all pictures taken by the participants and make sure the stories were attached to the right photos (MAFRI, n.d.). Participants who had access to computers emailed their pictures. For others, I met them in person, took their cameras and uploaded their photos onto my personal computer that is password protected. All pictures were printed and placed in each participant's file folder ready for the next meeting. All photographs captured by the participants were deemed appropriate and met the confidentiality guidelines. There were no photos of others in the community. Only two photographs had one person in it, however there was no identifiable information. One captured the person's back, and the other photo the person's face was hidden.

Third Meeting—Sharing Stories and Photographs (MAFRI, n.d.)

At the beginning of this meeting, 10 minutes were allocated for each participant to look over their photos and prepare what they wanted to share. As a group, the participants took turns

sharing pictures and stories. This provided an opportunity to learn more about each participant's perspectives and stories (MAFRI, n.d.). Sometimes through the discussion, more stories and experiences were revealed. With the participants' consent, an audiotape was utilized to record the discussions.

Fourth Meeting— Choosing Photos and Stories to Share (MAFRI, n.d.)

Photos with words can be quite powerful as they capture the essence and context of one's perspective and reality in a specific moment in time. As a group, we reviewed all materials, searched for common and or uncommon themes, and summarized all contents into a picture display. The following three steps were shared with the participants and used as a guide to help analyze pictures with stories. (MAFRI, n.d.):

1. **Review**—look at all the pictures including the words. Some pictures may be blurry but the words can be very inspirational. Thus, it is important to review the pictures and words as a combination.
2. **Code**—Identify the themes and/or issues. Is there a pattern? Are there similarities between the participants? Are there differences? Are they what you expected or did something new emerge?
3. **Select**—The photos and stories should be selected that best reflect the topic. There might be many photos capturing the same subject. Therefore, select photos that present a new angle, a different view, or a new story.

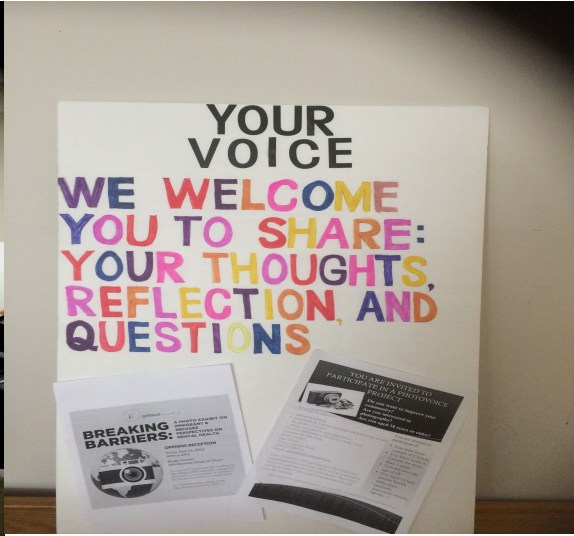
A total of 27 pictures with stories which best captured their voices were chosen by the group to be displayed at the exhibition. At least three photos were chosen from each participant. As a group the photos were organized into six themes for the exhibition—perception of mental health, perception of mental illness, community's perception, experiences with services, barriers to accessing services, and changes the participants want to see.

Exhibition and Launch

Figure 1: Photovoice Exhibition



Figure 2: Community Voice



27 pictures were framed and the stories were attached beside the corresponding photos. A poster invitation was created (please see Appendix J) and distributed electronically to the Faculty of Social Work, social media, and community agencies. The community exhibition and launch was an evening event, with musical entertainment and refreshments. The exhibit was open to all community members, partnering agencies, and policy-makers. The exhibit was considered the action piece, as the community become aware of the realities of immigrants dealing with mental health issues, access to care, and seeing the world from their perspective and mobilizing the community to take social action. Approximately 40 individuals attended the exhibition. Individuals who attended the launch and exhibit were also invited to share their voices by writing their feedback in a journal (see figure 2). It was important to hear the voices of the community to gain an understanding of how effective the exhibition was.

After the exhibition, the photographs continued to be displayed at Studio Central along with the journals, where many more community members attended to see the pictures and left

their feedback. Overall the exhibition received positive feedback from the community. After the exhibition, the photos and stories were donated to Studio Central, as a way for them to continue to raise awareness, and to safely store and catalogue the picture and stories. The plan for the exhibition is to be displayed at Siloam Mission and MOSAIC as a tool to start conversations regarding mental health. The plan for the future is to continue to circulate the exhibition to other community mental health agencies and immigrant and refugee services to use as a tool to raise mental health awareness. Additionally, Artbeat Studio and Studio Central have been invited to present at a conference hosted by the Manitoba Association of School Superintendents (MASS) in April 2017. The Conference titled “Our (Human Rights) Journey” will include approximately 1000 educators and students from across Manitoba. In a panel discussion, I will discuss utilizing arts-based research, disseminating the results of this study, and speaking about its connections to human rights.

Fifth Meeting— Feedback and Debriefing (MAFRI, n.d.)

Due to the participatory nature of this research, feedback and debriefing were an integral part of the photovoice project; was integrated at all stages of this study, and was built into the meetings. The fifth and final meeting was held at the end of the project on May 7, 2016, which was specifically used for debriefing and feedback. At that time, I verbally presented a brief summary of the findings. In addition, the participants had a choice of receiving the summary of the findings in a written format, either given to the participants at the meeting or to receive the summary of findings via email and/or mail by the end of May 2016. Member checking was utilized after sharing the findings, in order to receive the participants’ feedback about the accuracy of the interpretation of the findings. I used this opportunity to determine if the research had caused any significant distress to the participants. At the end of the meeting, each participant

was presented with a certificate that was tailored to the strengths and skills they brought to the meetings and this project.

Confidentiality

The photovoice project was conducted in a group setting; therefore all the members of the group including the researcher knew who the data (photographs and stories) belonged to. As a result, there could not be any anonymity and the participants' full confidentiality could not be guaranteed. In the initial meeting the importance of confidentiality and keeping other group members' information private was discussed as a ground rule for participation. Even so, I could not guarantee full confidentiality and the participants were made aware of this. The participants were also notified that the only instance when confidentiality would not apply was when there was a disclosure of abuse to a child or a vulnerable person, and/or foreseeable and imminent harm to the participants or others.

Photovoice projects can generate a large amount of data, and it is important to take appropriate measures to keep the data organized and protected (Palibroda et al., 2009). Prior to the start of the photovoice project, I created procedures to safeguard the participants' confidentiality. For example, at the beginning of the first meeting, each participant was provided with a file folder with a number on it (numbered from 1-6, the same as the number of participants). These file folders were a safe place to put all the participants' photos, stories, forms and notes. The folders were then kept in a locked cabinet at Studio Central, where, as the researcher, I was the only person with access to the locked filing cabinet. Each digital camera was also numbered to match each participant's file folder. When the participants took their photographs, instead of putting their names on the photo log, they wrote down the camera number. Therefore the participants could keep track of each photograph they took without

indicating any personal identifiers. This also made it easy for me to catalogue the photos and stories and place them in the right file folders.

Photos that were uploaded electronically were in electronic file folders that matched the numbers on the digital cameras, and thus did not have any identifying information. However, precautions were still taken with these pictures, which were kept in the researcher's personal password protected computer. With the permission of the participants, an audiotape was used to record group discussions. The audiotape had confidential information, as the voices of the participants could be identified and other information during the discussion could be a risk to the participants' identifications. These audiotapes were handled with care and stored in a locked cabinet at Studio Central. All audiotape recordings, electronic pictures, and related materials will be deleted by May 2017).

Dissemination process—each participant was made aware that their real names and any identifiable information would be removed upon the dissemination of this project. I also explained that they had the choice and option to waive their privacy and confidentiality. By signing the waiver form of privacy and confidentiality (see Appendix K), they were consenting to including their real names and pictures in the exhibition, thesis, future presentations and publications. The participants as a group appeared to be quite passionate and excited about this project. They all felt proud of their work and wanted their voices to be heard and acknowledged. Each participant signed the privacy and confidentiality waiver form, as they wanted their real names and identities to be known for their work and participation in this project. As a result their real names and pictures were included in the photovoice exhibition and thesis.

Ethical Consideration

The University of Manitoba Research Ethics Board approved this research, prior to conducting start of research with the participants. All aspects of the research design such as purpose, measurements, confidentiality, data collection, and data analysis, were shared verbally and in a written manner, as part of informed consent. In case of language barriers for the participants, translators were to be used and the Translator Confidentiality Agreement would need to be signed (please see appendix L). However, the participants in this study voiced having sufficient knowledge of the English language, both verbal and written, thus, no participants requested a translator. The use of language in this research process was clear, free of jargon, age appropriate, and took into consideration the participants' level of cognitive functioning and language barriers. Participants were informed they had the right to withdraw from this research and refuse consent at any point in the process. Cultural differences were respected and cultural values were incorporated in the research process. Pictures of others could not be included without consent, thus, confidentiality was discussed and a framework created with the participants; for example, consent forms were to be signed by any individual who appears on the participants' photos. For recruitment purposes, the community organizations only sent research information to potential participants who then contacted me directly, in order to keep the research relationship separate from a service relationship. Photovoice.org has an ethics of practice posted on their website; throughout the project, I consulted and considered those ethics set for photovoice conduct.

Data Collection

Data collection began from the early implementation of the project and continued through the final stages of sharing the photovoice exhibit. Data was gathered through the participants'

photographs, stories, and audiotapes of the group discussions per the participants' permission. Additionally, data was gathered from the community members' feedback and reflections in a journal after viewing the exhibition.

Chapter 4

DATA ANALYSIS PROCEDURES

I borrowed techniques from Wang and Burris (1997) to guide the group analysis with the participants in order to review all materials, search for common or uncommon threads, and to summarize content into a display. Furthermore, I utilized thematic analysis as highlighted step-by-step by Braun and Clarke (2006) to analyze the data set from the group meetings in order to explore the patterns that emerged from the participants shared stories. The analysis of the data involved four major parts; 1) analyzing pictures and stories with the participants as a group; 2) thematic analysis of the participants' shared stories; 3) thematic analysis of the participants' experiences in regards to their participation in the photovoice project; and 4) the community's voice in response to the photovoice exhibit. In part one, the pictures and stories shared by the participants were analyzed in accordance with the three steps highlighted by Wang and Burris (1997) - selecting photographs, contextualizing, and codifying.

Part 1: Analyzing Pictures and Stories as a Group

Selecting photographs—The participants presented a total of 45 pictures and accompanying stories. Out of the 45 pictures and stories, the participants as a group chose 27 pictures and stories to be displayed at the exhibit. The participants chose photos that best represented the challenges and strengths in their community, and they chose photos that best represented their lived experiences (Wang & Burris, 1997).

Contextualizing—participants contextualized the photographs when they shared their stories, lived experiences, and the meaning behind their photographs. It is through group dialogue that the participants can share their individual and group experiences (with permission of the group, the discussions were audio-tape recorded) (Wang & Burris, 1997). *Codifying*—this is the process where the data (photos and stories) were sorted into categories of issues and or

themes by the participants (Wang & Burris, 1997). The participants captured their photographs in relation to the research questions. The participants as a group chose to employ the research questions (perception of mental health, perception of mental illness; barriers in accessing mental health services; experiences with services; changes they would like to see) as themes when sorting their pictures and stories for the exhibit.

Part 2, Part 3, and Part 4: Thematic Analysis

In Parts two, three and four, thematic analysis was utilized to analyze the data set. I chose thematic analysis as it is flexible in nature and not tied to either theory or epistemology. It can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006). Therefore thematic analysis can be a useful tool that provides accounts of rich, detailed and complex data (Braun & Clarke, 2006). Additionally, for these three parts, the same thematic procedures were used—Phase 1: familiarizing self with data; Phase 2: generating initial codes; and Phase 3: searching for themes.

Phase 1— Familiarizing Self With Data

According to Braun and Clarke (2006) it is important to immerse yourself into the data set to the extent that you are familiar with the depth and breadth of the content. This can be achieved by repeated reading of the data in an active way (for example, searching for meaning and patterns) (Braun & Clarke, 2006). Being mindful of that, I began by transcribing the audio recordings of the group meetings (Part two—where the participants had shared their photos along with their stories; and Part three—when the participants shared their experiences in regards to the photovoice project). In Part four the data came from the written messages from the community members' feedback after viewing the participants' pictures and stories at the exhibit. I typed all of the messages of the community members verbatim. This was a great way to

familiarize myself with the data. The transcripts of the group discussions and community members' feedback from the exhibit were repeatedly read and studied in order to gain an overall understanding. Reading the transcripts several times in their entirety allowed me to immerse myself in the details, as well as gaining a deeper understanding of the participants' experiences beyond their written words (Braun & Clarke, 2006; Tutty et al., 1996). It also helped me gain an overall understanding of the community members' reactions and response to the exhibit

Phase 2—Generating Initial Codes

Once I was familiar with the data sets for part two, three and four, I started the second phase of analysis. This phase involved the production of initial codes from the verbatim transcripts of the group discussions and community members' feedback (Braun & Clarke, 2006; Tutty et al., 1996). The initial codes involved aggregating the text into small categories of information (words and phrases) that appeared interesting and reflected the overarching research question (Braun & Clarke, 2006; Creswell, 2013; Tutty et al., 1996).

Phase 3—Searching for Themes

This phase refocused the analysis at a broader level of themes, rather than codes (Braun & Clarke, 2006). This involved sorting the different codes into potential themes. Basically, this step involved analyzing the codes, and considering how different codes connect with one another to create overarching themes (Braun & Clarke, 2006; Tutty et al., 1996). A thematic table was utilized for part two, three, and four in order to sort the different codes into themes (for part two please see Appendix M; part three please see Appendix N; and part four please see Appendix O). Additionally, thematic maps (please see figure 3, 4, and 5) were used for organization of themes, but also to have a visual representation to gain a better understanding of the connection between each theme.

Trustworthiness

To ensure trustworthiness in this study, several steps suggested by Creswell (2013) were incorporated. This included prolonged immersion into the data and field, member checking, triangulation, and field notes (Creswell, 2013). I immersed myself by personally collecting all of the data, transcribing the data verbatim from audio to text, and analyzing the data. This contributed to the rigor of this study, as I continuously worked with the data, to ensure the themes, interpretations, and conclusion made sense and were in line with the research questions. Triangulation methods were utilized by collecting multiple and different sources of data—audiotape of group dialogue, field notes, pictures taken by the participants and their written stories. Due to the participatory nature of this photovoice research, I had a prolonged engagement with the participants (five group meetings, approximately for the duration of 1.5 hours, over the span of two months). I also incorporated literature to give meaning to the results and bring more perspectives (Creswell, 2013). The triangulation method contributed to the overall thoroughness of this study. Additionally, feedback and debriefing was an important part of the photovoice project. Therefore, feedback from the participants was integrated at all stages of this study, and was built in within the meetings. The final meeting was allocated specifically for debriefing and feedback. I verbally presented a brief summary of the findings. Member checking was utilized after sharing the findings, in order to receive the participants' feedback about the accuracy of the interpretation of the findings. Also all of the participants asked for a copy of this thesis. As a researcher, I kept a journal throughout the research process, so I could be reflexive and aware of my own positionality and biases.

Chapter 5
PRESENTING THE PARTICIPANTS AND THE FINDINGS

Introduction

This chapter will begin with a brief overview of the participants' demographics, followed by the research findings— including photos captured by the participants and accompanying stories, which present the reoccurring themes that emerged through the group dialogue. The outline of the findings are organized in this way in order to offer context to the voices, experiences, and realities of the immigrant and refugee participants who have or are experiencing mental health difficulties. The stories of the participants are written verbatim, as their voices are brought from the margins to the center of this research and need to be presented and heard. The participants are co-creators of knowledge who expressed their community needs in an artistic way through use of photography. Additionally, I have incorporated my own interpretations of the data throughout the findings.

Portrait of the Research Participants

The demographics of the research participants provide contextual understandings of their social location and how that may have shaped their perspectives and influenced the lens that they view the world through. As previously mentioned in chapter 3, the participants are co-researchers in this project, as they were involved in the research process, such as data collection (taking photographs in their community, attaching stories); and sharing their photos and stories in a group discussion; participants also were involved in the data analysis— (to review, code, and select photos and stories). For example, as a group the participants' reviewed all material, searched for common and or uncommon threads, and summarized all contents into a display, which best captured their voices. Their chosen photos were showcased at the exhibit.

Participant Diversity

In this photovoice project, six individuals volunteered to participate (three females, and three males). Out of the six participants, two of the individuals came to Canada as refugees, and four came as immigrants. Each of the participants came from different countries. Additionally, four of the participants have been residing in Canada for over 20 years, while one has been here for eight years, and the other has been here for two and a half years. The age of the participants range from 34-52. The participants expressed a range of mental health problems, which they have experienced such as depression, anxiety, bipolar disorder, delirium, schizophrenia, and schizophrenia with depression. Additionally, participants were at different levels in their journey to recovery. All of the participants at one point have accessed mental health services and community resources—psychiatric help, group homes, counselling through Welcome Place, Nor’West Co-op Community Health Centre, Mosaic Newcomer Family Resources Network, Artbeat Studio, Clubhouse of Winnipeg, and Crises Response Centre. Each participant voiced their appreciation for this project and how they felt proud to be part of this group in using their voices to raise awareness about immigrants and refugees’ mental health and barriers to accessing services. The participants want to be recognized and take ownership of their work. Thus in the results section, the real names of the participants will be used as per their request and permission.

Jason Cheung (age 34) was born in Hong Kong, immigrated to Canada at the age of 9 and has been residing in Canada for 25 years. Mesafint Haile (age 52) was born in Ethiopia and came to Canada as a refugee. He has been residing in Canada for 26 years. Khaled Al Kanaani (age 47) was born in Iraq, came to Canada as a refugee and has been residing in Canada for 20 years. Yekaterina Kaplun (age 37) born in Russia, grew up in Ukraine, lived in Israel, and immigrated to Canada. She has been residing in Canada for eight years. Ildiko Nova (age 49) was born in

Hungary, immigrated to Canada and has been residing in Canada for 24 years. Mihret Tekie (age 38) was born in Eritrea and resided in Sudan prior to immigrating to Canada. She has been living in Canada for over 2.5 years.

Findings

Prominent themes emerged through the group dialogue among the participants; in addition themes emerged from the community members' reflections after the viewing of the exhibition. Thematic maps (figure 3, 4, and 5) were used for organization of themes, but also to have a visual representation to gain a better understanding of the connection between each theme. The findings are presented and discussed in three chapters. This chapter will discuss *Reality: Barriers and Perception*; Chapter 6 will present—Resiliency, *Hope, Empowerment, and Actions*; and chapter 7 will discuss— *Community and Culture as Binary*.

Figure 3: Thematic Map—Participants’ Shared Stories

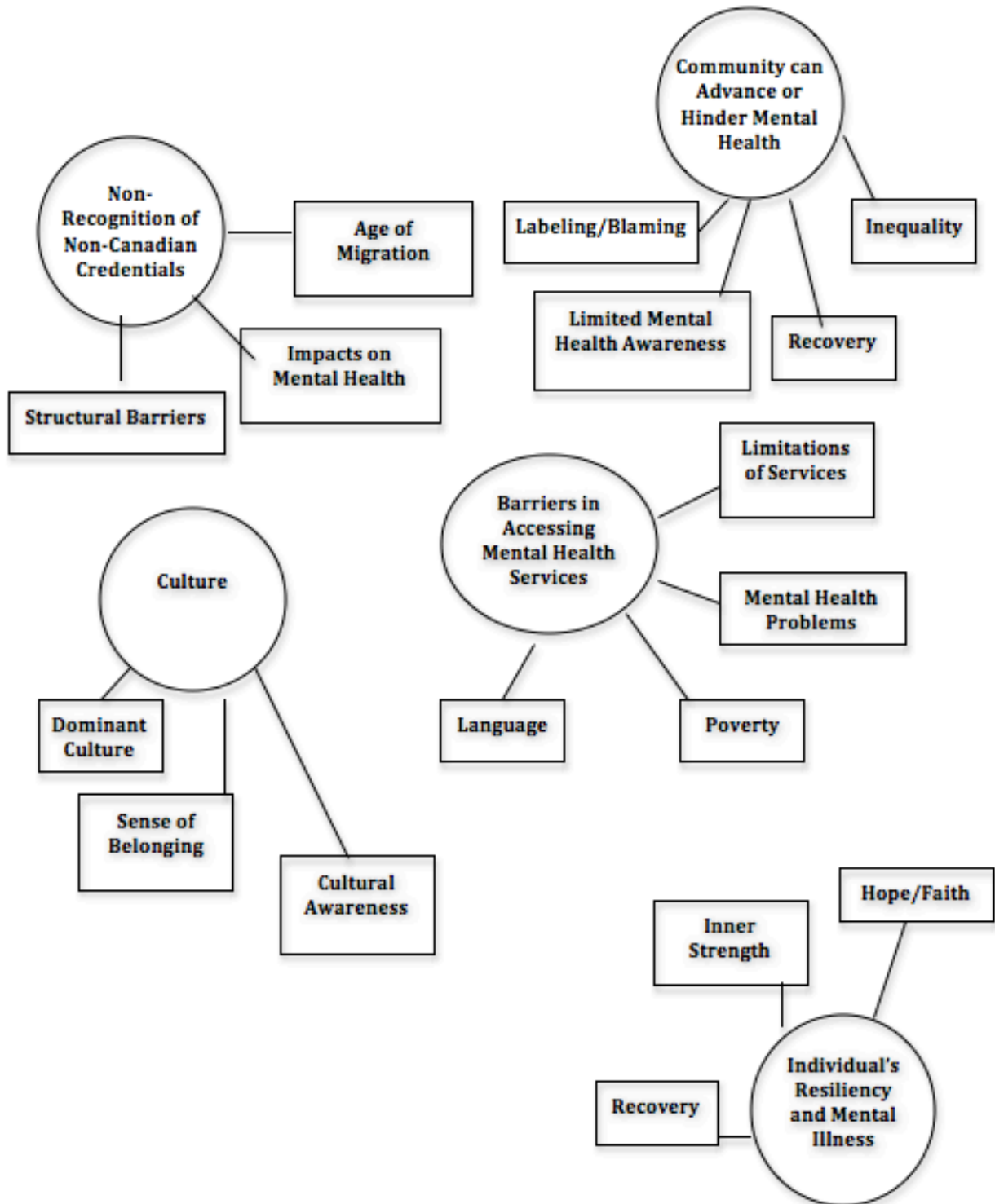


Figure 4: Thematic Map—Community’s Voice

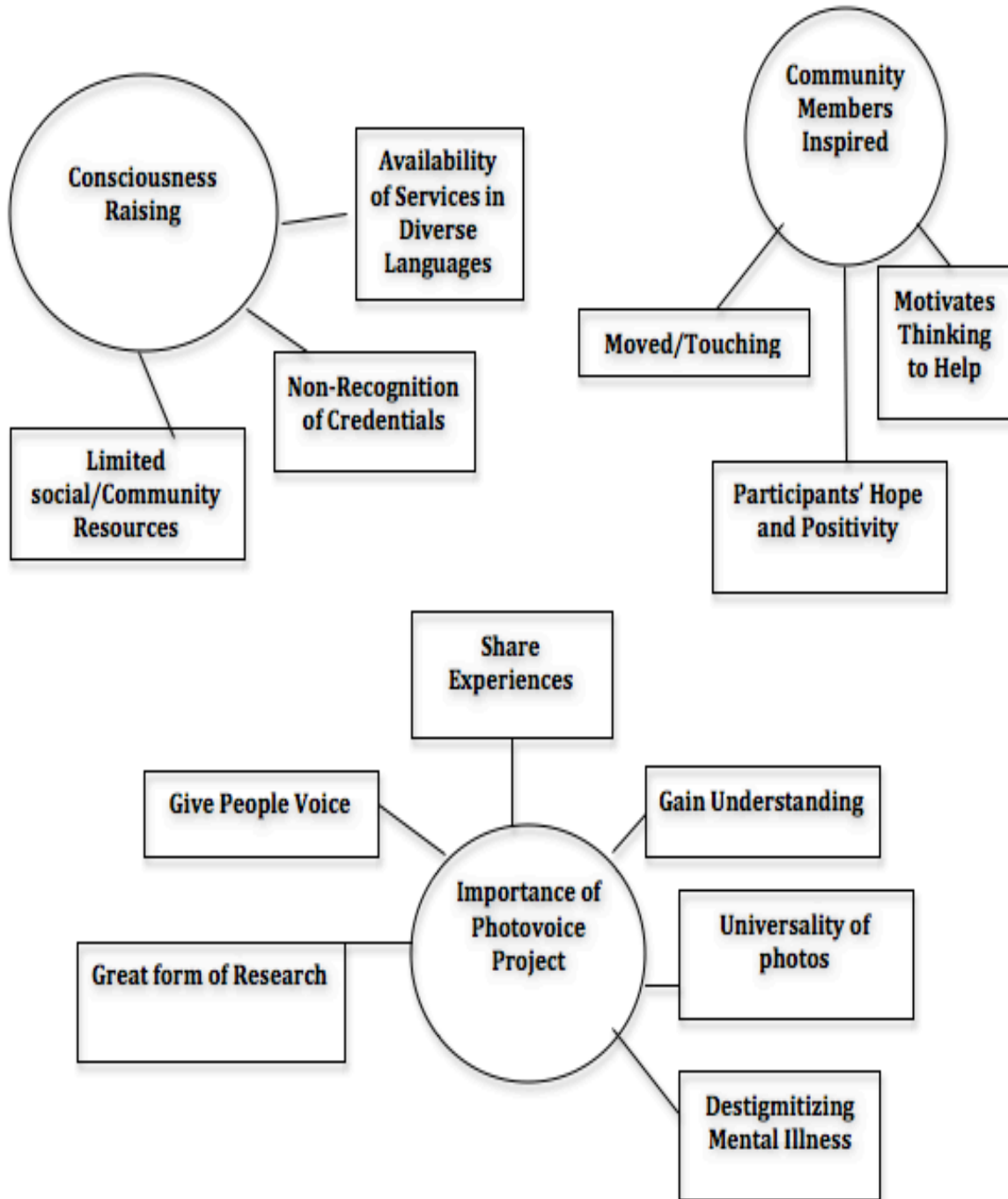
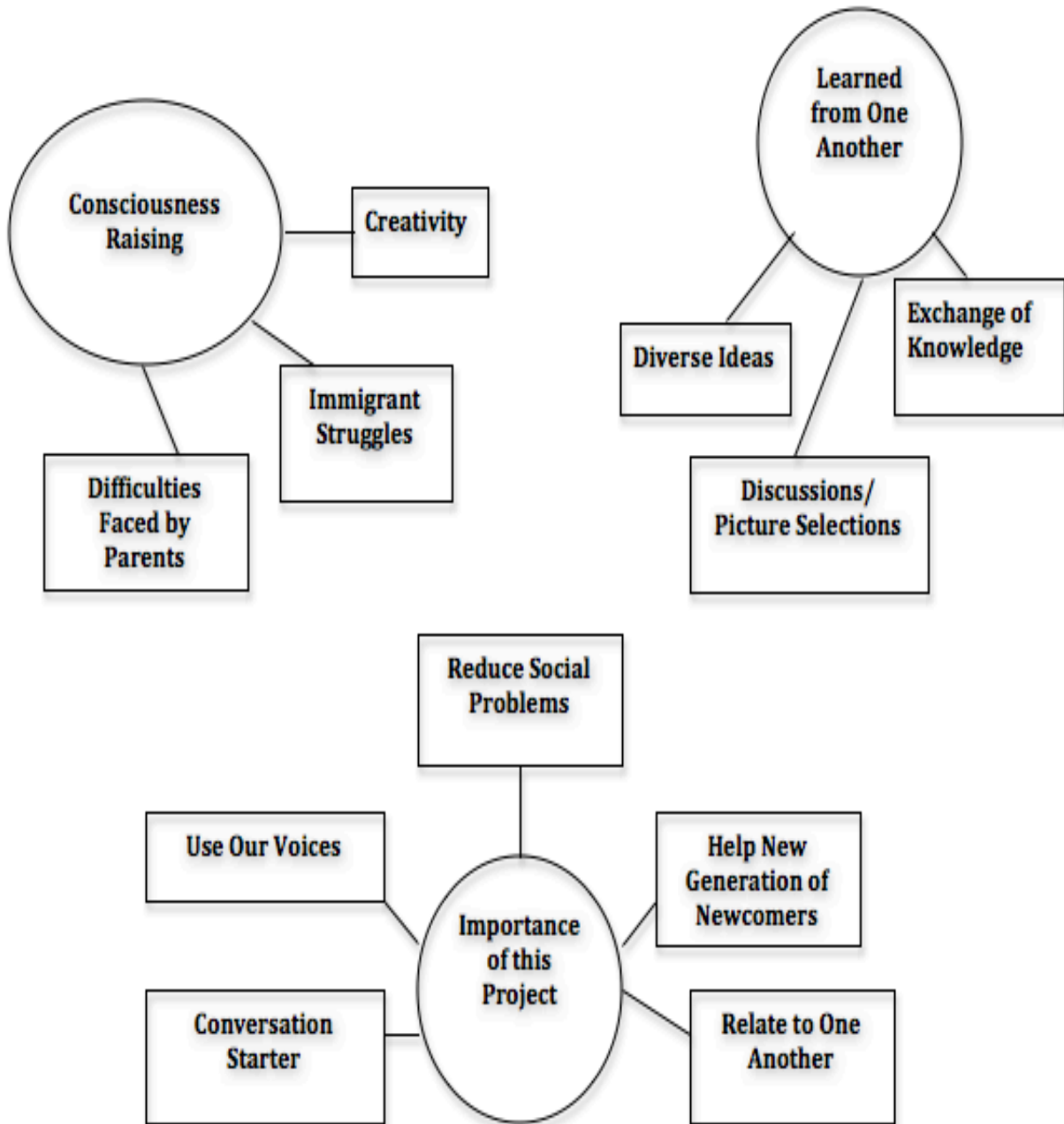


Figure 5: Thematic Map—Participants' Experiences

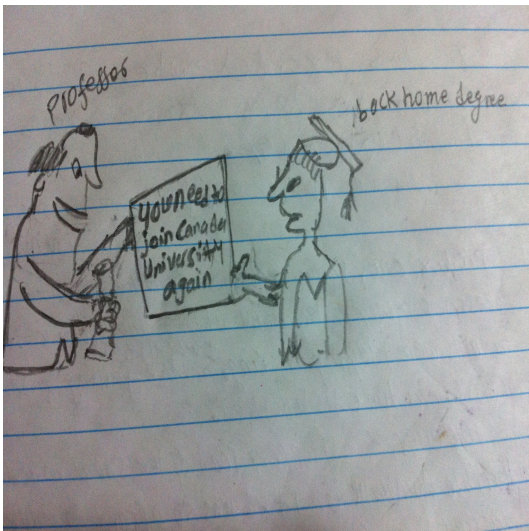


Reality: Barriers and Perception

Non- Recognition of Non-Canadian Credentials

Thousands of immigrant and refugee professionals come to Canada, under the impression that they will be working in a profession that is aligned with their educational training and skill set. However, upon the immigrants' and refugees' arrival in Canada, their education and work experiences were no longer accepted nor valued, depending on their country of origin. The following photograph and story by Mihret depicts this reality.

Figure 6: Credentials



This picture is important because it reflects the consequence of [the] Canadian education system on the new immigrant to school certificate value.

My friend, for instance, was rejected, his back home degree certificate for admission on the workplace, with the skills he earned. He has suffered a lot, and emotionally tortured.

The non-recognition of non-Canadian credentials is a predominant theme that emerged through the group discussions. This topic opened up many conversations with the participants who shared similar realities and experiences. This theme is divided into three subthemes in order to understand the participants' experiences more precisely.

Structural Barriers

Due to the structural barriers and discrimination that is embedded in our society, newcomer professionals are oppressed as a result of non-recognition and devaluation of their credentials. Despite their high education levels, immigrant professionals struggle to establish

themselves successfully in job and careers that align with their education and training. Additionally, a lack of financial opportunities creates another layer of barriers in obtaining Canadian credentials. The following statement from Ildiko reveals the challenges and impacts faced by immigrant and refugee professionals:

It's almost like a purposeful barrier. Because even my like ... like ahhh foreign credentials are not recognized. And then and then to go back to university you have to pay rent, feed your kids, often do shift work, and try to study. So that... that's... that's next to impossible. And that's how that's how you just, you just have to slowly, I don't know, give up your dreams and accept that you're gonna [sic] be a second... second class citizen doing jobs that you are overqualified, but you don't have a chance to do something better because you are not invited.

The way our system is structured marginalizes newcomer professionals. The participants not only felt that their credentials were no longer recognized upon their arrival to Canada, but there is a lack of supports, and hurdles that make it very difficult to obtain Canadian credentials. Lack of opportunities creates limited choices for newcomer professionals, and as a result the individuals are unable to successfully meet their career goals, and often jobs that they are overqualified for.

Mental Health Impact

The non-recognition of non-Canadian credentials results in several negative impacts such as integration impacts, mental health impacts, and overall well-being impacts. This sub-theme was dominant in the statements of most of the participants. They shared in the group how they have been impacted negatively by non-recognition of their non-Canadian credentials.

Mesafint stated:

I think what I remember was ... I was in English class and French class for newcomers and other Canadians. But most of the students, which I met them, I believe didn't have mental illness; probably I was the only person in their class. But it will be true what Mihret is say [*sic*]. Nobody can accept your back home certificate, diploma, or degree, or whatever it is. You have to return back to Canadian education standards in learning Canadian language, whatever English or French and try to return back to education area and getting ahh another Canadian certificate and documents from government... so probably, that's specially when, if you are a newcomer and a problem with mental illness it creates another... another environmental and social problems for you.

Mihret expressed similar impacts:

Because ...ahhh... you...thinking... example, when you was back home, you work on by your field when you was, if he was a professor, if he was a doctor, if he was any professionals he works [*sic*]. When he comes here... when he came here... you never to adapt to the situation. So even in our community and country, they support, you're all friends, you can stay with them, spend time with them. But still they think they stressed. Yeah... Because they are asking one question, because why, maybe for seven years they study, maybe eight years they study, maybe 10 years they study. All the years they return back here... it's very hard. Like my husband, he have [*sic*] first degree back home, but when he comes [here return back and study Canadian English] his mind is ... first time his mind is not so good. Because it took lots of years, more than 5 years, he study in

university and everything what can do [*sic*]... also one way is to adapt and to [forget your goals].

Yekaterina. also expressed similar frustration:

Me too... when I came... it is my second immigration. So what you're talking about right now, I was started at the university and then I moved to another country where I should start from the very beginning...and then I did for several years and years... and then I come here [made noise with mouth- suggestive of going down] again the same thing. I was just damaged by all that. Because it's... it's very hard to...you have to prove yourself again for several years. Draining... it's draining.

According to the participants, the non-recognition of their non-Canadian credentials creates challenges and has an impact on their well-being. For example, Mesafint, shed light on the challenges faced by newcomers who are struggling with mental health problems. Not having their credentials recognized, poses another layer of social and environmental barriers, as these individuals now have to return back to school in order to receive Canadian credentials. Mihret shared the reality of what it is like for a newcomer professional when they migrate to Canada. These individuals spent several years studying and working in their chosen field in their country of origin. However, once they arrive in Canada, these individuals face the challenge of not having their credentials and experiences recognized. The devaluation of the newcomer's credentials poses a lot of stress for these individuals. As they have spent several years studying and working, and now all of that time, money, and energy they have spent on their education is null and void. Not having their credentials recognized makes it difficult for the newcomer professional to adapt and integrate in their new communities. Yekaterina's story echoed Mihret's story. Yekaterina expressed how damaging it was for her to not have her credentials recognized.

As with every immigrant, she had to start from the beginning and work her way up. Devaluation of credentials and having to prove oneself again and again can be emotionally exhausting for individuals. Limited choices for many individuals whose credentials are not recognized can cause feelings of helplessness and hopelessness.

Age of Immigration

Not all immigrant and refugee individuals face similar experiences in regards to the non-recognition of credentials and its impacts on the overall well-being of the individuals. One of the group members grew up in Canada, whereas the rest of the participants came to Canada as an adult. Through group discussion there was an element of realization, when one of the participants gained a deeper understanding and awareness of the issues faced by immigrants and refugee individuals who arrive in Canada as adults. Jason's statements reflects this:

Can I just ask a question... does everybody come here as an adult newcomer, or are they like me? I came here when I was very young because my mom you know [immigrated]. I immigrated with my family, you know. So I grow up mostly here. I spent my first 10 years in Hong Kong...and then I grew up the rest here. Just wondering... I guess I don't share that experience, that's why I asked... just I'm curious about it... you know.

Individuals who migrate at a younger age may not be fully aware of the struggles and hardships faced by immigrant and refugee individuals who arrive in Canada as adults. Through group discussions, Jason expressed having different experiences than the rest of the group members. Jason, shared how hearing other participants' stories helped him understand the underlying reason that negatively impact immigrant and refugee individuals, and as a result they face many struggles.

Barriers to Accessing Mental Health Services

The second predominant theme in this chapter is Barriers to Accessing Mental Health Services. This theme is divided into four subthemes in order to gain a deeper understating of the barriers to services articulated by the participants.

Limitation of Services Offered

The services offered in our communities are often based on a Euro-Canadian lens. For many of the participants, the lack of culturally inclusive and competent services was perceived to be the main barrier in accessing care; as participants felt misunderstood by the service providers. The notion of not being understood came up a few times for most of the participants throughout the group meetings. The following photo and story by Jason captures this reality:

Figure 7: Barriers



I choose this one because it's the ice the river. The ice in the river symbolizes, you know, the barriers... It's like you are trying to cross the river, but there is, like, you know, ice and water, you know between from one end to this end. [Not] receiving culturally sensitive services [is a barrier]. Because it is so dominantly for a lack of a better terms Caucasian and Canadianized. People say they understand you, but they really don't.

Individuals from different cultures communicate their mental health symptoms in diverse ways, and there are different beliefs and behaviours in regards to health and illness. Having an understanding of different cultures promotes effective interactions with people from other cultures. For many of the participants, when receiving mental health services, they do not feel that the service providers understand them and their needs. When individuals do not feel

understood, it impacts how they feel about the services and often they do not return for further help and support.

Every situation and circumstance is unique for each individual. When services have eligibility criteria, it negatively impacts those individuals who do not meet the criteria. When services are not provided based on individual needs and do not take into consideration the context, it can cut off those who do not meet standard criteria. The following picture and story depicts the reality faced by Ildiko:

Figure 8: Willing, Ready, Capable



Yeah, so my, my picture is like, symbolizes like, like once, once like, ahhh, life, kind of slides under you, it's just like [a vacuum that moves to that direction]. So the open sign is there but it's upside down. And then, and then, so if you are like, I... I've been very frustrated, like I, I, I left an abusive relationship, yet I wasn't eligible for services because I had a minimum wage job, and the minimum wage job didn't cover a day off, an extra bus ticket, go to offices, so that, that's a whole mess and frustration and then, and then when you are homeless like, like what you put on your résumé as address to, somebody to contact you, and then, and then the ... the willing capable and ready that's, that's the message when you collect EI, and it's, and it's, it just like, like, there, like there is nobody listening to your, like what you are really dealing with so it's like a, it's like it's, like a square you don't fit... your situation don't fit in there or you can get is they cut back your money. So... Yeah. And I can, I can go like details, like how, but like, like often, like the whole system of services is, is just it's all like contradicting each other.

The above story provides a vivid example of what it is like to access services when individuals are in need. Although Employment Insurance (EI) and Employment Income Assistance (EIA) are put in place to help individuals who for various reasons are facing adversities and/or barriers that impede their ability to meet financial needs, the ways services are

offered make it quite difficult for those who do not meet strict criteria to access those services. When individuals do access services, the requirements to follow the rules are unrealistic and do not take into consideration the individual's circumstances. Ildiko expressed how you are supposed to go to offices and look for jobs. However, working in a minimum wage job does not provide individuals with paid leave or days off. Individuals who are already struggling financially cannot afford to miss a day of work or buy bus tickets. Unfortunately, programs are punitive in a sense that if you do not meet the requirements, your financial help may possibly be cut back or you can be denied services. Additionally, there are many barriers that prevent individuals from receiving services. Ildiko articulated that if you are homeless, it makes it difficult to get a job, as you do not have an address or contact information. You also cannot receive financial help, as you need an address to receive monetary support.

Poverty

Poverty is one of the barriers that was mentioned by the participants that impacts individuals from accessing mental health services. The following picture and statement by Mesafint reveals this awareness:

Figure 9: Shelter



This picture shows me barriers in accessing mental health services. One of them is not having a shelter. [Poverty].

Individuals with mental health problems are often faced with living in poverty; consequently, poverty is a risk factor for poor mental health. There is a vicious cycle between mental health and poverty. Additionally, poverty becomes a barrier for individuals in accessing mental health care. As Mesafint mentioned, not having shelter is a barrier to accessing services. Shelter is one of the basic needs and without shelter; there is no stability, which can impact mental health and recovery.

Language Barriers

Language is one of the barriers that impacts immigrant and refugee individuals from effectively communicating their mental health needs and receiving appropriate referrals and care. Mihret, illustrated the reality faced by individuals who are confronted with language barriers:

Figure 10: Language Barrier



Language is the main barrier for the new comers [sic] to communicate in effective way. For instance, the new comers [sic] patients are unable to explain their health condition effectively. Though, there is interpreters [sic] between patient and doctor, the main patient's feeling about the health situation remain unexplained. As a result the patient feel[s] anxiety. The main reason is the patient's shy to explain all details that feeling to tell for interpreter [sic]. Even when the interpreters are speaking your language, but the patient, especially newcomers has [sic] his own culture. So to explain or to hear the details, or what he have. It's really hard. This is a real situation.

Many of the participants cited language to be one of the barriers for them in receiving and accessing mental health care. As Mihret explained, individuals who are faced with language barriers are unable to explain their needs and concerns in an effective way. She mentioned that

although there are interpreters, the individual might not feel comfortable enough to fully explain what they are going through. This could be due in part to the interpreter being someone from their own community, and they do not feel safe disclosing their personal health information. This further impacts the individual, as they do not receive the help they require, which as Mihret stated, “causes more anxiety”. Another factor to take into consideration is that in many cultures, symptoms, health and illness might be understood, explained, and perceived in different ways. The interpreter may not be able to fully explain to the doctor what the patient is trying to communicate due to cultural differences. Often the individuals do not receive the care they need. Additionally, the individuals may feel discouraged and not return for further help.

Mental Illness As a Barrier to Accessing Services

One of the barriers that were discussed in the group meeting was the individual’s own mental health state and its impacts on accessing mental health services. The following picture and story by Yekaterina brings light to this reality:

Figure 11: Foggy Thinking



This picture is of a very foggy day, several lights that are not seen very well, a fence damaged in one spot. It symbolizes foggy thinking of a person with mental illness in its acute episode. When our thinking is so foggy and we cannot access any services for this reason. Plus, we are immigrants who do not explain our symptoms well in English language and even when we know where to go, we cannot even explain it. And in acute episode, in this condition a person needs advocacy of other people to get help and to be aware of what is going on with him.

Individuals who are experiencing mental health problems may not be fully cognizant that they need help and to access services, as a result of a distorted thought process. Additionally, due

to the stigma of mental illness, often individuals do not want to admit that they might be suffering from mental illness and thus, avoid seeking help. As Yekaterina mentioned above, the support of community and family is key, in order to advocate for individuals so their mental health needs can be met.

Chapter 6

RESILIENCY, HOPE, EMPOWERMENT, AND ACTIONS

Resiliency

Throughout the photovoice project, there was a strong element of hope and resiliency that exuded through the participants' photos, stories and group discussions. The following photos and accompanying stories depict the inner strengths and resiliency of the participants:

The following photo and story is by I.N.:

Figure 12: Holding the Sun



Story and Photo by Y.K.:

So this is, this is my only coloured picture because it's, it's actually very positive, so, but like the way I am holding the sun, it symbolizes that it's still up to me. And that's what he [psychiatrist] wants to see, that I, that I actually realize my potentials that I am okay and that that that [*sic*] the focus on the positive things and, and uh, gain some self-confidence and all those things. So it's, it's very positive.

Figure 13: Brilliant



I will start with how I see mental illness. It is a snake that comes through our perception straight to the brain, poisoning it, deforming our vision, distorting our reality, making us lose trust in our senses. And she can shine even...even she looks dark, but there is a shine around her... and people with mental illness can shine... people can be brilliant... there is something that is bothering... and it's mental illness...that's how it works.

A mental health problem may alter a person's life but it does not define the person.

Ildiko's illustration of holding the sun is quite powerful, as it represents that she still holds the power to her own recovery, as she has strengths and potential. Additionally, Yekaterina's photo

and story represent how individuals who are dealing with mental health problems can still shine and be brilliant. Individuals who are dealing with mental health problems are resilient, and it is important as a community to recognize and build on an individual's strengths and be mindful of their abilities.

Hope

The participants spoke about having hope for recovery. The picture and story below by Mesafint, provides a detailed example, which demonstrates hope for the future:

Figure 14: Hope



This one is umm, ashtray with a full of cigarette butts. Where do we start from the beginning? There is a tobacco plant in a factory, there business companies, stores, and lastly person smoking cigarettes. But you see that we burn that plant. Because those [*sic*] plants are prepared to be dead. So when I see this thing gives me the feeling that I still have hope, I'm not burnt out. I still have hope to be a recover one day and return to...umm... my...ahhh my regular way of life. So I don't feel like a damaged plant. I still have a hope and [a] chance to be recovered and return to a normal life. That's my feeling. That's the way I took it.

The metaphor of the tobacco plant shows how the destiny of the plant is pre-determined. However, mental illness does not determine a person's future. As mentioned above mental illness does not define the person, as there are so many elements to an individual, and mental illness is just one small part. Persons with mental illness have many strengths and capabilities, and as Mesafint mentioned, he does not feel damaged. There is hope for recovery and individuals have the opportunity to return to their "normal life" whatever normal means for that person.

Empowerment

The photovoice project brought immigrants and refugees from different countries and diverse cultures to come together as a group to share their realities and experiences concerning mental health and access to mental health services. The following reflections from the

participants illustrate how the participants built empowerment within themselves through the photovoice process. Their reflections are divided into two subthemes in order to analyze their experiences more precisely.

Figure 15: Empowerment



Group Consciousness

Through the group work and from each other's stories, photos and discussions, the participants empowered themselves by gaining a deeper level of awareness regarding the issues faced by immigrants and refugees. Additionally, the participants felt they were part of a team with the similar goal of voicing their concerns. The following statement from Ildiko reflects this:

Thanks for [*sic*] all the participants. I am so grateful that I met all of you, I learned a lot. You're all great people. And, and I learned so much from what is different, what is similar. And what I, I noticed is that, is that, can you imagine that all this creativity being found at a, at a place. We have so much to offer and we are just silenced and not heard

and put aside. So I think that the main thing to have a society where all this creativity deserves to shine ... thank you.

Jason voiced a similar experience:

I really love and appreciated this project not only so much for myself anymore, because I met you know, everybody who besides me came here after you know, they [became adults right]. So I actually looked back and actually with my, in my personal relationship with my mother, and my dad has [*sic*] gone since. I've realized life has been difficult for them too. It's just not me, me, me, and me, and bullying and me, and this and me, and you know, being discriminated and all that. They face the same thing, except they probably because in my culture, part of my culture, and part of being my elders, they want to protect me from you know, and shield me from their own hurts or harms. And at the end of the day after so many discussion and pictures selection and the project, I really learned from you guys. Because I grew appreciative that my parents didn't have it too easy, you know getting through these hurdles, I mean, maybe yes, it's easier because maybe by financially we're, excuse me, we're better off and stuff like that, but the psychology of things you know... like looking back at my dad you know... it wasn't easy for him up to the time he passed... so I just think that you know, it takes a little resilience and a little courage from everybody just to get to this point and voice them. I wish my dad was here, he would be so proud. Yeah, but you know at least I still have my mom. So the project was wonderful, it's not only promoting for, but for me it's looking back at... some of the weeks back you know, why we are having so much difficulty as immigrants you know... without all your help I wouldn't be able to recognize that.

Mesafint stated:

Being in the group like, uh, like what they say...200 hands are better than one hand. Like to be in-group, like there will be more... ahhh... outcomes like reflecting...ahhh...lot of ideas, new ideas, from different community and different culture. We are not the group from the same country the, the...from the same culture. So we can learn [from] each other by exchanging the idea...to, to be in-group, like it's the teamwork. Teamwork is not [a] one-person idea ... it's a group idea to become one person in [*sic*] under the same shelter and under the same idea to be more successful... so I like it, I like it.

Utilizing photovoice provided an opportunity for the participants to express themselves and share their stories in an artistic way. The photos they captured showcased their creativity and skills. Going through this process the participants became aware of their individual and collective skills, talents, courage and voices. Ildiko articulated how immigrants and refugees dealing with mental health problems have a lot to offer; yet they are silenced, not heard, and put to the side in our society. As Ildiko expressed it, we need a society where the voices and creativity of immigrants and refugees are included, as they deserve to shine.

Coming together and sharing their stories as a group helped each participant gain a deeper understanding of the immigrant and refugees' experiences and realities here in Winnipeg. They felt part of a team and were able to connect with one another on similar experiences they shared, but they also gain a perspective on the struggles some others faced that they themselves were not aware of. Jason articulated how being part of this group helped him to become aware of the struggles faced by immigrants and refugees who come to Canada as adults. The stories of other group members helped Jason to reflect and empathize with his parents and the struggles

they faced as immigrants. Additionally, they gained a contextual understanding of why so many immigrants and refugees experience difficulties in Canada.

Participants' Self-Efficacy and Contribution to Mobilize Change

All of the participants felt proud of their work and contributions to the photovoice project. The participants valued the importance of this topic regarding immigrants and refugees and the changes that could occur as a result of this project. The following statements from the participants reflect this.

Mesafitnt stated:

I think this project is [*sic*] help us to, to diminish our ahhh, ahhh... social problems, especially if somebody they are gonna suffer from mental illness [*sic*]. Mental illness is quite different from other sickness, because it's our part of memory set for our daily life, where we think, where we make a decision... where we make a communication and understand people. So this project is more helpful to be...to become somebody one day after our recovery, to be, to be more supportive.

Khaled stated:

I think your program [photovoice project] is very successful and ahhh, you make [*sic*] hard time to organize ahhh between...ahhh different nations... like we are many here like we are five or six nation different. I think...ahhh your program, it will be to help other generation, they coming to Canada, they have mental ill [*sic*], or ahhh in the future, I think this program will help... thank you.

Mihret stated:

Okay...uh, first of all I, I would like to thank you all guys [*sic*]. When I, I got this chance to meet and share all our story, life history, is I'm so excited about this project. Ahh, also

I got many, many calls from our people when they showed these pictures. Everybody he ask me, you're new in Canada how did you join this project and how did you explain this program and project. I'm so happy and excited. I don't know, I can't explain all in my heart. I hope to get other chance like that to do, or to prepare, or to explain more something. Again I like to say thank you.

Yekaterina stated:

Um... I would like to thank you and uh...all of the other participants and everyone participating in the project. Because... ahhh it's sometimes simpler and easier to live to just know how many people can relate. And if we wouldn't have this conversation starter, as we can call the program, the project [photovoice project]. It's a very good conversation starter for our community and for all of us, and we can talk about that, and it gives us more opportunities to actually talk about mental health openly and to deliver the message and everything. And I would like our voice to be heard for the purpose, so many, all of us would be able to not get credentials for some of the courses that only match with Canadian, but to get quick on-the-job training, because we know the job, just to get the terminology, which we are lacking. Thank you again for everything, and I believe we can break through and break through it's a consistent process.

The photovoice project became a platform for the participants to come together and voice their concerns and share with the community. The members felt proud of their work and believed the results of this project would bring change in the future. Mihret expressed excitement of having the opportunity as a new immigrant to partake in this project. She felt happy and proud of her own skills and ability to express and voice her experiences and realities. She articulated wanting to continue to share her voice in similar projects in the future. Mesafint mentioned how

the project might help to reduce some of the social problems faced by immigrants and refugees. He also expressed that going through this process has helped him to recognize the difficulty faced by individuals dealing with mental health problems and he wants to provide support in the future. Khaled expressed a similar perspective, as he explained how this project will be helpful in the future for other generations of immigrants and refugees dealing with mental health problems. Yekaterina echoed a similar perspective regarding this project. She felt the photovoice project was a good way to open up dialogue and start conversations regarding immigrants and refugees' mental health and access to services. Yekaterina wants their voices to be heard to mobilize change concerning the non-recognition of their credentials. By shedding light and consistently voicing their concerns, she believes they can break through.

Actions

The photovoice exhibition was the action piece of the project with the intent to share the perceptions and realities of immigrant and refugee participants, and to raise awareness and mobilize the community. The following are the reflections and voices of the community members in response to the photovoice project (artists, mental health workers, educators, students, and members of the community). The community members' reflections are divided into two subthemes in order to analyze the community members' experiences more precisely.

Figure 16: Actions



Figure 17: Actions



Importance of the Photovoice Project

Many of the community members highlighted aspects of the photovoice project and its importance. One of the community members wrote “What a great opportunity to give people a voice who may be struggling to not only express the challenges they are facing but also, if there are no words in first language for many cultures of what mental health is”. The use of photography is a great way to break language barriers and allow for individuals to express and voice their realities and perceptions of mental health and/or mental illness and barriers to accessing services. The photos invite others to view the world through the photographers’ lenses and help the community to gain perspective and understanding. Another community member wrote “Amazing photos. What a great way to share experiences and to help to understand each other’s journeys. Thank you for sharing”.

One of the community members shared how the exhibit in a non-objectifying manner provided an in-depth array of experiences and contextual factors impacting immigrant and refugee individuals’ mental health:

A wonderful exhibit demonstrating so many sides of mental illness, resilience, hope and well-being. The theories of hope, the negative impacts of lack of social/community supports, and structural barriers really stuck out to me. Beautiful + interesting images. I really like how by having the photographer’s names we could follow their stories and see their stories as a whole. Very humanizing and non-objectifying form of research.

Another community member wrote, “People can learn and express their feelings/emotions/thoughts in so many ways. Having immigrant/refugees share through photos is such a beautiful and poetic way to connect emotions in all of us regardless of our race, socioeconomic status, gender, etc.” Sharing the photographs taken by the participants provided

an opportunity for community members to connect to their stories on an emotional level. Thus creating more empathy and a deeper level of understanding, which may lead to mobilizing further action. One community member stated “So wonderful you’re doing something like this to start breaking those stigmas attached to mental health and illness especially to immigrants and newcomers to Canada. Touching and very good work from the participants.” Another community member articulated, “the images represented such personal viewpoints and experiences of how each person represented in visual pictures. As we all experience understanding in pictures universally.” Another community member wrote, “I feel this project is so very necessary and am grateful how newcomers voices on this subject are being understood. So much to learn”. Additionally, one of the community members articulated, “A very personal perspective on all these arts face- beyond the language barriers, they have expressed their frustrations and we need to listen”. Lastly, one of the community members wrote, “Thanks for the project. Inspires a lot of thinking about what can help”.

Raising Awareness

For many of the community members, having the opportunity to visually see and read participants’ stories helped them gain a deeper understanding and awareness of the realities faced by immigrant and refugee individuals. One of the community members wrote “This showed me that there is a lack of help/resources for newer immigrants in regards to mental health. That or the awareness for it should be more exposed”. Yet another community member wrote, “Wonderful show!! What strikes me is the lack of services available in all languages & cultures, compounded by the non-recognition of credentials in Canada and the shortsightedness of our government in this regard. The hope and positivity despite the barriers to care is inspiring”.

The photovoice exhibit raised awareness and shed light to help the community understand and become aware of the barriers faced by immigrant and refugee individuals and the lack and availability of culturally inclusive resources and services. Additionally, it created an opportunity to start the conversation regarding these issues and ways to take action and mobilize change.

Chapter 7

COMMUNITY AND CULTURE AS MULTIFACETED

Community and Culture as Multifaceted was a predominant theme that emerged through the participants' pictures, stories, and group discussions. This theme was divided into six subthemes in order to understand the participants' experiences and perceptions more precisely.

Community—Labeling and Blaming

Many of the participants discussed their experiences with being blamed or labeled in their community. The following photograph and story by Ildiko truly captures the reality faced by some of the participants:

Figure 18: I am Not



So.... so what I found is...ahhh, Canada and all the first world rich countries, it's kind of like have and have not. So people who feel that they belong to the group of have... they have a job, they have a car, they have a cottage, they have this and that ... and...while they work hard they pay their mortgage... yes... everything ... and ... and there is nothing wrong with that...however, as that... that was kind of one thing that pushed me away from Toronto. That...the joblessness. So... so once you like ... all these rich countries there to... like it's, it's victim blaming... so if you don't have a job, if you don't have a car, if you certain amount of years you lived in Canada... oh you never bought a house... its, it goes to like, what's wrong with you? And they... they don't see that like... like I personally, I got like... like a very turbulent marriage, I had to literally escape. Start from zero, so I had no other problems or addictions or nothing like that... it just, it's just like poverty, just like hit you so hard and it's almost like, you can never come back. So that, that person is like sitting on the street and like seeing what... what people think. And it's like how you, like you, just, you just somebody's ahhh... and... and when I had my community workers' studies I actually worked with with homeless people and they shared their stories and, and... and often there has been what they done wrong. But sometimes it's like, it's like, how the society is not providing support so you can start all over. So that's, I think that picture summarizes that.

Ildiko's story depicts how in our society individuals are divided into two groups one being the "haves" and one the "have-nots". When individuals are part of the "have not" group, society labels and blames these individuals for their circumstances. As Mesafint also stated " Yeah, the thing that I noticed they gave you a name... for example gypsy... they call you names...like in downtown... like crazy." Our society is quick to label and blame individuals and oftentimes overlook the contextual factors that have negatively impacted an individual. Blaming and labeling is often used as tactic to create gaps between individuals in order to justify actions or inactions toward individuals. In this example, it is clear that in our society we blame individuals instead of taking ownership of how we are failing by not providing individuals with supports.

Inequality

The following photograph and caption by Khaled depicts the perception of how we do not live in a just society, and inequity continues to exist within our society:

Figure 19: Equal



Made me comfortable. People are equal

The photograph above symbolizes how in a graveyard every individual is equal despite their age, sexual orientation, religion, culture, colour of their skin, gender, socioeconomic status, and state of their mental health. Khaled's perception of feeling more comfortable at a graveyard shows how he does not feel comfortable in the community, as he may perceive that he is treated unequally. The unequal treatment could be in part due to the stigma of mental illness, and

belonging to a visible minority group. His reality was that he did not have a sense of belonging in the community.

Takes a Whole Community to Heal

The theme of *it takes the whole community to heal* was brought up on different occasions through pictures and group discussions. According to some of the participants, the community plays an important role and is key to the recovery process. Yekaterina provides a great example:

Figure 20: Humpty Dumpty



This image is about a person who is smiling while being broken. It is a Humpty Dumpty, who had a great fall. He seems to be jolly, but he is a cracked egg that needs to be assembled by the army of loving and supportive people. Because personally I had this experience. I had delirium, and it was my first psychotic episode. I did not understand what was going on with me. I was moving somewhere; I was trying to reach out in every single place I could reach. I wasn't aware of being psychotic, I didn't understand what was going because in [*sic*] delirium people are not aware of them being delirious and I was going to work and I was behaving weird on daily basis, and people were not just advocating

or helping or talking about it. And I was trying to talk to people and people were trying to tell me, 'oh go talk to a psychologist, it's none of my business', and stuff like that. People were not knowledgeable enough about mental illness to actually understand that I needed help and my situation was a critical condition.

Yekaterina's picture and story depicts how individuals who are dealing with mental health problems may appear happy to others in the community, as they put on a smiling mask. However, on the inside the individual is suffering. In Yekaterina's case, when she was experiencing psychotic episodes she, herself was not aware and when she did seek help, individuals in the community 1) did not want to talk about it; 2) did not advocate on her behalf; and 3) said only an expert or professional can help and did not want to be involved. For many individuals, it is people in their community that they are in contact with on a daily basis and are

the ones who may see changes in behaviours. The community plays a crucial role, and thus mental health awareness and education is important so individuals who are experiencing mental health problems can receive support and advocacy to get the help they need. Also, the more informed individuals in the community are in regards to mental health, the more empathy and confidence they may have to provide support and direct the person to the right resources.

Diminished Sense of Community

Some of the difficulties faced by refugee and immigrant individuals are leaving behind their families and friends. Often they are faced with loneliness, as some no longer have social networks. The following photograph and story by Khaled reveals the reality and perception of what it is like to not have social networks:

Figure 21: Community



This picture means for me about my family. In my country my sister and my brothers they live close to me ... it's not far away. I don't know anybody on [*sic*] my neighbourhood. I don't know like a friend or a relative ... or like a family. That's why this picture, I don't know, this is my area, I don't know this [*sic*]... I don't know anyone. Just like they down the road. One block two block I find sister, brother, nephew, [and] niece. Right now it's nothing. And even if I did, nobody knows I'm dying inside [my] apartment. Maybe the caretaker if he coming after three years or four days [*sic*]. Because if I had relatives they would come see me in bad situation.

When looking beyond the words one can see the difficulty immigrant and refugee individual may face when they come to a new country. As Khaled's story reveals, although he has neighbours, he does not know them nor have any interactions with them. He does not have any family here in Winnipeg. It appears that Khaled feels quite alone without a sense of community. Friends and family are in one's life not only to share happy moments but also when we are going through difficult times and need support. The loneliness that Khaled feels can be

felt through his words as he mentions that if something were to happen to him no one would even notice. Additionally, culture plays a role in how individuals interact with others in their community. For example, Yekaterina voiced, “I think it’s a lot of differences in culture also. From point of your Canadian mentality... people want to know you well to communicate. And it’s not the same as for example in Ukraine to talk to strangers and just being bonding together. And while here it’s very different... actually people are not trusting other people when they don’t know them.”

Reflection of One’s Culture in the Community

Representation of individuals’ cultures and language in our broader community was a topic that came up many times in the group discussions. The following picture and story by Mesafint reveals this attitude:

Figure 22: Diverse Languages



So the mental health resources contain different language for our communication, especially when we are new and with mental health problems it’s really hard to adapt where we live. Whether you speak English or French, the resources we have here is there is the native language, French, English, and other language too. For example, in the clubhouse any voucher [brochure] found I can [sic] get in different language. And the college, I used to go it has some message in my own mother tongue mother language on the board. So I don’t feel lonely because there is somebody who reflects my culture and my language.

Mesafint shared how individuals who are dealing with mental health problems may have a hard time adjusting and it is even more difficult when the individual is adapting as an immigrant and or refugee. What Mesafint found helpful is when he saw his language and culture being represented in the community. This provided him with a sense of belonging and not feeling alone. When the community reflects our language and culture, we feel a sense of connection and

we become part of the community. Also, celebrating diversity and valuing all cultures creates opportunities to counteract racism and discrimination, as we get to know others in our community.

Importance of Services and Opportunities in the Community

The majority of the participants felt resources and opportunities in the community are important in their journey to recovery. The following photograph and story by Yekaterina portrays this perception:

Figure 23: Opportunities



I know I'm crazy about eggs, but egg is a big symbol for me, egg is the new beginning ... and ah for me my recovery was basically the egg hatching... and I... I... all those eggshells you can see that hatched was amazing volunteering opportunities that help me a lot with my recovery. Places I feel comfortable and safe to go to. Places that are [*sic*] friendly and welcoming and warm. And the back... background shows a bit of wildness, of how things changed for me, like footprints to follow. And I can recommend those [*sic*] services to other people because I know how it helps with my recover. It's very important or me because volunteering is a very important essential part of my

Community plays an important role on how much supports and opportunities are available. In Yekaterina's case, she expressed how the ways services are offered can make a difference in the recovery process. When services are offered in a way that is welcoming, feeling safe impacts utilization of services but also an individual can recommend it to others. Being an active member of society promotes mental health, and a community that provides opportunities such as volunteering helps individuals feel active and connected to their community. They feel valued and needed in their community. In turn, this helps individuals in their recovery process. Many of the participants spoke about volunteering being a very crucial aspect to their recovery and mental health.

Chapter 8
DISCUSSION
Introduction

The participants' photographs capture complex, interrelated and multifaceted factors that impact their mental health. Additionally, the stories and images capture how immigrant and refugee individuals perceive, understand and communicate their experiences in regards to mental health and access to mental health services. These photographs serve to raise awareness in the community and help others (for example, community members, advocates, teachers, frontline workers, case managers, policy makers, and so on) understand immigrant and refugee individuals' realities and begin to understand their situations. Using photovoice to present the stories of immigrant and refugee individuals allows the light to be shined not only on individual experiences but also on collective voices and needs.

From the perspective of an immigrant researcher interested in the real experiences of immigrant and refugee individuals' and mental health, I have highlighted in this chapter the following two concepts that have emerged through the synthesis of the findings: 1) community and culture as multifaceted— in the sense that there are factors that can either promote or hinder the mental health of immigrants and refugees and access to services; and 2) hope and resiliency—influenced by intersected factors and systems. Both of these concepts are interrelated and connected. Additionally, each of these concepts will be discussed and presented within the context of social determinants of mental health.

Community and Culture as Multifaceted

Throughout the social sciences, the term *community* is widely used with many definitions and meanings (Hacker, 2013). According to Hacker (2013), prior literature has identified more than 90 definitions of community. However, throughout the literature many authors in their

definitions consistently cite the following common characteristics: 1) social interactions; 2) geographic area (neighbourhood, city or country); and 3) common ties (Hacker, 2013).

Additionally, some of the key constructs in identifying a community are sharing common interests and perspectives, social ties, diversity within communities, social integration, social support networks, and membership (Hacker, 2013). The findings of this study suggest that community is an integral part of mental health and recovery. Many of the participants voiced the following aspects that create not only a sense of community, but also promote mental health and recovery: social networks, opportunities (volunteering), representations of one's culture, and community supports. In contrast, participants discussed factors in the community that create barriers and also how they impact their mental health: stigma (labeling and blaming); structural barriers (non-recognition of credentials); limited or no social networks; limitations of services; inequality (poverty, no shelter); and language and cultural barriers.

Social Network and Social Supports

A social network refers to the structure and quantity of a set of interconnected relationships and social ties, which varies in source and frequency (Smyth, Siriwardhana, Hotopf, & Hatch, 2015). Social supports on the other hand refer to the people one can turn to for help and support, the perception that help is available when needed and feeling valued by others (Puyat, 2013; Smyth et al., 2015). Additionally, one's social network is identified as one of the determinants of mental health and particularly significant to immigrant and refugee individuals due to broken social networks as a result of migration (MHCC, 2009; Simich et al., 2005). Throughout the literature and research with immigrant and refugee populations, social networks and supports have been a common theme that have emerged and have been discussed in relation to mental health (Chadwick & Collins, 2015; Derr, 2016; Lai & Hynie, 2010; McKenzie &

Hansson, 2009; Smyth et al., 2015; Pyat, 2013; Vasileyska & Simich, 2010). The findings of this study coincide with previous research, as the social network is a theme that emerged through the stories of all participants.

The results of this study depict how the participants' perceived experiences in regards to their social network is not homogeneous; instead they vary greatly. For each of the participants, the interconnected relationships and social ties were influenced by the age of migration, immigration status, and immigrating alone versus with family, and social supports in the community. For example, Khaled immigrated to Canada as an adult with refugee status. He came to Canada with no family or friends. His photograph (figure 21) and the story revealed how he has no social ties in his community and the loneliness that he feels. The social isolation can be observed through his story as he voices how no one would even be aware if he was "dying inside his apartment". Not having social networks such as family, friends, or relationships with one's neighbours can have not only an impact on one's mental health, but also the referrals to mental health care. On the other hand, Jason immigrated to Canada at a younger age with his family. Having a social network such as family helped Jason to receive supports but also referrals to other community supports. According to Derr (2016) family supports are crucial for individuals' help-seeking behaviours, and family serves as an important source of referral for mental health care.

One interesting aspect that was brought to light by the participants was neighbours as part of their social network, and the difference in culture between country of origin and Canada. Culture influences how individuals interact and connect with others in their community. Khaled's picture (figure 21) portrays houses very close to one another, and he voiced how he does not know anyone in his neighbourhood. Yet, in his country of origin he would have friends

and family in close proximity. Yekaterina expressed a similar experience, as she said there is a cultural difference between Canada and the Ukraine. For example, in the Ukraine, individuals talk to an unfamiliar person and create connections and bonds. However, Yekaterina expressed that in Canada, it is quite different, as individuals need to really know the other person and build trust prior to communicating with them. For immigrants and refugees who come from different cultures, many have their values challenged, not feel as part of the community, and face the loss of networks such as neighbours that they had in their country of origin. Research by Kitchen, Williams, and Gallina (2015) demonstrate that immigrants place a greater importance on knowing their neighbours on a first name basis and trusting individuals as an important part of creating sense of community belonging. According to the authors, sense of belonging to one's community is closely associated with mental health and well-being. On the other hand, a lower level of belonging is associated with higher rates of depression (Kitchen, Williams, & Gallina, 2015).

Importance of Services and Opportunities in the Community

Many immigrant and refugee individuals do not have pre-existing social supports that are already established within Canada, and turn to community organizations for supports (Chadwick & Collins, 2015; Simich et al., 2005). The availability and the delivery of services play important roles in the types of supports immigrant and refugee individuals receive and the rate of continuous utilization of those services. The results of this study showed multiple factors relating to service delivery that either promote individual's mental health or negatively impact the individual's recovery process. Yekaterina's picture (figure 23) and story reveal the importance of an organization's milieu. Her experiences with services in the community that were warm and welcoming created a place of safety where she could receive help and supports. Her experience

with services influences her recommendation of those services to others in her community. Organizations that are inclusive and reflect diverse cultures create an environment that help immigrant and refugee individuals connect to those programs and access their services. Mesafint's picture (figure 22) and story reveal how when he saw his language on a brochure or a message written in his language; he felt a sense of connection and belonging that decreased his sense of loneliness.

Volunteering Opportunities—Programs and services that create volunteering opportunities promote mental health well-being and inclusivity of immigrant and refugee individuals dealing with mental health problems. The majority of the participants discussed the role of volunteering opportunities in the community as an integral part of their journey to recovery. Yekaterina stated, “Volunteering is an essential part of my recovery”. Jason, Mesafint, and Mihret, shared a similar perspective in regards to volunteering being an important part of their mental health well-being. The benefits of volunteering include but are not limited to: 1) individuals feeling like an active member of their community; 2) increasing social networks; 3) building on an individual's skill set and increasing self-esteem; and 4) feeling valued and with a sense of worth within their community. To my knowledge, there is no research that has been conducted, which has explored benefits of volunteering with immigrant and refugee individuals dealing with mental health problems. However, literature review conducted by Farrell and Bryant (2009) examined voluntary work for adults with mental health problems. Voluntary work is viewed as a determinant of health, which promotes mental health through social inclusion (Farrel & Bryant, 2009). The results of the review found a lack of empirical studies concerning voluntary work, mental health, and social inclusions. Much of the available literature, although very small in number, found benefits of volunteer work such as: gained skills, social networks,

confidence, satisfaction, interpersonal skills, social integration, empowerment, self-worth, and a pathway to employment (Farrel & Bryant, 2009). The review also showed studies that discussed barriers to volunteering such as fears of over-commitment of time, fear of loss of benefits, and low confidence (Farrel & Bryant, 2009). A study by Handy and Greenspan (2009) explored immigrant volunteering. The results of their study showed that benefits of volunteering include enhancement of social capital, which in turn creates a stepping-stone for immigrants in their integration process into the host country (Handy & Greenspan, 2009). Although there are studies that have examined adult mental health and volunteering benefits, and immigrant and volunteering; as mentioned, there is no empirical research that has explored the benefits of volunteering for immigrant and refugee individuals who are dealing with mental health problems.

Limitation of services—Participants in this study voiced their concerns and talked about limitations of services in the community, which hindered their mental health well-being and created barriers to access services. Jason expressed that although there are some programs and services that are unified, from his experiences he found that a lot of them are disjointed and not cohesive. He voiced that in order for mental health services in the community to work well, it is important that they all communicate with one another, build bridges and have a unified front. When programs are not working together or in communication, services may be duplicated, or worse individuals can “slip through the cracks”. The participants in this study talked about the lack of culturally competent services. Jason’s picture and story (figure 7) depicts the barriers in accessing mental health services, as a result of services being offered through a Euro-Canadian lens. Jason stated, “receiving culturally sensitive services. Because it is so dominantly, for a lack of a better terms, Caucasian and Canadianized. People say they understand you but they really

don't". Yekaterina also voiced how services should not be "one-size-fits all". Other studies have found similar results in regards to lack of culturally competent services as perceived to be the main barrier for immigrants in accessing care (Durbin et al., 2015; Whitley, 2006; Wood & Newbold, 2012).

Individuals from different cultures communicated their mental health symptoms in diverse ways, and there are different beliefs and behaviours in regards to health and illness. Services offered through a Euro-Canadian lens could create barriers for immigrant and refugee individuals. A one size fits all service philosophy ignores the different needs and presentations of problems (McKenzie & Hansson, 2009). Cultural insensitivity may discourage immigrants' use of health services and community resources; it may deter immigrants from going back for future help or referring services to other immigrant and refugee individuals in the community (McKenzie & Hansson, 2009; Wood & Newbold, 2012).

Social and Structural Barriers

Non-recognition of Non-Canadian Credentials—In the past decade or so, several reviews have examined the effects of non-recognition of credentials. This is not limited to the following research (Bauder, 2003; Elgersma, 2012; Fang, 2012; Guo, 2009; Houle & Yssaad, 2010; McKenzie & Hansson, 2009; Melchers & Schwartz, 2011; Retiz, 2007). Although the results of this study is in line with previous literature regarding non-recognition of non-Canadian credentials and the negative effects such as mental health impacts, poor integration, over qualification and underemployment, poverty, and adverse well-being impact, the participants in this study showed a level of awareness about structural barriers and their ripple effects. Ildiko's statement was quite powerful when she voiced how it is a "purposeful barrier" when immigrant and refugee individuals' credentials and education are devalued and not recognized, and the

barriers in the community impede individuals from accessing Canadian education (for example lack of opportunities, financial constraints, lack of social networks, and language barriers). As Ildiko expressed, many immigrant and refugee individuals say they feel like second-class citizens who continue to work at jobs that they are overqualified for. Immigrant individuals are disproportionately represented in jobs requiring a low level of education and are more likely to not be working in the professional fields that they were trained in, even after being in Canada for as long as 15 years (Elgersma, 2012).

The systematic discrimination and non-recognition of non-Canadian credentials is differential treatment. For example, almost six in ten (58.3%) immigrant and refugee individuals were born in Asian countries (including the Middle East), with higher education than the general Canadian population (The Canadian Chamber of Commerce, 2009). However, immigrant and refugee individuals from South and Central Asia, and the Middle East, have particularly restricted access to highly-skilled occupations in Canada, as opposed to individuals from the United States, Australia, Britain and New Zealand (Bauder, 2004; Guo, 2009). Thus, the non-recognition of non-Canadian credentials results in a systematic social exclusion and marginalization of certain groups of immigrant and refugee individuals from integrating successfully into the upper segment of the labour market (Elez, 2014). The impact of social exclusion can be felt by the words of Mesafint as he stated, “ not having equality to Canadian school document and everything. That gives you depression for yourself and for your family, because you are not accepted by the community as you are.... as your culture what how it was [*sic*]”. Guo (2009) argues that knowledge has been racialized in Canada. For example, knowledge obtained by immigrants is deemed inferior, and the accreditation issue is used as a

strategy to maintain subordination of immigrants and maintain the extent of power relations in Canada (Guo, 2009).

There are many studies that have reported on the impacts of non-recognition of credentials, yet the situation has not improved. When analyzing the non-recognition of credentials from a critical perspective we can begin to understand the root causes of this issue. Although Canadian society claims a commitment to social pluralism (where individuals from different classes, religions, cultures, and ethnicities, live together in a society); however, it is superficial in nature, as we tolerate rather than embrace our differences (Guo, 2009). For example, one of the underlying reasons that prevent us from fully recognizing educational qualifications and professional experiences is existing attitudes towards difference (Guo, 2009). Additionally, the negative perceptions, attitudes and behaviours towards immigrant and refugee individuals continue to coexist with the democratic principles of social justice, equality and fairness (Guo, 2009). The two conflicting ideologies can be referred to as “democratic racism”, which prevents our government to fully accept difference and make policy changes that might improve the low status of immigrant and refugee individuals (Guo, 2009). The earning gap between immigrant and refugee individuals and Canadian born persons is substantial, especially among visible minority groups (Fang, 2012).

Poverty— is defined, measured, and discussed in a number of ways. For example, the United Nations Development Program (UNDP) defines poverty as “denial of choices and opportunities for living a tolerable life” (Hick, 2007, p. 207). There is also absolute poverty (being without the basic necessities) and relative poverty (measured in relation to others within a society) (Hick, 2007). Additionally, poverty can be described as experiencing varying levels of material and social deprivation of basic necessities, in relation to a combination of educational,

economic, and occupational criteria (Forchuk et al., 2016). Canada is one of the few countries that do not have an official poverty line. However, Statistics Canada produces Low-Income Cut-off (LICO), which is based on relative and absolute measures (Hick, 2007).

Regardless of the definition, poverty creates conditions that impact individuals and communities from reaching their full potentials (Forchuk et al., 2016). The results of this study depicts the interconnectedness of inequality and discrimination in our community (devaluation of immigrant and refugee educational qualification and non-recognition of credentials), resulting in unemployment and underemployment, which then impacts their mental health, sense of belonging and economic well-being. At the same time, poverty also creates stressors that impact mental health but also creates barriers for individuals to access mental health services.

When taking a closer look at inequality and discrimination, immigrant and refugee individuals, despite higher levels of education, are at a higher risk for rates of unemployment and underemployment or are employed in precarious work (temporary or part-time jobs, limited access to benefits, job insecurity, and low wages), and are more likely to be below the LICO (McKenzie & Hansson, 2009; MHCC, 2009). Additionally, a majority of racialized individuals (66%) living in poverty belong to immigrant and refugee groups, and face a poverty rate double than the rest of the Canadian population (Employment and Social Development Canada, 2013; Hick, 2007; Hyman, 2009; Simich et al., 2005). For example, if all things were equal, the odds of poverty increase by 56 % if one is an immigrant (Hicks, 2007). When analyzing poverty between the two largest cities in Canada, more than half of the individuals living in poverty were from racialized groups (58% in Vancouver; and 62 % in Toronto) (Employment and Social Development Canada, 2013).

Eligibility Criteria—Although the eligibility criteria for income security programs are not a direct social determinant of health, it is a factor that influences the social determinants of income and housing. Ildiko and Yekaterina discussed factors such as eligibility criteria, which create barriers for accessing and receiving services and supports. Ildiko’s photo and story (figure 8) show her reality and the hardship and frustration she faced when trying to access income assistance. Income security in Canada is put in place to help individuals by providing monetary or other material benefits to supplement income or maintain income levels (Hick, 2007). When critically analyzing income security in Canada, the Principle of Less Eligibility that dates back to *Elizabethan Poor Laws* continues today as a key idea—where assistance must be less than the lowest paying job (Hick, 2007). Income security programs are needs based in order to alleviate poverty, yet the benefits that are provided are distributed reluctantly and difficult to access. If individuals do not meet the eligibility criteria, they are not qualified to receive services. For example, Ildiko was denied monetary support from EIA due to that fact that she had a part-time job. However, the part time job was not sufficient to meet her basic needs, and she mentions that is how individuals become homeless, as they no longer can afford their homes. Additionally, Ildiko articulated how difficult it is to receive monetary support once you are homeless, as you need an address to be able to receive such support. She also discussed how contradictory these services are; on one hand they are supposed to help individuals meet their basic needs; but on the other, it is quite difficult to access the services and in most cases the supports do not adequately meet the needs of the individuals. Income security programs have created a cycle that pushes marginalized groups further into the margins of society, as they fall further and further behind the standard of living that the majority of Manitobans enjoy.

The participants in this study highlighted poverty as one of the barriers to accessing mental health care. The results of this study were similar to findings from previous research in regards to social economic constraints, which can lead to barriers for immigrant and refugee individuals in accessing services and improving their mental health (such as transportation costs and time off work) (Kirmayer, 2011; McKenzie & Hansson, 2009; MHCC, 2009; Simich et al., 2005). For example, Ildiko voiced the difficulty and unaffordability of taking time off work from a minimum wage job, or having the means to afford bus tickets. Additionally, Mesafint's picture (figure 9) depicts not having a shelter to be one of the barriers to accessing mental health services. Having shelter provides stability and is essential to an individual's recovery. The stability that shelter provides helps individuals to pursue other activities such as engaging in community mental health programs and services. It is inevitable that basic needs such as food, water, and shelter need to be met first, so individuals can focus on their mental health and recovery (Canadian Mental Health Association, 2007).

Stigma— refers to the negative perception and stereotypes people have regarding mental health problems and illnesses. Negative stereotypes in our community can be quite destructive not only to person's mental health well-being, but also is a barrier that creates challenges in accessing services (Chen, 2010; Kirmayer et al, 2007; McKenzie & Hansson, 2009; MHCC, 2009; Saechao et al., 2012; Tiwari & Wang, 2008; Wood & Newbold, 2012). Ildiko's photograph (figure 18) captures some of the stereotypes and labels used in our community. Although the majority of the literature (noted above) focused on stigma and mental illness, the results of this study also showed the stigma of poverty and its impacts on mental health. The participants in this study discussed how when individuals are faced with poverty they are associated with being "lazy" and blamed for their misfortunes, without any understanding of the

contextual factors that have negative impacts on their lives. Ildiko voiced how we should not be blaming individuals for their misfortunes, but instead looking at how our society is not providing supports. Mesafint shared experiences of being labeled and called “crazy” and “gypsy” in downtown Winnipeg. Such labels can be hurtful and have a lasting impact. Mesafint stated “give me call a name [*sic*] for me and it’s not proper I don’t take it ... but the position where I am the situation where I am [makes me think bad things]”. Thus individuals may isolate themselves for the fear of being labeled and viewed in a negative way by their community (Wood & Newbold, 2012).

Language Barriers— the results of this study coincides with previous research (McKeary & Newbold, 2010; McKenzie & Hansson, 2009; MHCC 2009; Thomson, Chaze, George, & Guruge, 2015; Tiwari & Wang, 2008) as it shows language as one of the major barriers to accessing mental health care. The participants in this study discussed the hardship and difficulty immigrant and refugee individuals face when trying to communicate and explain their mental health concerns in an effective way. Yekaterina’s picture (figure 11) and story illustrate the impacts of language barriers and access to services. She voiced how individuals who are dealing with mental health problems in an acute episode may impact the individual’s thinking process, and prevent them from accessing services. For immigrant and refugee individuals, even when they reach mental health services, the language creates another layer of barriers, as the individual is now faced with the difficulty of expressing and explaining their symptoms in the English language.

Mihret expressed concerns regarding interpreters (figure 10) and other studies found similar results with immigrants and refugees (McKeary & Newbold, 2010; Blignault, Ponzio, Rong, & Eisenbruch, 2008). Having an interpreter in the room does not allow for privacy and

confidentiality. As a result, the individuals may not fully disclose their health concerns and may not receive proper care. As Mihret voiced, individuals are left with unexplained health conditions that create feelings of anxiety. Additionally, another concern raised in regard to interpreter services was cultural differences between the individuals and the interpreter. Mihret expressed that although the interpreter may speak the same language, the cultural difference can act as a barrier in fully understanding and explaining what the immigrant and refugee individuals want to articulate. Thus individuals often feel frustrated and may not receive appropriate care to meet their needs and may not return for further help.

The results of this study also showed an interesting aspect regarding language use in mental health assessments with service users. For example, Yekaterina stated “ I was given 400 something questions, I was going with dictionary over each of that to actually understand my symptoms and to understand what they want from me”. Although Yekaterina voiced that she had a good understanding of the English language, the assessment questions used medical terminology that is much different from everyday English language. The use of medical jargon in mental health assessments creates barriers for individuals, especially immigrant and refugee individuals who already face with language barriers. Individuals may not be able to understand what is being asked and may not receive the appropriate care needed.

Research conducted by Simich et al. (2005) found that community services play an important role in providing support for immigrants and refugees to effectively meet challenges. However, many policy-makers who are concerned with the health and well-being of immigrants and refugees are faced with the fundamental challenges of providing supportive services. As the results of this study depict, immigrants and refugees are faced with many systematic challenges such as non-recognition of their credentials, unemployment and/or underemployment, systematic

discrimination, stigma, poverty and language barriers. Additionally, many settlement, health and social services are underfunded, which impacts the extent and types of services they provide. According to Simich et al. (2005), “challenges facing immigrants and refugees and equally important challenges facing service providers and policy-makers are intertwined” (p. 266). Thus we need to recognize the structural and systemic issues impacting immigrants and refugees. Services and supports for immigrants and refugees are needed on a systemic level in order to address their complex needs and provide holistic care (Simich et al., 2005).

Hope and Resiliency

Resiliency has been a topic of interest for almost three decades (Simich, Roche, & Ayton, 2012). Previous research has focused on individuals, mostly children and youth, and the focus has been mostly on personal traits, such as what strengths helped people cope or survive adversities (Simich, Roche, & Ayton, 2012). According to Herrman et al. (2011), generally, resiliency in the literature refers to “positive adaptation, or the ability to maintain or regain mental health, despite experiencing adversities” (p. 269). Resiliency has been broadened to acknowledge the interconnected factors and systems that contribute to resiliency (Herrman et al. 2011). Recent research has focused on cultural and contextual contributions to an individual’s resiliency. For example, Ungar (2012) supports that resiliency is best understood when examined across cultures and contexts. Facilitative environments where individuals have opportunities, community supports, and their needs are met, are more influential than internal resiliency (Simich, Roche, & Ayton, 2012; Ungar, 2012).

Majority of the participants in this study either through their photographs (figure 12, 13 and 14) or group discussions, described how individuals who are dealing with mental health problems, have many strengths, potential, and are capable individuals. The participants in this

study talk about having hope for the future, and a deep acknowledgment that recovery is possible. Research conducted by Edward, Welch, and Charter (2009) had similar findings in regards to hope and recovery with adults who have experienced mental illness. Therefore, mental illness is not the absence of resiliency, in fact, the participants in this study talked about their strengths and about adversity that they have overcome, but continue to overcome adversity on a day-to-day basis. The participants in this study articulated the importance of community supports, social networks, equality, work, education, meeting basic needs, language, and culture, to influence their mental health and or to promote resiliency. Similar results were found among immigrant and refugee individuals in Toronto (Simich, Roche, & Ayton, 2012).

The photovoice project created an opportunity for immigrants and refugees to come together as a group in the community. This created a chance for the participants to network with one another. As a researcher, observing the interaction among the participants and its positive impact was humbling. Yekaterina stated, “It’s sometimes simpler and easier to live to just know how many people [one] can relate.” By having a group of individuals who share similar experiences, connect and relate to one another helps to normalize the experience of dealing with mental health problems. Additionally, individuals no longer feel so alone, as there are other people who are going through similar experiences. Therefore social networks and supports act as a protective factor, which promotes one’s resiliency.

The environment also plays an important role in how inclusive and facilitative it is by creating opportunities in the community and providing accessible services. Participants said that when services are culturally competent and their culture and language is reflected in the community, it increases their sense of belonging and hope. Studio Central is a great example of being facilitating by engaging immigrants and refugees through community outreach and

research in order to make their services more accessible. It provides an opportunity for immigrants and refugees to come together in a safe place to share their realities and barriers to accessing services. The participants felt safe, welcomed and valued there. By attending meetings at Studio Central, the participants learned about the services and resources offered. Some of the participants mentioned they already had accessed services and/or volunteered with Studio Central and found it to be very helpful and supportive. Other participants said they had never heard of Studio Central prior to the photovoice project. However, now that they are aware of the programs, they want to come and access services through Studio Central. Some participants appeared to be very excited when they found out Studio Central has art supplies and musical instruments, as they could connect those resources with their own talents. It was remarkable to see how happy some of the participants were, knowing that such resources and supports existed in the community.

As discussed earlier in this chapter, the findings of this study depict how structural barriers such as non-recognition of credentials, language barriers, discrimination, stigma, poverty, and lack of culturally competent services are risk factors that negatively impact mental health and influence resiliency. The results of this study supports the notion by Ungar (2012) that resiliency is influenced by intersecting factors and systems; and how environment can either be facilitative (where there are opportunities, supports, and resources that act as protective factors) or imposing risk when there are limited opportunities, and certain groups of individuals face discrimination and barriers within the community.

Chapter 9

CONCLUSION

Implications for Social Work

Utilizing photovoice in this study created an opportunity for immigrant and refugee individuals to voice their realities and share their concerns through stories and images. Thus, providing implications for social work practice and policy. To my knowledge, there is limited arts-based research that has incorporated the voices of immigrants and refugees and their perceptions of mental health and access to services. Photovoice is an effective method to use with groups who are oppressed and marginalized in our society; and can bring individuals in the community together to start a dialogue to pursue social change. Additionally, photovoice can be used across cultures, and allows individuals with language barriers the opportunity to share knowledge and have their voices heard. Images can be quite powerful, as they create empathy by connecting individuals. Images can be used as a tool and means to raise awareness and educate social workers, policy makers, advocates, academics, and community members on issues facing immigrants and refugees. Arts-based research in social work allows for innovative and alternative ways of knowing and understanding immigrant and refugee individuals' realities.

Practice

Social workers work in an array of programs. These include hospitals, child welfare, mental health, immigration, policy analysis, program and community development, advocacy, and other areas where refugee and immigrant individuals may come to access these services. Social workers who engage in practice with immigrant and refugee individuals need to be cognizant of the complex and multifaceted factors that have an impact on their mental health and access to services. The participants in this study voiced concerns regarding structural barriers, non-recognition of non-Canadian credentials, underemployment and unemployment, poverty,

homelessness, discrimination, stigma, language barriers, lack of culturally inclusive services, inequality, lack of a social network, and marginalization. All of these are social determinants of mental health. As social workers, it is important that we be aware of these issues faced by immigrant and refugee communities, and incorporate their voices to inform social service design and delivery and additionally strive for inclusivity, reduce barriers, and increase accessibility to meet the unique needs of immigrant and refugee communities.

The participants in this study discussed how services in the community are offered from a Euro-Canadian lens, which creates barriers in receiving services. For example, “one-size fits all” ignores the differential needs and presentations of problems by immigrants and refugees. They do not feel understood and their needs are not met. The role of a social worker is to support individuals in obtaining resources necessary to meet their goals, provide counselling to clients, advocate for their rights, and create awareness of the issues that are creating barriers for clients. Therefore, developing culturally competent practices is important when working with immigrant and refugee individuals. Culturally competent practice refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, classes, religious beliefs, and ethnic backgrounds (NASW, 2015). As social workers we need to have a knowledge base regarding our clients’ cultures, values, beliefs, traditions, and views; and not impose our own values, beliefs, and culture on to our clients. Working cross culturally challenges our own values, which requires that we develop self-awareness, and take an anti-oppressive approach.

The results of this study depict several ways to break through barriers and make mental health services more accessible for immigrants and refugees:

- 1) Create a milieu that is warm and welcoming, which creates a place of safety for immigrants and refugees to receive help and supports.

2) Cultural sensitivity— treat immigrants and refugees with dignity and respect.

3) Programs and services need to reflect diverse cultures and languages. For example, programs can include different languages on their brochures, websites, and/or have art or symbols that represent different cultures. This helps immigrants and refugees feel a sense of connection and belonging to those programs, and as a result they will access those services.

4) Service providers and programs need to build bridges, unite and work collaboratively to provide wraparound holistic services.

5) Language —when working with immigrants and refugees, it is important to use language that is free of jargon, is clear and takes into consideration language barriers. For example, mental health assessments need to be clear and free of medical terminology in order to be mindful of language barriers. This ensures that individuals seeking services have a good understanding of what is being said, and in return, service providers receive correct information. This is important because individuals can then receive the appropriate care to meet their mental health needs.

6) Translators should have training in cultural competency, as well as mental health first aid training, to fully understand and explain the mental health concerns of immigrants and refugees.

7) Most of the mental health services are offered during office hours (Monday to Friday, 8:30 a.m. to 4:30 p.m.). However, this may act as a barrier for immigrants and refugees who do shift work or are unable to take time off during working hours. Community mental health programs should be flexible in their hours of operation to be inclusive and create accessibility.

8) Socioeconomic constraints can lead to barriers in accessing mental health services. For example, limited monetary funds can mean immigrants and refugees are not able to afford transportation costs. One way to increase accessibility is for services to offer bus tickets.

9) Mental health programs and services need to continue to develop initiatives and strategies by including the voices, ideas, and perspectives of immigrants and refugees.

10) Raising mental health awareness in the community is an important strategy as a way to de-stigmatize mental illness. Community mental health services can utilize tools such as photovoice projects with immigrants and refugees to raise mental health awareness and engage the community in a dialogue.

Policy

The results of this study shed light on the structural barriers in Canada that not only impact immigrants and refugees' mental health, but also create barriers in accessing mental health services. The participants discussed discrimination against their non-Canadian education and credentials to have domino effects on their lives. Immigrants and refugees have greater difficulty in becoming economically integrated due to higher rates of unemployment and underemployment (Simich et al., 2005). Additionally, the results of this study depict poverty to be one of the main determinants that impacts their mental health and well-being and access to services. The participants said, "You need your basic needs met first before accessing mental health services". According to Simich et al. (2005), it is important to understand and enhance the social supports for immigrants and refugees on a systematic level in order to close the gap between the "promise of citizenship and reality of exclusion" (p. 266).

The social work profession has a long and distinguished history of advocating for social justice and human rights (Healy, 2008; Jennissen & Lundy, 2011; Murdatch, 2011). Social

workers, who are informed of the structural barriers, discrimination, and inequality, need to advocate against the policies and practices that discriminate, oppress and marginalize immigrant and refugee communities. The *CASW Code of Ethics* (2005) states that as social workers we do not tolerate discrimination based on nationality, ethnic background, and gender. Social work by nature promotes policies and practices that safeguard the rights and confirm equity and social justice for people (Canadian Association of Social Workers, 2005). Additionally, the Accessibility for Manitobans Act was introduced as a way to remove barriers that prevent individuals from full participation and to create a more inclusive society by the identification, prevention, and removal of barriers (The Legislative Assembly of Manitoba, 2014).

As social workers and service providers, we need to critically analyze policies that are creating inequalities and barriers for immigrants and refugees. By identifying these policies we are better equipped to advocate against such policies. Additionally, we must strive for the amalgamation of policies that are inclusive and anti-oppressive. The results of this study show several implications for policy changes.

1) Advocate for culturally inclusive re-entry programs for individuals whose credentials are discriminated against and not accepted in Canada.

2) Remove financial barriers and create opportunities for immigrants and refugees to upgrade their education in order for their credentials to be recognized.

3) Poverty in this study is portrayed as one of the main factors that impacts the mental health of immigrants and refugees, and creates barriers to accessing services. Despite Canada's economic prosperity and a signatory to the United Nations, immigrants and refugees continue to live below LICO. Additionally, income security programs do not provide adequate benefits for individuals to meet their basic needs. Food banks and shelters continue to be prevalent in our

society. Thus we need to advocate for longer-term holistic policies that are supportive in providing systematic social supports and programs for immigrants and refugees (Simich et al., 2005). As social workers, we need to advocate for policies that ensure sufficient income benefits are provided so the basic needs of immigrants and refugees are met.

4) Community organizations play an important role in providing social supports to immigrants and refugees. However, many community organizations are underfunded, and as a result impact the availability and delivery of those services (Simich et al., 2005). We need policies that provide sufficient funding to programs so they can provide comprehensive services that promote mental health and the well-being of immigrants and refugees.

Limitations

Due to a small sample of participants, the results of this study cannot be generalized to all immigrant and refugee groups who are facing difficulties with mental health issues and barriers to services. Immigrant and refugee individuals in Canada are not a homogeneous population; they represent diverse countries, cultures, languages, age groups, sexual orientation, gender, education, socioeconomic status, and experiences (Bowen et al., 2010). The individuals who volunteered to participate in this study have at some point accessed mental health services. Therefore the results cannot be representative of individuals who have never accessed mental health services, as their needs and realities might be quite different. It is also important to mention that my own biases as a foreign-born researcher may have acted as a limitation. For example, my own biases and values may have influenced this study right from the beginning—from choosing this topic, to the interpretation of the findings, and representation of the results (what information was deemed important and presented and what was omitted).

Conclusion

In conclusion, photovoice is a creative process that provided the opportunity for a participatory way of engaging immigrants and refugees who have or are experiencing mental health difficulties. This photovoice project revealed real life stories, realities, needs, and perspectives of immigrants and refugees residing in Winnipeg, Manitoba. The barriers faced by immigrant and refugee community, and the contexts in which they are unable to access services were brought to light. Through the photographs, stories, and group discussions, the participants voiced their concerns from the context of social determinants of mental health. The results depicted how our community plays a crucial role in creating opportunities, breaking barriers, and increasing accessibility, in order to be facilitative and promote the flourishing of hope and resiliency.

Future research can utilize a photovoice project with immigrants and refugees who have or are experiencing mental difficulties, but have never accessed mental health services, this providing a deeper understanding of the barriers in accessing mental health care. To my knowledge, there is no research that has been conducted with immigrants and refugees dealing with mental health problems and the impacts of volunteering in their journey to recovery. It would be interesting to gain more knowledge in this area. Finally, future research can further explores hope and resiliency with immigrants and refugees experiencing mental health difficulties.

As a researcher, I was an active participant in the research process. Having an understanding and awareness of my own social location and biases was important. Keeping a reflexive journal throughout the research process helped me to reflect on my own thoughts and experiences. Practicing self-awareness and being cognizant of my own biases and preconceptions

was important so I did not influence the interpretation and findings by unconsciously projecting my own biases.

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Appendix A
Recruitment Poster

YOU ARE INVITED TO PARTICIPATE IN A PHOTOVOICE PROJECT



Do you want to improve your community?
Are you interested in photography?
Are you aged 18 years or older?

You would be asked to:

- take photographs
- participate in 5 group meetings (each meeting would be about 1.5 hours)
- share your photos and experiences

For more information about this study, or to volunteer for this study, please contact:

Ogai Sherzoi
Faculty of Social Work
204-4-██████████ or
Email: ██████████

You will receive a \$30 gift card from Wal-Mart as a compensation for your time, which will be presented to those who participated fully in the project. Bus tickets will be available if you require transportation to and from the meetings.

You are invited to participate if:

- You were born outside of Canada
- You have lived in Canada for more than 2 years
- You are over the age of 18
- You have or had mental health difficulties (sadness, depression, anxiety, bipolar...)

This research has been approved by the University of Manitoba Psychology/Sociology Research Ethics Board



Appendix B
Agency Letter

To:

Date:

Re: Photovoice: Exploring Immigrants and Refugees' Perceptions and Access to Mental Health Services in Winnipeg

Dear _____,

I am currently enrolled in the Master of Social Work program at the Faculty of Social Work, University of Manitoba. As part of my thesis, I will be conducting a research on immigrants and refugees' perceptions of mental health problems, and experiences in accessing mental health care in Winnipeg. The duration of the research will be from January 2016- May 2016. The research will be conducted under the supervision of the faculty advisor, Dr. Maria Cheung, at the University of Manitoba.

I hope you can send out the recruitment letter (please see letter in Appendix) to individuals who identify themselves as immigrants and or refugees and ask for their voluntary participation in my captioned research. If the individuals agree to participate in this study, they will be asked to participate in a photovoice project, which will consist of taking photographs in their community (disposable cameras will be provided), five group meetings, each meeting will be 1.5 hours in length, and with the permission of the potential participants, the group meetings will be audio-recorded. The group meetings will be scheduled at Studio Central, at 444 Kennedy Street. The photos captured by the potential participants will be part of the launch and exhibit hosted by Artbeat Studio.

The research is to capture the voices of 5-10 immigrant and refugee individuals who have or is dealing with mental health problems and are living in Winnipeg. My main focus is on their perception of mental health and mental illness; what they believe others' (family, friends, and community) perceptions are regarding mental health and mental illness; their experiences with mental health services offered in their community; barriers they may have experienced in accessing these services; and what they would you like to see different with the mental health services being offered. The group meetings will be in a safe and confidential manner to help us understand what the barriers are in accessing services and use photos and stories to raise awareness within the community.

Each potential participant will receive a \$30 gift card from Wal-Mart as a compensation for their time, which will be presented to those who participated fully in the project. Also, bus tickets will be available for participants who require transportation to and from the meetings. Refreshments will be provided at each meeting (coffee/tea and muffins or cookies).

This research has been approved by the University of Manitoba Psychology/Sociology Research Ethics Board. It is of paramount importance that research participants voluntarily participate in the study. Even if they choose to participate, they can withdraw at anytime. Their decline to participate will have no negative consequences, now or in the future, in their involvement with Artbeat Studio Inc., Immigrant and Refugee Community Organization of Manitoba Inc.

(IRCOM), Mosaic Newcomer Family Resource Network, Wolseley Family Place, and without prejudice. If you have any concerns or complaints about this project you may contact myself (see undersigned), Maria Cheung xxx@umanitoba, or the Human Ethics Coordinator at 204-474-7122 or email humanethics@umanitoba.ca. A copy of the consent form is given to you for your record and reference. A copy of the research proposal can be made available to you upon request.

In my academic literature review, in the past ten years, there have been quite a few Canadian-based studies that have investigated mental health and mental illnesses/problems with immigrant and refugee groups. However, the majority of the studies and published research have been conducted and focused particularly in large cities such as Montreal, Toronto, and Vancouver. Medium size cities like Winnipeg, which is the 6th highest city in Canada for immigration has nearly none. In 2013, Winnipeg received approximately 11,000 immigrants including refugees. Yet, to my knowledge there is no systematic research that has been conducted with immigrant and refugee population, which investigates mental health problems and access to services in Winnipeg. It would be appropriate to conduct a photovoice project in Winnipeg, in order to engage immigrant and refugee community in the research process to voice what the community needs are and how they believe mental health needs can be met.

If you have any question about this research, please do not hesitate to contact me via the following email or phone number.

Thank you for your support and effort in making this project work!

Yours sincerely,

Ogai Sherzoi, BHecol, BSW

Phone: 204-000-0000

Email: xxx@myumanitoba.ca

Appendix C
Recruitment letter

Project title: Photovoice: Exploring Immigrants and Refugees' Perceptions and Access to Mental Health Services in Winnipeg.

Email Script for Research Participants

You are being invited to participate in a photovoice project, and to share your experiences and perspectives of mental health and mental health problem (s), and barriers in accessing mental care. If you agree to participate, the tasks include: taking photos in your community (disposable cameras will be provided), attend 5 group meetings, and each group meeting will be approximately 1.5 hour in length. The group meetings will be held at Studio Central, at 444 Kennedy Street, in a private room, from January 2016-May 2016. The group meetings will be conducted in a safe and confidential manner to create an opportunity to share with others your experiences and concerns. The photos you capture and the stories attached will be part of a launch and exhibit hosted by Artbeat Studio, to raise awareness in the community for better access to mental health care.

This research has been approved by the University of Manitoba Psychology/Sociology Research Ethics Board. I, Ogai Sherzoi, master's student at the Faculty of Social Work, University of Manitoba, is the principal investigator. The research will be conducted under the supervision of the faculty advisor, Dr. Maria Cheung, at the University of Manitoba.

You will receive a \$30 gift card from Wal-Mart as a compensation for your time, which will be presented to those who participated fully in the project. Bus tickets will be available if you require transportation to and from the meetings. Also, refreshments will be provided at each meeting (coffee/tea and muffins or cookies).

The photovoice project is conducted in a group setting, therefore all the members of the group including the researcher will know whom the data (photographs/stories) belongs to. As a result, there cannot be any anonymity, and your full confidentiality cannot be guaranteed. In the initial meeting the importance of confidentiality and keeping other group members information private will be discussed as a ground rule for participation. But even so, there is still possibility that I cannot guarantee your full confidentiality. I ask that you consider this possibility prior to consenting to be part of the photovoice project. The photos chosen to be included in the final exhibition and other public dissemination are displayed without real names of participants, unless you prefer to use your real name. In this latter situation, you'll need to sign a waiver form of confidentiality. Additionally, the only time confidentiality will not apply is when there is a disclosure of abuse to a child or vulnerable persons, and or foreseeable and imminent harm to you or others.

Participation is voluntary and you can withdraw from the study at any time. I want you to know that declining to participate in this project will have no negative consequences, now or in the future, in your involvement with Artbeat Studio Inc., Immigrant and Refugee Community Organization of Manitoba Inc. (IRCOM), Mosaic Newcomer Family Resource Net and without prejudice.

For more details about the research, please refer to the informed consent form. If you have questions or would like to participate, please contact Ogai Sherzoi Email: xxx@myumanitoba.ca or phone: 204-000-0000.

Appendix D
Oral Recruitment Script for Partnering Agencies

Principal Investigator: Ogai Sherzoi, MSW Student, Faculty of Social Work, University of Manitoba

Research Supervisor: Dr. Maria Cheung, Associate Professor, Faculty of Social Work.

Research Project Title: Photovoice: Exploring Immigrants and Refugees' Perceptions and Access to Mental Health Services in Winnipeg.

- Hello, my name is Ogai Sherzoi and I am currently enrolled in the master's program, at the Faculty of Social Work, University of Manitoba.
- Thank you for meeting with me today.
- As part of my thesis, I am conducting a photovoice project on immigrants and refugees' perceptions of mental health problems, and access to mental health care in Winnipeg. The research will be carried out under the supervision of the faculty advisor, Dr. Maria Cheung, at the University of Manitoba.
- The duration of the research will be from January 2016- May 2016.
- I have partnered with Artbeat Studio, who have connected me with your agency and have informed me about the services you provide to immigrants and refugees.
- Through my academic literature review, in the past ten years, there have been many Canadian-based studies that have investigated mental health and mental illnesses/problems with immigrant and refugee groups. However, the majority of the studies and published research have been conducted and focused particularly in Montreal, Toronto, and Vancouver.
- Medium size cities like Winnipeg, which is the 6th highest city in Canada for immigration has nearly none. In 2013, Winnipeg received approximately 11,000 immigrants including refugees. Yet, to my knowledge there is no systematic research that has been conducted with immigrant and refugee population, which investigates mental health problems and access to services in Winnipeg.
- It would be appropriate to conduct a photovoice project in Winnipeg, in order to engage immigrant and refugee community in the research process to voice what the community needs are and how they believe mental health needs can be met.
- The purpose of the photovoice project is to capture the voices of 5-10 immigrant and refugee individuals who have or is dealing with mental health problems and are living in Winnipeg.
- My main focus of the research is on their perception of mental health and mental illness; what they believe others' (family, friends, and community) perception are regarding mental health and mental illness; their experiences with mental health services offered in their community; barriers they may have experienced in accessing these services; and what they would you like to see different with the mental health services being offered.
- The inclusion criteria for the photovoice project includes individuals who identify themselves as an immigrant and or refugee, who have been residing in Canada for at least two years; between the ages of 18-55; and who have or is dealing with mental health problems.

- If the individuals agree to participate in this study, they will be asked to participate in a photovoice project, which will consist of taking photographs (disposable cameras will be provided) in their community, five group meetings, and each meeting will be 1.5 hours in length. The photos captured by the potential participants will be part of the launch and exhibit hosted by Artbeat Studio. With their permission, the group meetings will be audio-recorded.
- The group meetings will be scheduled at Studio Central, at 444 Kennedy Street.
- The potential participants will receive a \$30 gift card from Wal-Mart as a compensation for their time, which will be presented to them at the end of the project. Bus tickets will be available for the individuals who require transportation to and from the meetings. Also, refreshments will be provided at each meeting (coffee/tea and muffins or cookies).
- This research has been approved by the University of Manitoba Psychology/Sociology Research Ethics Board.
- It is important that I mention the importance of voluntary participation in this project. Even if the potential participants choose to participate, they can withdraw at anytime. Also, their decline to participate will have no negative consequences, now or in the future, in their involvement with your agency.
- Would you be interested in helping me recruit individuals who identify themselves as immigrants and or refugees and ask for their voluntary participation in my captioned research?

If Yes:

- Would you like a copy of my research proposal for your reference?
- Would it be ok with you, if I posted recruitment posters around your agency, after you have reviewed the poster?
- What is the best way for you to receive research proposal, recruitment poster, consent form, and recruitment letter for participants?
- If email is preferred: what is your email?
- If hard copy is preferred: When is it convenient for you to meet again?
Date: _____ Time: _____ location: _____
- If you think of any questions, please do not hesitate to contact me by phone or email (204-000-0000/ or xxx@myumanitoba.ca).
- If you have any concerns or you have complaints about this project you may contact myself, or Maria Cheung (xxx@umanitoba.ca), and or the Human Ethics Coordinator at 204-474-7122.
- Thank you for your support and effort in making this project work.

If No:

- Thank you for your time and consideration.

Appendix E
Consent Form

Photovoice Project
Permission to Use Photograph of You

Photovoice: Exploring Immigrants and Refugees' Perceptions and Access to Mental Health Services in Winnipeg.

Purpose:

The purpose of this study is to better understand the perspective and experiences of immigrants and refugees who have or is dealing with mental health problems; bring to light the barriers faced by immigrant and refugee community, and the context in which they are unable to access mental health care; and raise awareness.

This study has been reviewed by, and received ethics clearance by the University of Manitoba Psychology/Sociology Research Ethics Board.

Process:

Individuals are given disposable cameras and asked to take photographs that best illustrate their perception and the perception of their community in regards to mental health and mental illness; barriers in accessing mental health care, and what changes they would like to see with the mental health services being offered.

The photographs

The photographs maybe used as part of an exhibit, hosted by Artbeat Studio, in order to raise awareness in the community. The pictures may also be used as part of data for the thesis research, and the findings will be presented as part of the thesis defense to the Faculty of Social Work, and Social work students. Additionally the findings maybe published or presented at professional conferences. No names will be attached to identify individuals in the photographs. Unless you wish to have your name attached; in that case you would need to provide permission to waive this privacy and confidentiality by signing an additional waiver form.

Permission

We require your permission to use this photograph, if chosen by the photographer, which contains yourself for the display. To provide consent, please fill out this form and return it to the photographer as soon as possible.

For further information please on this project, please contact:

Ogai Sherzoi
Faculty of Social Work

204-000-0000 or
Email: xxx@myumanitoba.ca

I give my consent for a photograph containing myself _____
_____ (name of yourself) to be displayed at a public community
presentation in an exhibit, a mounted display and any subsequent opportunity that arise.

Print name of the person
Photographed: _____

Date: _____

Signature name of the person photographed: _____

Photo Log

Picture #1 Photographer _____

- My perception of mental health and or mental illness
- Others (family, friends, community) perception of mental illness
- My experiences of mental health services offered in the community
- Barriers in accessing mental health services
- Changes I would like to see with mental health services being offered

This picture is of _____

This picture is important because _____

Picture #2 Photographer _____

- My perception of mental health and or mental illness
- Others (family, friends, community) perception of mental illness
- My experiences of mental health services offered in the community
- Barriers in accessing mental health services
- Changes I would like to see with mental health services being offered

This picture is of _____

This picture is important because _____

Appendix G Consent Form

Project title: Photovoice: Exploring Immigrants and Refugees' Perceptions and Access to Mental Health Services in Winnipeg.

Principal Investigator: Ogai Sherzoi, MSW Student, Social Work, University of Manitoba.
Email: xxx@myumanitoba.ca
Phone: (204)-000-0000

Research Supervisor: Dr. Maria Cheung, Associate Professor, Faculty of Social Work.
Email: xxx@umanitoba.ca
Phone: 204-000-0000

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask Ogai Sherzoi. Please take the time to read this carefully and to understand any accompanying information.

You are being invited to participate in a photovoice project, to be facilitated by the principal investigator (researcher) regarding your experiences as an immigrant or refugee dealing with mental health problems, and access to mental health care in Winnipeg, Manitoba. This research is being conducted by Ogai Sherzoi, as part of the master's thesis, at the Faculty of Social Work, under the supervision of the faculty advisor, Dr. Maria Cheung, at the University of Manitoba.

The purpose of the photovoice project is to find out what the barriers are for immigrants and refugees in accessing mental health services, through the use of photography. Your involvement in this study is to participate in five group meetings, which will be held at Studio Central, at 444 Kennedy Street, in a private room. Each group meeting will be for the duration of 1.5 hours. You will be asked a number of questions (see interview guide in Appendix) focusing on your perception of mental health and mental illness; others' (family, friends, and community) perception regarding mental health and mental illness; your experiences with mental health services and access to mental health care; and what changes you would like to see with the mental health services being offered. You would then take photographs in your community that best represent the answers to the questions and share your photographs and stories with the group members. The questions asked are just a guideline and are subjected to change depending on what questions are important to you and your mental health needs and collective needs of your community. With your consent, the meetings will be audio-recorded. If you do not consent to being recorded, the facilitator will take notes instead. Please indicate your choice at the end of this form.

You will receive a \$30 gift card from Wal-Mart as a compensation for your time, which will be presented to those who participated fully in the project. Bus tickets will be available if you

require transportation to and from the meetings. Also, refreshments will be provided at each meeting (coffee/tea and muffins or cookies).

Please note that sharing one's story carries with it the risk of experiencing emotional distress. With this possibility in mind, a list of counselling resources in Winnipeg has been attached to this consent form for your assistance. If the research causes you significant distress, then urgent care can be arranged. Crises Response Centre is open 24/7 and has mobile crises services (204-940-1781) for adults experiencing mental health crises, and the staffs are mental health expertise that will help those in distress to resolve crises. On the other hand, there will be some direct and indirect benefits to you in terms of having the opportunity to share with others you experiences and concerns, and contribute to creating change for yourself and those in the community for better access to mental health care.

The fifth and final meeting will be at the end of the project, May 2016. The time allocated for the meeting will be used for debriefing and feedback. At that time, I will verbally present the transcripts and a brief summary of the findings. If you would like, at the end of the form you have the option to indicate how you would like to receive a hard copy of the brief summary, which would be provided to you at the end of the project, May 2016 (e-mail, mail, or provided to you at the beginning of the final meeting). Member checking will be utilized after sharing the main results of the findings, in order to receive your feedback in the accuracy of the interpretation of the findings.

In May 2016, the photographs identified by participants will be part of an exhibit, hosted by Artbeat Studio, in order to raise awareness in the community. As part of the requirement of the Faculty of Social Work, I will present my findings, as part of the defense for my thesis. In addition, I may publish my findings or present them at professional conferences. However, in all cases I will do so without revealing identifying characteristics such as names, addresses, and specific participant details unless you want to be identified. If you prefer to use your real name in public dissemination of the project, you would need to give permission and sign a privacy and confidentiality waiver form to indicate your willingness to share your stories and photos openly (see attached waiver form). Without this permission, I will only use quotations from your stories and use photographs after removing identifying details, so they cannot be attributed to any single person. You will be asked to read and identify any data in the summary, which you believe identifies you personally. If you are uncomfortable with this potential identification, the data will be removed.

The photovoice project is conducted in a group setting, therefore all the members of the group including the researcher will know whom the data (photographs/stories) belongs to. As a result, there cannot be any anonymity, and your full confidentiality cannot be guaranteed. In the initial meeting the importance of confidentiality and keeping other group members information private will be discussed as a ground rule for participation. But even so, there is still possibility that I cannot guarantee your full confidentiality. The photos chosen to be included in the final exhibition and other public dissemination are displayed without real names of participants, unless you prefer to use your real name. In this latter situation, you'll need to sign a waiver form of confidentiality. Additionally, the only time confidentiality will not apply is when there is a

disclosure of abuse to a child or vulnerable persons, and or foreseeable and imminent harm to you or others.

The only people who will have access to the information collected in the project beside myself are my faculty advisor, Dr. Maria Cheung, and the University of Manitoba Research Ethics Board, if needed. All information collected will be kept strictly confidential. Documents related to the group meetings and photographs that are electronically uploaded will be stored on my password-protected personal computer. You will have a file folder, where you can safely store your photos, photo logs, and written stories. The file folders will be kept in a locked cabinet at Studio Central (I will be the only person with access to the locked filing cabinet). Audio-recordings and hand-written notes, if any, will also be stored in a locked cabinet at Studio Central. I will transcribe group discussions, and in the process remove all personal identifiers. Unless you would like to be identified, in that case, you would give permission to waive this privacy and confidentiality. Documents with your identifiable information will be destroyed in at the end of project. All other documents will be shredded and/or deleted by May 2017, after the completion of project dissemination.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate. In no way does this waive your legal rights nor release the researcher, Ogai Sherzoi from her legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. If you are receiving services from the participating agencies, your are free to withdraw and/or refrain from answering any questions at any time without any prejudice or consequences on your receiving services. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the University of Manitoba Psychology/Sociology Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122, or by email at humanethics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

If you agree to each of the following, please place a check mark in the “yes” box. “No” means you do not agree to that item of request.

	Yes	No
I have read or had read to me the details of this consent form.	()	()
My questions have been addressed.	()	()
I, _____ (print name), agree to participate in this study.	()	()

I agree to have the interview audio-recorded. () ()

I agree to be contacted by phone or e-mail if further information is required after the meetings () ()

I agree to have the findings (which may include quotations) from this project published or presented in a manner that does not reveal my identity. () ()

Do you wish to receive a summary of the findings? () ()

If you do, how would you wish to receive the summary? () E-mail () Mail () At the final meeting

Address: _____

Participant's Signature _____ Date _____

Researcher's Signature _____ Date _____

Appendix—Interview Guide

- What is your perception of mental health and mental illness?
- What do you think others' (family, friends, community) perceptions are regarding mental illness?
- What are your experiences with mental health services offered in your community?
- What are some barriers you experienced in accessing these services?
- What would you like to see different with the mental health services being offered

Appendix H
Counselling or Therapy Resource List

Finding a Counsellor:

- Ask your doctor for referral to a quality counsellor
- See the yellow page under Counsellor
- Contact these professional organizations:

Psychological Association of Manitoba

204-487-0784

Manitoba Institute of Registered Social Workers

204-888-9477

College of Registered Psychiatric Nurses of Manitoba

204-888-4841

- Your employer may have an Employee Assistance Plan (EAP) that provides free confidential counselling- **204-786-8880**
- Check if your private medical insurance plan covers professional counselling
- **Or call one of the agencies listed below**

Low-Cost or No-Cost Professional Counselling

Aluneau Renewal Centre

228 Hamel Ave.—204-987-7090

Family Therapy Centre

515 Portage Ave— 204-786-9251

Access Nor' West Co-op Community Health

785 Keewatin Street. —204-938-5900

Family Dynamics

401-393 Portage Avenue (Portage Place)

204-947-1401

Hope Centre Health Centre

240 Powers street—204-589-8354

Jewsih Child and Family Services

C200-123 Doncaster St.—204-477-7430

New Immigrant Chai Centre Inc.

Chai For Men

356 Hargrave Street. 204-415-2550 Aurora

North End Women's Centre

394 Selkirk Ave.—204-589-7347

WRHA Cross Cultural Mental Health

Specialist. Ms. Laura Coogan.

763 Portage Ave.—204- 940-6654

The Men's Resource Centre of Manitoba.

115 Pulford Street 204-415-6797

The Laurel Centre

104-Roslyn Road—204-783-5460

Drop-in Counselling:

Klinik Community Health Centre
870 portage Ave.—204-784-4090
Counselling intake- 204-784-4059

Klinik Community Drop-in Counselling
204-784-4067. 545 Broadway or 845
Regent Ave. West (Access Transcona)
(Call for Drop-in Hours)

Mount Carmel Clinic
886 Main St.—204-582-2311

Crises Services:

Crises Response Centre. Open 24 hrs
817 Bannatyne Ave. 204-940-1781

Appendix I
Privacy and Confidentiality Waiver

Project title: Photovoice: Exploring Immigrants and Refugees’ Perceptions and Access to Mental Health Services in Winnipeg.

Principal Investigator: Ogai Sherzoi, MSW Student, Social Work, University of Manitoba.
Email: xxx@myumanitoba.ca
Phone: (204)-000-0000

Research Supervisor: Dr. Maria Cheung, Associate Professor, Faculty of Social Work.
Email: xxx@umanitoba.ca
Phone: 204-000-0000

I, _____, hereby give permission for the above-mentioned researcher to present the research data concerning my experiences in a public manner for being used in photovoice project and disseminated in photovoice exhibit and launch, in an academic thesis article and academic conferences.

By signing this form and checking “yes” in the following boxes, I voluntarily and knowingly waive my rights to the confidentiality of the following personal information that I have provided to the researcher (please check “yes” to the items that you agree to waive confidentiality of):

	Yes	No
My name	()	()
My shared stories in the audio recording	()	()
My shared stories in the researchers’ written format	()	()
My stories attached to the photos	()	()

Also, please specify what you do NOT want to be revealed to people other than the research team:

I understand that this waiver signed by me automatically overrides the protection for my confidentiality in the Consent Form that I have signed earlier, although other information in the Consent Form remains applicable.

I understand that signing this form does not waive my legal rights nor release the researchers from their legal and professional responsibilities. I have the right to revoke this waiver at anytime by notifying the researchers in writing or verbally. However, the researchers will not be responsible for any consequences of previous disclosure of my information up to the time of my revoking this waiver.

Participant’s Signature _____ Date _____

Researcher’s Signature _____ Date _____

Appendix J
Photovoice Exhibit Poster



BREAKING BARRIERS:

A PHOTO EXHIBIT ON IMMIGRANT & REFUGEE PERSPECTIVES ON MENTAL HEALTH



OPENING RECEPTION

Friday, April 22, 2016
4PM to 6PM

Studio Central
444 Kennedy Street, 2nd Floor

This special PhotoVoice project, facilitated by Ogai Sherzoi (MSW candidate), engages the community in a conversation on immigrant and refugee perceptions on mental health.

For more information, please phone Ogai Sherzoi at [REDACTED]

Appendix K
Privacy and Confidentiality Waiver

Project title: Photovoice: Exploring Immigrants and Refugees’ Perceptions and Access to Mental Health Services in Winnipeg.

Principal Investigator: Ogai Sherzoi, MSW Student, Social Work, University of Manitoba.
Email: xxx@myumanitoba.ca
Phone: (204)-000-0000

Research Supervisor: Dr. Maria Cheung, Associate Professor, Faculty of Social Work.
Email: xxx@umanitoba.ca
Phone: 204-000-0000

I, _____, hereby give permission for the above-mentioned researcher to present the research data concerning my identifiable information in a public manner for being used in photovoice project and disseminated in photovoice exhibit and launch, in an academic thesis article and academic conferences.

By signing this form and checking “yes” in the following boxes, I voluntarily and knowingly waive my rights to the confidentiality of the following personal information that I have provided to the researcher and research participants (please check “yes” to the items that you agree to waive confidentiality of):

	Yes	No
My name on my photograph	()	()

Also, please specify what you do NOT want to be revealed to people other than the research team:

I understand that this waiver signed by me automatically overrides the protection for my confidentiality in the Consent Form that I have signed earlier, although other information in the Consent Form remains applicable.

I understand that signing this form does not waive my legal rights nor release the researchers from their legal and professional responsibilities. I have the right to revoke this waiver at anytime by notifying the researchers in writing or verbally. However, the researchers will not be responsible for any consequences of previous disclosure of my information up to the time of my revoking this waiver.

Signature of the person photographed _____ Date _____

Researcher’s Signature _____ Date _____

Appendix M
Sort Different Codes into Themes— Part Two

Theme	Subtheme	Code
Theme 1: non-recognition of non-Canadian credentials	<ul style="list-style-type: none"> • Structural barrier • Mental health impacts • Age of immigration 	<ul style="list-style-type: none"> ○ Non acceptance of credentials ○ Financial situation make it impossible to obtain Canadian credentials (rent/food, shift work, pay for school, take care of family, and so on) ○ No choice but to work in jobs that you are over qualified. Thus unable to do better as your credentials are not recognized. ○ Emotionally tortured ○ Prove yourself for several years ○ Loss of status ○ Draining ○ Stressful ○ Difficulty adapting to the situation ○ Loss of time studying (Spent 5, 7, or 10 years studying. Come to Canada and start from scratch) ○ Give up dreams/goals ○ Accept your going to be a second class citizen ○ If you have mental health problems it creates more environmental and social problem ○ Depression-not accepted in the community as you are ○ Experience differs amongst individuals who are raised in Canada from individuals who migrate as an adult
Theme 2: Importance of Culture		<ul style="list-style-type: none"> ○ Cultural Sensitivity- having an awareness of other cultures and diversity when beginning to understand others ○ Services through the lens of dominant culture ○ Cultural differences ○ There is a sense of belonging when culture and language is reflected in the community ○ Being understood
Theme 3: Role of Community		<ul style="list-style-type: none"> ○ Labeling/Blaming ○ Limited supports ○ Limited awareness regarding mental illness ○ Not accepted ○ Inequality ○ Limited social networks ○ Loneliness ○ Takes a community to heal- it takes more

		<p>than one person to help and support an individual going through a mental health problem. It takes a community. (Friendly neighbours, friends, family, co-workers, community resources, and so on).</p> <ul style="list-style-type: none"> ○ Lack of relationships
	<ul style="list-style-type: none"> ▪ Language barriers ▪ Eligibility Criteria ▪ Services 	<ul style="list-style-type: none"> ▪ Difficulty explaining symptoms ▪ Not understood by others ○ Poverty <ul style="list-style-type: none"> ▪ You need to fit under a specific category in order to receive supports. Instead of receiving services based on your unique need ▪ Most services disconnected from one another (contradictory) ▪ Waiting lists ▪ Medical terminology ▪ Mental illness itself can act as a barrier (foggy thinking) ▪ Not being aware ○ Inaction from community (not advocating, helping, talking about it) ○ Isolation ○ Connecting dots (quest)- having to figure out where to receive services, how to use tools provided. In other words putting the puzzle pieces together
Theme 5: Resiliency towards mental health		<ul style="list-style-type: none"> ○ Inner strength ○ Hope ○ New beginnings ○ Recovery is possible ○ Faith that things can get better

Appendix N
Sort Different Codes Into Themes: Part Three

Themes	Subthemes	Code
Theme 1: Consciousness raising		<ul style="list-style-type: none"> ○ Realization of the difficulty parents faced ○ Difficulties faced by immigrants ○ All the creativity found at one place
Theme 2: Learning from each other	<ul style="list-style-type: none"> ▪ Diversity 	<ul style="list-style-type: none"> ○ Different ideas from different culture/community ○ We are from 5 to 6 different nations ○ Exchanging new ideas ○ Learned a lot through discussion and picture selections ○ Learned a lot from group members (similarities and differences)
Theme 3: Importance of the project	<ul style="list-style-type: none"> ▪ Our voices 	<ul style="list-style-type: none"> ○ We have so much to offer but we are silenced, not heard, put to the side ○ Opportunity to use our voices ○ Help reduce social problems ○ Help new generation of newcomers to Canada ○ With so much creativity we deserve to shine ○ Relate to one another ○ Great conversation starter with community

Appendix O
Sort Different Codes Into Themes Part Four

Themes	Subthemes	Codes
Theme 1: Importance of Photovoice Project		<ul style="list-style-type: none"> ○ Give people voice ○ Express mental health without words ○ Share experiences ○ Understand each others journey/experiences ○ Photos connect emotions in all ○ Understanding through photos is universal ○ Destigmatization of mental illness ○ Great form of research (non-objectifying)
Theme 2: Consciousness raising		<ul style="list-style-type: none"> ○ Limited services for immigrants re: mental health ○ Limited social/community resources and structural barriers ○ Lack of services available in all languages& cultures ○ Non-recognition of credentials ○
Theme 3: Community members inspired		<ul style="list-style-type: none"> ○ Hope and positivity despite the barriers to care ○ Very moving, beautiful scenes ○ Inspires a lot of thinking that can help