A scoping review of mental health issues and concerns among immigrant and refugee youth in Canada: Looking back, moving forward

Sepali Guruge, RN, PhD,[1] Hissan Butt, BA (Hons)[2]

ABSTRACT

BACKGROUND: Youth comprise a significant portion of the total immigrant population in Canada. Immigrant and refugee youth often have different migration trajectories and experiences, which can result in different mental health outcomes. Research is emerging in this area, but study findings have not yet been consolidated.

RESEARCH QUESTION: What is known from the existing literature about mental health issues and concerns among immigrant and refugee youth in Canada?

METHOD: We searched Embase, Health Star, Medline, CINAHL, PsycINFO, and Social Science Abstracts databases for the period 1990–2013 for Canadian studies related to the mental health of youth born outside Canada. Seventeen studies met inclusion criteria.

RESULTS: Determinants of mental illness included pre-migration experiences, number of years since immigration to Canada, post-migration family and school environment, in- and out-group problems, discrimination, and lack of equitable access to health care. Only a few common categories of mental illness were identified, and the burden of mental illness was shared differently across gender and immigration status, with female youth experiencing more mental health problems than male youth. Some studies identified fewer emotional and behavioural problems among refugee youth; others reported higher rates of psychopathology among refugee youth compared with their Canadian-born provincial counterparts. Pre-migration experiences and the kinds of trauma experienced were important for refugee youth's mental health. Findings also indicated the importance of family involvement, school settings as points of care and services, and in terms of timing, focusing on the first year of arrival in Canada.

PRACTICE IMPLICATIONS: Professionals must work across health, social, and settlement sectors to address the various pre- and post-migration determinants of mental health and illness, and provide more timely and effective services based on how and when these determinants affect different groups of youth.

KEY WORDS: Canada; immigrant youth; mental health; mental illness; refugee youth; scoping review

La traduction du résumé se trouve à la fin de l'article.

Can J Public Health 2015;106(2):e72–e78
doi: 10.17269/CJPH.106.4588

One in five Canadians is born outside the country, and a large portion (approximately 22%) of the total immigrant population is composed of refugee and immigrant youth (aged 15–24 years).[1] In 2012, approximately 12% of the 234,793 immigrants admitted to Canada were youth, and of the 23,094 refugees admitted in the same year, approximately 21% were youth.[2] Refugee and immigrant youth often have different migration trajectories and experiences from each other, which may result in different mental health outcomes. Refugee youth have often fled war or natural disasters in their home countries and may be separated from their families or have had to depart their homes or countries without plans about how and where they will go. They may have lived for prolonged periods of time in refugee camps uncertain as to when they would migrate.[3,4] These experiences, along with others (such as torture, violence, forced labour, targeted persecution, and forced migration) have been suggested as determinants of mental illness among refugees.[3,5] In contrast, immigrant youth are more likely to arrive with their families, who have often had the chance to consider and plan their journey to the new country.[4,6,7]

Regardless of whether they come as immigrants or refugees, newcomers face common post-migration challenges that may affect their mental health.[8] Post-migration determinants of mental health and illness among immigrants and refugees have been identified at various levels: *individual* (e.g., age, gender, language fluency, ethnicity, knowledge of the health care system); *familial* (e.g., family (in)stability, socio-economic status, intergenerational conflict); *institutional* (e.g., availability (or lack)

Author Affiliations

1. Associate Professor, Daphne Cockwell School of Nursing, Ryerson University, Toronto, ON
2. Research Assistant, Division of Urology, The Hospital for Sick Children, Toronto, ON

Correspondence: Sepali Guruge, PhD, Daphne Cockwell School of Nursing, Ryerson University, 350 Victoria Street, Toronto, ON M5B 2K3, Tel: ☎416-979-5000, ext. 4964, E-mail: sguruge@ryerson.ca

Acknowledgements: This study was supported by a grant from the Ministry of Health and Long-Term Care (Grant # 06662). The first author also acknowledges financial support for her work from the Institute of Gender and Health of Canadian Institutes of Health Research in the form of a New Investigator Award.
Conflict of Interest: None to declare.

© Canadian Public Health Association, 2015. All rights reserved.

of access to appropriate care and services, (non)acceptance of foreign credentials); and *societal* (e.g., discrimination, racism, poverty).[8–10] Although both groups may be affected by the same post-migration determinants of mental illness, refugees may experience these determinants in "acute and unique ways," which may result in more mental health problems.[3] To date, findings from different studies about mental health among immigrant and refugee youth in Canada have not been consolidated.Therefore, we conducted a scoping review to assess the current state of knowledge about various aspects of mental health among immigrant and refugee youth in Canada, identify gaps within the literature, and provide implications for research, practice and policy.

METHOD

Various definitions of scoping reviews exist, along with various purposes that they can serve.[11] Mays, Roberts and Popay wrote that scoping reviews "aim to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available, and can be undertaken as stand-alone projects in their own right especially where an area is complex or has not been reviewed before".[12] Arksey and O'Malley suggested four objectives for scoping reviews: 1) to examine the extent, range and nature of research activity; 2) to determine the value of undertaking a full systematic review; 3) to summarize and disseminate research findings; and 4) to identify research gaps in the existing literature.[13] Our objectives were in line with 1, 3 and 4.

We applied the five-stage framework proposed by Arksey and O'Malley for conducting scoping reviews: Stage 1: Identifying the research question; Stage 2: Identifying the relevant studies; Stage 3: Selecting studies; Stage 4: Charting the data; and Stage 5: Collating, summarizing and reporting the results.

Stage 1: Identifying the research question

Our research question was: *What is known from the existing literature about mental health issues and concerns among immigrant and refugee youth in Canada?* We defined immigrant and refugee youth as those aged 13–29 years and born outside Canada, regardless of their official immigration status.

Stage 2: Identifying the relevant studies

With the help of an experienced librarian, we searched CINAHL, Embase, HealthStar, Medline, PsycINFO, and Social Science Abstracts (SSA) databases using the following combinations of keywords: immigrant/immigration/precarious/refugee/newcomer OR culture/cultural/multicultural/ethnocultural/minority/diversity/diverse AND mental health/mental disease/mental illness/mental disorder/mental problem/depression/schizophrenia/mood disorder/anxiety/posttraumatic stress disorder/psychiatry/psychiatric AND Canada. Inclusion criteria for articles were: 1) peer-reviewed; 2) focused on the Canadian context; 3) based on primary studies; 4) focused on immigrants and/or refugees; 5) published in English; and 6) published between January 1990 and August 2013.

The databases yielded a total of 1,384 articles (CINAHL: 74, Embase: 341, Health Star: 332, Medline: 318, PsycINFO: 247, and SSA: 72). We removed 722 duplicates from this set.

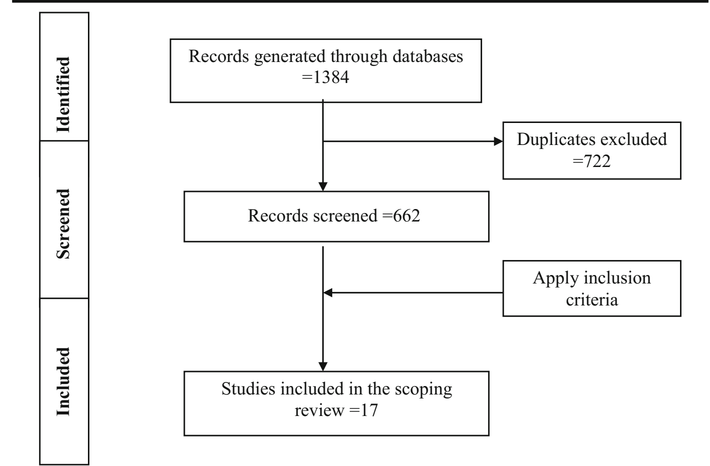

Figure 1. Flow chart: Literature search and selection

Stage 3: Selecting studies

We assessed the abstracts of the remaining 662 articles to confirm that: they were based on primary data, they had a mean/median age between the specified age range of 13–29, and at least 50% of study participants were born outside Canada. The latter criterion was determined easily if the articles explicitly used terms such as 'refugee(s)' and/or 'immigrant(s)' to identify the participants. If these criteria were not clear from the abstracts, articles were retrieved and read. A total of 44 full articles were read and 17 of these met the inclusion criteria and were included in this scoping review (see Figure 1).

Stage 4: Charting the data

The 17 articles were charted in Microsoft Excel 2011 using the following headings: Author/s; Name of journal; Year of publication; Title; Aim of the study; Focus area; Study method; Study design; Ethnicity; Age; Immigration status; Gender; Sample size; Study setting; Data collection; Data analysis; Major findings; Limitations; and Implications for research, practice, and policy. Table 1 displays the charted data (with the exception of the findings, limitations and implications).

Stage 5: Collating, summarizing and reporting the data

Based on the content of the articles included in the scoping review, we devised the following categories of focus and placed each article in the appropriate category: determinants of mental health; rates of mental symptoms/illness; and program evaluation/intervention. Common themes across articles were identified, and when possible, articles were compared.

The next sections present the findings.

Characteristics of the studies included

In the 17 articles selected for analysis, sample sizes ranged from 10–281. Eleven (65%) studies were conducted in Quebec and five (29%) in Ontario. One study was conducted in both Quebec and Ontario. All studies were carried out in major metropolises. In terms of study design, 15 (88%) studies were cross-sectional and 2 (12%) were longitudinal. Three (18%) were qualitative and the remaining 14 (82%) used mixed methods.

Table 1. Charted data

No.	Author information	Sample information	Research design	Focus area
1	Hyman et al. 2000[14]	Ethnicity or country/continent of birth/ origin: South-east Asian Age: Range = 10–24; mean/median = * Immigration status: Refugees Gender: M & F Sample size: 52 Location: Ontario	Method: Qualitative Design: Cross-sectional Collection: Interviews, focus groups Analysis: Qualitative analysis	Determinants of mental health
2	Jorden et al. 2009[15]	Ethnicity or country/continent of birth/ origin: Somali Age: Range = 18–62; mean = 29 Immigration status: Refugees Gender: M & F Sample size: 169 Location: Ontario	Method: Mixed Design: Cross-sectional Collection: Questionnaires, interviews Analysis: Multiple regression analysis; qualitative analysis	Determinants of mental health
3	Khanlou et al. 2006[16]	Ethnicity or country/continent of birth/ origin: Korea, China, Russia, Taiwan, Macao Age: Range = n/a; Mean = 17 Immigration status: n/a; 100% of sample born outside Canada Gender: F Sample size: 10 Location: Ontario	Method: Qualitative Design: Cross-sectional Collection: Interviews, focus groups Analysis: Qualitative analysis	Determinants of mental health
4	Lay et al. 1998[17]	Ethnicity or country/continent of birth/ origin: Vietnamese Age: Range: 19–34; median 22 Immigration status: Immigrants and refugees Gender: M & F Sample size: 60 Location: Ontario	Method: Mixed Design: Cross-sectional Collection: Questionnaires Analysis: Multiple regression analysis	Determinants of mental health
5	Pak et al. 1991[18]	Ethnicity or country/continent of birth/ origin: Chinese Age: Range = n/a: 26% 18–19 years; 68% early 20s Immigration status: n/a; 88% of sample born outside Canada Gender: M & F Sample size: 90 Location: Ontario	Method: Mixed Design: Cross-sectional Collection: Questionnaires Analysis: Variance and covariance analyses using general linear model procedure	Determinants of mental health and rates of mental symptoms/illness
6	Persson et al. 2012[19]	Ethnicity or country/continent of birth/ origin: Asia, Latin America, Africa, Europe, North America Age: Range = 12–18; mean = 15.5 Immigration status: Immigrants and refugees Gender: M & F Sample size: 111 Location: Quebec	Method: Mixed Design: Cross-sectional data from a longitudinal study Collection: Questionnaires Analysis: Multiple linear regression	Determinants of mental health
7	Rousseau et al. 1998[20]	Ethnicity or country/continent of birth/ origin: Central American and Cambodian Age: Range: = 12–16; mean = 14 Immigration status: Refugees Gender: M & F Sample size: 158 adolescents of a total sample of 281. The remaining sample consisted of children 8–12. Location: Quebec	Method: Mixed Design: Cross-sectional Collection: Interviews Analysis: Comparisons of means and Spearman correlation coefficients	Rates of mental symptoms/illness
8	Rousseau et. al. 1998[21]	Ethnicity or country/continent of birth/ origin: Somali Age: Range = 13–18; mean = n/a Immigration status: Refugees Gender: M Sample size: 10 Study setting/location: Ontario and Quebec	Method: Qualitative Design: Cross-sectional Collection: Interviews Analysis: n/a (qualitative ethnographic analysis?)	Determinants of mental health
9	Rousseau et al. 2000[22]	Ethnicity or country/continent of birth/ origin: Central American and Cambodian Age: Range = n/a; mean = 14 Immigration status: Refugees Gender: M & F Sample size: 152 Location: Quebec	Method: Mixed Design: Cross-sectional Collection: Interviews Analysis: Difference between mean scores and percentage using confidence intervals, correlation analyses, Spearman rank correlation coefficient	Determinants of mental health
10	Rousseau et al. 2000[23]	Ethnicity or country/continent of birth/ origin: Central American, Cambodian. Age: Range = n/a; mean = 15 Immigration status: n/a; all Central American and Cambodian youth born outside Canada Gender: M & F Sample size: 158 of 225 Central American and Cambodian youth Location: Quebec	Method: Mixed Design: Cross-sectional Collection: Interviews and questionnaire Analysis: Means, confidence intervals, multiple regression	Rates of mental symptoms/illness

continues...

Table 1, continued

No.	Author information	Sample information	Research design	Focus area
11	Rousseau et al. 2003[24]	Ethnicity or country/continent of birth/ origin: Cambodian Age: Range = n/a; mean at baseline = 14 Immigration status: Refugees Gender: M & F Sample size: 57 Location: Quebec	Method: Mixed Study design: Longitudinal Collection: Interviews Analysis: Generalized linear models, Spearman correlation coefficient, means comparisons, odds ratios	Determinants of mental health; Rates of mental symptoms/illness
12	Rousseau et al. 2004[25]	Ethnicity or country/continent of birth/ origin: Cambodian Age: Range = n/a; mean at baseline = 14 Immigration status: Refugees Gender: M & F Sample size: 67 Location: Quebec	Method: Mixed Design: Longitudinal Collection: Interviews Analysis: Paired *t*-tests, multiple linear regression analyses	Determinants of mental health
13	Rousseau et al. 2007[26]	Ethnicity or country/continent of birth/ origin: Asia, Eastern Europe, South America, Middle East and Africa Age: Range = 12–18; mean = 15 Immigration status: Refugees and immigrants Gender: M & F Sample size: 123 Location: Quebec	Method: Mixed Design: Cross-sectional Collection: Questionnaires Analysis: Univariate generalized linear models	Program evaluation
14	Rousseau et al. 2008[27]	Ethnicity or country/continent of birth/ origin: Caribbean & Filipino (and Quebecois) Age: Range = 12–19; mean: 15 Immigration status: n/a; 63% born outside of Canada Gender: M & F Sample size: 252 of 319 Caribbean-Canadian and Filipino-Canadian youth Location: Quebec	Method: Mixed Design: Cross-sectional Collection: Interviews Analysis: Descriptive statistics; *t*-tests and chi-tests	Rates of mental symptoms/illness
15	Rousseau et al. 2009[28]	Ethnicity or country/continent of birth/ origin: Caribbean and Filipino Age: Range 12–19; mean 15 Immigration status: n/a; 61% born outside of Canada Gender: M & F Sample size: 254 Location: Quebec	Method: Mixed Design: Cross-sectional Collection: Interviews, focus groups with youth Analysis: Qualitative analyses; Pearson correlations and *t*-tests, correlations, hierarchical multiple regression	Determinants of mental health
16	Rousseau et al. 2012[29]	Ethnicity or country/continent of birth/ origin: Africa, Latin America and Caribbean, Asia, Other Age: 12–18; mean: 15 Immigration status: Immigrant and refugees Gender: M & F Sample size: 55 Location: Quebec	Method: Mixed Design: Cross-sectional Collection: Interviews Data analysis: Chi-square, *t*-test, paired *t*-test; qualitative analysis of participant observation	Interventions
17	Tousignant et al. 1999[30]	Ethnicity or country/continent of birth/ origin: Over 35 countries Age: 13–19; mean: 16 Immigration status: Refugees Gender: M & F Sample size: 203 Location: Quebec	Method: Mixed Design: Cross-sectional Data collection: Interviews at home, university, or community centre in multiple languages Data analysis: Chi-squared test with Yates correction	Rates of mental illness

*Mean age for individual interviews = 16; age range for 3 focus groups = 13–24.

Age ranges of study populations fell within our definition of youth (13–29 years of age) in 2 of the 17 studies (12%). Nine (53%) studies were labeled as 'mixed,' which included children (<12 years) and youth, or youth and adults (>29 years), or children, youth and adults, and the mean or median age of the study sample was between 13 and 29 years. The remaining six studies (35%) did not mention the age range of participants, but were included in our review because the mean or median age of their study populations were between 13 and 29 years.

Eight (47%) studies included refugee youth and three (18%) included both immigrant and refugee youth. The remaining six studies (23%) did not clearly state the official immigration status of the study participants. However, these studies did provide information about their birthplaces. In terms of gender, one (6%) study focused on young women; one (6%) on young men; and the other 15 (88%) articles included young men and women. The studies captured ethnicity in different ways: many used categories such as 'country of origin,' 'country of birth,' or 'continent of birth' instead of ethnicity. Six (43%) studies included only one ethnic group (e.g., ref. 21). Eleven (65%) studies focused on more than one ethnicity (e.g., ref. 22). A few ethnic groups were common across a number of articles. For example, Cambodian youth were discussed in five articles, Central American in three, Caribbean in three, Somali in two, and Filipino in two.

Summary of study findings

Three themes emerged from the articles: *determinants of mental health* were discussed in nine articles, *rates of mental illness* in four, and *program evaluation/intervention* in two. Two articles

discussed both determinants of mental health and rates of mental illness. Mental health problems discussed in the articles included but were not limited to emotional and conduct problems ($n = 4$), depression ($n = 3$), self-esteem ($n = 2$), stress ($n = 1$), anxiety ($n = 1$), and conduct disorders ($n = 1$).

Determinants of mental health included both pre- and post-migration determinants. Pre-migration determinants included pre-migration experiences, culture and trauma. Pre-migration experiences and culture appeared to provide youth of various ethnocultural backgrounds and genders with coping mechanisms in Canada. For example, one study reported that Somali refugee youth were relatively "protected" through the collective meaning of separation embedded in their "nomadic" culture.[21] Two types of pre-migration trauma, personal and collective, and their effects on cultural adaptation and mental health were discussed. For example, one study reported that Somali refugees' experiences of pre-migration collective trauma (exposure to warfare, ethnic discrimination, stay in a refugee camp) were *not* related to depressive symptoms, although these experiences were associated with *poorer* adaptation. However, personal trauma (serious accident, death of a loved one, assault from a familiar other, etc.) was associated with depressive symptoms among Somali refugee youth.[15] A study with Cambodian youth[24] contested the negative relation between collective trauma and adaptation, but confirmed that the relation between collective trauma and mental health may not necessarily be negative: Cambodian families exposed to political violence prior to migration reported *positive* 'social adjustment' and *fewer* mental health symptoms.[24] In another study,[19] however, immigrant and refugee youth who had experienced collective and/or personal trauma self-reported greater emotional problems. The latter study involved youth participants from a range of countries of origin. Post-migration determinants included the number of years since immigration to Canada (negatively related to depression),[17] in- and out-group conflict (positively related to depression),[17] discrimination (associated with increase in stress symptoms),[18] family environment (associated with externalization),[25] and family structure (associated with internalization).[25] The Youth Self Report (YSR) was used to measure internalizing and externalizing symptoms, and the Family Environment Scale (FES) was used to measure family environment, specifically cohesion and conflict.[25]

Rates of mental illness appeared to vary by gender, ethnicity, and immigration status. According to one study,[30] female refugee adolescents (from a range of countries of origin) had higher rates of psychopathology than their male refugee counterparts. Another study[18] reported that Chinese female youth had lower self-esteem than their Chinese male counterparts after experiencing discrimination. In one study, Central American refugee youth reportedly had fewer emotional and behavioural problems compared with both Cambodian and Québécois youth.[23] However, another study[20] found no significant difference in self-reported psychiatric symptoms between Central American and Cambodian adolescents. Canadian-born youth were reported in one study to have lower rates of psychopathology in comparison with their refugee youth counterparts.[30] Another study reported that Canadian-born youth had higher rates of emotional and behavioural problems and were more likely to engage in risky behaviours compared with Central American and Cambodian refugee youth.[23] These findings were substantiated by another study in which Caribbean and Filipino youth reported fewer behavioural problems than their Canadian-born provincial counterparts.[27]

Two articles discussed a *program* and an *intervention* designed for immigrant and refugee adolescents in schools. The first evaluated a 9-week school drama therapy program[26] and the second evaluated an intervention involving a 12-week series of workshops integrating drama and language awareness.[29] Both of these studies reported post-program/intervention reductions in impairment related to emotional and behavioural symptoms among participants compared with comparison groups. For the 9-week drama therapy program, performance in mathematics increased significantly compared with the comparison group, although there was no reported improvement in self-esteem or emotional and behavioural symptoms. This program also appeared to be associated with "a decrease in impairment in girls, while the program appeared to prevent an increase in impairment in boys."[26]

DISCUSSION

The findings presented above should be interpreted with caution for several reasons related primarily to the methods used in the original studies. First, studies often used non-representative and small samples, which did not permit inferences to be made about youth from the particular ethnic group or across groups. Second, all the studies took place in Ontario and/or Quebec, and one research team conducted 10 of the 11 Quebec-based studies. The findings cannot, therefore, be generalized to immigrant and refugee populations across Canada. Third, only a few mental illnesses were examined across the studies. Depression was mentioned in three studies but in different contexts, without much basis to draw comparisons between particular groups of youth. Fourth, although the studies generally reported gender differences, it was difficult to identify the challenges faced specifically by female and male youth because these were not explicitly discussed. Fifth, although there were a few common ethnic groups across articles, the focus areas of these articles did not necessarily converge, making it difficult to draw conclusions about the status of a specific ethnic group. For example, the five articles that included Cambodian youth covered three separate themes. Finally, no studies explicitly compared the rates of mental illness among immigrant and refugee youth, thus preventing comparisons and conclusions regarding their mental health.

Pre-migration trauma appeared as a complex factor for the post-migration mental health of refugee youth. The relationship between pre-migration collective trauma and cultural adaptation in the 'host' country appeared to conflict: Somali refugees who had experienced collective trauma prior to migration (e.g., through civil war), had 'poorer cultural adaptation',[15] whereas Cambodian refugee youth, after exposure to political violence in their home country, reported positive 'social adjustment'.[24] The relationship between collective trauma and mental health was also not clear, as some findings suggest collective trauma could act as a protective factor. To determine whether trauma is a risk or protective factor in refugee youth mental health, it would be

necessary to consider not only the intensity and duration of trauma, but the age at which the trauma is experienced. Even when the trauma is experienced as collective, the intensity of its effects may vary among and between groups of youth. It is also important to note that the two articles that examined this relationship had relatively small samples (57 and 169), and (as noted above) focused on only two ethnic groups (one on Cambodian youth and one on Somali youth). More research with larger sample sizes and more ethnic groups is needed to further clarify these findings.

The importance of engaging families in addressing the mental health and illness concerns of immigrant and refugee youth was highlighted in a number of articles. One study[20] recommended the involvement of multiple informants, especially from the family, to bring in multiple perspectives about the mental health of their children. The school was commonly identified as an important site to address the needs of immigrant and refugee youth, and the two programs/interventions that appeared to offer innovative approaches to address the mental health needs of immigrant and refugee youth were both located in schools. The 12-week intervention was designed to help youth cope with adversity, and the 9-week program was designed to prevent emotional and behavioural problems and to improve school performance. Evaluation of the program revealed a differential impact based on gender, which should be taken into account when designing future programs. One article suggested traditional methods for dealing with assimilation in the new country, such as family therapy.[25] One article recommended reaching out to refugee youth, especially during their turbulent first year of arrival in Canada.[30] One article recommended using self-reported questionnaires in schools to assess symptoms quickly.[19] Overall, considerably more research is needed to evaluate various aspects of such interventions and programs to clarify which components of which intervention could be of long-term benefit, to which groups of youth, at which period of post-migration, in which settings.

Limitations

One key limitation of our scoping review was the exclusion of grey literature, which can include important research conducted by community organizations. Second, our literature search did not include a comprehensive search of social science databases, which could have yielded additional articles on the topic. Third, we did not search for articles on addictions – which are often perceived as part of the mental health, illness, and disorder continuum. Fourth, we followed the suggestion of Arksey and O'Malley (2005) and did not assess the quality of studies included (which could be done in a systematic review). Despite these limitations, this scoping review makes valuable contributions to the existing body of literature about immigrants and refugee youth and their mental health, by identifying research gaps and providing recommendations/ implications for research, practice and policy.

Implications for research, practice and policy

The small number of articles (n = 17) published over a 23-year period demonstrates the paucity of research focused on mental health among immigrant and refugee youth in Canada. Substantially more research is needed on this topic. In particular, more research is needed to assess the prevalence rates and pre- and post-migration factors to explain variability in symptoms, and to gain a holistic picture of the mental health of refugee and immigrant youth. More research is also needed to assess the use of mental health services among youth of both genders and of various ethnic groups, immigration status, and length of stay in Canada. Potential subject areas for future study include trauma, resilience, and protection among refugee youth, further clarification of the determinants of mental health, pathways to care, and the dynamics within immigrant and refugee families (e.g., parent–child relations) and between the family and the socio-economic environment. Future research could also explore the reasons for potential variability in specific mental illnesses by gender and immigrant groups. Many of the articles stressed the need for longitudinal research to explore specific mental health issues among individuals and subpopulations over time, as well as the need for gender-based analyses to identify different styles of coping across genders and ethnic groups.

The articles revealed several implications for practice, such as the importance of family involvement and school settings as points of care. Both of the programs/interventions were based in schools, and drama therapy programs and workshops appear to be promising, although more research is required to evaluate their effectiveness in the medium and long term. Reaching out to refugee youth, especially during their first year of arrival in Canada, may be helpful. Health care professionals should work across health, social, and settlement sectors to address the various determinants of mental health and provide more effective services based on how these have differential effects on various youth groups.

The articles also revealed some implications for policy. Policies need to be developed with an awareness of the importance of and need for intersectoral collaboration to reduce structural discrimination and racism, which negatively affect immigrant and refugee youth. Policies should also include multisectoral and context-specific mental health promotion programs: different sectors need to work together to address mental health issues among immigrant and refugee youth, particularly at the time of arrival, to assess their health status and refer them to the appropriate services. This kind of pre-emptive action may help prevent the costs of treatments associated with the management of full-blown mental illnesses, and benefit youth, their families, and society.

REFERENCES

1. Statistics Canada. NHS Profile, Canada, 2011. Ottawa, ON: Statistics Canada, 2013. Available at: http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=01&Data=Count&SearchText=Canada&SearchType=Begins&SearchPR=01&A1=All&B1=All&GeoLevel=PR&GeoCode=10 (Accessed February 5, 2014).
2. Department of Citizenship and Immigration Canada Facts and Figures 2013: Immigration Overview. Available at: http://www.cic.gc.ca/english/resources/menu-research-stats.asp (Accessed March 11, 2015).
3. Wilson RM, Murtaza R, Shakya YB. Determinants of mental health for newly arrived refugees in Toronto. *Canadian Issues: Immigrant Mental Health* Summer 2010;45–50.
4. Hynie M, Guruge S, Shakya YB. Family Relationships of Afghan, Karen and Sudanese refugee youth. *Can Ethn Stud* 2013;44(3):11–28.
5. Beiser M, Simich L, Pandalangat N. Community in distress: Mental health needs and help-seeking in the Tamil community in Toronto. *Int Migr* 2003;41(5):233–45.

6. Guruge S, Khanlou N. *Refugee Youth, Gender and Identity: On the Margins of Mental Health Promotion. Not Born a Refugee Woman*. New York, NY: Berghahn Books, 2008; 173–79.
7. Shakya YB, Guruge S, Hynie M, Akbari A, Malik M, Htoo S, et al. Aspirations for higher education among newcomer refugee youth in Toronto: Expectations, challenges, and strategies. *Refuge* 2010;27(2):65–78.
8. Pumariega AJ, Rothe E, Pumariega JB. Mental health of immigrants and refugees. *Community Ment Health J* 2005;41(5):581–97.
9. Beiser M, Hou F, Hyman I, Tousignant M. Poverty, family process, and the mental health of immigrant children in Canada. *Am J Public Health* 2002; 92(2):220–27.
10. O'Mahony JM, Donnelly TT. The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers. *Issues Ment Health Nurs* 2007;28(5):453–71.
11. Levac D, Colquhoun H, O'Brien KK. Scoping studies: Advancing the methodology. *Implement Sci* 2010;5:69.
12. Mays N, Roberts E, Popay J. Synthesizing research evidence. In: Fulop N, Allen P, Clarke A, Black N (Eds.), *Studying the Organisation and Delivery of Health Services: Research Methods*. London, UK: Routledge, 2001;194.
13. Arksey H, O'Malley L. Scoping studies: Towards a methodological framework. *Int J Soc Res Methodol* 2005;8(1):19–32.
14. *Hyman I. Post-migration stresses among Southeast Asian refugee youth in Canada: A research note. *J Comp Fam Stud* 2000;31(2):281–93.
15. *Jorden S, Matheson K, Anisman H. Supportive and unsupportive social interactions in relation to cultural adaptation and psychological distress among Somali refugees exposed to collective or personal traumas. *J Cross Cult Psychol* 2009;40(5):853–74.
16. *Khanlou N, Crawford C. Post-migratory experiences of newcomer female youth: Self-esteem and identity development. *J Immigr Minor Health* 2006;8(1):45–56.
17. *Lay C, Nguyen T. The role of acculturation-related and acculturation non-specific daily hassles: Vietnamese-Canadian students and psychological distress. *Can J Behav Sci* 1998;30(3):172–81.
18. *Pak AW, Dion KL, Dion KK. Social-psychological correlates of experienced discrimination: Test of the double jeopardy hypothesis. *Int J Intercult Relations* 1991;15(2):243–53.
19. *Persson TJ, Rousseau C. The association between migratory factors and emotional and behavioural symptoms in very recently arrived immigrant and refugee adolescents. *Adolesc Psychiatry (Hilversum)* 2012;2(1):46–51.
20. *Rousseau C, Drapeau A. Parent-child agreement on refugee children's psychiatric symptoms: A transcultural perspective. *J Am Acad Child Adolesc Psychiatry* 1998;37(6):629–36.
21. *Rousseau C, Said TM, Gagné MJ, Bibeau G. Resilience in unaccompanied minors from the north of Somalia. *Psychoanal Rev* [Internet] 1998;85(4):615–37.
22. *Rousseau C, Drapeau A. Scholastic achievement of adolescent refugees from Cambodia and Central America. *Adolescence* 2000;35(138):243–58.
23. *Rousseau C, Drapeau A, Platt R. Living conditions and emotional profiles of Cambodian, Central American, and Québécois youth. *Can J Psychiatry* 2000;45(10):905–11.
24. *Rousseau C, Drapeau A, Rahimi S. The complexity of trauma response: A 4-year follow-up of adolescent Cambodian refugees. *Child Abuse Negl* 2003;27(11):1277–90.
25. *Rousseau C, Drapeau A, Platt R. Family environment and emotional and behavioural symptoms in adolescent Cambodian refugees: Influence of time, gender, and acculturation. *Med Confl Surviv* 2004;20(2):151–65.
26. *Rousseau C, Benoit M, Gauthier M-F, Lacroix L, Alain N, Viger Rojas M, et al. Classroom drama therapy program for immigrant and refugee adolescents: A pilot study. *Clin Child Psychol Psychiatry* 2007;12(3):451–65.
27. *Rousseau C, Hassan G, Measham T, Lashley M. Prevalence and correlates of conduct disorder and problem behavior in Caribbean and Filipino immigrant adolescents. *Eur Child Adolesc Psychiatry* 2008;17(5):264–73.
28. *Rousseau C, Hassan G, Measham T, Moreau N, Lashley M, Castro T, et al. From the family universe to the outside world: Family relations, school attitude, and perception of racism in Caribbean and Filipino adolescents. *Health Place* 2009;15(3):721–30.
29. *Rousseau C, Armand F, Laurin-Lamothe A, Gauthier M-F, Saboundjian R. A pilot project of school-based intervention integrating drama and language awareness. *Child Adolesc Ment Health* 2012;17(3):187–90.
30. Tousignant M, Habinama E, Biron C, Malo C, Sidoli-LeBlanc. The Quebec adolescent refugee project: Psychopathology and family variables in a sample from 35 nations. *J Am Acad Child Adolesc Psychiatry* 1999;38(11):1426–32.

* Those references included in the scoping review are identified with an asterisk.

Received: May 15, 2014
Accepted: November 1, 2014

RÉSUMÉ

CONTEXTE : Les jeunes représentent une part importante de la population immigrante au Canada. Les jeunes immigrants et réfugiés ont souvent des trajectoires et des expériences migratoires différentes, ce qui peut entraîner des différences dans leurs résultats de santé mentale. La recherche en ce domaine commence à émerger, mais les constatations des études n'ont pas encore été regroupées.

QUESTION DE RECHERCHE : Que dit la littérature actuelle sur les problèmes et les préoccupations de santé mentale des jeunes immigrants et réfugiés au Canada?

MÉTHODE : Nous avons interrogé les bases de données Embase, Health Star, Medline, CINAHL, PsycINFO et Social Sciences Abstracts pour la période de 1990 à 2013 afin de répertorier les études canadiennes portant sur la santé mentale des jeunes nés à l'extérieur du Canada. Dix-sept études ont répondu à nos critères d'inclusion.

RÉSULTATS : Les déterminants de la maladie mentale étaient les expériences pré-migratoires, le nombre d'années depuis l'immigration au Canada, le milieu familial et scolaire post-migration, les problèmes intra- et extra-groupe, la discrimination et le manque d'accès équitable aux soins de santé. Seul un petit nombre de catégories courantes de maladies mentales ont été répertoriées, et le fardeau de la maladie mentale était inégalement réparti selon le sexe et le statut d'immigration, les jeunes filles éprouvant davantage de troubles de santé mentale que les jeunes garçons. Certaines études font état d'un moins grand nombre de problèmes émotionnels et comportementaux chez les jeunes réfugiés; d'autres observent des taux supérieurs de psychopathologies chez les jeunes réfugiés comparativement à leurs homologues provinciaux nés au Canada. Les expériences pré-migratoires et les types de traumatismes vécus sont importants pour la santé mentale des jeunes réfugiés. Les constatations indiquent aussi l'importance de l'implication familiale, du milieu scolaire en tant que point d'intervention et de service, et de la première année suivant l'arrivée au Canada.

IMPLICATIONS PRATIQUES : Les professionnels doivent travailler à la fois dans le secteur sociosanitaire et avec les services d'établissement pour aborder les divers déterminants pré- et post-migratoires de la santé et de la maladie mentales; ils doivent également offrir des services plus rapides et plus efficaces, fondés sur la façon dont ces déterminants affectent différents groupes de jeunes et sur le moment où ils les affectent.

MOTS CLÉS : Canada; jeunes immigrants; santé mentale; maladie mentale; jeunes réfugiés; étude de champ