COMPASSIONATE ADMISSION AND SELF-DEFEATING NEGLECT: THE MENTAL HEALTH OF REFUGEES IN CANADA

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ABSTRACT

The Ryerson University Refugee Resettlement Project, a decade-long investigation of the admission and resettlement of 1348 Southeast Asian "Boat People," is the largest and longest-lived investigation of refugee resettlement and mental health ever attempted. Findings are summarized in the form of four propositions: i) considerations of refugee mental health must take into account not only vulnerabilities but also resilience and its sources ii) resettlement is a long, perhaps even a life-long process iii) men and women experience resettlement differently and iv) mental health is human capital. Each of these propositions is illustrated by research findings.

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Canada is one of 147 countries who have signed the UN Convention on refugees, pledging to provide asylum for the persecuted and the stateless. Canada is also one of a much smaller group of Convention signatories—about 20—who offer not just temporary protection, but the option of permanent resettlement. Although protecting the oppressed is consistent with our national values, critics question the wisdom of this country's relatively generous refugee policies. They ask how much it costs to admit and resettle refugees, and whether the demand for mental health and social services is a drain on the country's resources.

The Ryerson University Refugee Resettlement Project, a decade-long investigation of the admission and resettlement of 1348 Southeast Asian "Boat People," provides some answers. It also points to ways in which policy and practice could be improved in order to better safeguard the mental health and human capital of refugees coming to Canada.

THE REFUGEE RESETTLEMENT PROJECT

The admission of a large complement of Southeast Asian "Boat People" between 1979 and 1981 was a singular and important event in Canadian immigration history. Prior to 1979, Canada's response to asylum seekers had ranged from tight-fisted to shameful. In a dramatic about-face, this country responded to the Southeast Asian refugee crisis by admitting more people on a per capita basis than any other country. In the years since, Canada has become a world leader in refugee and immigrant affairs, and the citizens of Canada have gained an enviable reputation as people who care.

The history of the Boat People crisis begins with the fall of Saigon in 1975, an event that precipitated a large-scale exodus from Southeast Asia. Shortly after their victory over the combined forces of the US and the South Vietnamese military, the new North Vietnamese communist government sealed the country's borders. A few years later, angered by China's incursions along its northern border, Hanoi expelled all ethnic Chinese living in Vietnam. Ethnic Vietnamese, unhappy about living under the communist regime, took advantage of the confusion surrounding the massive expulsions to escape along with the Chinese. At roughly the same time, Vietnam began conducting raids on neighbouring Southeast Asian countries. The ensuing instability created

an opportunity for Cambodians to escape the tyranny of Pol Pot, and for Laotians who feared retaliation because of previous alliances with the west to flee their homeland.

Canada's 1976 Immigration Act contained a provision for private sponsorship of refugees. To encourage individuals as well as organizations such as church groups to become private sponsors, the government of the day pledged to match every refugee admitted under private auspices with another to be sponsored by government. The final tally of refugee admissions between 1979 and 1981 was 60,000, among whom 5,000 were resettled in and around Vancouver, British Columbia. With funding from Canada's National Health Research and Development Program (NHRDP) in 1981, two University of British Columbia (UBC) colleagues, Dr. Phyllis Johnson and Dr. Richard Nann, and I initiated the Refugee Resettlement Project (RRP). We conducted an initial mental health survey on a community sample of 1348 adult refugees in 1981, and two follow-up surveys, the first in 1983, the last in 1991. When I left UBC in 1991, the administrative base for the project shifted to the University of Toronto, and from there to Ryerson, the first university in Canada to declare a major focus on immigration studies. RRP products include one book (Strangers at the Gate, University of Toronto Press, 1999) and approximately 50 scientific publications. This article recaps some important lessons learned from the study in the form of propositions: i) there is a need to shift from a single-minded focus on risk factors that jeopardize mental health to a broader framework that includes not only risk, but an understanding of resilience and its determinant, ii) resettlement is a long, perhaps even a life-long process; iii) men and women experience resettlement differently; and iv) mental health is human capital.

Proposition 1: Challenge and Resilience: By definition, refugees have suffered trauma and persecution, experiences that jeopardize mental health. On top of that, coming to Canada entails challenges—cultural disruption, separation from family and community, and the need to learn a new language and new ways of doing things—all of which threaten well-being. Since all refugees suffer these psychological assaults, the rate of mental disorder among refugees could potentially be very high. However, most refugees never become mental health casualties. Despite all the pre- and post-migration challenges they face, most refugees manage to attain some degree of inner peace, to work, and to find a way to integrate into Canadian society. In other words, risk does not necessarily translate into damaged mental health. Human resilience helps convert risk into challenges, most of which refugees apparently manage to overcome. Finding ways to support the personal and social resources that promote resilience is at least as important as identifying pre- and post-migration miseries.

According to the RRP results, the availability of a like-ethnic community is one of the most powerful forces promoting resilience, at least in the short and medium term. In 1981, when the refugees arrived in Vancouver, that city could boast one of the largest Chinese communities anywhere in North America. There were, however, no Vietnamese, Laotian or Cambodian communities in place. In 1981, the rate of depression among non-Chinese refugees was three times higher than it was for the Chinese. The mental health advantage did not last long. By 1983, non-Chinese rates of depression dropped to the point where they equalled Chinese rates. During that time, the non-Chinese were establishing their own ethnic-based communities thereby linking an uncertain present to the past, and affirming the worthiness of their shared history and culture within the largely uncomprehending European-dominated Canadian society of that era.

Newcomers do not always have ready-made like-ethnic communities waiting for them. Someone has to be the first to arrive. Canada's decision to admit the Southeast Asian refugees under either private or government sponsorship created an "experiment in nature" that the RRP investigators used to test the idea that private sponsors might potentially provide the support refugees typically look for in like-ethnic communities.

Like all citizens and permanent residents of Canada, the refugees were entitled to provincially administered insured health care. Many received language training in federally funded programs, and their children attended schools supported by provincial tax dollars. Privately sponsored refugees got a little extra. Sponsors were obliged to provide financial support for the person or family they sponsored for a period of one year, or until the person or family had achieved financial stability, whichever came first. Moved by the horrors of the Southeast Asian experience, most private sponsors did much more: they helped refugees find jobs, schools for their children, doctors and dentists.

Assuming that the level of welcome the privately sponsored group received would give them an advantage over the government sponsored whose only official guide to the new society was a usually overworked civil servant, we predicted that privately sponsored refugees would enjoy better mental health than the government sponsored refugee. In the short run, the prediction proved wrong. There were no mental health differences between the two groups in 1981 or in 1983. In retrospect, government and academics were more impressed with the virtues of private

sponsorship than the refugees themselves. Half of all privately sponsored Southeast Asian refugees and almost all the government sponsored refugees said that government sponsorship was preferable. One reason was that private sponsors sometimes confused kindliness with intrusiveness, calling the refugees at all hours and insisting on taking them to various activities. They forgot that refugee families, like all other families, need and value privacy. Sponsors were sometimes insensitive to the refugees' needs. For example, they often found housing that the refugees could no longer afford after the sponsorship period terminated. Inequality was another source of discontent. Government sponsored refugees all got the same treatment, whereas, in the words of one refugee, "With private sponsorship, sometimes it depended on luck whether you met a nice group or not."

A sub-group of privately sponsored refugees in the RRP was, in fact, at greater risk for depression than the government sponsored. These were refugees whose religions did not match their sponsors. Most of the sponsors were Christian or non-denominational, most of the refugees were either Christian, Buddhist or members of one of the smaller Southeast Asian religious groups. Non-Christian refugees sponsored by Christian groups developed very high rates of depression.

Although some overt attempts to proselytize the refugees probably contributed to the burden of depression among the religiously-mismatched privately sponsored refugees, other, more wide-spread psychological pressures operated at a more subtle level. The refugees had difficulty understanding the concept of voluntary sponsorship. Since the sponsors were not family, but strangers, many refugees reasoned that something was required in return. Virtually all the sponsoring groups had been organized through a network of multi-faith religious institutions. Since religious institutions provided the context for sponsorship, the refugees came to believe that they were expected to adopt their sponsors' religions. Some did and regretted it. Others did not, but felt they were being ungrateful. Both circumstances increased the risk of depression.

Proposition 2: Resettlement is a long, perhaps even a life-long process. Factors that jeopardize or protect mental health early on can recede in importance over time, to be replaced by others that are more important for the later stages of resettlement.

Without language one can never really enter a new society. Two years after their arrival in Vancouver, 17 per cent of the refugees in the RRP sample spoke English well, 67 per cent had moderate command of the language, and 16 per cent spoke no English. Ten years later, 32 per cent had good language skills, 60 per cent moderate skills, and 8 per cent still spoke no English. It is troubling that, as long as a decade after arriving in Canada, a small, but significant number of newcomers had not acquired one of the most basic tools for integration.

During the initial period of resettlement, English-speaking ability had no effect on depression or on employment. By the end of the first decade in Canada, however, English language fluency was a significant predictor of depression and employment, particularly among refugee women and among people who did not become engaged in the labor market during the earliest years of resettlement.

Young, well educated male refugees were the most likely to learn English during the first year or two in Canada. In comparison with their young male counterparts, females and elderly refugees tended to be less well educated and less likely to have had any prior exposure to English, and their level of language fluency was correspondingly lower. The initial linguistic disadvantages of women and the elderly were compounded by lack of opportunity. For example, because English as a Second Language (ESL) classes were primarily directed to persons deemed likely to enter the labour force, women and the elderly were less likely to receive such instruction. More recent developments such as Canada's Language Instruction for Newcomers to Canada programmes have been adapted in order to reach previously neglected groups, but women are still underserviced. Lack of language compromises employability and access to services; it also limits options to participate in other important domains such as civic life and mainstream entertainment. It is particularly troubling that precisely those persons most likely to be isolated by circumstance—women, the poorly educated and the elderly—are those least likely to learn English, and thus to risk further isolation.

According to evaluation reports from Citizenship and Immigration Canada (CIC) (2004), most new immigrants participate in ESL training (or other second-language training). However, the average length of exposure is less than six months, and most people attend as part-time students during that period. Research from other countries demonstrates that the longer the period of language training, the greater the linguistic benefit. Immigrant ESL students in Canada have complained that teaching methods and materials are often inappropriate, that classes are too large, and that instruction is compromised by an inappropriate mix of students with differing levels of English ability. Addressing these problems should have an impact on both mental health and integration.

Sponsorship offers an example of the way in which time affects mental health salience. As already pointed

out, privately sponsored refugees had no material or mental health advantages over their government-sponsored counterparts during the early years of resettlement. By the time 10 years had passed, that changed. In 1991, the refugees who had been admitted under private sponsorship were more likely than their government-sponsored counterparts to be employed, to be speaking English and to have made friends outside their like-ethnic community. These RRP findings are consistent with an evaluation report from CIC (2007) which found that privately sponsored refugees entered the labour force more quickly than government sponsored, and enjoyed better incomes. The CIC report also pointed out that the number of applications by potential sponsors consistently exceeded the numbers of refugees admitted to the country each year.

Canada's private sponsorship program could support the country's humanitarian goals by making it possible to admit more refugees. Suggested improvements to help prevent the development of mental health risks and to promote integration include the provision of expert back-up for sponsors to help the latter effect an appropriate balance between helping and respecting the need for privacy and dignity, and to promote awareness of how vulnerable refugees are to outside influence, well-intentioned or not.

Proposition 3: Gender makes a difference.

In 1981, shortly after the refugees arrived, men had higher rates of depression than women. This finding runs counter to almost every other community study of depression in the literature. During the years thereafter, male rates of depression dropped more rapidly than female rates. By the end of the first decade of resettlement, sex ratios for depression among the Southeast Asian refugees resembled those in most community studies.

There is, and probably always will be, disagreement concerning the relative importance of nature versus nurture in the genesis of depression. The RRP gender analyses introduced an intriguing commentary on the debate. Among women, depression scores in 1981 predicted depression scores in 1983 more strongly than the 1983 scores predicted depression levels in 1991. The reverse was true for men. Persistent or recurrent depression suggests genetic or physiological predisposition, whereas depression which disappears over time is more likely to be associated with external factors. Shortly after the refugees arrived, men were more likely than women to be subjected to acculturative stress because they were more likely to be in the labour force. Men tended to be charged with the burden not only of providing for family who accompanied them to Canada, but for those remaining at home or in refugee camps abroad. During this same period, women were more sheltered from stressors. With the passage of time and the resolution of initial resettlement stresses, depression rates for men declined. Perhaps, as the risk factors for depression gradually lessened, predisposition began to play a stronger role in predicting future depression. In other words, men with a constitutional predisposition tended to stay depressed, whereas others improved when external pressures began to recede.

The opposite may have happened among women. Predisposition may have played a strong role in accounting for the relatively strong relationship between depression levels in 1981 and 1983, periods when, compared to their male counterparts, the female refugees were relatively protected from acculturative stresses. However, the longer they remained in Canada, the more likely refugee women were to be exposed to the structural inequities and inequalities in North American society that help account for elevated rates of depression among women in general. The increasing importance of external factors in the genesis of depression may have diluted the role of predisposition, thereby reducing the strength of association between the 1983 and 1991 levels of depression.

Proposition 4: Mental health is human capital. Paying attention to mental health needs during resettlement will promote integration and could have long-term economic benefits for Canada.

At the time of the final RRP survey in 1991, Greater Vancouver's former Boat People were more likely than their native-born counterparts to be working. For people between 25 and 44, the age of most of the refugees, the national unemployment rate was 9.6 percent and, in Vancouver, it was 9.1 percent. In comparison, the unemployment rate for the refugees was 8 percent. The refugees were making a disproportionate contribution to the economy. At the same time, they were taking less out of it than their fellow Canadians. (Most refugees visited a doctor two to three times per year, just about the national average, and, compared to their majority culture counterparts, they were less likely to use social assistance.)

Although many of the refugees in the RRP eventually achieved economic success, it came neither quickly nor easily. Studies by economists such as Don deVoretz and Jeffrey Reitz have shown that it takes seven to ten years for newcomers—immigrants and refugees alike—to achieve economic stability. In the interim, unemployment rates are apt to be high, and incomes to be low. About one third of all immigrant and refugee families in Canada live in officially defined poverty during the first ten years of resettlement. Recent trends are even more troubling. Compared with refugees who came to Canada in the early 1980s, more recent arrivals are at even greater risk of living in poverty during the initial years of resettlement. When they do find employment, visible minority immi-

grants (the majority of today's immigrants and refugees) earn less than their native-born counterparts, even when working at the same jobs.

Many community-based studies have shown that job loss is associated with a high risk for depression. Because the RRP was longitudinal, we were able to examine sequencing—in other words, does unemployment precede, and possibly cause depression, or are depressed people more likely than the non-depressed to lose their jobs? Both proved to be correct—unemployment is followed by depression, but depression also raises the risk of losing a job. One implication is that mental health should be added to education, training, and ability to speak English or French, the attributes that come to mind more usually in discussions about human capital.

Although mental health should be of concern to policy makers, it rarely is. More attention needs to be paid to both the stresses of resettlement that create risk and to the determinants of resilience.

Unemployment has already been discussed as a risk factor. Discrimination is another important force. One in five of the refugees reported experiences with discrimination in the year prior to each of our surveys. Discrimination was associated with a high risk for depression. Once again, the RRP's longitudinal design made it possible to address a question that has plagued research. Does the experience of discrimination tend to make people depressed, or are depressed people more likely to perceive discrimination in situations that other people would likely disregard? The data show that the first proposition is true, the second is not. People who reported an experience with discrimination were more likely to be depressed on a subsequent interview than people who had not experienced discrimination, but people who were depressed at a particular point in time were no more likely than anyone else to subsequently perceive discrimination.

Turning to the resilience side of the equation, it is important to acknowledge the important role of personal factors, such as linguistic fluency. The ability to speak English or French is another of those variables that affects both mental health and integration.

Regionalizing is an example of a situation in which resettlement policy would benefit from considering mental health. In accordance with the policy of regionalization, government-sponsored refugees are spread across the country, preferably to small towns and rural areas. However, within the first year after coming to Canada, 50 percent of government-sponsored refugees leave, and migrate elsewhere in Canada, mostly to southern Ontario. Refugees do not identify jobs as the number one reason for their behaviour, but instead, the wish to be close to a like-ethnic community. Debate about regionalization tends to focus on whether or not the policy is consistent with safeguarding human rights. This is a serious issue. There is, however, little if any debate about the equally serious issue of the role of the like-ethnic community in safeguarding mental health, or about the feasibility of creating communities of welcome that are not necessarily ethnically based, but that might help provide the mental health support new settlers want and need.

Personal Reflections: National policy has been too exclusively preoccupied with adjudicating the legitimacy of refugee claims, and with developing selection procedures to ensure that Canada admits healthy people. Too little policy and practice are directed to ensuring that refugees stay healthy. This neglect is wrong-headed: ensuring that new settlers not only are healthy when they get here, but that they stay that way is just, humane, and consistent with achieving long-term national benefit.

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