I Belong to Canada: The Role of Neighbourhood House for the Mental Health of Older Visible Minority Immigrants

by

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Abstract

Considering Canadian immigration trends, the current aging of the country's population, and access issues related to services that promote the mental health needs of older visible minority immigrants, more attention is required to understand the role of organizations that offer programs and services to this population group. Using qualitative inquiry and the PRECEDE-PROCEED model, this study aims to determine to what extent programs and services available in the Neighbourhood House sector contribute to the mental health of older visible minority immigrants as understood in the VicHealth Framework.

Keywords: Mental health; Wellness; Mental health promotion; Older visible minority immigrants; Neighbourhood House

Dedication

I dedicate this work to my husband and daughter, Sávio and Bárbara, who are my mission statement in this world, and the reason to be. They provided all the imaginable and unimaginable support one needs to finish a journey of writing a dissertation as an immigrant who came to Canada without speaking any English. Without them, this study would never had happened.

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Definitions

Community-Based Seniors Services - Organizations that provide a range of programs and services to older adults. These sites—through established policies that guide services and the relationships between staff members and the community—create close connections to the community (Wilson et al., 2012). In these facilities, the person-centered approach goes a step further, not only making each individual the focus of the services provided but also considering and supporting the community that surrounds them. (Kadowaki & Cohen, 2017).

Mental Health/Wellness - recognized as being "not the mere absence of mental illness." Moreover, being diagnosed with a mental illness is not necessarily synonymous with an absence of mental health, as appropriate treatments for symptoms of mental illness have proven successful in some instances (Bechi et al., 2017; Chiao et al., 2011; Herring et al., 2010; Olsson et al., 2016; Wehmeier et al., 2007). The present study uses the terms *mental health* and *wellness* interchangeably. Neither refer to the psychological clinical perspective but to an integral part of health that results from physical, mental, and social well-being.

Neighbourhood Houses – Organizations that provide programs and services to different age groups. Participants are usually immigrants and individuals with low socioeconomic status. Neighbourhood Houses provide an extensive range of services to older visible minority immigrants, including physical exercise, nutritional support, cultural and recreational programs, advocacy, as well as physical, social, and mental health programs (Kadowaki & Cohen, 2017). Neighbourhood Houses are often located in the neighbourhoods where low-income immigrant seniors reside. They are more likely than community centres to offer an open and inclusive environment that embraces cultural diversity (Union of British Columbia Municipalities' Seniors Housing and Support Initiative, 2009).

Chapter 1.

Introduction

Immigration is a significant part of Canadian history. In addition to enriching the cultural and ethnic composition of the population, immigrants play an important role in the social and economic development of Canada (Boyd & Vickers, 2000). The most recent census reveals that immigrants comprise 21.9% of Canada's population, indicating that more than one in five Canadians were born outside of Canada (Statistics Canada, 2017). As immigration has continued to increase, and patterns of migration have shifted from European to non-European countries of origin, visible minorities have become the main group of immigrants in Canada. Statistics Canada (2017) has determined that visible minorities represent 22.3% of Canada's population. If immigration trends continue in this direction, visible minority immigrants will represent an estimated 31.2% to 35.9% of the population by 2036. Following a similar trend, Canada's older visible minority immigrant population is increasingly more representative of overall migration patterns. Between 2012 and 2016, the proportion of immigrants who were visible minorities was 15.3% (Asia, Africa, Central America, and South America). This percentage will more than double in less than 50 years, with estimates reaching 39.5% (Statistics Canada, 2016). Such considerable numbers point to the likelihood of health inequities becoming noticeable in this population group.

The limited literature about older visible minority immigrants' mental health needs, and the lack of services to address unmet health needs, are examples of such inequity (Lai & Chau, 2007). Considering Canada's current immigration trends and aging population, more attention to older visible minority immigrants' mental health is needed. Studies show that the intersecting influences of aging, culture, racialization, and immigration contribute to the challenges that older visible minority immigrants face in the healthcare system with respect to accessing mental health services (Kirmayer et al., 2007; Koehn et al., 2013).

"Open door" mental healthcare services such as those provided through community-based seniors' centres in Canada represent a suitable and affordable strategy to support the mental health of older visible minority immigrants (Kadowaki &

Cohen, 2017). With a range of programs and services, these centres are a potential alternative model of healthcare that can promote users' mental health.

1.1. Focus of Study

A recent report shows that despite the growth and the array of programs and services provided by community-based seniors service model, little research has been done to explore the understanding of the role of different subsectors of the Community-based seniors services (Kadowaki and Cohen, 2017). Many older adults in Canada reach out to community-based seniors services to access programs that can help them remain healthy as they age. Neighbourhood Houses are organizations that focus on providing services to people with diverse backgrounds. Indeed, in British Columbia, many Neighbourhood Houses are located in ethno-diverse communities which facilitate the use of services by visible minority groups. Older visible minority immigrants seeking a variety of programs and services such as those that promote mental health are among the users of Neighbourhood Houses. However, there is a dearth of research that explores the potential of this sector to benefit the mental health of older visible minority immigrants. My research aims to contribute to the understanding of the role of Neighbourhood Houses in mental health promotion of older visible minority immigrants. The research questions for this study are:

1. Do older visible minority immigrants perceive any benefits to their mental health from their participation in Neighbourhood House programs? If so, what are they?

2. How do Neighbourhood House staff perceive their roles in promoting the mental health of their older visible minority immigrant clients? To what extent do their perceptions align with the organizational mandate of the Neighbourhood House (i.e., relative to the vision statement and responsibilities to funders)?

3. To what extent do the programs of Neighbourhood House meet the mental health needs of older visible minority immigrants? Are there opportunities for improvement to better serve the needs of this client group?

Due to the complexity of mental health and issues related to stigmatization, terms such as "wellness" have been used to facilitate the discussion of this topic in many areas of health (Green & Kreuter, 1991). For this reason, the present study uses the terms

mental health and *wellness* interchangeably. It is important to note that in this study, mental health and wellness do not refer to the psychological clinical perspective but to an integral part of health that results from physical, mental, and social well-being.

Chapter 2.

Literature Review

The literature review for this study consists of an extensive look at the major themes and empirical findings from the existing research on the meaning of mental health, mental health constructs and needs among ethnic older adult population, mental health promotion policies and community-based seniors services.

2.1. Search Strategy

To identify studies for the literature review, electronic keyword searches of the following databases were completed: Ageline, AnthroSource, CINAHL, Medline, PsycINFO, SAGE Research Methods Online, and Sociological Abstracts. The search terms used for this review are included in Figure 2.1.

Mental health, wellness, mental illness, health
Older visible minority adults, ethnic older adults
Community-based seniors services, Neighbourhood Houses, Settlement Houses
Mental health promotion, mental health promotion policies, global mental health, medical anthropology, health care systems
Immigrants
Culture

Figure 2.1 Search terms

2.2. The Meaning of Mental Health

The concept of mental health is often linked erroneously to the mere absence of mental illness and its symptoms. Such assumptions are rooted in the history of mental healthcare, which evolved through the process of identifying symptoms considered “abnormal” or “deviant,” then using these to categorize individuals as either “normal” or mentally ill (Keyes, 2005). However, a substantial body of research now suggests that

wellness refers to a broad array of biological, psychological, and social factors that all intersect and play a critical role in the wellness outcomes of individuals.

Definitions of mental health currently include well-being, self-determination, the management of emotions and behaviours, the development of positive coping mechanisms, the ability to develop and maintain social relationships, and the ability to contribute to one's community (Kashdan et al., 2008; Manderscheid et al., 2010; World Health Organization, 2013), reflecting the recognition that mental health is not an isolated personal factor. Knowledge in this area continues to grow (Keyes & Lopez, 2002; Keyes & Westerhof, 2012).

As the understanding of mental health evolves, more sophisticated and complex explanations are emerging that challenge and expand its meaning. Mental health is recognized as being "not the mere absence of mental illness." Moreover, being diagnosed with a mental illness is not necessarily synonymous with an absence of mental health, as appropriate treatments for symptoms of mental illness have proven successful in some instances (Bechi et al., 2017; Chiao et al., 2011; Herring et al., 2010; Olsson et al., 2016; Wehmeier et al., 2007). The dynamics between mental health and mental illness raise concerns because current mental health categorizations simply mirror the opposite of mental illness symptoms (Keyes, 2005; Robles et al., 2014).

Psychiatric studies are heavily based on prevailing views of mental illness and can distort the overall view of the person by projecting a single abnormal health result—out of many normal ones—onto the entirety of the person's being. Although extremely important, mental illnesses are one of a myriad of mental health outcomes. An illness-focused approach thus leads to a narrow understanding of wellness and limits efforts to promote it (Cowen, 1991; McMahon & Fleury, 2012).

Poor mental health does not necessarily imply the presence of mental illness; instead, it suggests a risk factor for the individual's mental health. Constant exposure to a poor mental state may eventually lead to mental and physical illness (Chaddha et al., 2016; Prince et al., 2007). For instance, poor mental health has been associated with health problems such as increased risk of both cardiovascular and immune systems problems. Prolonged exposure to stress also leads to negative coping mechanisms (e.g., substance-use addiction) and mental illnesses such as depression and anxiety

(Cranford et al., 2009; McFarlane, 2010). These are critical health situations that have implications for long-term disability, and that can accrue high costs to the healthcare system (Keyes & Lopez, 2002; Weitzman, 2004).

Although the topic of mental health transcends the pathological realm, public mental health is committed primarily to the treatment of mental illness (Keyes, 2005). However, it is just as important to implement health programs that support people facing poor mental health as it is to provide adequate care and treatment for those experiencing mental illness. Promoting mental health among individuals dealing with poor mental health promotes overall health and can prevent the development of more serious health issues. It also has the potential to mitigate the high cost associated with the treatment of such issues.

2.2.1. Explaining Mental Health through the Complete Health Model

Mental illness and mental health can be understood as points on a continuum (Cowen, 1991), although they are not mutually exclusive and may intersect at times. This view suggests that (a) the absence of mental illness does not indicate the presence of mental health, and (b) the absence of mental health does not suggest the presence of mental illness (Keyes, 2005, 2007). The complete mental health model proposes that whether or not they have a mental illness, individuals may experience negative or positive states of mental health, identified as “languishing” or “flourishing,” respectively. The combination of mental health or mental illness with either languishing or flourishing in life will determine the functional and adaptive state of an individual (Keyes, 2005).

2.2.2. The Construction of Meaning and Well-being: Sources of Mental Health

Specific properties of languishing and flourishing that may promote wellness differ according to age group and life situation (Luria & Torjman, 2009). Identity, which is influenced by ethnicity and age, has been considered a critical component of wellness (Haslam et al., 2009; Priess et al., 2009; Thoits, 2013). When considering wellness, Saari (1993) suggests that the processes involved are associated with the construction of the self—identity—which creates a system of meaning. Identity, the core of who we are, guides not only the sense of ourselves but also our selection of behaviours. Further,

it is on the grounds of one's identity that systems of meaning are developed; therefore, the self is constantly active in creating and altering meaning throughout one's life (Saari, 1993). Jung (2001) suggests that a meaning system is critical for wellness because individuals need to understand what life means for them and how their personal meaning is constructed in their social environmental context. Similarly, Hansen (2016, p. 27) states that "meaning systems are the ways in which people structure and make sense of the world on individual, social and cultural levels."

Factors associated with systems of meaning increase in number, complexity, and magnitude as individuals get older (Bronfenbrenner, 1977). *Competence*, *resilience*, *social systems modification*, and *empowerment* are critical elements in the construction of meaning systems (Cowen, 1991). ***Competence*** is being able to do something or to successfully play a role in society (Cowen, 1991). ***Resilience*** refers to the process of adaptation or positive management of significant sources of stress. Contrary to past research, resilience cannot be attributed solely to one's personal ability to cope with adverse events; it also concerns the ways in which the environment does or does not facilitate this capacity (Windle, 2011). ***Social systems modification*** occurs in relation to social institutions in which individuals interact over long periods. Such institutions are considered to positively or negatively influence the health of individuals (Cowen, 1991). ***Empowerment*** refers to the ability of individuals to exercise autonomy and control over their lives (Cooke, 2015). As people age, these sources of meaning become essential to mental health, especially among older visible minority immigrants, because this population is more susceptible to negative stressors in the social environment that can threaten the continuous process of meaning development (Prilleltensky & Prilleltensky, 2006; Schure et al., 2013; Ungar, 2010).

High levels of resilience, competence, and empowerment have been connected to well-being—an important wellness outcome (Delle Fave, 2013; Molix & Bettencourt, 2010; Ryan et al., 2008; Smith & Hollinger-Smith, 2015). Seligman (2012) proposes that well-being is a construct with five pillars—positive emotions, engagements, relationships, meaning, and achievement. He argues that "the way we choose our course in life is to maximize all five of these elements" (2012, p. 25) and that each one contributes to well-being as a whole. Well-being is thus a critical factor in overall health and quality of life (Cummins, 2010; Low et al., 2008; Park, 2014).

2.2.3. Mental Health Promotion Policies

In Canada, wellness care services are publicly funded by the federal government and governed by the *Canada Health Act* (Library of Parliament, 2017). Provinces and/or territories must operate their healthcare plans on a non-profit basis, ensuring that they provide all medically necessary services, such as hospital care, physicians, and dentists (within the hospital).

Despite recognition that wellness and the delivery of wellness promotion services are essential to all segments of the population in Canada, older visible minority immigrants are at the margins of the mental healthcare system, and wellness among this demographic is at risk. Many mental health promotion programs in Canada are biased toward the treatment of mental illnesses; therefore, those who do not have a mental illness diagnosis face challenges in accessing wellness promotion services (Ross et al., 2015). In addition, even when they are experiencing symptoms of mental illness, older visible minority immigrants are not guaranteed access to services, since frontline service providers (e.g., primary care doctors) are insufficiently prepared to recognize physical symptomology that indicates wellness problems cross-culturally (Bhui et al., 2003; Gone & Kirmayer, 2010).

Moreover, mental health promotion policies tend to focus on education, which suggests that changes in individual behaviour are sufficient to promote wellness. This shifts the onus of responsibility entirely onto the individual, whose behaviour is deemed the reason for any wellness challenges they encounter. Provincial/territorial health organizations support policies that highlight the importance of self-determination and community capacity to decrease demand on acute and emergency care. However, ignoring the fundamental role of mental health policy (e.g., providing culturally sensitive services, protecting against exclusion) raises insurmountable barriers for the individual. So long as mental health—a *biopsychosocial* phenomenon—is primarily supported through health promotion programs contingent on the efforts of those afflicted, people at risk are prevented from attaining wellness.

2.2.4. Older Visible Minority Immigrants and Mental Health

Every individual has the need for wellness, the perceptions and outcomes of which are closely shaped by one's culture (Bhui & Bhugra, 2007). For those with immigrant status, this reality increases the complexity of wellness. Poor understanding about individuals' cultural frames of reference, as well as low awareness about and empathy for individuals' ways of communicating distress, create barriers to mental health (Bhui & Bhugra, 2007).

Difficulty in diagnosing mental illness among older visible minority immigrants is also due in part to practitioners having insufficient knowledge (O'Mahony & Donnelly, 2009). For instance, general practitioners are often unable to recognize the signs of wellness problems among older visible minority immigrants due to differences in their presentation (Gone & Kirmayer, 2010). An English study evaluating general practitioners' wellness assessments for two different immigrant groups—Caucasians and Punjabis—showed that when patients reported similar levels of common mental disorders (anxiety and depression), clinicians were more likely to assign a mental illness label to white immigrants, whereas Punjabis were more likely to be diagnosed with a somatic illness (Bhui et al., 2001). Mental illnesses are diagnosed using the criteria listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5); however, the symptomology of mental illness among older visible minority immigrants does not always match the DSM-5 diagnostic criteria (Gone & Kirmayer, 2010).

The DSM-5 is viewed as a complete manual of mental disorders, and it is used by many mental health practitioners in Canada and other North and Latin American countries as an authority for psychiatric diagnoses. Nevertheless, the DSM-5 does not adequately address wellness issues among the aging ethnic population because the normative reference point for understanding wellness is Western culture. For instance, older adults are less likely to report traditional mood symptoms (e.g., depressed mood, feelings of worthlessness) that meet current DSM-5 depression criteria, and they might not fit the criteria for sadness, which is considered an essential symptom for diagnosing depression (American Psychiatric Association, 2013; Kirmayer & Ryder, 2016). In addition, when having mental health issues, older adults—including visible and non-visible minority individuals—may report physical complaints rather than emotional symptoms (Whitbourne & Whitbourne, 2014). Furthermore, the symptomology of

neuropsychiatric diseases (e.g., dementia) differs between white and black older adults. For instance, black older adults with dementia show more delusions and hallucinations, whereas white seniors have higher rates of depression (Cohen, 2000). General practitioners are considered the first point of entry[1] in healthcare; they control referrals for medical specialist care and are the most readily accessible medical resource. Unfortunately, however, they are unlikely to recognize mental illness amongst older visible minority groups (Bhui et al., 2003).

2.2.5. Idioms of Distress and Somatization

Across all cultures—including Western ones—psychological suffering is presented in different forms and languages (Nichter, 2010). These varied expressions, or *idioms of distress*, are unclear to most physicians because the idioms do not conform to psychiatric semiotics language (i.e., signs and symbols used to interpret wellness complaints) and lack an organic known cause (Harris et al., 2008; So, 2008). Nonetheless, these poorly addressed languages of psychological suffering "are in no way vague for the person suffering from these symptoms" (Desai & Chaturvedi, 2017, p. 94). Although idioms of distress might not reflect a clinical problem, they need to be seriously considered and understood because they can influence the individual's capacity to function (Nichter, 2010). Unfortunately, Western medical practitioners often perceive idioms of distress as more "primitive" modes of communicating health problems and view them as psychosomatic (Hurwitz, 2004). Also relevant is somatization, which refers to a process by which psychological distress is transposed into bodily symptoms. Contrary to the idea that somatization is "an exclusively non-western cultural phenomenon," it is in fact widely found in Western culture (So, 2008, p. 170).

When trying to interpret idioms of distress among older visible minority immigrants, physicians may not be aware of the impact of immigration (e.g., loss of status, shift in family roles). Furthermore, the aging experience in a Western cultural context might present challenges for older visible minority immigrants, who may be more

[1] While other points of entry (e.g., emergency rooms) are perhaps more readily accessible, they are not necessarily suitable as a first point of contact for people with depression, unless the individual is suicidal.

vulnerable to experiences of discrimination, loss of power, and injustice. These sources of stress may be expressed through idioms of distress.

Although Western medicine is an important asset in the mental health field, recognizing the essential role of culture in mental health diagnoses, treatments, and outcomes is critical if we are to make progress in this area. The DSM-5, based on theories and practices in Western medicine, is applied as a comprehensive nosology of mental illnesses, the implication being that this nosology is itself free of cultural context. This false assumption not only neglects the cultural expression of mental illness but also imposes the Western cultural view on individuals in other cultures (Kleinman, 1978).

2.2.6. Dynamics Involved in Mental Health Care for Older Minority Immigrants

While the biomedical model stresses the relevance of psychiatric nosology to diagnose, and subsequently treat, a mental illness label does not in fact guarantee access to mental health treatment. Access is limited by a dearth of culturally sensitive services, a shortage of professionals, and difficulties in getting referrals accepted, even when services exist (Cunningham, 2009; Lai & Surood, 2010). For example, in Vancouver, British Columbia, only 3% of psychiatrists offered “immediate” appointments (4–55 days’ waiting time) and being a “geriatric patient” was among the criteria for rejection by practitioners (Goldner et al., 2011). Even though this study was done almost 10 years ago, Puyat et al. (2016) similarly reported that the majority of individuals receive minimum treatment for clinical mental health complaints. Issues related to family involvement in health decisions are also a challenge for older visible minority immigrants. Although some individuals may not always feel comfortable discussing mental health issues in front of their family due to concerns about shame and “losing face,” other older visible minority immigrants prefer to involve families in the process of mental health treatment (Acharya & Northcott, 2007). However, mental healthcare services often fail to accommodate family involvement (Sadavoy et al., 2004). Moreover, healthcare practitioners often do not speak the language of older visible minority immigrants (Lai & Chau, 2007), a considerably challenging issue to solve, since more than 200 different languages are spoken in Canada (Statistics Canada, 2011). Stigma and cultural barriers further complicate mental healthcare (Lai & Chau 2007; Zanchetta & Poureslami, 2006). Forms of mental health stigmatization amongst older visible

minority immigrants include individuals' own negative perceptions about psychological issues, and factors such as shame, fear of damaging the family's reputation, uncertainty about the family's ability to understand the problem, and feelings of rejection (Lai & Surood, 2009; Sadavoy et al., 2004).

Non-medical interventions such as prayer and staying busy can also be barriers to seeking out mental healthcare, as can an aversion to Western medicine (Chiu et al., 2005; Jarvis et al., 2005; Lai & Surood, 2009). Mental health stigma—although not exclusive to visible minorities—is considered a major barrier to mental health help-seeking (Marwaha & Livingston, 2002). Increased knowledge about the critical role of mental health in individuals' overall health state (e.g., for the prevention of disease) has not proven effective for improving mental health help-seeking behaviour among older visible minority immigrants (Cuijpers et al., 2013; Egede & Ellis, 2010; Moussavi et al., 2007; Prince et al., 2007).

Studies also show that different patterns of healthcare utilization across visible minorities are associated with culture and belief systems. Although the dynamics between culture and behaviour are complex and cannot be fully explored in this dissertation, culture is a crucial factor in individuals' personality, impacting not only health behaviours but also the perception and understanding of illness and treatment (Bhui & Bhugra, 2007). Leininger (1991, p. 38) explains that each culture has its own way to "ameliorate or improve a human health condition, disability, lifeway, or to face death." These are conceptualized as healthcare activities, which are socially organized health practices, responses to illness, and patterns of individual interaction constituting healthcare systems (Baer et al., 2013). Although the professional scientific sector is recognized as the main healthcare system in Western culture, other domains include the popular and folk sectors (Kleinman, 1980).

The professional health sector is typically associated with the Western biomedical model, while the folk domain—referring to the individual, family, community, and society—are associated with indigenous traditional healing (Kleinman, 1987). Although one might argue that the professional scientific healthcare system is grounded in evidence-based practice, biomedical mental healthcare practices are also grounded in colonial psychiatric institutions. European colonizers were simultaneously fascinated with and horrified by the different cultures and traditions they encountered. The

colonizers' belief that European culture was superior, and their desire to maintain power over colonized individuals, resulted in the development of psychiatric asylums (Keller, 2001), although the literature suggests that these places were also intended to provide care to individuals who were suffering (Littlewood & Bhugra, 2001). While these sites were considered critical to the study of psychopathology, they were physically and socially segregated spaces that did not enable "practitioners to recognize the social and cultural context of individuals' affliction" (Kirmayer, 2007, p. 5).

This is critical because psychiatry's perception of non-Western cultures as deviant has not been relegated to the past; there remains a persistent belief among psychiatrists that the psychological suffering of visible minorities is divergent, as evinced by the culture-bound syndromes described in the DSM-5. Culture—Western and non-Western—influences not only disease etiology, but also the perception of mental healthcare need. In contrast to the understanding in the West that mental health problems arise due to interactions between the individual and environment (Mallinckrodt et al., 2005), Asians tend to attribute mental health issues to internal and personal causes. Alternatively, many African cultures attribute mental illness to spiritual causes, such as possession and the "evil eye" (Ally & Laher, 2008; Mallinckrodt et al., 2005). While these are broad categories and generalizations about visible minorities' perceptions about mental health, such examples illustrate how divergent different cultural interpretations of mental illness can be.

Privileging the Western healthcare system in the provision of mental healthcare disregards the potentially valuable role that popular and folk healthcare systems can play in supporting the mental health of older visible minority immigrants. Findings show that when facing a mental health issue, older visible minority immigrants are more likely to look to family or close friends, seek out alternative types of help, such as religion, and try to resolve the mental health issue by themselves (Chiu et al., 2005; Jarvis et al., 2005; Lai & Chau, 2007). An awareness among clinicians about the significant influence of culture on the psychopathology itself and on their own constructions of mental illnesses would help them be more culturally sensitive and provide diagnoses and treatments that are more synchronized with patients' preferences. Mental healthcare organizations play a key role in supporting the mental health of older visible minority immigrants, yet issues such as eligibility, access, and availability restrict utilization of services and impact mental health outcomes among this population group. Each of

these facets is constrained by the values inherent in both the culture of the healthcare organizations as a whole—designed, as they are, in accordance with dominant norms—and in the healthcare practitioners who work in them. Therefore, a clinical consultation is mediated by meaning and actions influenced by the individual's characteristics (e.g., cultural background), the clinician's values, and organizational policies (Bhui & Bhugra, 2007).

Culture also influences social roles and structural arrangements that contribute to mental health issues among minority groups (Chou et al., 2012). In Canada, the approach of mental healthcare organizations is grounded in evidence-based practices informed by the life experiences of Europeans and Euro-Americans. Research shows that these practices are not only inappropriate for ethnic minority older adults but also harmful (Kirmayer, 2007). In fact, the evidence suggests that mental health services based on European and Euro-American models might alienate, invalidate, stereotype, or even oppress ethno-racial minorities, resulting in the reinforcement of mental illness issues (Sue et al., 2007; Wendt et al., 2015).

The dynamics of power relationships between physicians and patients also play a significant role in mental healthcare. In the Western healthcare system, physicians are seen as gatekeepers to knowledge and understanding of individuals' health and illness. Therefore, it is the physician's assessment of health complaints that facilitates or denies access to mental healthcare services. When primary care physicians recognize older visible minority immigrant patients' need for mental healthcare Western medicine tends to ignore treatment options and individual preferences that are grounded elsewhere. Ignoring the benefits of culturally responsive services for managing the mental healthcare needs of older visible minority immigrants can foster even greater levels of marginalization in this population group. Foucault (1977) suggests that power excludes certain types of knowledge and experiences, dictating what should be considered relevant. Consequently, power imbalances operate together to shape privilege and/or oppression between groups and within them (Collins, 2009). Therefore, when mental health organizations view ethnic minority older adults as the "other," these organizations are at risk of fostering discriminatory experiences that can push this population group away from services provided by mainstream society; such othering creates an impermeable barrier for ethnic minority older immigrants who already experience day-to-

day racism and inequitable healthcare access (Williams & Mohameed, 2008; Williams et al., 2003).

Additionally, Western constructions of aging portray the aging body as the outcome/embodiment of progressive and unchangeable physical deterioration. For the aging population, mental illness, especially memory loss, is often depicted as expected and normal. Such an attitude creates a disadvantage for this population because memory loss is perceived as inevitable and incurable by many aging immigrants. The curative bias of the healthcare system thus marginalizes such individuals through popular notions of “unchangeable aging-related conditions” (Biggs & Powell, 2001; Chrisler et al., 2015; Jin et al., 2015). The Western cultural belief that medical intervention is the primary approach for “managing” the aging body further transforms a biopsychosocial process into an exclusively personal and biological outcome. This view pathologizes the aging process and suggests that certain emotions, such as loneliness, are the cause of underlying illness symptoms (Cruikshank, 2013). For instance, depression and loneliness among older adults are seen as the isolated result of personal biochemical depletions due to aging. Therefore, antidepressants are prescribed as the medically recommended route to address the problem (Charles, 2011). However, underlying critical social situations that are potentially reversible, such as social exclusion and limited social relationships, are overlooked (Whitbourne & Meeks, 2011).

The collective failure of healthcare policies, organizations, and mental healthcare professionals to recognize that Western medicine only partially addresses aspects of mental healthcare and is not sufficient for the diverse mental healthcare needs of Canada’s population results in systemic racism. These dynamics not only influence the perceived needs and help-seeking behaviours of marginalized populations but also contribute to a perception of Western-based treatments as lacking credibility and trustworthiness. This, in turn, limits these individuals’ utilization of healthcare services, adherence to treatment, and subsequent outcomes (Atkinson et al., 1991; Cooper et al., 2003; Iselin & Addis, 2003; Lai & Chau, 2007).

While there is limited research about incidence and prevalence rates of mental health issues among older visible minority immigrants, the existing evidence reveals that they are a vulnerable group, especially those who immigrate later in life (Koehn et al., 2011; Kung, 2004). Factors such as changes in social capital and reduced status

following immigration are associated with greater risk of mental distress (Kesler & Bloemraad, 2010; McKenzie et al., 2009). For example, rates of depression are almost twice as high among older Chinese immigrants, particularly women, than among older Canadians in general (Lai, 2000). Another study assessing self-perceived mental health among Chinese and Caucasian older immigrants similarly revealed that more people in the Chinese group reported that their mental health was poor to fair than in the Caucasian group, who typically reported theirs as being excellent, very good, or good (Tiwari & Wang, 2006).

Despite its diversity, Canada is not free from prejudice. A 2015 report by the Canadian Race Relations Foundation [CRRF] found, for example, that access to healthcare is negatively influenced by discrimination based on age, racial background, and low income. A combination of ageist and racist attitudes and actions contribute to health inequity amongst older visible minority immigrants (Hyman, 2009). For example, although the health status of immigrants (both visible and non-visible minorities) is typically better than that of their Canadian-born counterparts when they arrive (the "healthy immigrant effect"), the health of immigrants declines over time, especially among visible minorities. Importantly, visible minority immigrants from Asian countries are twice as likely to report declines in health outcomes (Chen et al., 1996; Ng et al., 2005). This phenomenon has been linked to institutionalized racism in the healthcare system and other key organizations, such as those that control housing and education, resulting in a paucity of resources for visible minorities. Consequently, unfairness, injustice, and social oppression are likely to diminish the wellness of older visible minority immigrants (Nestel, 2012; Raphael, 2016).

Interactions between physical and mental health status can have cascading effects on marginalized older immigrants. For instance, Prince et al. (2007) suggest that mental illnesses increase individuals' risk for both communicable and non-communicable diseases, which in turn heighten the risk for mental health challenges; these then influence help-seeking, diagnoses, treatment, and prognosis. Moreover, mental health conditions (e.g., depression) account for up to a quarter of all disability-adjusted life-years (Mathers & Loncar, 2006). Physical health is clearly interrelated with mental health; hence, greater prioritization of mental healthcare is needed if we are to improve the overall health status of older visible minority immigrants. Community-based services and programs have the potential to address mental health issues because they offer

culturally responsive services to ethno-racially diverse communities, with the explicit goal of addressing underlying health inequities (Ahmad et al., 2005; Lai, 2001).

2.3. Community-Based Seniors' Services and the Mental Health of Older Visible Minority Adults

Recognition of the importance of ***community-based seniors' services*** (CBSS) in improving the health of older adults and reducing costs in the healthcare system has resulted in recent increased interest from health authorities in this sector (Kadowaki & Cohen, 2017). CBSS are vital to health promotion and disease prevention efforts for older adults from various backgrounds, providing a broad range of services. In relation to my research, it is significant that they recognize the need to eliminate potential barriers for older visible minority immigrants. For instance, the programs and services provided are low cost and embrace an open-door model that, in principle, allows those seeking support to receive it, so such initiatives can play a critical role in supporting the physical, psychological, and social aspects of older visible minority immigrants' health (Fitzpatrick et al., 2008; Koehn et al., 2016; Wang et al., 2014). CBSS also know and understand community members and their needs. These sites—through established policies that guide services and the relationships between staff members and the community—create close connections to the community (Wilson et al., 2012). In these facilities, the person-centered approach goes a step further, not only making individuals the focus of the services provided but also considering and supporting the community that surrounds them. Often, members of the community, including seniors, look for support from CBSS when facing difficulties in primary areas such as food, settlement, and health (Kadowaki & Cohen, 2017). The availability of such services results in trusting relationships that facilitate adherence to health programs, participation in the community, social inclusion, and community resilience (Carpiano & Fitterer, 2014; MacLeod et al., 2016; Zautra et al., 2008).

British Columbia has two main organizational modes of CBSS delivery: community centres and Neighbourhood Houses. Although both modes have critical roles to play in promoting the health of older immigrants, their structure, programs, and types of services tend to target different older immigrant groups. Low-income older adults are more likely to participate in CBSS than their counterparts (Kadowaki & Cohen, 2017), and Neighbourhood Houses are more likely than community centres to offer an open

and inclusive environment that embraces cultural diversity (Union of British Columbia Municipalities' Seniors Housing and Support Initiative, 2009). Since older visible minority immigrants tend to participate in organizations that are sensitive to their cultural background, and they are considerably more likely to have low incomes, this dissertation focuses specifically on the Neighbourhood House model.

2.3.1. The Rise of Settlement Services and the Equity Mandate

Neighbourhood Houses are rooted in the "settlement houses" model—a social welfare movement that dates back to 1884 in London, United Kingdom. Literature suggests that Toynbee Hall was the first "settlement house" in London, created to offer support to individuals living in poverty, deprivation, and racial segregation on the East Side of London (Briggs & Macartney, 1984). Following the Toynbee Hall example, Canada's first "settlement house" was established in 1902 in the city of Toronto as a religious initiative, with the financial support of the Young Men's Christian Association (YMCA) (Herrick & Stuart, 2005). During the first years of settlement house diffusion in Canada, Christian religious organizations provided the lion's share of the funding that supported services provided to individuals in need, a reality that constrained programs and services to Christian values and doctrines.

As programs and services diversified and were increasingly secular, financial resources from Christian organizations diminished. Despite their financial difficulties, settlement houses spread throughout many Canadian provinces, and the services they provided played a critical role in supporting individuals during times of political strain, racial conflict, financial depression, and war (Yan, 2004). Throughout its history, the settlement house movement was grounded in a humanistic and communitarian philosophy intended to minimize social inequalities among individuals.

2.3.2. Neighbourhood Houses and the Comprehensive Models of Health Approach

Ultimately, settlement houses gave rise to Neighbourhood Houses, established to nurture a sense of ownership, capacity building, and empowerment in various groups of people living in the same geographical area (Chesler, 1996; Herrick & Stuart, 2005; British Columbia Ministry of Health Services, 2004). Neighbourhood Houses provide an

extensive range of services to older visible minority immigrants, including physical exercise, nutritional support, cultural and recreational programs, advocacy, as well as physical, social, and mental health programs (Kadowaki & Cohen, 2017).

These services are based on a framework that includes broader social determinants of health, such as social support, income security, and protection against discrimination. This framework, known as the “comprehensive models of health” approach, has key concepts that go beyond the disease-centered medical model. For instance, comprehensive models of health consider factors such as immigration status and the impact of social isolation to be key determinants of health among older visible minority immigrants. These dimensions influence the health of individuals by imposing barriers, reducing their opportunities to access resources, and decreasing their utilization of healthcare services (Blaxter, 2004; Kadowaki & Cohen, 2017; Raphael, 2016).

The first Comprehensive Model of Health was proposed by Engel (2012), who argues that illness, to be fully accounted for, must entail biological, psychological, and social dimensions—all aspects aligned with the World Health Organization’s (2013) current definition of mental health. This idea is supported by the fact that most psychiatric issues are not measurable using biological parameters; rather, they are often identified in terms of behavioural and social dimensions. However, the biological model reduces illness to biological systems, thereby excluding the social, psychological, and behavioral dimensions of illness (Engel, 2012). To illustrate, a National Seniors Council (2017) study found that social isolation increased the risk of poor mental health, dementia, depression, and poor quality of life among older adults. A comprehensive model of health approach rejects categorizing individuals in binary terms as either mentally ill or mentally healthy without considering the critical nuances that can predict mortality and incapacitation (Holt-Lunstad et al., 2015; McClintock et al., 2016; Wang et al., 2014). This model thus moves attention away from the illness treatment approach and focuses more intently on health promotion and illness prevention. Comprehensive models of health are more effective at predicting which groups of individuals are at greatest health risk (Keyes, 2005), and they may also decrease healthcare costs (Hildebrandt et al., 2012).

As noted earlier, older visible minority immigrants are deemed to be at higher risk of social isolation and its negative health outcomes (Nicholson, 2012). Neighbourhood

Houses typically combine a comprehensive model of health approach with a culturally responsive stance. According to Lavretsky (2014), culturally responsive services foster social connectedness, provide meaningful volunteer opportunities, and build skills to increase positive emotions among older visible minority immigrants, outcomes that are all associated with increased resilience.

2.3.3. Neighbourhood Houses and Mental Health Promotion

The frameworks and approaches used by Neighbourhood Houses indicate their considerable potential to promote the mental health of visible minority older adults. Securing financial resources to support these services is nonetheless often challenging. Neighbourhood Houses in British Columbia (BC) tend to rely on funding received from sources such as municipal governments, community foundations, the United Way, local donors, regional health authorities, and the BC Ministry of Health, but they struggle to support their services and programs. Financial support is usually neither substantial enough nor stable enough to support the ongoing needs of older visible minority immigrants. Consequently, Neighbourhood Houses are constantly pursuing a variety of financial resources to keep their services running. The literature suggests that despite the growth of this sector, non-profit organizations like Neighbourhood Houses receive disproportionately low government funding when the high demand for services and large number of participants are taken into consideration (Hall et al., 2005; Levi & Kadowaki, 2016). The diversity of funders to which Neighbourhood Houses regularly apply indicates the high degree of competition for those resources, and the government's limited perception of their role in supporting the overall health of older visible minority immigrants. Even though Neighbourhood Houses do not receive enough financial support, it is likely that the importance of their services and programs will continue to grow as the number of older visible minority immigrants increases in Canada.

2.4. Gaps in the Literature

The considerable number of visible minorities, the continuously growing number of aging individuals in Canada, the persistent issue of mental healthcare inequity amongst older visible minority immigrants, and the role of Neighbourhood Houses in wellness promotion underscore the relevance of these questions.

Compared to the US, Canadian provincial ministries of health and regional health authorities have more financial involvement in the community-based seniors service (CBSS) sector. Moreover, Canada has a wide range of models of CBSS services—i.e., Neighbourhood Houses, Seniors' Centres, Community Centres, Community Coalitions, Ethno-Cultural Organizations, and Multi-Service Non-Profit Societies. These differences suggest the need to explore how the sector impacts wellness promotion for older visible minority immigrants in this country. Also, since research about this sector in Canada has just begun, the available literature pertains more broadly to the general characteristics of the entire CBSS sector; thus, differences within the sector—which are likely to exist—have not yet been established.

Issues related to the mental health of older visible minority immigrants include the dominance of the Western biomedical psychiatric approach, as well as inequities in access to treatments and resources developed to support wellness promotion practices. Although the diversification of Canada's population is increasing, the unmet wellness needs of older visible minority immigrants are a recurrent problem (Bowen et al., 2011). Given that Neighbourhood Houses provide open, receptive, engaging, safe, and culturally sensitive environments and programs (Levi & Kadowaki, 2016), they offer a potential model to promote and support the mental health of older visible minority immigrants (e.g., by addressing discrimination and social exclusion).

Finally, there is an emerging need to decrease the gap between evidence-based practices and practical frameworks that support action in wellness promotion for underprivileged and culturally diverse older immigrants (Bowen et al., 2011). Studying the Neighbourhood House approach and the perception that participants (i.e., older visible minority immigrants) have of services provided in Neighbourhood Houses will enhance our understanding of the relative importance of these facilities in wellness promotion. It may also identify transferable principles that can be applied to other CBSS facilities and models.

Chapter 3.

Developmental Model and Analytical Framework

This study adopted a health model and a mental health promotion framework. The health model PRECEDE-PROCEED (Green & Kreuter, 1991) was used to orient my inquiry, to design the semi-structured interview protocol, and to draw conclusions from the findings. Thus, this health model served as a developmental tool, rather than a framework in which the findings were broken down and analysed according to its components. The analytical framework used in this study was the VicHealth framework, which is a mental health promotion planning tool based on a conceptual approach to health developed by the World Health Organization (Keleher & Armstrong, 2005).

While numerous models and frameworks can be used to support the study of wellness among visible minority groups, the PRECEDE-PROCEED model and the VicHealth framework offer a comprehensive structure; the first allows a developmental approach focused on the micro, meso, and macro levels. The latter was used as an analytical lens focused on different dimensions of social determinants of health known as critical influencers of wellness outcomes among visible minority populations.

3.1. The PRECEDE-PROCEED Model

The PRECEDE-PROCEED model (see Appendix A) views individuals as participants in a social system and not as isolated entities solely responsible for their state of health. According to the PRECEDE-PROCEED model, health is a result of "multiple factors" that should all be considered potential areas for health promotion intervention (Green et al., 1994, p. 399). This model is divided into two main stages. The **PRECEDE phase** is focused on a series of assessments that include the micro, meso, and macro levels (i.e., social; epidemiological; educational and ecological; and administrative, policy, and intervention alignment). These assessments yield an understanding of what health results individuals and communities need and want, what the health-related issues are, what influences outcomes, how to enable the desired outcomes, and how to identify best practices, which include guidance on designing health interventions, the availability of organizational resources, as well as regulations

and policies that can influence the desired health outcomes. The **PROCEED phase** emphasizes the implementation process and the evaluation of procedures, impacts, and outcomes. Hence, the PRECEDE-PROCEED model proposes that a bottom-up approach is crucial when aiming to promote the health of individuals in a community.

This model is considered a robust and valuable structure and is normally employed to design or evaluate health promotion programs (Glanz et al., 2008; Nutbeam et al., 2010). It serves as a valuable holistic guide to the understanding of wellness; therefore, in this study, I refer to the orienting model as a "road map" (Gielen et al., 2008, p. 408).

3.2. The VicHealth Framework

The Mental Health and Well-Being VicHealth framework (see Appendix B) was established in response to an increasing need to promote mental health programs. The framework involves mapping key social and economic determinants of mental health, as well as themes and action areas. Key social and economic determinants include social inclusion, freedom from discrimination and violence, and access to economic resources. These determinants of wellness indicate that mental health outcomes are "the embodiment of social, emotional, and spiritual well-being," which all individuals need.

This framework asserts that focusing on communities is an effective way to promote the wellness of individuals. Similar to in the PRECEDE-PROCEED model, wellness is achieved by influencing the social, physical, and economic environments. Improving these environments can support communities and individuals in accessing appropriate resources that can impact their wellness outcomes. In this study, the collected data were coded and analysed through the lens of the VicHealth framework.

3.3. Shifting the Focus: Social and Economic Determinants of Wellness

A common notion in the field of wellness is that individuals can minimize the risk of mental illness by "adhering to a regimen of health-directed behaviours" (Green & Kreuter, 1991, p. 1). However, a substantive body of evidence points to the fact that successful wellness promotion should combine personal behaviour with the social

determinants of health—critical external sources that mediate and stimulate human behavioural responses (Short & Mollborn, 2015). Acknowledging the importance and limitations of the goal-oriented approach, Green et al. (1980, p. 1) have argued that aligning ideas about health-directed behaviour and education-oriented approaches is effective for promoting individual health. They also assert that while health-directed behaviour and education-oriented approaches are both exclusively focused on individuals' behaviours, health-*related* behaviours refer to the actions of those who control resources. Although each of these components works as an open system in health promotion, health-related behaviours, which deal with "patterns and conditions of living," are considered to be more pervasive—and sometimes inescapable—factors in the health outcomes of individuals, whatever their personal efforts.

The need to view health promotion as the result of socially embedded lifestyles and the equitable distribution of health resources to all segments of a population requires a comprehensive model that links behaviour/lifestyle to the environment. From this perspective, individuals are not solely accountable for reducing their experience of mental illness. On the contrary, they are enabled by person–environment interactions that facilitate health promotion and quality of life (Green & Kreuter, 1991). "Socially embedded lifestyles" refers to the complex relationship between individuals' personal health decisions and the enduring lifestyle patterns that are conditioned and constrained by a person's social and cultural circumstances (Green et al., 1980). Socially and culturally challenging situations are potential sources of distress that negatively affect wellness/flourishing (Keyes, 2005).

Green and Kreuter (1991, p. 4) argue that community is the most effective and proper "center of gravity" for mental health promotion because it includes participatory roles for individuals and governments alike (Green & Kreuter, 1991, p. 4). Similarly, the VicHealth framework (Keleher & Armstrong, 2005) proposes key social and economic determinants of wellness and suggests that wellness promotion activities, particularly those engaged in by community agencies, need to focus on reducing social isolation, supporting freedom from discrimination and violence, and facilitating access to economic resources (Keleher & Armstrong, 2005; Koehn et al., 2014). Like the PRECEDE-PROCEDE model, the VicHealth framework acknowledges that systemic factors are also determinants of mental health outcomes, enabling or diminishing opportunities for individuals and communities to be healthy.

The PRECEDE-PROCEED model and the VicHealth framework compliment each other: while the first connects the individual, the community, and health authorities, the latter points to specific key social and economic factors for aligning wellness needs, and to practices that offer structure and a holistic exploratory approach for the present study.

Chapter 4.

Methods

I used a qualitative ethnography approach for my study. This chapter presents details about the research design, data collection, and analyses.

4.1. Research Design

To address the research questions proposed in this study, I adopted a qualitative ethnographic approach using field observations and in-depth interviews. This approach provides space for individuals to express themselves while helping with the gathering of valuable information reflecting real-life circumstances that otherwise would be hard to identify (Agar & Reisinger, 2001). This method is key to research that aims to understand individuals' concepts, perceptions, and actions. Ethnographic inquiry is particularly appropriate when studying culturally diverse groups and health promotion because it seeks to obtain insiders' perspectives on the meaning of health while at the same time considering the roles that larger social and economic issues play in influencing living conditions (Cook, 2005; Patton & Westby, 1992; Schwandt, 1997).

4.1.1. Site Selection

The study was conducted at a Neighbourhood House (NH) located in British Columbia, Canada. This location offers programs to over 500 unique older adults[2], the majority of whom are older visible minority immigrants from China, Japan, Korea, Latin America, and the Middle East. The NH provides a range of services and programs (e.g., physical activity and social engagement for older adults) to a working-class and ethnically diverse community of immigrants.

This location was chosen because their services are particularly focused on promoting the wellness of older visible minority immigrants. Due to this emphasis, the NH is funded by BC's Community Action Initiative [CAI], which aims to improve the

[2] Older adults who go to the NH as an individual, and not as a guest of someone else who attends the NH.

wellness of BC residents. The CAI was established in 2008 by the BC Alliance for Mental Health/Illness and Addiction, complementing other provincial programs dedicated to addressing mental health.[3] The CAI provides financial and educational support to community-based organizations that offer wellness promotion programs (CAI, 2010).

I initiated my practicum at this location in the fall of 2016, knowing the adults at this NH were potential participants in my study. After volunteering at this NH for a year and a half, I corresponded with the director of family and seniors' programs at the facility, inviting staff members, volunteers, and older adults to participate in this study. Permission was subsequently granted to start field observations, recruitment, and interviews at the NH (see permission letter Appendix C).

4.1.2. Field Observations

I engaged in field observations for four months, timing these to coincide with the facilitation of programs or events. Activities were delivered on various days of the week and during different periods of the day (i.e., early morning, lunch time, and early evening). Programs and events observed included physical exercises, cooking and knitting programs, educational workshops (wellness and computer classes), wellness events, a food delivery assistance program, a caregiver support program, and holiday events (e.g., Lunar New Year and Santa Claus banquet). I also had the privilege of observing three seniors' advisory committee meetings, held once a month, and three child drop-in programs, offered during the mornings. I observed each program or event offered to older adults for half the length of the activity. The child drop-in program was important to observe because older adults were both the responsible adults bringing the

[3] These include Healthy Minds, Healthy People (a 10-year plan to address mental health and substance use in BC) and the BC First Nations and Aboriginal People's Mental Wellness and Substance Use Ten Year Plan.

children to the program and the volunteers who helped with providing activities, cooking, and lunch for the children. In total, I engaged in 200 hours of field observations.

Before starting field observations, I engaged in reflections to set up my intentions for the observation. Primeau (2003) suggests that because researchers become immersed in the experiences of their participants, reflexivity facilitates an understanding of the impact of their own subjective influences on the collection and interpretation of data. Since I was also a volunteer in this facility, I would schedule specific days to arrive at the NH just to engage in field observations. I would arrive at the facility and usually sit on a chair located close to participants, although depending on the program, the chair was sometimes in a corner. Since the space was small, wherever I sat, I had an optimal view of the activity, participants' reactions and comments, and staff members' actions. Occasionally, I would have to pause in my notetaking and help with something, especially when observing the child drop-in program. Assistance on these occasions included setting up the space, helping to gather materials, and playing with a child.

I strategically planned my attendance at each field observation session, from my clothing to what I would specifically observe. I would wear jeans, a plain t-shirt, and comfortable sneakers, and carry a bag containing my notepad and pencils. My outfit was important because this was how most staff members dressed for work, and I wanted to blend in. I also knew they were short-staffed and might ask me to help with setting up for programs.

Based on my previous experiences with conducting field observations, I decided to adopt a productive approach, as suggested by Emerson et al. (2011). They assert that fieldnotes require first that the researcher get "close to the activities and everyday experiences of other people" (p. 33). Having achieved this, I then took notes on my "initial impressions" from the "physical setting," such as "size, space, noise, colours, equipment, and movement," and "about people in the setting," such as "number, gender, race, appearance, dress, movement, comportment and feeling tone" (Emerson et al., 2011, p. 70). Second, I made sure to pay attention to "significant" situations and take notes about "key events," trying not to rely on my own feelings about the social setting (Emerson et al., 2011, p. 74) but instead staying focused on my topic: the wellness of older visible minority immigrants. Finally, to add relevance to my notes, I was careful about what I considered *significant*. Eriksson et al. (2012, p. 10) warn researchers about

“selection” and “sense-making” in relation to field notes. This was critical to my study, as selection and sense-making can unintentionally marginalize some individuals. To address this issue, I adopted Eriksson et al.’s (2012) suggestions, which included deeply immersing myself in the social setting and trying to describe the individuals’ culture, values, and attitudes.

I started each observation by writing about the physical space, the caring way staff members would prepare refreshments for the older adult participants, how people would greet each other, older adults’ arrival and how they actively helped set up the space without anybody asking them, laughter and hugs between staff and older participants, the types of conversation between participants, and the way staff members would engage with and encourage participation by older adults. It was a very dynamic environment. Older adult participants knew I was a Simon Fraser University graduate student, and at the very beginning, some older adults were not especially comfortable with my presence. They would make comments about the way white people in Canada waste resources, such as food and water. This would cause the other older adult participants and the staff members to look at me, perhaps waiting to see my reaction. I would try to be serene and acknowledge the difficulties and discontent around unfair distribution and lack of resources among people in Canada.

I was also always available to help in any way I could. Prior to one of the field observation sessions, I remember being asked to arrive early. When I got to the location, staff members and older adults were washing toys in a big plastic pool in preparation for a child drop-in program and seniors’ wellness event. I joined the activity and started washing the toys too. I believe that my approach and attitude led to the development of a rapport with older adult participants and staff members after the slightly uncomfortable beginning. I became immersed in their world and felt as if I had known them for a long time. After finishing each field observation session, I would sit in my little black SmartCar and write a few more details about what had happened, trying to link events and observations back to the literature as well as noticing my reactions to key events, and possible biases and meanings.

4.1.3. Demographic Questionnaire and Semi-Structured Interviews

The interviews were scheduled after completion of field observations. Each interview had two components: (a) a brief demographic questionnaire (see Appendix D and E) that specifically aimed to gather information such as the participant's age, cultural background, year of immigration to Canada, etc.; and (b) a semi-structured, in-depth, one-on-one interview protocol (see Appendix F and G).

The semi-structured interviews aimed to collect information about patterns of immigration, views about wellness, and the appropriateness of wellness programs and services provided by the NH model. It also aimed to understand staff members' perceptions of such services. In-depth interviews are often described as conversations with purpose (Showkat & Parveen, 2017). They are viewed as having central importance because such conversations provide access to the meanings people attribute to their experiences (Burgess, 1984). In addition, this method encourages participants to share rich descriptions of their experiences, which can assist in the construction of knowledge about individuals' interactions with the social world (Rorty, 2009).

This protocol was conducted in a specific NH location in Canada with two different groups of participants: (1) older visible minority immigrants and (2) staff members and volunteers who engaged in various jobs. To facilitate references to the two groups, the older visible minority immigrants were labelled group A, while staff and volunteers were labeled group B.

Demographic questionnaires and semi-structured in-depth interview protocols were piloted prior to starting the study. Adjustments were made in the use of terminology and probes to support interviewees' understanding of questions, and to explore topics of interest to the researcher.

A limitation of semi-structured interviews is the influence of the interviewer in the process of interpreting participants' views and feelings (Kallio et al., 2016). As noted by Seidman (2006), one will never *fully* and *perfectly* know the experiences that someone else has/had without *being* that person. Therefore, the process of conducting qualitative research is, at least to some degree, "a function of the participant's interaction with the interviewer" (Seidman, 2013 p. 26). Nevertheless, recognizing the existence of "this

interaction and affirming its possibilities can help to minimize the distortion" (Patton, 1989, p. 157).

4.2. Data Collection

To recruit participants from group A, a poster with information about this study was created in English (Appendix H), Chinese (Appendix I), and Spanish (Appendix J) and displayed in many areas of the NH. These languages were selected to reflect the composition of the older visible minority immigrant adults at the NH, many of whom reported either Chinese or Latin American origins. Staff members and volunteers made announcements about the study and recruitment process before and after seniors' programs. The option to have interpreter services was given to accommodate group A participants who did not speak English. Child-minding provided in the same room where the interview was scheduled to be conducted was also offered to older visible minority immigrant participants. This was critical because members of this group were often the primary caregivers for their grandchildren.

To recruit participants from group B, a formal letter (Appendix K) was written in English and delivered in person to key staff members and volunteers at the NH.

A $20 gift card (see receipt in Appendix L) was offered to all participants to motivate participation and demonstrate my appreciation for their time. This sort of remuneration is often provided in qualitative studies.

4.2.1. Older Visible Minority Immigrant Participants

This study included a sample of 10 older visible minority immigrants who had been engaged in programs and services offered at the NH for at least six months. The literature suggests that the sample size chosen for this study is appropriate to reach saturation in the coding categories for the selected research methods (Mason, 2010).

Each participant contacted me by phone, and an interview was scheduled at their preferred location. Most interviews were conducted at the participant's house, but two were completed in a private room located inside the NH. One older visible minority immigrant required child-minding, and another required a Farsi interpreter. Child-minding was provided by a first-year student in psychology, and interpretation was provided by a

social worker who spoke fluent English and Farsi. Both were paid by the hour, and I covered this expense.

4.2.2. Staff Members and Volunteer Participants

Five staff members and two volunteers comprised the group B participants. The number of staff members reflected the total number of personnel allocated to the seniors' department at the NH. These participants contacted me by email, and an interview was scheduled. Most interviews were conducted in a private room at the NH. However, three interviews were completed outside the NH location: one at the participant's house, and two others at coffee houses, as these were the participants' preferred locations.

4.2.3. Interview Process

Interviews were individually scheduled according to the participant's day, time and location of preference, and they lasted around 45 to 90 minutes. Interviews with staff members were the most challenging to complete, particularly with staff members who worked directly with older adults. Two staff members had to schedule the interviews in two sessions because we were being constantly interrupted by phone calls and other job-related demands. I knew this was common at the NH, so I made all possible adjustments to help them feel comfortable and willing to complete the interview process.

Each interview started with a brief conversation, followed by the participant reviewing and signing the consent form (Appendix M). After giving their formal consent to start the interview, participants were asked to complete the demographic questionnaire. Following this, a recording device was initiated, and the interview was fully recorded. At various points in each interview, I reminded participants of their right to withdraw from the interview and study (Appendix N) to ensure that participants knew they had the right to decline participation at any point in the interview. All participants allowed the interview to be recorded, and there was no attrition in this study.

I conducted each in-depth interview according to the semi-structured protocol previously created for each group of participants. This protocol was useful as it provided me with a road map for focusing on the topics of interest. It also helped me stay focused

on the interview questions if the participant was inclined to digress into stories that were not germane to the research topics. I always listened to their stories, but the protocol always helped me return to the topic at hand. Before and after each interview, I made notes about the environment, setting, events, and interview that could yield additional information. I also took notes during the interview about the participant's body language (e.g., hand gestures and facial expressions) and tone of voice. At the end of each interview, I explained to participants that I would have to transcribe the interview, write a summary of the content and key meanings, and start the process of coding. I also explained that after writing an individual interview summary, I would be contacting them to book our second interview, when we would verify my understanding.

The interview transcription was done using headphones and the recording device's voice speed changer, pause, and play options. Initially, I had intended to use Express Scribe software, but I was used to doing transcription and felt more comfortable adopting the process just described. Following transcription, I wrote a summary of each interview and proceeded with booking the follow-up session with each participant.

4.2.4. Data Security

Data obtained from interviews, such as consent forms, demographic questionnaires, and other documentation pertaining to the study, were kept in a locked drawer. Before starting to transcribe the interviews, I uploaded each audio file to the SFU vault to ensure I would have a copy on a safe server. Each interview had a separate transcription file, also uploaded to the SFU vault, and an extra copy was saved on a flash drive using encrypted password-protection options, and uploaded on NVivo 12® software, which was obtained through SFU. The coded interviews were also kept in NVivo 12®.

4.3. Data Analyses

This research adopted inductive and deductive reasoning approaches. While I was open to the emergence of inductive themes, I recognize that I started this study with some preconceived thoughts, fostered by my previous involvement with the NH. Additionally, preparation of the literature review for this study raised my awareness about wellness and factors that might challenge or support it, and these notions

inevitably generated in my mind some preconceived ideas about the topic. As O'Reilly observes, "everyone starts out with some preconceived ideas, and some (even lay) theories about how the world works" (2009, p. 3). Accordingly, I adopted a process described by O'Reilly (2009) as moving "back and forth between theory and analysis, data and interpretation," leading to a reflexive process to orient the data analysis.

After transcribing all the interviews, I began coding, line by line, using NVivo 12®, searching for themes that emerged inductively from the data. The initial codes provided me with ideas about the data and led me to select relevant and recurrent themes that emerged during analysis (Charmaz, 2002). From an analytical perspective, I adopted a hermeneutic process, seeking to understand participants' motivations, thought processes, and ideas to identify patterns in their social life. I used memo writing to facilitate the analysis of codes and their relationships. The field observation provided a broad understanding of how the NH operates.

After using the tools provided by an inductive approach, I reassessed the data through the VicHealth framework lenses. This analysis required me to engage in reading the transcribed interviews and coding them based on the key social and economic determinants of wellness indicated by the VicHealth framework—i.e., social inclusion, freedom from discrimination and violence, and access to economic resources (Keleher & Armstrong, 2005). Following this process, I generated a matrix of codes using the matrix query function in NVivo 12® to explore patterns in the data.

4.3.1. Verisimilitude

Since this study seeks to comprehend processes and meanings of social experiences that are not experimentally examined or measured, verisimilitude will serve as an "alternative" strategy to validation. Establishing verisimilitude entails the researcher getting as close as possible to the participants' perceptions and experiences (Denzin & Lincoln, 2008). However, it would be naive to assume that the researcher's interpretation could ever be free from the influence of their own background and experiences. Therefore, the process of summarizing the interviews and inviting feedback from each participant, through the process of member checking, created space to correct my interpretations before reporting on the findings, thereby ensuring rigour

(Morse et al., 2002). Member checking is important to “validate, verify, or assess the trustworthiness of a qualitative study” (Birt et al., 2016, p. 1802).

Chapter 5.

Findings

This chapter presents key findings drawn from data collected after field observations and semi-structured interviews with the two groups of participants: older visible minority immigrants (OVMI), and the staff members and volunteers who either work directly with older adults or are involved with seniors' programs at the Neighbourhood House (NH). Findings were organized according to themes within three main categories: access facilitators, access barriers, and wellness outcomes. Emergent substantive themes from each of these categories are presented in Table 5.1.

Table 5.1 Study themes

Category	Theme	Subtheme
Context	Being an Older Visible Minority in Canada	Gender Roles
		Social Isolation and Loneliness
		Discontinuity
		Family Ties: Pros and Cons
		Aging, Culture and Wellness
"I would be lost without the NH."	Utilization	
	Social Inclusion	
	Practicing English	
Access Facilitators	Knowing about Programs	
	Physical Environment	
	Access to Economic Resources	
	Freedom from Violence and Discrimination	
	Supportive Relationships	
	Access and Retention	
Access Barriers	Language and Cultural Issues	
	Environment	
	Funding Limitations	
	Staffing	
Wellness	Social Inclusion	
	Sense of Belonging	
	Self-Determination and Control	

To facilitate an understanding of the data, the next section will present demographic profiles of the OVMI, staff, and volunteer participants in this study, followed by information about the NH organization.

5.1. Participant Characteristics – Demographics

5.1.1. Older Visible Minority Participants

Ten OVMI and seven staff members and volunteers were interviewed for this study. Participants in the OVMI group identified themselves by the following pseudonyms: Mrs. Ada, Mrs. Ann, Ms. Carmen, Mrs. Cecilia, Mrs. Lidia, Mrs. Lisa, Mrs. Little Girl, Mrs. Magnolia, Mrs. Manu, and Mrs. Samila. Staff members and volunteers received the following pseudonyms: Melissa, Laura, Maggie, Naomi, Rebecca, Kelly, and Nick.

Mrs. Ada, Mrs. Ann, Ms. Carmen, Mrs. Cecilia, Mrs. Lidia, Mrs. Lisa, Mrs. Little Girl, Mrs. Magnolia, Mrs. Manu, and Mrs. Samila

Figure 5.1 OVMI participants' pseudonyms

Melissa, Laura, Maggie, Naomi, Rebecca, Kelly, and Nick

Figure 5.2 Staff and volunteer participants' pseudonyms

The sample of 10 older visible minority immigrant participants was diverse across multiple socio-demographic dimensions, as captured in Table 5.2. All were young-old (< age 74) in the age classification. The majority were or had been married, came from China, earned CAD 20,000–40,000 annually, and had secondary school education. Most of them had been in Canada for more than 20 years and had spoken some English prior to immigration. Figure 5.3 shows that most of them indicated Cantonese as their mother tongue. Eight percent of the OVMI said that they do not speak English at home.

Although all interviews were done in English, one participant spoke Farsi only, so this interview was done with the support of an interpreter.

Table 5.2 Demographic characteristics – OVMI (group A)

Variable	Result	Total (%)
Gender	Male	0
	Female	100
Age	55–64	60
	65–74	40
	75–84	0
	85+	0
Marital Status	Never married	10
	Married	50
	Widowed	10
	Divorced	20
	Other	10
Country of birth	China	50
	India	10
	Italy	10
	Spain	10
	Syria	10
	Uruguay	10
Income	< CAD20,000	20
	CAD20,000 – CAD30,000	30
	CAD30,000 – CAD40,000	30
	CAD40,000 – CAD50,000	10
	> CAD50,000	0
Education	No formal education	10
	Primary school	20
	Secondary school	50
	Post-secondary school	20
	Other	0

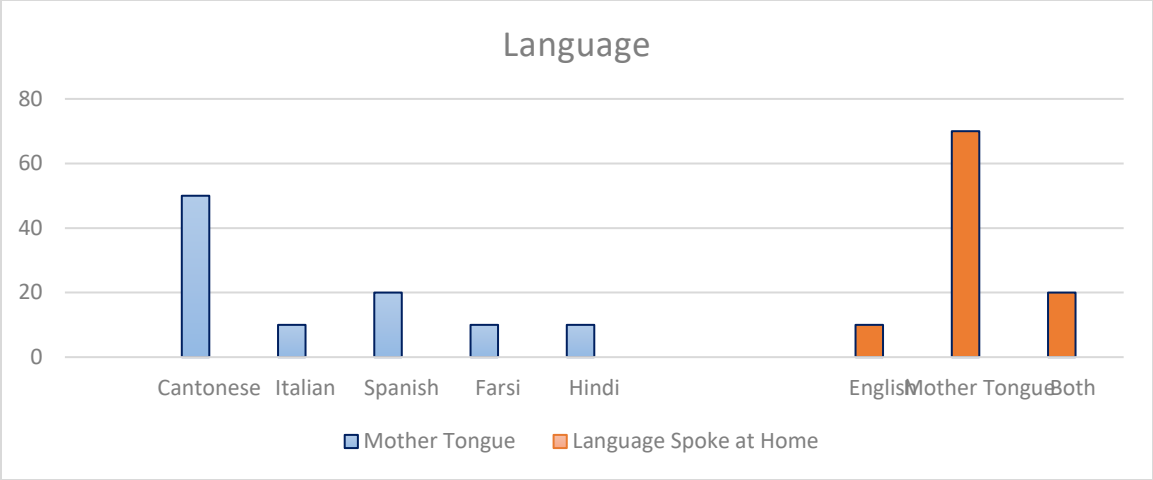

Figure 5.3 Mother language

With respect to participation in wellness programs, 70% of OVMI participants (Mrs. Ada, Mrs. Cecilia, Mrs. Lidia, Mrs. Lisa, Mrs. Magnolia, Mrs. Manu, and Mrs. Samila) indicated that they participate in wellness programs and services at the NH only, while 30% (Ms. Carmen, Mrs. Ann, and Mrs. Little Girl) said that they attend programs and services at both the NH and other seniors' centres.

5.1.2. Staff Members and Volunteer Participants

Five staff members and two volunteers were interviewed. As Table 5.3 illustrates, this sample comprised six females and one male, most of them were between 35–44 years old and married. The majority were from Canada, had an income between CAD 30,000–50,000, and had completed some post-secondary school education.

Table 5.3 Demographic characteristics – staff and volunteers (group B)

Variable	Result	Total (%)
Gender	Male	10
	Female	90
Age	25–34	14.3
	35–44	42.8
	45–54	0
	55–64	28.6
	65–74	14.3
	75–84	0
	85+	0
Marital Status	Never married	0
	Married	85.7
	Widowed	0
	Divorced	0
	Other	14.3
Country of birth	Canada	71.4
	China	14.3
	England	14.3
Income	< CAD20,000	0
	CAD20,000 – CAD30,000	0
	CAD30,000 – CAD40,000	42.8
	CAD40,000 – CAD50,000	42.8
	> CAD50,000	0
Education	No formal education	0
	Primary school	0
	Secondary school	28.6
	Post-secondary school	42.8
	Other	28.6

5.2. The Neighbourhood House

5.2.1. Overview

The NH is in a low- to middle-income suburb of a metropolitan area in British Columbia, Canada. The organization offers programs and services to about 3,000 individuals, including children, youths, older adults, and immigrants. Activities for each

one of these groups are planned, designed, and delivered by staff members who work under the direction of three main departments: Childcare, Communications and Youth, and Family and Seniors. Each one of these units has its staff team, comprised of coordinators, programmers, and facilitators. Besides these groups of staff, the NH has two levels of administrators: three directors and one executive director. The structure is supported by a total of 25 staff members and over 200 volunteers, who work together to provide services from Monday to Saturday (and sporadically on Sundays) during mornings, afternoons, and evenings.

Nearly 500 older adults are members and active attendees in the NH programs and services, which are designed and offered by the seniors' department, a subdivision of the family department. With a total of six staff members, the family and seniors' departments provide support to each other when there are large numbers of participants during certain programs or when interpreting services are required, such as for Spanish or Farsi speakers. Although there is cross-departmental staff cooperation, the seniors' department staff members—one coordinator and one programmer—operate most programs, with the support of volunteers. Other than occasional "hands-on work," a significant part of the cost linked to seniors' programming is covered by the family department.

5.2.2. The Neighbourhood House Building

The NH has two floors, with most rooms located on the first floor. A flight of stairs and one elevator allow access to the second floor. The entrance door is kept wide open, and there is coffee and tea available to all participants throughout the day. The interior space resembles a house with many rooms. Chairs and a front desk are located just inside the entrance door. The first floor has four small activity rooms, and three of them are reserved for children's programs only. This floor also has a big "flexible space", and a computer/coffee room available to clients and community members who needs access to a computer and the Internet. The flexible space has a folding door that divides the area in half when necessary for different programs. The flexible room is equipped with chairs, folding tables, rugs, sofas, floor lamps, bookshelves, toys, and materials needed for programs. The computer/coffee room has extra chairs, a round dining table, and a sofa, which are often used during seniors' programs. There is also a well-equipped kitchen, used to cook and serve lunch to those who attend programs and events. The

second floor has three rooms and two of them have sink and utensils, used during programs. Each storey has small corridors and hallways that in some cases serve as more than passageways; a computer workstation reserved for older adults is located in the corner of the second-floor hall. In addition, the house has a basement that is used to store food as well as different types of materials and equipment, such as balls, tents, more folding tables and chairs, toys, etc. There are two yards, one at the front of the NH and another one at the back, used by staff and participants as a community garden to plant vegetables and herbs that are distributed to the community.

Figure 5.4 Neighbourhood House – entrance

Figure 5.5 Seating area in the flexible space

Figure 5.6 Activity area – flexible space

5.2.3. Seniors' Programs at the Neighbourhood House

The NH has been serving OVMI for over 20 years. All programs and services offered to older adults are free of cost. While there is a minimum age requirement—50 years old—the NH accommodates younger individuals in the older adults' programs when space allows. Participants at the NH face no restrictions related to cultural or religious background, language requirements, or status in Canada.

The NH serves over 500 unique older adults, nearly 100% of whom are immigrants and 90% of whom are older immigrants from a visible minority background. Although most clients at the NH immigrated from China to Canada, a significant number of the older immigrants are from Latin America and Middle Eastern countries. Other participants include Italian, Spanish, and Aboriginal peoples. According to staff members, many older adult clients at the NH are low-income, do not have a high school education, and are not fluent in English. A small group of the older adult clients have a high school diploma and are fluent in English. Very few have post-secondary education. Although programs are facilitated in English, interpretation services are provided in Cantonese, Mandarin, Spanish, and Farsi when needed. In addition, the NH offers older adult clients help with the translation of official documents and emails, and support with writing letters and emails to Canadian authorities. The NH also provides space for older adults who want to facilitate their own programs; in these cases, the NH and staff members are not directly involved with the programs, but staff reserve the room and provide certain types of equipment, such as chairs and tables.

The variety of programs includes physical and mental wellness workshops, computer and knitting activities, opportunities to play traditional culture-related board games (e.g., Mah Jong), chatting and coffee time, cooking and yoga classes, walking programs, and more. In addition, the NH provides tax information sessions, assistance with accessing social support and completing citizenship applications, and referrals to other services offered in the broader community. In addition, they organize and offer intergenerational (i.e., youths and older adults) movie sessions on topics related to racism, equality, and seniors' issues. Although the NH is aware of social disparities among OVMI, my findings show that the NH programming does not necessarily address discrimination directly. Instead, staff and clients choose activities like going to exhibitions and sightseeing areas that show or are connected to topics related to discrimination and immigration issues. During these types of events, staff avoid using the term "discrimination." During interviews, staff mentioned that even though discrimination-related topics are taken into consideration and are part of the NH programs, initiatives are mainly focused on showing how people overcome and achieve success despite experiencing negative situations.

The numerous programs and services provided at the NH are designed and planned according to needs assessment, priority of issues, availability of space, and financial resources. Each program offered to OVMI has specific goals, with the most common being related to increasing social networks, fostering community engagement, building capacity, and promoting wellness.

5.2.4. Family and Seniors' Department Profiles

The sample of staff and volunteer participants in this study received the following pseudonyms: Melissa, Laura, Maggie, Naomi, Rebecca, Kelly and Nick. The two staff members (Laura and Melissa) who work in the seniors' department oversee needs assessment, planning, organizing, and facilitating programs. Both speak English, Cantonese, and a little bit of Mandarin. They also help clients to navigate medical healthcare services, social services, and immigration-related concerns. Besides being the first point of contact for services in the NH and, in many cases, in the wider community, Laura and Melissa often receive older adults who do not have anyone else to talk with about their problems and concerns. A typical day of work for Melissa includes making check-in calls to older adult clients, visiting those who are isolated or cannot

attend programs due to health limitations, providing interpretation for older adults who do not speak English or cannot understand the complex language used during health workshops, buying groceries and materials for programs, making coffee, preparing snacks, cooking traditional dishes for programs, setting up for programs, as well as facilitating and managing older adults' volunteering activities.

Since many older adult members are involved in the NH seniors' programs, Laura also calls, pay visits, offers individual assistance to older adult clients, and provides interpretation services during programs and services. Besides being closely connected to the older adult members, she continually tries to create partnerships with other organizations, such as regional health authorities, other community-based seniors' services, churches, and temples located in the surrounding area. In addition, Laura is responsible for submitting grant fund applications, managing the funds received, writing reports to funders, and reporting to the higher-level administration.

Maggie, the family and senior's department coordinator, analyzes the community's characteristics in order to develop programs and services that can support the clientele as a group, including older adults', families', and children's needs. When she is available, Maggie also provides interpretation in Spanish for the seniors' programs. Besides helping in older adults' programs and services, Maggie manages family activities and provides support to the family and seniors department director, Naomi.

Besides overseeing the department, Naomi is responsible for a higher level of financial management, partnerships, and consortiums with governmental and non-governmental organizations. In order to receive and add support to address the community's needs, she is often trying to create relationships between the community and political leaders (e.g., members of parliament and members of the provincial legislative assembly). Maggie concisely explained how this support is provided,

> We do assessments with each person that we meet, we see what types of, um, you know, support they already have in place and maybe where we can bridge the gap. Um, so because we look at those first needs, we look at food security and we look at the social aspects and we look at family responsibilities, whether it's being a caregiver of a child or another family member, we look at the educational piece so that they have more resources and they are linked to more supportive networks. Um, and um, you know, this idea of just having a safety net, having a new group

> of people to support you or to share that experience with, um, and knowing that you are valued and you're cared for. I think that we do a lot to support people's mental wellness by providing [pause] communities there [pause] but providing and you know, a place for people to come together and connect and talk about what they want and then see it happen and see it come together. Sometimes it takes a little bit of work and time.

Nick, the executive director of the NH, oversees all the departments and provides leadership and resources to develop and maintain programs. He also offers individual assistance to some OVMI clients who have been attending the NH for more than ten years.

Staff tasks and activities are guided by periodic training sessions (i.e., once every three months), which involve all staff members and key volunteers working in the family and seniors' department. Critical topics include, but are not limited to, best practices to support clients, knowledge about culture and religious diversity, inequality and needs of OVMI and other age group clients, and information about other NH departments and projects.

The NH staff are aware that their clientele struggle to access many services available in the wider community. Often, access barriers relate to programs and services that are irrelevant or do not meet the mental health needs of OVMI. In such instances, the NH's work is critical, as it tries to provide evidence-based programs and services in ways that are accessible and relevant, promoting continuous long-term attendance.

5.3. Being an Older Visible Minority Immigrant in Canada

Being an OVMI in Canada is marked by challenges; for some, the difficulties began when they were still relatively young, as new immigrants, and these experiences had lasting effects throughout their lives. The life stories of this sample after immigration included social disconnection and feelings of loneliness. Such experiences were related to the immigrants' transition period (i.e., when they had disconnected from their country of origin and were trying to connect to the host country) and then were exacerbated by long working hours inside and outside the house, childcare demands, and language barriers.

5.3.1. Gender Roles and Self-Care

Eighty percent of the OVMI participants mentioned they had never thought about the need for and importance of engaging in self-care, and they linked this view to the cultural beliefs with which they had been raised. Women perform most of the caregiving and home-making tasks in their families. These are demanding activities and particular behaviours that are part of their socially assigned and expected roles. For the OVMI participants, these social roles were viewed as essential for family dynamics and harmony, especially taking care of children and sick older parents, even when doing so would impose financial and health constraints on their own lives. For instance, Mrs. Ann, Mrs. Ada, Mrs. Cecilia, Mrs. Lidia, and Mrs. Manu had all decided to retire to provide care to their grandchildren, despite knowing that they would have less income and less time to care for themselves. The OVMI said that after their adult children had their own children, the grandparents were expected to help take care of the grandchildren. Some explained this was a common expectation, taught to them when they were girls and performed by women in past generations, showing the power of these social roles for women. Mrs. Cecilia said,

> I got married and then I, I don't do much. When my kids were younger... I have four children, right. When they were young, I'm a housewife. When they get were a little older, my mom come, came over from Hong Kong. She helped me to take care of the family, you know, for cooking and everything. So, I can start working. Because my grandchildren stayed with me when they were born. They needed me to, you know, to baby sit.

Those who were working exclusively inside the home said they would continue to do so, and they would also have to provide care to one or more grandchildren, older parents, or both.

5.3.2. Social Isolation and Loneliness

OVMI participants in this study stated they had never had a chance to participate in regular wellness programs when they were younger. They attributed this situation to the need to fulfill social roles attached to their gender and to having formal work responsibilities outside the household realm. They also expressed challenges in relation to self-care due to cultural beliefs that regarded self-care as selfish when they should instead be self-sacrificing. They stated that social roles linked to their gender and the

need to supplement the family income consumed most of their time, leaving few opportunities to engage with other activities. Lack of time combined with low English fluency—and little chance to improve it in their working environments—were critical factors interfering with social engagement, which resulted in loneliness.

For most (90%) of the OVMI, the decision to immigrate to Canada was attached to reuniting with family members. This was usually connected to a husband, father, father-in-law, or adult child who was already living in Canada. Apart from Ms. Carmen, who was single and had never had children, all the other OVMI participants had adult children. When these women were younger and newcomers in Canada, they had to organize their lives around fulfilling household obligations, taking care of children, and having a full-time job outside the house.

Mrs. Ada, Ms. Carmen, Mrs. Cecilia, Mrs. Laura, Mrs. Lidia, and Mrs. Lisa had to work for extended hours every day, with one day off a week. On many occasions, they had two different jobs to make sufficient income to support their family. According to all participants, life after immigration had been challenging and financially difficult. Mrs. Lidia explained, “I always... my life was very hard. And I had to provide to my whole family. You know my friends would laughs at me... because I had many foods in a can like beans, and I ate this... for two years, I only ate beans.” Similarly, Mrs. Ada said,

> I only know my father-in-law when I got here. At the time, we don’t have too much the things to do it because we work so busy. I get three kids. I had to get up five o’clock every morning. I do most of the cooking and take care of the kids. Then we go to work... [laughs]. Before, I worked so hard... daytime, I get the one job, and nighttime I get another job, too. About 25 years. Because I start one at 6, I finish at 2... I go home to make the dinner for my kids, I go back to work at 5 until 9 o’clock.

Although Mrs. Ann, Mrs. Little Girl, Mrs. Magnolia, Mrs. Manu, and Mrs. Samila did not work outside the house, they mentioned that being a housewife and a caregiver for their children was like having a full-time job. They explained that with their husband always working outside the house and no other family members or friends close by to share experiences and provide support, life was challenging, and they felt very isolated.

Besides having an intense schedule, all OVMI participants except Mrs. Manu experienced challenges with the English language post-immigration. Forty percent mentioned that they did not speak English, 20% spoke a few words, and 10% were able

to hold a simple conversation in English. The other 30% were either able to hold a little bit more than a simple conversation (20%) or were fluent in English (10%). For example, Mrs. Lidia said that after immigration, she had to start her life from nothing. Coming from a Spanish-speaking country that has its own challenges and lacks English language services for citizens, she had to learn a language that was completely unfamiliar to her. Also, as a divorced woman, alone, and with small children, she did not have the opportunity to attend English classes offered to newcomers, nor did she have close social connections to support her in Canada.

Mrs. Magnolia referred to the importance of the help she received in relieving her isolation,

> Yeah, so I don't know where this lady come from… her name is Santa Maria, she help me so much, she come here, because we are not allow to speak… just English. The government say [pause] the social work sent somebody to help me because I did not speak English. I was here… alone.

Unfortunately, lack of English fluency created barriers to interacting with other people in Canada. Many participants said that social interactions were limited to conversations with their husbands, who would speak their native language at home. Mrs. Samila said that she spent a whole year inside her house talking only with her family in Farsi because she did not speak English and she did not know anyone else who spoke her language. Mrs. Samila said she had felt isolated and devastated during this time. For participants like Mrs. Little Girl, who had their hands full with household tasks and childcare, English fluency became a secondary need. Due to her heavy household workload, she was unable to attend English classes or to practice English. In both cases, lack of time, family priorities, and lack of English fluency became critical factors that hindered these women's opportunities for social connections. As Mrs. Little Girl stated,

> I got three children you know. Go to a school, and then I picked up after school and cooking, cleaning, no stop. Yeah. And outside work, it was only me. Because my husband… ah... is in the restaurant. Yeah. The hours a morning 10' clock to the midnight hour, one o'clock come home. Not time to friends.

Also, for almost all participants who had a formal job, except Mrs. Manu, lack of English fluency was connected to the types of work they had acquired in Canada. According to participants, these jobs required minimal English, and they did not pay

enough—hence, the need to work extended hours or at two different jobs. For instance, Mrs. Ada said that she had to work at two produce shops because the jobs did not require her to know much English. She and five other participants said that having a low level of education was a barrier to finding a job outside the food business (i.e., restaurants, supermarkets, and produce shops).

When they were young, these OVMI did not have opportunities to practice English during working hours or with other individuals in their neighbourhoods. They said that many other workers did not speak English, and the opportunities to speak with neighbours did not expand their knowledge of the language. Some participants, such as Mrs. Ada and Mrs. Lidia, stated that they would take English classes for newcomers at night; however, learning English as an adult was challenging, and they found that practising English only during these classes was insufficient for them to learn the language. When discussing learning a new language and talking to other people, Mrs. Lidia stated, “I did not speak English… When I arrived here, I felt that I had a big dark wall that I had to pull... and I used to pull and pull.” Many, like Mrs. Ada, said, “[when] I came here I did not know English, I not talk too much.”

As transitions were occurring over the OVMI participants’ life course, such as retirement, they felt they did not have much to do after they were no longer active in the workforce. Some said that this situation left them with enough free hours and even days that would be often spent lonely inside the house. Ms. Carmen said,

> Sometimes, you just look out the window and see the birds flying. Because... no in my back, at my backyard… it was just close to the uh, park play, so just watch people playing there like... sometimes they play with a baseball or something... I don’t know... I see them through the window every Saturday, sometimes Sunday. I know they are playing there like, you can hear lots of voice... you know what they are doing... But most of the time would just listen to the radio or sometimes watch TV or playing with my dog. So, it’s a different, different kind of living I guess... but still.

Similarly, Mrs. Ada, Mrs. Ann, Mrs. Little Girl, and Mrs. Manu said that when they did not have to provide care to their grandchildren, they would have nobody to interact with and would feel lonely. All participants also mentioned that once they got older, they found the isolation more difficult to tolerate. Mrs. Ada and Mrs. Little Girl, for instance,

indicated that the short conversations they used to have with their husbands became rarer because after many years together, there was not much to say.

As the aging process unfolded, the obstacles they had faced after immigration—such as not having secure financial resources, lacking social connections, and having limited English fluency—impacted their wellness. Some participants were feeling the senescence process, others had developed chronic diseases, and they became more aware of the isolation in which they had lived so far. Mrs. Manu revealed that after having heart surgery, she felt the need to live close to her children in case she required extra support. Yet Mrs. Little Girl, who has a severe chronic disease, stated that although she had the company of her family members, she needed to get out of the house and connect with other people to help her cope with the disease. Indeed, other four participants also stated the need to interact with individuals other than their family members.

For most OVMI participants, the challenges they experienced after immigrating were exacerbated by the “discontinuation of life”. Discontinuation of life related to having to make a new social network, navigating and accommodating to unfamiliar culture and values, and restarting their lives in a new country.

5.3.3. Discontinuity

Somewhat contrary to the previously discussed participants, Mrs. Manu, who spoke fluent English in her country of origin, had a different experience after immigrating to Canada. She mentioned going through the immigration process twice. The first time, she immigrated at around 30 years old, with her husband and children, and lived in Canada for 14 years before leaving to migrate to another country, where she stayed for 16 years. She had returned to Canada as an older adult and widow to be reunited with her adult children and her grandchildren. Of her first arrival in Canada, Mrs. Manu said the family had been “shopping for a country” and had enough financial resources to invest in a business. Immigrating to Canada at a younger age, speaking the language fluently, and being able to invest in a business that generated an adequate income to support her family was, in her opinion, the reason she had developed social connections in Canada. Mrs. Manu also said that they came to Canada around the same time as

some friends from India, so they all ended up supporting each other during the first years of transition,

> Canada actually gave us a red-carpet treatment. As I said, as we said. You showed that our bank papers. And then they said, okay, come on down. You know, so it was easy. We had friends and all. They came around the same time.

However, returning to Canada as an older, widowed adult with little in the way of financial resources made it a challenging experience the second time around. Mrs. Manu mentioned that she had believed it would be possible to find a job, have the same friends, and lead a similar life to that experienced during her first sojourn in Canada. However, she said that her job credentials were no longer valid after she had spent so much time outside the country, and her social connections decreased considerably. She mused,

> Social life... I do have friends, uh, I have kept my social life to the limiting... to family. I just have one or two friends really that, uh, that I've gone back to. So, it has, uh, so my social life definitely has decreased tremendously because of different reasons.… So, let's do the professional one. As I say, my licensing, um, lack of, uh, this feeling I got wasn't a good feeling that they're not valued here. Although having all the credentials. I had to redo my credentials and bringing it to update, I had to update it, um professionally. That to me was a real big stumbling block... and when I look at jobs, they are horrible, I mean, what kind of jobs can I get? Fifteen-dollar one, $16 one, nanny, housekeeper. I'm not that, I'm not, my credentials don't value, I mean the uh, the pay does not, uh, not only the pay, but the type of work does not value who I am.

English fluency, higher education, and some family members in Canada had not prevented her from experiencing challenges after immigrating to Canada as an older adult. Indeed, Mrs. Manu had a similar experience of discontinuity as those OVMI who did not leave the country but had little language fluency, a lower level of education, and low income. For example, Mrs. Ada, Mrs. Ann, and Mrs. Little Girl said they felt their lives had been put on hold for a while because they were not able to talk to friends from their original country, nor did they have new social relationships in Canada.

Discontinuity was described as a sense of encountering enough obstacles that made them feel the continuity of life had been disrupted. Among all participants, continuity of life was characterized by securing basic human needs, such as having adequate financial resources and forging social relationships. Participants agreed that

the reasons for discontinuity were most often related to leaving family and friends behind, feeling different from others, adapting to a different culture, and having to redo credentials or find ways to pursue a new career. For Mrs. Manu, “the discontinuation happened because of two factors culturally and the stumbling blocks, the obstacles I had to overcome for professionally also.” Mrs. Lidia explained her experience of discontinuity as follows: “So, at the same time I was learning a new career, I was also learning English.” Mrs. Ann focused on how she felt after immigration,

> you feel different. Different because you are different. You come from another culture, and it takes time to adapt. And I come to realize now I, I, when I first came, I say: Oh, these people don’t like me, should I stay away from them [laughs]... but the case is that it takes time to adapt. So, I can’t say now, oh no. I… everything was fine. No, of course you had to struggle, and it takes time.

Besides having to adapt to a new country, most participants mentioned that it was challenging to establish social connections with Canadian-born citizens. This situation was attributed partly to the OVMI participants’ challenges with the language and partly to cultural differences in how and with whom people socially connect. For instance, participants mentioned that Canadian-born citizens are more private individuals who prefer to stay within their family circle. Although participants recognized that this was simply an individual preference that should be respected, they noted that it affected them. They said that they were not used to this situation in their native country, and some of them felt segregated. This disengagement from society then limited their opportunities for learning about Canadian social norms and culture.

5.3.4. Family Ties – Pros and Cons

Family was considered a critical factor for social connections that would help OVMI participants learn about programs and services provided to older adults at the NH; however, family obligations were sometimes a barrier to attending the NH. Among OVMI participants, family was the priority, so when seniors needed to care for their grandchildren or older parents, these participants had to skip NH programs. Mrs. Lidia explained, “[T]here was a program in the evening, but then, they had to changed it to the morning, and I cannot come in the mornings because I need to take care of my mother.” Similarly, Mrs. Cecilia mentioned that sometimes she is busy taking care of

grandchildren or taking her older mother to medical appointments, so she cannot attend certain programs. She mused,

> Sometimes they invite me to programs or to volunteer… but I am busy... so you know, I have something to do. I can't, I can't do this. Sometimes if the program I really want to attend and then I'll tell them, oh, maybe next time when I have time, if you have certain kind of program like this, can you let me know and I will join you [laughs].

OVMI participants also said that they feel resentful of and isolated by close family members when not receiving enough attention from their adult children. Five OVMI participants stated that their family members were always busy, so there was nobody available to talk with and help them manage their physical decline, although the OVMI now relied more on their adult children to fulfil their social and emotional needs. Mrs. Lidia felt that,

> When you get old, you become secondary, you know... like second plan... because it is first kids and parents and then grandparents... grandparents are last... there is no time for grandparents... if they need you they tell you... But you are not 100% active in the family, and when you are not 100% active in the family you become unimportant.

Mrs. Lidia expressed feeling frustration, a certain level of isolation, and a lack of reciprocity in the family circle.

5.3.5. Aging, Culture, and Wellness

In one way or another, all participants in my study stated that they had concerns related to talking about mental health issues. Staff members and volunteers also found it challenging to talk about and try to address wellness, due to the stigma attached to the mental health terminology used by some OVMI and the health authorities that provide support to the NH. The OVMI avoided the topic with family and friends because of the stigma of mental illnesses. Constructs of mental health among participants were most often associated with "being crazy," "losing your mind," and fearing isolation. It was noteworthy that during the interviews, the OVMI felt greater comfort talking about mental health using the term *wellness*, which seemed to induce more open discussion about the topic.

Most of the OVMI participants and four volunteers also expressed having trust issues with healthcare professionals because participants were afraid that their care preferences in terms of treatment options would not be taken into consideration. Rebecca is a participant and a volunteer at the NH, and while she is a visible minority, she is not an immigrant. She expressed frustration with the healthcare system's approach to mental illness as follows,

> The medical system has to do better for people with depression [pause]. We have to do something better than just pills. And that is basically what I was talking and um, um exclusion [pause] you are excluded. That is another, when you are not well you are excluded because you can't participate, keep up with the crowd, with all the exercise and um, the party, and the… you know.

Besides the stigma associated with mental health issues, participants were inclined to link mental health difficulties with the aging process. Mrs. Lidia, Mrs. Ann, and Mrs. Manu told me that they avoided talking to their family members about their wellness concerns because they feared the family would think aging made depression and dementia-related diseases inevitable. Concerns about family views were most often connected to participants' own negative perceptions of aging and wellness. When asked about being old, Mrs. Lidia stated that she did not mind her current way of life, but she had no wish to be old and incapacitated, relying on her adult children to shower her and change her diapers. Similarly, Mrs. Manu said,

> I really don't look because even though... appearance that I do or the dressing I do is very, you know, it's not the old style, old people. But my journey to self, in the senior journey. I really... I was thrown into it literally... [laughs] I was not ready for it... I was not ready for it.

Most participants viewed body and mind as one entity. This perception was clearly observed when participants were asked about dualism versus monism with respect to the mind and body. For example, Mrs. Carmen explained,

> If you [pause] say something physical, you are not well, you mentally that distract you too. Right. So, you don't, you don't, you don't feel the same. You know, you, you, you probably, uh, uh, these, uh, distract you to like, no... depress you too, right. If you not well.

Mrs. Lidia and Mrs. Manu, however, expressed a more complex relationship between mind and body. For example, Mrs. Lidia thought that,

> […] physical health and mental health go together. But sometimes there are things that affect more our mental health or our physical health. For example, now, I cannot do things that need me to use strength, so my physical health is not really well, but not my mental health.

Intensifying this view and adding more complex factors, Mrs. Manu said,

> For physical health, you take a medication. Mental health is much deeper. It is definitely, and it is tiered, it is layered, it is a tiered… if you're not taking care of it, it has gone to a level where it is affecting you and your mental state. But then when... So physically you can look all happy and make that effort, but really, it's so deep and tiered that it has to go beyond the surface.

The greater complexity of their views most likely reflects the higher educational attainment of these two women, their former professions, and their English language skills, which may have provided them with more familiarity and alignment with Western biomedical belief systems.

When asked about ways to keep the mind healthy, none of the participants mentioned consulting a physician, even when prompted about the role of medical professionals in individuals' wellness. Mrs. Ada, Ms. Carmen, and Mrs. Cecilia, for instance, mentioned the role of thinking positively and trying to forget about the past. Similarly, most participants linked wellness to individual behaviours. For example, Mrs. Manu stated that one's attitudes are essential for keeping a healthy mind: "You have to prepare yourself, you have to have a schedule for the day. So, get up, do the things, do have some schedule that will help you and definitely don't be in your, in your PJs all day, dress up."

Individuals' experiences post-immigration affected how they lived and often interfered with how these participants experienced the aging process, influencing their mental health needs later in life.

5.4. "I would be lost without the Neighbourhood House"

During the interviews, many of the OVMI stated the NH was critical in their daily lives and in their wellness outcomes. They mentioned that being connected to programs and services provided a routine for the week, a sense of daily structure that included activities and contact with other people. Some of the OVMI indicated that without the

NH, they would find it more challenging to engage in activities outside the house and have contact with other individuals; for those with limited English and full-time obligations to look after grandchildren, activities and social contact would not be feasible. They said the routine of coming to the NH nurtured a feeling of social inclusion and a sense of accomplishment.

All the OVMI in this study emphasized that they count on the NH to relate to the community, to receive social support, and to have other wellness needs fulfilled, such as assistance with food. When asked how they would feel if they could not attend the NH or did not have the NH's programs available to them, Carmen firmly said: "Well, you are kind of feel lost. Oh, I should be here and now if you can't, you'll get the feeling of loss… I would be completely lost." OVMI's reliance on the NH was observed to be a critical factor in the frequency and regularity of their attendance at the facility.

5.4.1. Utilization

Attending programs and using services at the NH were key daily activities for all the OVMI participants. The average frequency of attending programs or using services was 3.5 times a week. Mrs. Magnolia stated that she went to the NH every day, even when there were no programs or services being offered to older adults. Of the 10 OVMI, nine not only participated in programs but also volunteered at the NH in either the kitchen, the children's drop-in sessions, or the seniors' programs.

5.4.2. Social Inclusion

According to all the OVMI interviewed, having a space that accepted their limitations with English and that welcomed people their age as well as visible minorities was crucial. To provide this, staff members had to consider how and when to offer wellness programs that mindfully supported these older adults, finding a balance between their cultural beliefs and personal needs.

All participants in the OVMI sample mentioned that programs at the NH motivated them to spend some time doing exciting things, getting social support, practicing physical exercises, and interacting with other older adults. Some, such as Ms. Carmen, Mrs. Cecilia, Mrs. Ada, and Mrs. Manu, said that being part of the NH helped

them plan for the week, gave them a sense of having productive days, and made them feel emotionally healthier. As Mrs. Manu put it, “So, definitely, one day out of the five days is planned. It’s a planned agenda and I really like that. It makes you feel productive.” Mrs. Samila, who needed the support of a Farsi interpreter, spoke about her experiences during the first years of immigration to Canada. Her interpreter explained that “in the past two years, she only missed one session [at the NH]. She was saying that she is very consistent, she really likes coming here because she will talk to people and she will feel just much better emotionally when she sees, um people. She just enjoys the energy.”

Indeed, all participants stated that attending programs and using services at the NH was a critical factor in their wellness. When asked about what they did when they planned to come to the NH but for some unexpected reason could not, Mrs. Ada said, “Maybe I stay home with my husband... make something to eat. Don’t like to stay home… no much. I get married in 1970... so many years, not that much to talk [laughs]. It’s so boring. Not happy.” Ms. Carmen said,

> If I cannot come to the NH, you are kind of feel lost. Oh, I should be here and know if you can’t now you’ll get the feeling of loss. Like oh... I wish I could be here like, yeah, but if, if something’s like something come up that you’ll have to skip it... Then no... I miss that, I wish I could can have be there.

The NH provides not only a space to be but also a social structure within which these OVMI can access an enriched environment that offers them resources and new roles.

5.4.3. Practising English

According to 90% of the OVMI participants, speaking English was frequently a challenge because they either did not have opportunities to practise the language or did not feel confident speaking around people. Some explained that they were unable to gain English fluency even many years post-immigration because their work had rarely required them to speak English. All of them except Mrs. Manu had few connections outside their family and working environments and rarely had contact with English speakers. They mentioned being able to learn and practise English after starting to attend the NH. The OVMI participants explained that when they attended programs at

the NH, they spent a lot of time around older adults from different language backgrounds, so they ended up having more opportunities to talk to each other in English. Some also stated that everyone at the NH had an accent, so they did not feel uncomfortable or embarrassed about their English accent. In addition, they were able to improve their English skills because the NH staff members encouraged them to speak up about their ideas and suggestions, and to help with programs and events by directing and giving information to people who arrived at the NH. Staff members at the NH prompted and provided opportunities for the OVMI to help staff facilitate programs. In addition, the OVMI would facilitate some programs and activities themselves with the support of staff members.

The OVMI participants mentioned being comfortable speaking English at the NH because others did not keep correcting them, and people understood what the older adults were saying, regardless of their accent. Attending programs and volunteering at the NH put these seniors in contact with a range of diverse language backgrounds, which helped them have conversations in English since this was the one common language between all participants.

Furthermore, the OVMI participants said they no longer felt intimidated when they needed to speak with people outside the NH. They also felt more comfortable when having to make a phone call to solve a personal issue or go to a doctor's appointment and explain their health concerns. This is a significant outcome related to capacity building among this population group.

5.5. Access Facilitators

Community-based seniors' services are designed to support community-dwelling older adults with their needs. Facilitating access to these services is key and is connected to social, economic, and environmental factors. Staff members working at the NH believe they can encourage OVMI to participate by promoting programs and services through family members and neighbours and by offering programs that are appealing to OVMI's cultural backgrounds. Hence, facilitating access to programs and services is connected to characteristics in the environment and to avoiding financial and eligibility issues that would interfere with participation.

All OVMI participants stated they were interested in expanding their knowledge and said they found appealing topics and opportunities to learn new things at the NH—where they acquired most of their new skills and information. According to participants, these activities involved learning about healthy diet and exercise, attending wellness workshops, cooking new dishes, sewing, knitting, developing computer skills, filling out tax forms, and learning how to access social services available to older adults in British Columbia.

5.5.1. Knowing about Programs and Services

Most (90%) of the OVMI participants mentioned that they learned about the NH's seniors' programs through their neighbours and family members, particularly grandchildren. Eight participants had heard about the NH through their neighbours, who in all these cases told the OVMI about the children's drop-in programs at this facility. Taking grandchildren to the children's programs helped these older adults learn about what was available for seniors. Mrs. Ada, Mrs. Ann, Mrs. Cecilia, and Mrs. Manu said that their first involvement at the NH happened when they brought their grandchildren to the drop-in children's program. It is important to note that children's drop-in activities do not require pre-registration or documentation, and they are free. The only criterion is that an adult caregiver accompanies the children. For OVMI, this is considered a low-barrier, accessible program.

I noticed during field observations that while the grandchildren were doing their activities, the NH staff members from the seniors' department would introduce themselves, offer coffee or tea, show the adults around the NH building, and tell them about the programs available to older adults. When Mrs. Manu visited the NH for the first time, Melissa, one of the staff who works directly with older adults, told Mrs. Manu about the seniors' program. Mrs. Manu described the occasion,

> I came to visit and observe and, and then that's how I know. And then when I came to register my, my, granddaughter uh, give the papers here, and Melissa took me around to say that they have this program for seniors and she showed me the calendar and that's how I know about the seniors' program.

Neighbours played a critical role in helping the OVMI learn about the NH's seniors' programs. For example, Mrs. Samila, who does not speak English, heard about

the NH from a neighbour, who told her about the cooking and English classes being offered in Farsi. Mrs. Samila told me the NH and a multicultural agency were the only two places she was able to attend and was currently attending, because both places offered culturally sensitive programs.

Information about the NH seniors' programs is also disseminated by local health organizations that provide medical and wellness services to older adults who have a medical diagnosis of depression and/or anxiety and have lost connection with the community for any of a variety of reasons (e.g., language barriers, life events, and complexities that lead to isolation). The NH staff members, in partnership with these local health agencies, frequently visit and participate in their local wellness programs to develop a relationship with these isolated older adults, disseminate information about the NH seniors' programs, and encourage these seniors to attend.

According to Laura and Melissa, wellness programs provided by regional health authorities follow the medical model. For example, older adults in need of wellness services participate in group activities (e.g., playing games, doing crafts) to support their sense of social connection. However, I learned from Laura that these activities are offered in an office-like environment where there is no involvement with the community, leading to a new type of marginalization of these seniors. Hoping to address this issue, the NH and some health organizations try to motivate these older adults to participate in programs that are sustained in the community and provide a sense of inclusion.

5.5.1.1. Time of the Day/Year

Many older adult clients at the NH are the primary caregiver for a grandchild, which means that these seniors are also responsible for taking their grandchildren to school. To promote participation, many seniors' programs and services thus need to be offered during school hours. The OVMI mentioned similar morning routines, in which they took grandchildren to school and then attended NH seniors' programs. For example, Mrs. Ada said, "When I retire, I take care of the grandchildren when the kids are small. Give breakfast, take to school, give dinner. I go to the NH when they are at school and I pick up them."

Some participants, such as Mrs. Cecilia, who provided caregiving to her grandchildren and her mother, mentioned that besides having programs delivered during

school hours, she appreciated that the NH also provided programs in the evening, when she had no caregiving obligations. Fulfilling their family responsibilities is the priority for these participants, and NH staff members are aware of this. Time constraints due to family obligations (e.g., taking grandchildren to school and cooking for the family) are taken into consideration when programs and services are scheduled, to mesh with their OVMI clients' availability. During the summer, seniors' programs are delivered concomitantly with children's drop-in sessions to facilitate attendance in both groups.

Staff members also take into consideration cultural factors when designing program parameters and policies, such as time of registration, age eligibility, etc. Maggie explained that thinking and responding to people's diversity, considering how resources might impact their lives, and having flexible policies attracts more people to the NH. Maggie further explained,

> I think diversity is looking at the main ways that people can get involved, who we might be leaving out consciously or unconsciously. So, every decision that we make, there is a process and there is a conversation and there is some conscious thought about what could be the impact even though it is not our intent.

Considering cultural factors and finding successful ways to respond to the community's needs not only attracts more people to the NH programs but also promotes equitable distribution of services among members.

5.5.1.2. Language Services

During programs and services, staff members provide interpretation to help OVMI attend and participate. Interpretation is offered in Cantonese, Mandarin, Spanish, and Farsi. Besides offering language services, staff members who provide interpretation are usually aware of cultural characteristics. Mrs. Samila's interpreter told me that Mrs. Samila felt supported and encouraged to attend the NH because she knew that staff spoke her language and understood her culture.

The NH also offers other types of interpretation and translation services, such as helping OVMI clients read immigration documents, medical records, and social assistance-related materials. According to two OVMI participants, this service helps them understand how to access services available in the city and what to do with letters

they receive in the mail from government and medical offices. Mrs. Samila told me through an interpreter,

> With these letters is just so difficult like if it was you know someone who would call her and you know go there and do that, it would be easier, but no. Of course, in Arabic because she does not understand English but the fact that she has go through the letters and figure out the address, that is very difficult for her. They have the services, but she was saying, they don't even know, know about it at times.

Although the Canadian government offers social assistance and health-related support to immigrants, communication is often done through mail and written in English. However, many OVMI, depending on their country of origin, are illiterate and therefore unable to understand what the government is offering them. Therefore, interpretation services are essential to this population.

5.5.2. Physical Environment

5.5.2.1. Location

The NH is in an area with lots of houses and condos occupied by visible minority immigrant families. Nine OVMI participants said that having the NH established in a residential area facilitated their attendance. Mrs. Ada, Mrs. Ann, Ms. Carmen, Mrs. Cecilia, Mrs. Little Girl, and Mrs. Magnolia mentioned that they live close enough to walk to the NH. When activities are offered outside the NH building (e.g., during summer, programs are sometimes held outdoors), participants said that staff members choose a nearby city park that is within walking distance. Mrs. Manu and Mrs. Lidia, who drive to the NH, mentioned that even though they live in another nearby city, the route to the to the NH is easy and the streets well kept.

5.5.2.1. Open-Door Building

Staff members at the NH have an "open-door policy," meaning the front door is left wide open during all hours of operation. All staff stated that this approach encourages clients to enter the NH and ask questions, because it eliminates a physical barrier. Interestingly, leaving one's own front door open was mentioned by some of the OVMI participants when they talked about how people would come to each other's homes and enter to have an afternoon coffee or tea.

5.5.2.1.1 Interior Rooms

Three OVMI participants mentioned how easy it was to access the NH's activity rooms. They described the layout of the building and its flexible space. Mrs. Lidia and Mrs. Ada, who disclosed that they are shy, appreciated having a chance to see what was happening inside activity rooms through the glass windows because it gave them a chance to decide whether they wanted to participate or not. Mrs. Ann mentioned that the rooms are close to each other, and she does not have to walk too much inside the building, searching for where activities are being facilitated. She also mentioned that the building's size helps people get to know each other,

> I think [pause] because the building itself feels just for one group of people... I mean, ah... I am sure there are other programs, but when I come, I feel ah, I feel, ah... first of all we are all immigrants [laughs], and second it is as… is not too big... I think so. You get to know everybody. I think that is what it is... yeah.

These attributes of the NH's physical environment facilitate mobility and a sense of community among the OVMI participants.

5.5.3. Access to Economic Resources

5.5.3.1. Income in Later Life

The OVMI participants emphasized the importance of having enough financial resources as they aged. They mentioned that having a pension that covers basic, essential needs, such as rent, food, and medication, helps them feel at ease and not worry about having to work as they grow older. Access to a pension plan was clearly central for their participation in wellness programs. Ms. Carmen said: "after retire like... because you do not have to worry about work, you don't have to worry about money [pause] problem... how to keep... keep the house going, how to, how the cost of living. I just, now I just, I am on my budget, so I think I am doing well." Yet as Mrs. Lisa explained, "[T]here is little left over after the basics; we need enough money to buy like food or pay rent. Otherwise, you know, you cannot go enjoy something like doing exercise, helping here." Although the OVMI indicated they had enough income to cover basic expenses, these statements suggested that they would be unable to engage in wellness activities if they had to pay out of pocket.

While having financial resources supported attendance, not having access to a pension or equivalent similar to their pre-retirement income interfered with their frequency of participation in the NH programs. For instance, Mrs. Manu said that although having to find ways to supplement her pension did not create a barrier to attending health programs, it did not allow her to attend all the programs she felt would benefit her wellness.

Lack of adequate financial resources in old age impacts the wellness of OVMI because they must choose between finding ways to supplement their income and taking care of their wellness. Besides putting OVMI in stressful situations after so many years of contributing to the work force, it limits their time for self-care.

5.5.3.2. Free Programs

All the OVMI participants stated that one of the key elements supporting their access to the NH is that this organization offers free programs and services. The only out-of-pocket cost for them is a $5 membership fee that is waived if the participant declares lack of financial resource to pay it. This was the case for one OVMI participant in this study.

All other participants asserted that free programs are indispensable for attendance at wellness programs and use of services. Some, such as Mrs. Little Girl, who has a serious chronic condition, said that she is barely able to afford expensive essential needs such as her medication. Hence, it is imperative for her that wellness programs be free of any cost. Similarly, Mrs. Ada, Ms. Carmen, Mrs. Lisa, and Mrs. Magnolia commented on the importance of having access to free programs and affirmed that they would not be able to attend the NH programs if they had to pay more than the $5 membership fee. Ms. Carmen and Mrs. Ada further pointed out that wellness program fees and service fees usually charged at other community-based locations, such as community centres and seniors' centres, were access barriers for them, although the programs at these centres were attractive.

Providing free programs and services also includes supplying all of the required materials, as well as bus fares or other transportation for outside programs, plus tickets for cultural programs such as outings to museums, galleries, and other types of exhibition. According to NH staff members, financial limitations are experienced by

nearly 90% of all their older adult clients, so a great number of participants depend on programs and services being free. However, funding for the NH is extremely limited, and when it is available, it frequently prescribes specific activities that often do not fit OVMI's needs.

5.5.3.3. Eligibility for NH Resources Conferred by Caregiver Status

The NH faces many challenges to funding programs for older adults. There is a dearth of ongoing, sustainable funding from government agencies, a high demand for services in the community, and a need for programs and services outside the scope of funding offered by governmental and non-governmental agencies. In a detailed discussion, Naomi explained that some funders who provide financial resources to support children's programming have policies in place that allow payment not only for the children's activities but also for those who provide care. Since in this community, most parents work outside the house, and grandparents are the primary caregivers for grandchildren, the NH management staff can fund some of the programs for older adults in this way. Mrs. Magnolia, for instance, accessed the food security program because she provided care to her three-year-old granddaughter.

5.5.3.4. Food

Many OVMI participants in this study mentioned that life was extremely challenging, and they sometimes had limited resources to secure regular nutritious meals for themselves. This situation was exacerbated in some cases by the need to feed their grandchild. Seventy percent of the OVMI participants said that they were attracted to the older adults' programs because the NH offers food during and after most programs and services. Besides serving snacks or meals to those who attend programs, the NH also provides groceries such as vegetables, fruits, bread, and meat to older adults who are unable to afford them every week.

The OVMI participants who brought their grandchildren to the children's drop-in program also stated that they did not need to worry about buying and cooking food for their grandchildren because they knew that a full meal would be served after the program. Although the NH sometimes did not have enough food to distribute to caregivers (i.e., grandparents), the participants felt good that at least their grandchildren were receiving a complete meal.

5.5.4. Freedom from Violence and Discrimination

5.5.4.1. Safe Space

All OVMI participants asserted that having a space where they can go and know that everyone accepts their ethnicity significantly motivated them to participate in the NH programs. Mrs. Lidia, Mrs. Manu, Mrs. Lisa, Mrs. Samila, Ms. Carmen, and Mrs. Ann highlighted that they felt safe going to the NH because they knew the staff and other participants would respect their ethnicity and religious background. Although Mrs. Lidia did not experience being discriminated against for her skin colour, she explained her experiences in relation to her views about Canada,

> I did not feel discrimination for my colour because I am white… I am Latina, but my skin is white. But here [in Canada] like… they don't listen to you because... I worked at the [name of place], and they do not consider your opinion because you are not from here. But here [at the NH] they want to know what I think… I am important at the NH.

In one way or another, all OVMI participants stated that they attended programs and services at the NH because they felt people joining the NH were similar to them, either old or immigrants or both. Many OVMI participants mentioned that at the NH, they celebrate different cultural holy days and festivities, something that makes them feel included in the organization.

Interestingly, 80% of the participants had internalized ageism (i.e., believes that older adults, including themselves, do not deserve access to resources because they are too old). In contrast, staff treated them with dignity, respect, and appreciation for their knowledge. Half of the OVMI participants also mentioned that they did not feel ashamed when they needed to ask for food or other resources at the NH, because staff members understood older adults' struggles and helped them in a non-judgmental way.

5.5.4.2. Welcoming and Home-Like Feeling

Another important theme mentioned by most OVMI participants (80%) was related to feeling welcome when they arrive and participate in programs at the NH. Participants mentioned four main aspects that contribute to them feeling welcome at the NH: being noticed, having choices and opportunities, feeling cared for, and being comfortable. OVMI participants mused that when they arrived at the building and for programs, staff and other participants noticed them and engaged in informal

conversations. They also said that staff members were friendly and knew everyone by their first name, which all the OVMI appreciated. To these participants, having choices and opportunities meant being able to participate and help in any way they were able. For instance, the NH frequently needs older adults to take roles in the seniors' programs; however, if someone does not want to get involved in this way, there is no retaliation or judgment. At the same time, staff members ask older adult participants to voice their wants and needs, so programs can reflect their suggestions. According to OVMI participants, if they stopped attending programs, they received phone calls from staff members checking to ensure they were alright. This was considered very important and made the OVMI participants feel cared for. Finally, all OVMI participants stated that they felt at ease and relaxed, as if they were in their own house. As Mrs. Lisa expressed it,

> Well just the staff... they are nice right... they notice you... they say hi, how are you you know... staff like that eh. Yeah... Because the staff is friendly here. It is ahhh just... the staff is friendly, right? And even some of them really encouraging. Yeah... it made me feel comfortable, right? I mean they... I feel welcome, right?

Such statements suggest that staff are committed to providing a pleasant environment using a compassionate approach that allows OVMI to feel safe, understood, and comfortable.

5.5.5. Supportive Relationships

All 10 OVMI participants made positive statements about the importance of their relationships with other participants and with staff and volunteers. They indicated having strong connections with other participants and said that on many occasions, the friendships they had developed at the NH helped them cope with challenging situations. When asked what characteristics most promoted their relationships with other participants and staff/volunteers, 90% of the OVMI participants reported reciprocity, speaking and being heard, and trust.

5.5.5.1. Reciprocity between Participants and the NH

The OVMI participants stated that they appreciated being able to ask for support at the NH, and that staff members counted on OVMI to help them run programs. All 10 women said that they offer help at all big events and with running programs, either for children or for older adults. This exchange of support seems to create a relationship of

reciprocity, influencing attendance at programs because these older adults feel that they not only attend the NH to receive benefits, but also offer something to the NH. A positive impact of this reciprocal relationship between the organization and its clients is observable through comments that some OVMI made about feeling like an essential part of programs and the NH. Mrs. Little Girl said, “They [NH staff members] give me so many help. And I help, too. So, I go working in the volunteer... the kitchen. Wednesday and Thursday in the kitchen. Feel good! I always help because they need me.” Similarly, Mrs. Lisa said,

> Yeah, and after the learning, you know, the basic computer. The instructor asked me to do volunteer to teach the senior... there is a beginning you know... basic computer. It is really nice eh. I am a facilitator too. When they [the NH] need me I always help. It feels really nice eh.

Others, such as Ms. Carmen, expressed a commitment to supporting the NH: “Yeah, because I participate in the program there right, so you know, you can do what you like here [laughs] I feel like. and I kind of... Like in a way I volunteer here. So, it makes me feel good that I can be of any help to everybody, too.”

5.5.5.2. Speaking and Being Heard

Most OVMI participants suggested that many times, they would like someone to talk to about their worries and needs, and they feel that reaching out to staff members is often their best option. This is because staff members not only let OVMI participants speak up, but they try to address the issues brought to their attention. OVMI participants explained that they are part of the NH advisory committee, where they bring their ideas and suggestions for developing, organizing, and facilitating programs and services for older adults in the community. As Mrs. Cecilia, Ms. Carmen, and Mrs. Lisa said, the NH asks for OVMI’s input through an advisory group because they want to make sure that programs and services reflect what older adults need and want. Ms. Carmen explained this process: “Once a month, we have the advisory meeting. So, in here on that meeting, we kind of acts for the seniors. We speak for them in here, know what they need, and you know... We pass on the message to the staff.

The advisory group meetings happen every last Friday of the month. About eight OVMI come to this meeting and inform staff members of things they would like to do or change. They also tell staff about identified issues happening with other older adult

members and in the community. Mrs. Cecilia explained what happens when the advisory group meets,

> Sometime, you bring it up, right. We can discuss things... we find out the right one, the better one to use [she is referring to finding a better way to do something, together]. Sometime, they even... they brought up the questions, and then I will you know... tell my opinion which way is better... can we go this way... I will put my suggestion. We are quite open. Because there is like... they are friendly, right. They listen to what you say... they listen, I do something right or wrong they will please about it... so you feel comfortable, someone respect you, too.

Supporting the involvement of OVMI participants at the NH encourages and validates these clients' views and ideas, making them part of the decisions made about the resources offered at the NH.

5.5.5.3. Trust

All OVMI participants mentioned trust as part of the relationship between staff and participants. They indicated that when they have serious issues related to taxes, health-related problems, immigration, or a food shortage, they trust that they can bring these sensitive topics to staff members. This cohort expressed significant trust issues with the healthcare system and mental health treatment options. So, for the OVMI, it was critical to have a trusting relationship with the NH staff members, because they endorse and facilitate access to mental healthcare. Some of the OVMI participants also rely on the NH's support with many other types of issues. Mrs. Magnolia explained that every time she has a problem, she goes to the NH, because she knows they will find a way to help her. Trust among clients and staff members is a critical factor that promotes adherence to health-related programs offered at the NH. Also, older visible minority might be more likely to accept and follow health recommendations that comes from organizations they trust, like the NH.

5.5.6. Access and Retention

5.5.6.1. Group Activities

Most programs offered at the NH are group activities. According to all the OVMI participants, being in a group activity where they did things together was an essential motivator for their attendance. They explained that connections with other people

needed to be meaningful for them to want to keep participating and remain involved at the NH.

5.5.6.2. Family and Intergenerational Activities

The NH also offers activities that include the whole family, especially older adults and their grandchildren. As already noted, these seniors are often the primary caregivers of their small grandchildren. Hence, having programs that allow seniors to engage with each other and, at the same time, offering something to the grandchildren is an important aspect of trying to engage this cohort in wellness programs.

This population group prioritizes the family, so it is important to offer programs that include their family members. Hearing this from the seniors helps the NH to consider, plan, and offer appropriate programs. Family activities are viewed as a critical factor for promoting the participation of OVMI clients, especially during big events, so the NH invites the whole family.

5.6. Access Barriers

5.6.1. Language and Cultural Issues

5.6.1.1. Cultural and Linguistic Dominance

The NH serves OVMI of many ethnicities. However, participants and staff members are predominantly Chinese for two reasons. First, the NH is located in an area predominantly inhabited by a Chinese population. Second, since many participants are Chinese, and funding limitations do not allow the NH administrators to hire staff who can speak other languages, there is an unintended cultural and linguistic dominance at the NH. Consequently, cultural clashes occur because some ethnic groups feel less supported. Mrs. Lidia explained how she feels,

> Well, it is not easy because the majority here are Chinese but... like they do not touch you know... but we like to hug, hug. One time I met with a Latina person here and I gave her a huge hug... and the other one who was not Latina told me: why you don’t give me a hug like that?

Mrs. Magnolia expressed her disappointment that when she tries to communicate an emotion or ask for something based on her needs, new staff do not understand what

she requires and do not value her interactions, such as saying hello and voicing her opinions during casual conversations.

5.6.2. Environment

5.6.2.1. Issues Related to Transportation and Street Grade

Although most OVMI participants live near the NH, a few pointed out that they sometimes wished they could catch a bus to the NH. They explained that they have to walk about eight to ten blocks, and the street grade is very steep. Mrs. Samila, for instance, said that she had knee issues, plus she had to bring her daughter, who lives with disabilities and uses a wheelchair, with her to programs and services. She also explained that there are no transportation options from her house to the NH, so she has to walk there and back, with her daughter in a wheelchair, to attend the programs. A similar issue was described by two other OVMI participants, who also live close to the NH. They mentioned that mobility limitations made it challenging for them to walk the steep streets; however, taking a bus was not an option, in part due to financial limitations. Ms. Carmen said, “I walk here… sometimes I take the bus, but I don’t have enough money to always take the bus, and I have to walk anyway because the bus stop is far from my house.”

These statements imply that although many OVMIs can get to the NH, they face mobility challenges and still need assistance with transportation. According to staff members, one of the greatest challenges to promoting access to the NH is the lack of transportation. The NH does not have the financial resources to provide transportation services, and the city does not provide accessible transportation.

5.6.2.1.1. Lack of Space and Storage

Some OVMI participants mentioned that often, a room at the NH is not available to offer programs to older adults. Others explained that they have to share the flexible space at the NH with the children’s programs, which sometimes is challenging because it becomes hard to concentrate and listen to the facilitator. Lack of sufficient space to run programs for all older adults was also mentioned by staff and volunteer participants. Laura and Maggie explained that the NH is not big enough to support all its clients, so staff and clients from different departments frequently need to negotiate space.

Occasionally, programs for older adults are postponed because there are no rooms available and priority is sometimes given to children's programs. When asked what OVMI would like to have more of at the NH, Mrs. Ada replied, "I hope make more place we can use because now when we go there [the NH], is not enough place for us to stay. Yeah, yeah... a lot of people. We do not have space sometimes." Similarly, Mrs. Ann answered,

> I like to come for workshops, but sometimes I do not tell everyone, but I cannot hear well because I have a little hearing problem. So, I do not mind the kids, but I have problem to hear the workshop and I know they do everything they can, but we just do not have the space.

These answers suggest that even though OVMI participants understand the space limitations at the NH, their needs and physical limitations ought to be considered so this population can better benefit from programs.

5.6.3. Funding Limitations

Funding limitations interfere with access and were mentioned by all participants in this study. Reasons were the insufficient blocked funds[4] provided by the government, dependency on grants available in the area, selective distribution of resources, and funding organizations with rigid systems and prescribed activities.

Naomi (the NH director) expressed her concerns about not receiving a blocked fund from the government that would secure seniors' programming according to the number of attendees. She also said that the NH receives CAD6,000 per year to support 500 older adults. This is CAD12 per older adult client to fund a year of programming. Thus, to support participants, the NH staff members have to constantly search and apply for grants. When a grant is received, the financial support is provided for a specific time frame, and when that is over, staff must identify new grant opportunities. Since resources are limited, not all OVMI are able to receive certain types of assistance because there is not enough for everybody. Therefore, staff members are pressured to create a system that prioritizes who will first receive the resources, and some are left without the assistance they need. Funders also tend to be specific about what types of

[4] The city provides steady funding to some community-based seniors services and they get it every year without the need to send grant application.

activities can be offered and these are frequently based on Western practices that do not always align with the OVMI population's needs.

5.6.4. Understaffing

Working with OVMI requires time, so they can receive enough attention for their needs to be understood and supported. Some OVMI participants said that there are not enough staff members to provide support to all participants. Although none of the OVMI participants complained about helping the staff team, they noticed that staff members were often overloaded.

5.7. Mental Health/Wellness

All OVMI participants stated that they feel physical and wellness benefits from their participation in the NH seniors' programs. OVMI participants mentioned perceived physical health benefits such as being motivated to exercise and adopting a healthier diet, but more notably, benefits related to social inclusion, a sense of belonging, self-efficacy and self-esteem, self-control, and views about aging.

5.7.1. Social inclusion

All OVMI participants stated that the NH provides a space to connect not only with other older adults, but with individuals from other generations, such as children, youths, and younger adults. These participants explained that when they started participating in NH programs, they became involved with more activities that further increased connection with other older adults. For instance, Ms. Carmen said that she started going to the NH to learn how to use a computer. After that, she was invited to participate in the walking exercise program and in wellness workshops. Increasing her participation boosted the number of people she became connected to and helped her become involved with the community. She also said that by participating at the NH for over six years, she had the opportunity to know all the other older adults there, and some of them had become her closest friends. Mrs. Ada, who first went to the NH to bring her grandchild, learned about the computer and wellness workshops for older adults and decided to participate in these activities. After that, other older adult participants at the NH invited her to participate in additional programs. She became

more involved with the seniors' programs, started to attend them every day, and developed friendships with other participants and staff members. When asked about people she had had the chance to meet at the NH, Ms. Carmen replied,

> I know a lot people, many people... almost everybody... when you... walk on the street you can... like you can... many so many people say hello to you and then I know they are from [Neighbourhood House name] [laughs]. And I have friends… I mean… not everyone but you get to know people and they become a friend right. Before that… I would be at the house, taking care of my dog.

Similarly, Mrs. Ada said, "So many friends at the NH. We join the computer, and dancing and community walk and karaoke... Yeah, so many things we do. Yeah. Like that once a month we had it, the friendship group once a month. So that, I know all those people that come to that group there." Likewise, Mrs. Cecilia mused, "I know so many people here. We say hello and then some, some of them, we chitchat, you know... we know quite a few. We do things together here and outside, it is fun." Connecting with staff members and volunteers was mentioned as an important social inclusion factor for all OVMI participants. They said that after getting to know the staff members, they became involved in the community, helping isolated older adults connect to the NH and supporting them.

5.7.2. Sense of Belonging

Besides connecting with other individuals, all OVMI participants commented about feeling part of the NH, as if they were like a family. Mrs. Ada, Mrs. Ann, Ms. Carmen, Mrs. Cecilia, Mrs. Lidia, Mrs. Little Girl, and Mrs. Lisa described the NH as their second home. Although these participants did not use the term "belong," the home-like feelings they expressed reflected a range of perceptions connected to belonging. These feelings included acceptance, comfort, worthiness, respect, a strong sense of attachment, and connection, all of which contributed to them feeling part of the NH community. Mrs. Lidia said, "I think that here we are like a family. We like to come back and there is a very active group of people and they would not work as volunteers here if they did not like it you know." Similarly, Mrs. Magnolia mused, "I told you it is my second home [laughs]. I talk to like family, you know. Not the new people, because they change all the time, they have new people all the time." A sense of belonging plays a central role in connecting these OVMI to their community and society.

5.7.3. Self-Determination and Control

Self-determination and sense of control are important characteristics observed among older adults with positive wellness outcomes. Most (80%) OVMI participants suggested that attending workshops at the NH related to physical and mental health influenced their views about aging and wellness. Besides gaining a more positive way to perceive aging, these participants commented that they were able to understand and change certain behaviours, thereby improving their wellness. For instance, Ms. Carmen realized that in order to promote her wellness, she needed to participate in social activities and be engaged with the community. Similarly, Mrs. Lisa said that not staying alone in the house had contributed to her feeling less anxiety and loneliness. Mrs. Cecilia commented that she realized she can be active while she ages, and she planned to continue her connection with the NH to maintain and promote her wellness. Mrs. Ada said she had learned that not staying at home all the time was really helpful to her wellness, and she appreciated having access to the NH every day to stay mentally healthy.

When OVMI participants were asked whether they had learned anything at the NH that had influenced their views about aging, wellness, and how to be mentally healthy, Mrs. Ada identified her participation in the NH programs as a form of providing self-care:

> Somebody came here... like last time, the people talking about how to take care by myself, what kinds of exercise for that, too. Sometimes tell me how to cook the healthy things for the diabetes so I do not feel sick. Come here too… Because I can make the friend, go out, I can do some volunteer, make me happy, when we learn the new things. I always keep me happy, no sad.

Similarly, Ms. Carmen stated,

> They always have these programs, so give you more knowledge, like, yeah, it helps right! So sometimes I feel like, oh, I cannot do this, but I can do it this way. Or I did not know that, oh, or that. Well, that is one part... we will all go one day anyway [laughs]... They have quite a lot information really. I think it is really helpful.

Mrs. Lisa felt encouraged and motivated to learn from the behaviours and attitudes of older individuals at the NH so she could remain healthy:

> Yeah, yeah... I think you know... from the workshop, you really know, you learn a lot of stuff from the speaker. Oh, like bringing you know more awareness [giggling]. I think is good thing because you see you know some other you know senior right. How they uh... still so active, so they still come and join this program. Yeah, you see some good example... I know they [*indistinguishable*] we used to have a lady... you know, she is very old... she used to coming like every day. I want to do that too [giggling].

As noted earlier, the OVMI participants felt closely involved in planning and designing the seniors' programs and active in choosing activities that they considered appropriate to support their health. Their answers suggest that participation in the NH seniors' programs, their active roles, and their interactions with one another helped them become aware that they had opportunities and options to control their wellness outcomes.

5.7.3.1. Self-efficacy

The NH provides training in a range of skills (e.g., computing, yoga, laughter yoga) for all older adults who want to participate, and many attend these training sessions. However, some OVMI participants said that when they first started attending, they had low confidence and few expectations that they would be able to learn and use the new skills. According to staff members, low self-efficacy is observed among many OVMI participants at the NH. Therefore, as well as offering training, these opportunities are designed to meet participants' other needs—for instance, simple language, interactive activities, and one-on-one assistance. In addition, staff members make sure to encourage participants individually, so they can feel more confident about participating.

Furthermore, the NH is a safe space where OVMI participants can apply what they have learned during the training sessions. OVMI participants said that having a space where they could practice what they learned was a way to develop confidence and belief in their ability to succeed in their new skills. Since training is offered according to OVMI's needs and wants, they feel motivated to participate and be actively involved in practising. Mrs. Lisa told me about her lack of confidence prior to realizing her ability to do something she liked:

> I was taking some other program in the NH, right. And then like, you know, one of the home assignments, we are required to like make a program you know... for the members, right and then use your talent. I say the talent! I

> don’t have the talent. I cannot cook, I cannot you know sew, I cannot knit... like I have no talent [smiling] What am I going to do? Actually, I was going to skip the class [giggling].

With the support of staff members, Mrs. Lisa has become one of the key members at the NH. She continued,

> You know, I got the Laughter Yoga training after that, you know, I was like... get you know, my confidence, you know, like, you know, I can do something [giggling]. I would never, you know dream that I can, you know, go out and you do be there and do the Laughter Yoga. And then, when we go to other, you know, they ask me to do right... and then, you know, they invite me to, you know like, do Laughter Yoga here… and I do at their, you know, organization! Yeah... One time, I was doing the Laughter Yoga, you know, in front of 400 people. You know, just for a few minutes right... maybe you know, 10 minutes right.

Similarly, Mrs. Samila’s interpreter told me,

> During the summer, when they did not have English school, so they were coming here a lot, and so they really enjoyed coming here because they were doing a lot of fun activities like cooking [smiles]. But in the summer because it was cooking. It was really funny because you know, when it comes to cooking and she was teaching everyone, so she felt really good. But this was the first time she was teaching people here.

These OVMI participants had spent many years of their lives without the chance to explore their abilities. Some had not even had the opportunity to show what they know because their skills were often connected to domestic tasks such as cooking, sewing, knitting, etc. However, clients and staff members at the NH value these skills and want to learn them, giving OVMI participants a platform to present and develop their abilities.

Chapter 6.

Discussion: Exploring Mental Health Promotion through the VicHealth Lens

This study sought to investigate the role of the Neighbourhood House (NH) in the wellness of older visible minority immigrants (OVMI). The primary goal was to explore access facilitators, barriers and wellness outcomes for this population group. The analysis of my findings is guided by the VicHealth framework, an evidence-based approach centered on the understanding that wellness and wellness promotion require long-term sustainable interventions that target key social and economic factors. These factors are related to (a) social inclusion: supportive relationships as well as involvement in group activities and with the community; (b) freedom from discrimination and violence: the valuing of diversity, the provision of physical security, and the availability of programs that support participants' self-determination and sense of control; and (c) access to economic resources: access to work, education, proper housing, and money (Keleher & Armstrong, 2005). Overall, the findings of this research highlight the position of the NH through the lens of the VicHealth framework.

6.1. Social Inclusion

Social inclusion is associated with equal opportunities and access to resources that can enhance people's participation in society (UN, 2016). Data collected for this research indicate that post-immigration experiences affected the degree of social inclusion of OVMI participants. Previous researchers (Becker et al., 2003; Blair, 2012; Treas & Mazudar, 2002) have emphasized barriers that OVMI encounter when immigration occurs later in life (e.g., social isolation, lack of social support, and estrangement from essential social services). This study shows that those who immigrate at a younger age are not exempt from similar challenges. Although limited English fluency and demanding working hours were considered key issues hindering social inclusion after immigration, OVMI participants faced additional difficulties later in life, including low socioeconomic status, gendered social roles (e.g., caregiver of grandchildren and/or ill older adult parents), and discontinuity or weakened ties with family and earlier friendship. Hardships early in their lives as immigrants to Canada

shaped the aging experiences of OVMI, making them susceptible to isolation and marginalization. Considering these barriers, the NH offers programs and services focused on providing a suitable social environment, offering language interpretation, group activities, and free programs and services during various times of the day. Correspondingly, OVMI participants mentioned having opportunities to participate in the NH, gaining access to socially supportive resources, and feeling integrated in the NH.

Due to their experiences of social isolation over the years, OVMI require access to structured social organizations that can mitigate the negative effects of life experiences influenced by social inequalities related to their visible minority background and immigration. Contrary to previous studies in gerontology showing that older visible minorities might be protected against social isolation due to family supports and cultural networks (Ikram et al., 2016; Novak & Campbell, 2006), my study indicates that the OVMI participants would be socially isolated without the NH support. A strong sense of connection and participation can be promoted through community-based seniors' services (i.e., Neighbourhood Houses and other immigrant-serving organizations) that consider older adults' culture and life transitions, and their influences on both earlier and later life experiences.

6.1.1. Supportive Relationships

Trust between staff members, volunteers, and OVMI participants was associated with the likelihood of OVMI connecting to primary healthcare services in the wider community. This finding reflects those of Jennings-Sanders (2001), suggesting that contact with community-based services increases the level of trust in Western medicine. The Western healthcare system rarely includes the healthcare practices of culturally diverse populations, and it is considered unfamiliar territory for this population group. Healthcare providers lack the skills to effectively communicate with culturally diverse individuals, thereby failing to act as mediators of Western practices. However, staff members in the community-based seniors' services sector (i.e., Neighbourhood Houses and multicultural agencies) are equipped to understand the roots of cultural disapproval of Western medicine services, and concomitantly to communicate Western practices using culturally sensitive approaches in an accessible health-related language (Blair 2012; Boughtwood, 2011; Kreps et al., 2008). Gilson (2003) suggests that trust is mediated through affiliation with social organizations that invest in forming emotional ties

with their participants. From the standpoint of staff members, volunteers, and OVMI participants, the NH provides supportive relationships through social engagement, reciprocity, trust, and capacity building.

Staff are well positioned to provide this support because they have built relationships with participants, allowing staff members to learn and understand the local context, and the needs and wants of OVMI participants. In addition, ongoing partnerships between this NH and several local health authorities that provide health information and training support the development of health education and literacy among staff members and volunteers. This facilitates communication that is more aligned with each person's culturally based values, beliefs, and perceptions about credible health information.

The failure to recognize older adults' caregiving obligations can present a significant barrier to their participation in programs, particularly for OVMI (Koehn et al. 2011, 2016). NH staff members are aware of these constraints and are proactive in designing their programs to match the needs of OVMI, taking into account their grandchildren and their responsibilities as caregivers of older parents. Since the NH provides low-barrier child drop-in activities (i.e., no pre-registration, low commitment, and no fees), and the interconnected departments in this organization (i.e., family and seniors department) work together, OVMI participants who bring their grandchildren to the NH end up interacting with the seniors' programs' personnel, other grandparents, and older adult volunteers. Similarly, OVMI who are the primary caregivers of older adult parents can access resources such as social connections and wellness workshops that help them alleviate stress as well as learn about self-care and caring for older parents. In this manner, the staff members and volunteers encourage OVMI to get involved with the community and with other seniors' programs offered at the NH.

To strengthen participation, the NH facilitates opportunities to develop and enhance OVMI's skills and abilities. The data reveal that the NH perceives all OVMI participants as "whole" individuals with considerable, valuable skills and an intrinsic capacity. Although this capacity is often not recognized by the OVMI themselves, as observed through the data, the NH facilitates an environment that is determined to understand what these capabilities are, and how to better support OVMI in the process of capacity building.

This study thus shows that the NH is the “bridging point” between OVMI participants and access to social networks. The NH promotes social engagement and involvement with the community that ultimately facilitates the development of social capital.

6.1.2. Leisure Activities

Frequent leisure participation provides a range of benefits, such as decreasing age-related diseases, providing socialization, and enhancing the wellness of ethnically diverse older adults (Bauman et al., 2017; Depp & Jeste, 2006; Gravelle et al., 2015). Early life limitations in leisure activities among ethnic minority immigrant women are influenced by cultural gender roles and beliefs that expect young girls and women to learn domestic activities (e.g., cleaning the house, cooking, baking, knitting, sewing, and taking care of younger siblings) in preparation for marriage and motherhood (Weerasinghe & Numer, 2010). Although leisure opportunities are vital to the health of OVMI, this area presents considerable challenges to service providers. Lack of knowledge about the relationship between culture and leisure preference, providers’ own cultural views about what represents leisure, and the variety of cultural backgrounds of participants imposes access barriers (Karlis et al., 2018; Edington & Chen, 2014).

Consistent with the literature, most OVMI participants said they had had very few opportunities for leisure activities over their life-course. Staff members and volunteers indicated that the NH provides a variety of leisure activities to OVMI. Notably, OVMI participants referred to these opportunities as their main source of entertainment. Inadequate leisure time is linked to lack of financial resources and transportation literacy among this group of OVMI. Many OVMI participants mentioned that since entering the NH, they were able to engage in day and weekend trips, visiting parks, libraries, museums, art galleries, etc. However, opportunities to travel with a group or to visit a park are not always easily accepted due to cultural beliefs constructed on patriarchal gender stereotypes that suggest women are putting their families aside and being self-centered if they wish to pursue activities outside the domestic realm. This contradictory perception of leisure was clearly observed among these OVMI participants, with some (20%) suggesting they had fulfilled their family’s expectations while others (80%) resisting engagement in leisure activities without the family. Knowing about this complexity, and the influences of aging in leisure choices and activities, the opportunities

for leisure offered by the NH are often connected with children's programs, activities attached to cultural meaning, and health-related workshops. Similarly, Kim et al. (2002) have found that OVMI are likely to engage in leisure activities that connect them to their cultural background, helping to preserve their ethnic identity and propagate their cultural values. This suggests that aligning leisure programs and services with the cultural meaning attached to these activities results in improved access to leisure among OVMI participants.

Partnerships between health authorities with ethnocultural organizations such as the NH provide an important foundation for responding to cultural differences between service providers and OVMI's leisure needs. Augmenting the VicHealth framework by including access to leisure opportunities would acknowledge both the value of leisure to mental well-being and the barriers many visible minority older adults face in accessing such opportunities. Improved accessibility of leisure services could be an important and cost-effective way to promote wellness and decrease health care expenses due to complex age-related diseases.

6.2. Freedom from Violence and Discrimination

OVMI participants in this study mentioned several situations in which they had experienced discrimination in Canada, and these events were predominantly connected to their ethnicity, immigration status, and socioeconomic background. Having non-Caucasian physical features was often what prompted discrimination against OVMI participants. Historical events such as white European settlers' dominion over Indigenous populations, negativity toward immigrants of colour, discriminatory legislation (e.g., the biannual tax of Chinese Canadian workers), the racialization of non-white immigrants, along with immigration policies restricting and sometimes even prohibiting specific nationalities (e.g., Chinese) (Fernando, 2006; Knowles, 2016) underscore the opposition faced by visible minority immigrants. Thus, for OVMI participants, racialization alongside migration comprised different domains that simultaneously influenced their experiences of discrimination.

In addition to encountering explicit discrimination, OVMI still experience concealed forms of exclusion, an issue pervasive in Canada's social structures and systems. Furthermore, marginalized older adults are significantly more likely to

experience health inequalities that appear to move across generations, particularly among immigrants (Bhui & Bhugra, 2007; Raphael, 2016). Limited access to equitable, fair, broad participation in Canadian social systems—observed, for instance, through multicultural policies[5] that while celebrating diversity are still vague about systemic change and the tangible, beneficial inclusion of visible minorities—are markers that discrimination and exclusion are complex and still prevalent for OVMI in this country. In the context of immigration in Canada, the exclusion of OVMI is, at least to a certain extent, interpreted as the result of time since their immigration, lack of acculturation, and continued attachment to their cultural background and beliefs (Berry, 2006; Wister, 2019). Although these factors can influence social isolation (Nazroo et al., 2019), the social location of a group largely influences how society will (un)favorably regard a group of older immigrants.

While OVMI participants identified several situations of discrimination experienced in the wider community, they mentioned feeling safe and free from discrimination and violence in the NH. As reflected in the data, the sense of freedom and safety was associated with the physical security and opportunities for self-determination and self-efficacy promoted at the NH.

The literature often shows low utilization of resources among culturally diverse population groups; however, many of these studies tend to emphasize cultural adjustment to the receiving society as well as language barriers (i.e., English fluency), neglecting to consider other factors such as ethnicity and the accessibility of programs and services offered to this population (Mui & Kang, 2006; Treas & Mazumdar, 2002). The findings of this study reveal that OVMI participants feel government health authorities are not interested in providing appropriate spaces where older adults can engage in activities and social interactions. Furthermore, OVMI participants feel like alienated and unimportant members of society because their needs, as older adults, are ignored by some of their family members—and, more importantly, because these needs are not taken into consideration by those in power (i.e., health authorities) to promote better health conditions. Such perceptions were highlighted by OVMI who experienced

[5] See, the Canadian Multiculturalism Policy, 1971, explained on the website of the Canadian Museum of Immigration at Pier 21: https://pier21.ca/research/immigration-history/canadian-multiculturalism-policy-1971.

low interest from family members about their needs, and a lack of resources available in the wider community.

6.2.1. Physical Security

Chao and Huang (2016) argue that views on what constitutes accessibility of spaces may vary across cultures. Studies indicate that when offering programs to older adults, it is essential to consider the physical characteristics of the environment in order to promote a range of diverse mobility capacities and physical limitations (Campo & Chaudhury, 2012; Gray et al., 2008; Mahmood et al., 2012).

Staff members, volunteers, and OVMI view the NH building as a place where people can gain easy access through the front door, easily meet one another, and find out on their own which programs are running in the rooms. My findings show that physical accessibility for OVMI participants in the context of the NH entails offering a physical space that takes into consideration mobility issues and the need for cues offered by certain physical features. For instance, the small windows in the activity room doors of the NH confer more autonomy to OVMI participants because they preclude their need for assistance to identify programs or groups of people they are looking for. Simplifying building entry by adopting an open-door policy serves as an invitation to OVMI to initiate an interaction with the NH. These physical elements can be categorized as permeable physical environmental features that ensure OVMI do not require the mobilization of a range of resources to access the NH (Dixon-Woods et al., 2006).

Staff members and volunteers view the NH location as easy to access, and more physically healthy OVMI participants did not mind walking five to ten blocks to get there. However, OVMI participants with mobility issues and those who provide complex caregiving support to family members experience significant challenges in getting to the NH. Limited public transportation in the area, lack of financial resources, and the unavailability of transportation exclusively dedicated to bringing OVMI to and from the NH cause barriers to participation in programs and services. Comparable findings have been reported with respect to lack of transportation among culturally diverse older adult populations trying to access health-related services elsewhere in Canada (Aroian et al., 2005; Lai et al., 2007; Lai & Surrood, 2009). Transportation challenges for older visible minorities often involve individual factors affecting access to transportation (e.g., not

having a driver's licence); nonetheless, issues related to transportation are largely associated with governments' unwillingness to provide some form of free public transportation for older adults to access health-related services.

6.2.2. Self-Determination

Durst (2010) suggests that OVMI need to have "decision-making powers" (p. 31) in any sector involved in providing them with services and resources, including the government sector. However, the prerequisites of funders (e.g., public funding agencies) are not always consistent with what is considered necessary and relevant to OVMI. Funding provided to community-based seniors' services stipulates several pre-determined activities, administrative guidelines, and evaluation protocols that do not always align with the specific needs and views of OVMI participants. This rigid process is based on Western views that assume evidence-based practices and evaluation models are devoid of cultural influence. Despite the value and putatively objective nature of Western evidence-based practices, the principles underlying prescriptions of activities and procedures to evaluate the results of funding are not congruent with ethnically diverse populations (Kirmayer et al., 2003).

Staff members and volunteers mentioned that the process of planning and offering suitable programs and services to OVMI entails understanding the perceptions and interests of these participants and involving them in decision-making processes at the NH organizational level. OVMI participants indicated that the NH encourages them to express their perspectives, ideas, interests, and hobbies and often incorporates their suggestions into the programs and services offered. OVMI also said that they feel supported to develop new projects at the NH.

This study shows that the NH facilitates self-determination among OVMI participants by encouraging their autonomy. In this process, OVMI are conferred decision-making power wherein they can make their own choices of programs at the NH. This happens through an advisory committee that meets frequently to plan and develop programs and services that will address the needs of older adults. Although staff members and volunteers are part of this committee, OVMI clients at the NH are the key members. They act as mediators between other older adult clients and the NH, informing the latter of clients' needs and wants to provide systemic support to OVMI. Since OVMI's

perspectives are considered essential to the NH, programs offered reflect their interests and values. Consequently, in order to properly respond to OVMI, the NH is constantly trying to find ways to best match OVMI's needs with funders' requirements.

6.2.3. Self-Efficacy

Research shows the strong influence of migration and "the need to address the social and cultural contexts in which self-efficacy is perceived and experienced". Immigration creates stressful situations that can include challenges such as finding employment and struggling with social integration, which, in turn, can diminish immigrants' sense of efficacy (Burke et al., 2009, p.11; Jerusalem & Mittag, 2010).

All participants indicated that the NH enhances the self-efficacy of OVMI clients. My study data reveal that the immigration experience for visible minority individuals in Canada involves challenges (e.g., limited access to resources and low social support) that affect a person's sense of personal efficacy. Immigration imposes new life situations, and the need to adjust and find ways to navigate an unfamiliar social and cultural environment. Barriers encountered over the life-course can generate a history of failure. Earlier experiences of low self-efficacy impact faith in one's own capacity later in life.

In order to shift negative beliefs around confidence, OVMI participants need access to social environments that offer opportunities for successful performance. Besides offering learning activities that are relevant and meaningful to OVMI, the NH facilitates access to a supportive environment (e.g., verbal encouragement from staff members and volunteers) where OVMI participants can apply and master the learning they acquire. These occasions allow OVMI to experience successes that may serve as indicators of their capacity. As clients accumulate successful experiences, they enhance their self-efficacy. Notably, these experiences involve significant contributions from staff members and volunteers with respect to providing verbal encouragement and training opportunities for OVMI participants. Self-efficacy has been generally understood as an individual trait that rests largely on psychological factors. Although individual factors can be not overlooked, my study indicates that the social context, at least for culturally diverse older adults, can directly influence self-efficacy. This study underscores the importance of providing a supportive environment through culturally sensitive,

community-based seniors' services to enhance the self-efficacy of OVMI, going beyond individual attributions of self-efficacy to include the influence of culture and past experiences, including immigration.

Previous research has found that older adults who witness the achievements of their peers, observing how they successfully control tasks, appear to experience enhanced self-efficacy (Lin et al., 2013). In this vein, successes related to different types of participation by OVMI are intentionally showcased during community events hosted by the NH. This practice generates role models that encourage OVMI who are less involved to increase their participation at the NH. OVMI participants mentioned that witnessing their peers' achievements not only generates in them a desire to engage in similar behaviours and tasks, but also improves their confidence in their own capacities.

The context in which self-efficacy interventions take place is also important to OVMI participants. Since many activities and programs provide a range of support to families and other older adults, OVMI feel confident about taking leadership roles (e.g., visiting and bringing groceries supplied by the NH to isolated seniors). Moreover, OVMI feel compelled to try these types of activities to promote harmony in the community, something that might be connected to values of collectivism observed among older visible minority adults.

6.2.4. Offering Familiarity

Gopalkrishnan (2018) suggests that valuing and respecting people's cultural backgrounds and enabling an environment that integrates and respects different ethnicities provides opportunities to address marginalization and lack of power. This is especially salient for OVMI who—like all individuals—need to feel respected and appreciated, and to sense the possibility of continuity in their lives (Bigby, 2010; Nimrod & Kleiber, 2007).

Unfortunately, the OVMI in my study related experiences of discrimination and sometimes even violence in their native countries and in Canada. These included frequent references to racial discrimination involving verbal assault and threats. Although they avoided highlighting experiences of inequality and exclusion, particularly in Canada,

violence and discrimination made them question their cultural practices and their sense of belonging, worthiness, and capabilities (e.g., speaking in English).

My findings show that participation in the NH programs helps OVMI feel included, respected, and valued. These perceptions are associated with staff members' and volunteers' practices that reflect the NH's values (i.e., inclusion and respect of diverse individuals). Moreover, the NH offers programs that resemble activities familiar to OVMI participants, such as cooking and eating food together, and participating in cultural events and festivities. Familiar language, food, social- and cultural-related activities, and events offered at the NH not only remind OVMI participants of their native homes, but also provide a sense of cultural freedom, continuity, and acceptance that culminates in a feeling of being at home. Participation at the NH is hence tantamount to being accepted, encouraged, and valued for being a visible minority immigrant.

Kim and Ko (2007) argue that social and cultural activities are considered mediators of self-expression. They also suggest that for culturally diverse groups, the "self" is connected to their social surroundings, and it is through this connection that individuals perceive a sense of acceptance and worthiness. Numerous studies in gerontology have demonstrated the potential of and need for the person-centered approach to care; however, this model is often justified and applied mostly in the context of illness care (Chenoweth et al., 2018; McCormack et al., 2011; McKeown et al., 2010; Ulin et al., 2016). The person-centered approach acknowledges that facilitating social environments is essential to help unfold individuals' existing capacities and resources that support the development of their personal potential (Lood et al., 2015). This view is particularly relevant to health promotion programs offered in the community setting because it shifts the emphasis from prescribed and rigid interventions to the need to understand individuals' realities, including what works for and what is most beneficial to them. To say that this view puts the individual at the centre might be too simplistic. Such an approach requires that organizations offering mental health programs incorporate a learning culture that is reflective of and responsive to people's needs. The fact that recent studies on health promotion recommend tailoring programs to older adults' needs emphasizes the relevance of a person-centered approach in community-based services (Geraedts et al., 2014; Harwood et al., 2018; Peek et al., 2007). For instance, incorporating familiar social and cultural activities in mental health promotion programs can convey a key message of acknowledgment and approval of OVMI's cultural

backgrounds and practices, reducing the marginalization and exclusion of this population group. Cultural values and beliefs are pivotal to health outcomes, which take place in social settings (Dressler, 2018). Neglecting this relationship reinforces systemic discrimination, promoting exclusion that consequently increases inequity and health disparities.

6.2.5. Valuing Age

Respect and social inclusion of older people is expressed through the attitudes and behaviours of other individuals and the community. It is also conveyed through the attitudes of community-based seniors' services, health organizations, and government authorities. These stances are consistent with characteristics described and prescribed in age-friendly environment literature showing that age-friendly cities need to be intersectional and inclusive of all ages (Joy, 2018). The government's rhetoric about age-friendly built environments exists alongside the narrow application of this model, which is permeated by ageist decisions, preventing the optimization of OVMI health outcomes (Koehn, 2020).

Despite the importance of including all individuals, OVMI participants noted the lack of spaces where older adults feel welcomed and can spend time, as well as inequality of opportunities and limited access to resources. Previous studies have also indicated that many initiatives fall short in terms of benefiting ethnically diverse older adults because government health organizations tend to privilege certain groups of older adults. Consequently, resources are inequitably distributed, increasing the disadvantages experienced by ethnically non-Western older adults (Ball & Lawler, 2014; Kendig et al., 2014).

The VicHealth framework does not directly explore discrimination against age; however, it emphasizes that circumstances in which age is a significant factor can either protect or damage people's health (Horton et al., 2015). Accordingly, the findings of this study illustrate that OVMI participants experience ageism, and many have internalized negative ageist views about themselves. Experiencing aging through the ageist lenses of society has a profound impact on older adults' wellness because it shapes the meaning of getting old. When this meaning becomes attached to feeling unworthy and socially dispensable, it interferes with OVMI's desire to stay active as they age.

All participants agreed that providing a space that values age and the experiences and knowledge of older people is a crucial component of NH programs and services. OVMI participants argued that the NH is a space where they can go, express their ideas and needs, fully participate, and be appreciated.

The constructions of age and aging incorporated in health public policy identify older adults as a problematic population group. Consequently, aging is viewed as a "problem" that should be controlled to cause the least disturbance and burden to society. These negative constructs limit the scale of programs and services by shifting the focus of health promotion programs. Consequently, these programs become standardized manuals intent on managing older adults instead of being services that provide a more favorable aging process (Joy, 2018). Ageism creates significant barriers to accessing health promoting services and activities, and OVMI face additional challenges because already scarce resources tend to target the dominant older population group.

The NH shifts away from this reductionist approach, recognizing that OVMI participants are citizens with rights and duties, like all other individuals living in society. As one participant put it: "Here, we are treated as a person." In this way, the NH promotes a change in the community's public discourse on aging, and participants perceive it as a social environment conducive to wellness.

6.3. Access to Economic Resources

The VicHealth framework themes related to access to economic resources include work, education, housing, and money. Although the NH offers programs that encompass certain aspects of work and housing among OVMI, the data collected for this study were only sufficient to examine themes related to education and financial resources. Leisure as a source of new opportunities was also a theme. Leisure pursuits are often how OVMI develop networks that provide new information and opportunities. Kim et al. (2002) explain that cultural traditions can be incorporated in leisure contexts, offering a familiar social setting where older adult immigrants can preserve their traditions while also gaining exposure to and familiarity with the host culture. The process of social interaction in turn provides access to opportunities for "the acquisition of knowledge, information, and different perspectives" (p. 116).

6.3.1. Education

Health-related educational programs provided as part of community-based seniors' services support physical and mental health literacy, which can then help OVMI be aware of what actions they need to take in order to maintain their health (Israel et al., 2010; Mitchell & Sackney, 2011). As Griffith et al. (2010) and Jorm (2012) suggest, these programs are considered empowering strategies that can increase problem-solving capacities, improve well-being, and decrease health disparities among visible minority groups.

Staff members and volunteers in my study similarly emphasized that educational programs offered at the NH are an essential resource that promotes awareness, knowledge, and skills about physical and mental health for OVMI. Most importantly, OVMI participants view educational programs (e.g., workshops and computer classes) at the NH as an easy way to learn about health issues and how they can maintain a healthier body and mind. OVMI also affirmed that as they learn healthier behaviours, they feel motivated to convey them to their family members and community.

Makwarimba et al. (2010) suggest that language translation and opportunities for socialization are valuable ways to attract ethnically diverse groups to participate in educational programmes. The accessibility of educational resources is increased by having facilitators, either staff or volunteers, who speak OVMI's languages, and translation contributions provided by OVMI who speak English. Also helpful for accessibility are culturally sensitive content, the use of simple terminology and participatory action, group learning activities, and opportunities to share learning experiences. OVMI participants commented that compared to other types of seniors' centres (e.g., community centres), the NH offers a receptive and accessible social environment in which OVMI can reach out to facilitators, other older adults, as well as both frontline and administrative staff members. This creates a safe atmosphere that supports learning among OVMI participants.

The goal of many educational programs available at the NH is to create health connectors. These are OVMI clients who reach out to the older adults living in the NH area and disseminate the knowledge they acquire during programs to family members, friends, and neighbours. Other research (Jitramontree et al., 2015; Sotomayor et al.,

2007) has found that extending knowledge about health beyond the conventional health sector is an effective health promotion strategy that can create more sustainable healthy behaviours among visible minority older adults.

In addition, the NH's educational workshops such as those related to technology (e.g., the use of computers, tablets, smartphones, the Internet, social media, etc.) are recognized as a crucial way to promote technological literacy among OVMI participants. Sayago et al. (2011) propose that older adults are more likely to learn technology if they can use it in meaningful ways, especially when it enhances social interactions. My data reveal that OVMI feel motivated to learn about technology because it helps them adapt to "new" forms of social interaction, enhancing their sense of inclusion within their family, friends, and community social environments.

The NH understands OVMI's characteristics and the realities of their lives; hence, the organization (i.e., its staff and volunteers) offer a unique social space, collaboration with older adult peers, and accessible learning programs that facilitate OVMI participation. These programs contain a range of substantial but uncomplicated information that helps participants develop the capacity required to gain control over their health and lives.

6.3.2. Money

Ongoing, adequate, and sustainable funding is a major concern for community-based seniors' services. Besides relying heavily on short-term funding resources and encountering barriers to renewing this funding, these services, particularly Neighbourhood Houses, have a history of financial insecurity and inconsistent financial support (Kadowaki & Cohen, 2017; Rose, 2001). Yan et al. (2017) suggest that funding committed to Neighbourhood Houses varies greatly, lacks reliable assistance from the government, and is highly dependent on local partnerships.

All participants indicated that the NH indirectly facilitates access to monetary resources by offering food assistance and programs free of cost. OVMI participants experience financial challenges that impact their access to basic needs. Recognizing that financial instability is common among participants, NH seniors' programs include providing food (e.g., meals, drinks, and snacks) to OVMI participants. Additionally, the

NH offers food assistance programs, available to OVMI who are at high risk of food insecurity. However, the NH seniors' department does not receive funding that can be exclusively allocated to support OVMI to meet their nutritional needs. Therefore, food assistance for OVMI participants is provided through either financial resources that the NH family department receives (via the seniors' department working as a subdivision of the family department) or food donations from local businesses, the latter being the most reliable option. Since the NH also provides food programs to other population groups living in the area, there is a system of first-come, first-served that does not always allow for equitable provision of food resources to all. To satisfy funders' requirements, the family department needs to prioritize food distribution to families with children. While this includes caregivers of these children and hence some OVMI, not all OVMI have or provide care for grandchildren. These individuals are less likely to receive food assistance.

Staff members also commented on funding-related concerns such as the continuous process of applying for funding in competition with other community-based seniors' services, and financial agreements made between the NH and funders that are not always compatible with the needs of their OVMI clients. Although OVMI participants are not aware of this level of detail regarding funding, they mention the consequences of funding limitations, such as feeling unworthy of public health investment, having to volunteer more hours to keep certain programs running, and having to choose what programs will be terminated when funding ends, thereby losing access to beneficial activities. These findings reveal that whilst OVMI participants rely on access to free programs and services at the NH, the organization is not always able to provide a continuous level of support due to financial limitations imposed by funding constraints. Indeed, previous studies show that services for immigrants are often restricted to newcomers (Lim et al., 2005), excluding older adult immigrants if they have been living in Canada for over five years. This situation is paired with and aggravated by the low-income circumstances that necessitate the OVMI clients' reliance on organizations that offer free programs and services. For all participants, funding limitations are associated with low recognition of the importance of the NH and wellness outcomes among OVMI, lack of interest in their population, and systemic oppression of minorities, leading to lack of financial investment in community-based seniors' services from health authorities. Indeed, funding limitations in the community-based seniors' services sector have been

associated with governmental funding policy that tends to invest few resources in ethno-specific organizations, despite the benefits of their services to culturally diverse populations (Couton, 2014). In the case of the NH and OVMI participants, these benefits include the promotion of physical activity and wellness that can potentially delay or even prevent the use of more expensive healthcare services (e.g., emergency room visits) that can occur due to lack of access to beneficial health promotion services.

Unlike many community centres in Canada, Neighbourhood Houses offer all programs free of cost to all participants. This suggests that Neighbourhood House organizations require greater consideration and financial resources from health authorities and other funders. My research findings show that the NH strives to provide programs and services to all OVMI participants. A staff member stated, “The city gives us around $13 dollar per senior for the whole year, and we serve over 500 seniors, so this money is not sufficient.” As the NH’s mandate is flexible, allowing a comprehensive, inclusive set of criteria that enhance the accessibility of their services among OVMI, they attract many older adults and a wide range of needs. However, health authorities (Couton, 2014) and community funders have a rigid mentality that demands the standardization of services.

The NH recognizes OVMI’s attributes, needs, and social contexts, and it is committed to providing suitable services to this population group. However, the NH encounters significant challenges in its acquisition of financial support. This financial predicament creates barriers to their hiring and retaining staff to work at the NH, directly impacting the ongoing provision of programs and services for OVMI. Ironically, the reasons the NH is considered a valuable resource for OVMI are at least to some degree what impede the NH from receiving adequate financial support. The NH has to implement flexible eligibility criteria in order to support a variety of clients and meet their needs. However, government health authorities insist on a standardization of services that does not make room for mental health promotion services that are culturally appropriate and appealing. Hence, the NH receives insufficient funding to cover the breadth of services it offers to clients.

6.4. Unique Contributions

6.4.1. Organizational Dimensions of Mental Health

The VicHealth framework was developed to address health differences socially produced among different population groups, such as visible minorities. This social model of health is focused on the individual level, and it illustrates how social inclusion, freedom from violence and discrimination, and access to economic resources (i.e., key social and economic components) are essential to promote mental health (Keleher & Armstrong, 2005). My study affirms the importance of the VicHealth framework's dimensions, and it indicates the relevance of the framework to the meso and macro levels at which publicly funded community-based seniors services such as the NH operate.

Although OVMI participants did not report experiencing discrimination at the NH, all participants recognize there are limited numbers of programs offered to certain ethnic older adult groups. All participants also acknowledge the need to increase capacity due to the high number of OVMI clients reaching out and strongly relying on seniors' programs and services offered at the NH.

Added to these issues, staff members viewed low remuneration to frontline workers—who tend to be ethno-racially diverse service users—as an extension of discriminatory attitudes towards those who work in the Neighbourhood House sector. All participants perceived a sense of systemic exclusion and discrimination by governmental health authorities towards the age, ethnicity, and immigration status of participants.

Zajicek et al. (2006) argue that age is a unique power element rooted in societal standards that value youthful bodies and devalue aging ones. Occurring at the individual, relational, and organizational level, ageism creates a hierarchy of deservingness of resources, thereby justifying public health practices (Willen & Cook, 2016). Dynamic power relations related to age, ethnicity, and immigration status influence government health policies and regulations, maintaining the power imbalances that generate health disparities among diverse population groups (Koehn & Kobayashi, 2011; Zajicek et al., 2006). This power system can impact the wellness of OVMI participants and generate the need for more complex healthcare services, because the

NH's health promotion programs and services receive inequitable funding. Although the focus of this study did not include conducting an economic analysis, this would be worthy of further investigation from another disciplinary perspective (e.g., health economics).

Previous studies illustrate a growing demand for mental healthcare services among ethnically diverse older populations who immigrate to Canada (Guruge et al., 2015). As reflected in my data, NH staff members regularly interact with OVMI who contact the NH for wellness support. Similarly, a study assessing the mental healthcare services available to ethnically diverse older adults in Canada found that community-based seniors' agencies are "often the first contact and routinely confront mental health problems of varying severity" (Sadavoy et al., 2004, p. 195). OVMI consider community-based seniors' services more accessible for many reasons, including the services' cultural sensitivity and permeability; yet these organizations are often disregarded by government health agencies, which fail to systemically include organizations such as the NH as essential partners in the healthcare system (Blair 2012; Koehn et al., 2019; Kreps et al., 2008). The NH's staff members suggest that marginalization—experienced, for instance, through low funding—is a result of the low status associated with their job positions and the inadequate value accorded to the NH's practices in the context of the healthcare system. However, as already pointed out, community-based seniors' services (e.g., Neighbourhood Houses and other immigrant-serving agencies) have "an understanding, sensitivity, and knowledge surrounding cultural barriers" (Koehn et al., 2019, p. 12) and therefore need to be recognized as an essential sector that supports the healthcare system. As several factors influencing the wellness of OVMI currently lie outside the healthcare system, supporting organizations such as the NH and creating a partnership with this sector is pivotal to effective mental health promotion. Recognizing the significance and raising the status of marginalized community-based seniors' services organizations would allow sustainable funding from governmental health organizations. Incorporating this sector as a critical branch of the health system could increase their capacity and therefore improve OVMI's access to the services they need.

This study indicates that considering the organizational level as one of the key determinants of mental health is a significant theme of action to promote wellness among OVMI. Therefore, including in the VicHealth framework the organizations that provide services to visible minority immigrant populations would allow for a more

integrated model that considers systemic problems preventing this population from achieving optimal wellness.

6.5. Study Limitations

This study has a few limitations. The literature shows that many community-based seniors' services (CBSS) in Canada face similar situations to those considered in this study, such as a high demand for services coupled with stringent financial constraints; however, the culturally diverse backgrounds of my study sample and the selected geographical location might limit the generalizability of my findings to other CBSS located in other social contexts.

Selection bias linked to purposeful sampling and the potential biases of participants should also be considered as a limitation. The 10 OVMI participants interviewed most likely represent those who are more involved with the NH's programs and services, are potentially healthier, are more comfortable speaking English, and are willing to share the experiences they have with the NH. Another potential limitation is that OVMI participants may have been concerned about exposing the NH to criticism that would risk them losing access to programs and services the NH offers them. I made sure that this was not the case, and I was committed to making them feel comfortable and certain that their programs and services would not be affected by this study. This was another reason it was critical for me to establish a connection with this NH and its members prior to developing this study, so I could develop trusting relationships with the participants.

Furthermore, I wish to acknowledge that qualitative inquiry deals with hierarchical relations of power between researcher and participants (Reason, 1994). While researchers need to be cautious about the potentially asymmetrical power relationships in studies, they also must follow a methodological process required to make the study acceptable in the field. I addressed this potential limitation by creating transparency and engaging in reflexive practice before each interview (Taylor et al., 2016), ensuring that my main focus was to do no harm. Since I was a volunteer at the NH and was conscious about language limitations, I knew that interviews would require the use of simple language. So before interviewing participants, I piloted the semi-structured interview protocol, a process that gave me great insights into adapting the language to make it

more accessible (Few et al., 2003). Before asking the questions per se, I made sure to clarify my role and responsibilities, and the participants' rights (Bravo-Moreno, 2003). As culture is a critical factor in this study, I also made an effort to familiarize myself with participants' cultures, which helped me to be sensitive during interviews and in the subsequent coding and analysis of data. In addition, I constantly clarified to myself my cultural and social contexts and my immigration experience, making sure to let participants' voices stand out. Since I knew some of the participants' social realities, I was conscious that sending a message of being equal in this inquiry would require an extra effort, so I made the decision to do each interview seated on a lower chair to send a message that participants were in control of the process. I followed the ethics requirements (e.g., informed consent form, confidentiality) and proposed methodological protocol (e.g., semi-structured interview and member checking). I also obtained a great amount of knowledge about working with visible minority immigrants, cultural differences, mental illness, and mental health, all of which was indispensable in every phase of this study.

This study aimed to elicit subjective assessments of mental health, but with the understanding that this concept might be unclear and/or different to different people. The subjective assessments facilitated exploring how participants talked about the determinants of mental health (as understood in the VicHealth framework) and how the determinants correspond to this framework. This study did not assess the psychological state of participants and therefore does not intend to make claims about their clinical mental health.

6.6. Researcher's Reflection

Since participants' voices and experiences are being heard through my role as an observer and researcher, I am providing the following reflection to render transparent my own positionality relative to the participants in this study.

My relationship with the NH began in 2017 was a critical component of this study. I volunteered with this organization and fulfilled my practicum hours required as one of the components of this master's degree program. As suggested by Koehn et al. (2014), the study of mental health among OVMI requires an element of trust, which can be facilitated through investing in long-term relationships with this population group and the

agencies that provide services to them. I need to acknowledge that my own skin colour (i.e., white) differs from most of the OVMI participants' (and the NH staff members' and volunteers' skin colours). This was, at the beginning, a barrier that only time and the opportunity to develop relationships with my participants could overcome. While it is inevitable that this pre-existing relationship influenced my perception of the NH's programs and services, this trusting relationship allowed me to learn in depth about the NH and the experiences of OVMI participants.

Furthermore, my cultural background (i.e., Latin American from Brazil) is also present in all stages of this study. However, all of us students and researchers come to the field with an ingrained culture that, even when it is similar to participants', has its own array of views and ways of being expressed and experienced. Again, immersing myself in this community was a necessary strategy to understand and explain the phenomena occurring there. Patton (2014, p. 100) suggests that culture explains a range of human behaviours and health outcomes, and deep immersion is a strategy that creates "a way of seeing." I also committed to engaging in a considerable degree of reflexivity as an additional approach to deal with my own perceptions and biases. After each interview, coding session, and analysis of results, I made notes about my own position in relation to the topic being explored. I continually urged myself to ask whether what I was understanding was in fact what was being told. Furthermore, I had additional meetings with my participants to do member checking, so I could either confirm or adjust my understanding of each story to help me as a validation technique.

Upon reflection, I am certain that the OVMI participants (and the NH organization) only revealed their experiences and stories for this study because they were aware of who I was and what I was doing at the NH. Similarly, I was able to understand the role of this organization in the wellness of its OVMI members because I was involved in their daily lives.

Chapter 7.

Conclusion

The aim of this study was to understand the role of the Neighbourhood House in the mental health of older visible minority immigrants in Canada. Green and Kreuter's (1991) PRECEDE-PROCEED model was used as a developmental model to structure the study. This model asserts that mental health is comprised of a constellation of elements that include individual and, more importantly, social, cultural, economic, and political factors that interact with each other.

The data provide evidence that the specific NH in this study considers OVMI to be part of a social system, and this population, like any other, is therefore dependent on social and economic resources to promote their mental health. Providing a social, physical, and economic environment that is sensitive to addressing the access barriers experienced by the OVMI population requires acknowledging post-immigration situations and the intersectionality of OVMI identities as factors that influence these individuals' life experiences; these, in turn, affect their access to the wellness programs and services offered at the NH. Since the NH objective is to promote the best conditions of living to OVMI, which in turn can promote their mental health, the NH puts OVMI at the centre of programs and services involving them in analyses and offering decision-making power to determine their needs, interests and abilities. In this process, OVMI life experiences, social contexts, and social determinants of health become the "benchmark" measurements used to guide programs, services, and activities to OVMI. This comprehensive approach to health intervention provides tailored activities to OVMI while simultaneously addressing pervasive conditions of living that affect the mental health of this population group. Promoting the mental health of OVMI, the NH might be perceived as a culturally sensitive healthcare system.

The findings emphasize for health authorities the gaps in the healthcare system when it comes to supporting the wellness of OVMI. The beliefs underpinning the Canadian healthcare system tend to neglect and/or engage in a process of "othering" the wellness needs of OVMI because the Western health system is typically viewed as free of cultural bias and therefore capable of meeting the wellness needs of any individual.

This study indicates that OVMI participants perceived a range of benefits associated with their participation at the NH, such as a sense of social inclusion fostered by access to a socioculturally sensitive and responsive environment, particularly in relation to aging, immigration, and cultural background. Being socially included as a member of society through participation in the NH environment facilitated the involvement of OVMI in determining best practices for wellness promotion based on sociocultural contexts. OVMI have an active role at the NH, facilitating the alignment of activities and programs to OVMI's needs. Indeed, each OVMI participant suggested that the NH's activities, programs, and services are appropriate to their mental health needs and wants and enhance their conditions of living. For OVMI to perceive that wellness programs and services are accessible, they need to feel comfortable (i.e., "at home") in a community-based seniors' environment and able to voice their perspectives and needs. This speaks to the NH's commitment to develop an inclusive, compassionate, and open community that encourages participation, education, capabilities, and healthy lifestyles and promotes a favorable environment to enhance the conditions in which OVMI live. Consequently, this interaction between person and environment promotes OVMI's mental health and quality of life and ultimately contributes to shaping a more positive aging experience.

The comprehensive, person-centered and inclusive approach employed by the NH to develop and offer programs and services for OVMI clients can be viewed as a model to other neighbourhood houses and community-based seniors' services. Resources are facilitated by staff members who understand that their ability to be sensitive to OVMI needs and responsive to funders is the foundation of the NH's programs and services. Although the practices of staff members are aligned with the NH mission statement and responsibilities to funders, staff members often must go beyond the NH mandate due to the lack of resources available in the wider community. Solutions that address the financial challenges experienced by the NH are therefore needed to ensure sustainability and fully meet their OVMI clients' needs.

Despite the limitations mentioned, this study addresses significant gaps in the research on the role of Neighbourhood Houses (and possibly other segments of the community-based seniors' sector) in the wellness of OVMI participants.

The funding of wellness promotion programs is often accompanied by evidence-based practices, which means that programs and activities funded are usually those that have been previously studied, and studies tend to focus on Western views of what works for people. Grant opportunities try therefore to “control” and fund activities that have been previously reported as helpful to older adults, but these activities are not always aligned with the needs of OVMI. However, my findings indicate that mental health needs of OVMI are linked to their cultural consonance and immigration experiences. Limiting programs and services to Western views is associated with OVMI resistance to using wellness promotion programs that are not aligned with their cultural perceptions of health and their post-immigration experiences. Policies aimed at supporting the wellness of older adults frequently offer standardized health promotion interventions that might not reflect the wellness needs of OVMI. Consequently, systemic discriminatory barriers to service utilization and wellness improvement can arise. Just as all individuals exist in a specific social context at every stage of life, older adults are heterogeneous and inevitably age in a specific social context. Understanding that mental health needs are associated with lived experiences throughout the life course of OVMI can support healthcare authorities to identify determinant social factors that affect the mental health outcomes of this population group. Health authorities must become aware of the demands, responsibilities, and practices of Neighbourhood Houses in supporting the wellness of OVMI. Acknowledging that the vast majority of what has to be done to support the mental health of OVMI is related to their daily life experiences can generate a more comprehensive health system that is likely to provide more resources for support services outside the clinical psychological realm. government authorities should consider Neighbourhood Houses to be a vital part of the non-medical health promotion sector that, with appropriate financial support, can reduce the need for expenditures on more costly medical healthcare services

As with all individuals, the need for medically related services is expensive and complex, and it often imposes a burden on the individual and their family members. Directing attention to health promotion in the community-based seniors’ services sector can meet OVMI mental health needs while reducing the expenses associated with more complex health issues. Governments play a crucial role in decreasing health disparities for the OVMI population. Health disparities might be targeted by creating initiatives that

support organizations that are sensitive to the needs of this population and have trusting relationships with their clients.

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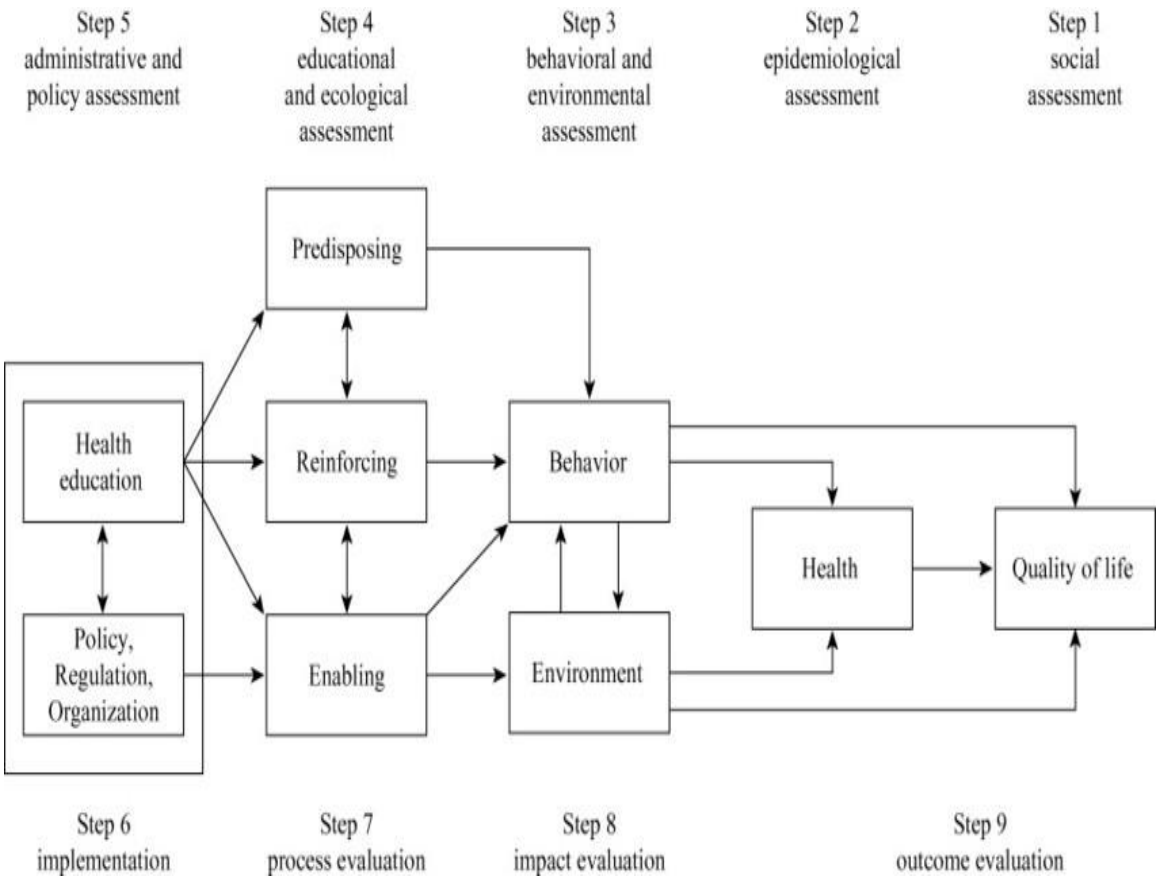
Appendix A.

PRECEDE-PROCEED Model[6]



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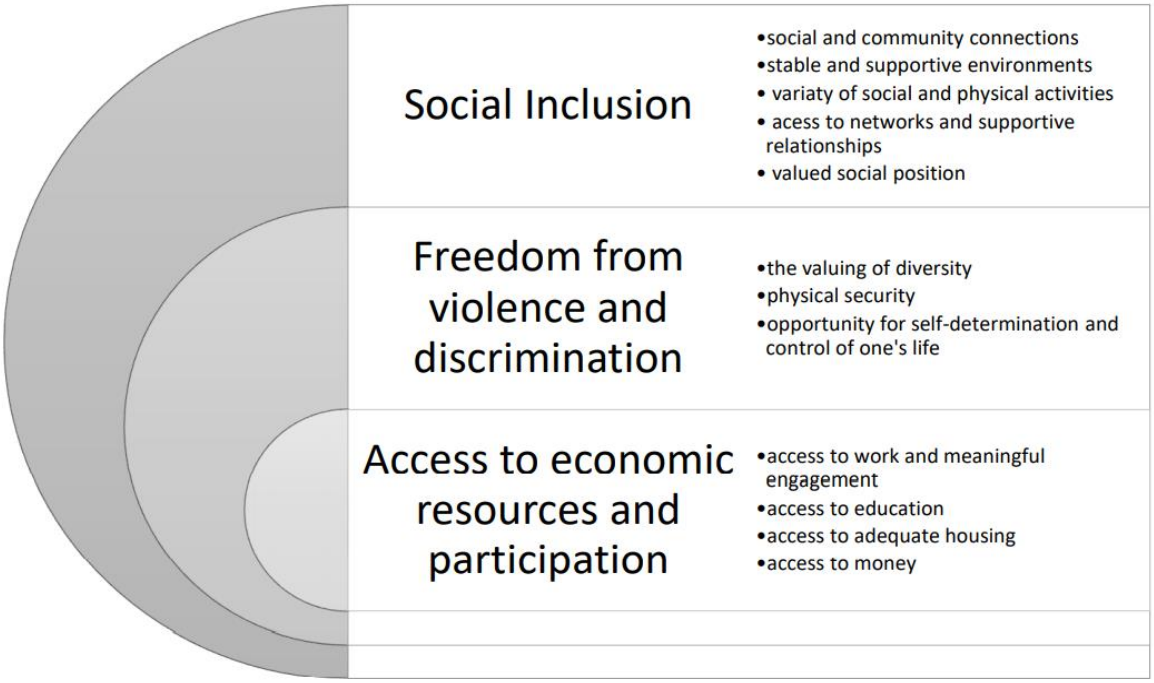
Appendix B.

VicHealth Framework[7]



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Appendix C.

Invitation Letter to Executive Director

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood Houses in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

INVITATION TO PARTICIPATE IN RESEARCH STUDY

Title: "I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants"

Dear Mr. _____

I would like to invite [*name of the Neighbourhood House]* to participate in the study that aims to understand the benefits of Neighbourhood Houses services and programs in the mental health of older visible minority immigrants.

My goal is to understand the perception that Neighbourhood Houses' participants have about programs and services provided. Also, I would like to understand the factors existing in this organizational model that promotes mental health of older visible minority immigrants.

In order to gather data for this study, we would like to observe, and document programs and services delivered at [*name of the Neighbourhood House]*. I also would like to interview staff/volunteers' members and older adult participants. Therefore, we would like to ask your permission to proceed with this study at [*name of the Neighbourhood House]*.

I would sincerely appreciate your participation in this study because this type of inquiry can help to improve and acknowledge the role of Neighbourhood Houses in the mental health sector.

This study is being conducted as part of the requirements for a graduate thesis in the Department of Gerontology at Simon Fraser University.

Sincerely,

Glaucia Salgado, Master's Candidate

Department of Gerontology, Simon Fraser University

[…] @sfu.ca

Appendix D.

Demographic Questionnaire – OVMI

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

Participant _____

Please check the boxes that apply to you for each question (the research assistants can read these to you and check the appropriate boxes with your response if you prefer):

(1) Do you identify as

- ☐ Female
- ☐ Male
- ☐ Other

(2) What is your age?

- ☐ 55-64 years old
- ☐ 65 – 74 years old
- ☐ 75 – 84 years old
- ☐ 85+

(3) What is your country of birth?

- ☐ China
- ☐ Mexico
- ☐ India
- ☐ Iran
- ☐ Italy

- ☐ Other (specify) _____

(4) How long have you been in Canad

- ☐ < 5 years
- ☐ 5-9 years
- ☐ 10 – 19 years
- ☐ > 20 years

(5) What class of immigrant are you?

- ☐ Family Class (sponsored)
- ☐ Economic class (applicant)
- ☐ Economic class (family of applicant)
- ☐ Investment/retirement class

(6) Are you currently

- ☐ Never married
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Other (specify) _____

(7) How many children do you have & where do they live?

In Canada	In U.S.	In country of origin	Elsewhere

Insert # of children under each location

(8) Who do you live with?

Check all that apply

- ☐ No-one
- ☐ Spouse
- ☐ Own school-age children

- ☐ Adult children
- ☐ Grandchildren
- ☐ Other (specify) _____

(9) Income per year

- ☐ > $20.000
- ☐ $20.000 - $30.000
- ☐ $30.000 - $40.000
- ☐ $40.000 - $50.000
- ☐ Other (specify)

(10) Are you attending programs at any of the following, and for how long?

Insert start and end dates (YR) if applicable

- ☐ Immigrant serving agency e.g., SUCCESS/MOSAIC
- ☐ Community Centre
- ☐ Neighbourhood House
- ☐ Senior's Centre
- ☐ Other (specify) _____

(11) How many years did you go to school?

Insert # of years

- ☐ Primary School
- ☐ Secondary School
- ☐ Post-Secondary School
- ☐ Other (specify) _____

(12) Did you speak or understand any English before coming to Canada?

- ☐ YES
- ☐ NO (If NO, skip question 13)

(13) How much?

- ☐ Few words

- Enough to hold a simple conversation
- Fluent

Appendix E.

Demographic Questionnaire – Staff Members and Volunteers

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

Participant _____

Please check the boxes that apply to you for each question (the research assistants can read these to you and check the appropriate boxes with your response if you prefer):

(1) Do you identify as

- ☐ Female
- ☐ Male
- ☐ Other

(2) What is your age?

- ☐ 25-34 years old
- ☐ 35-44 years old
- ☐ 45-54 years old
- ☐ 55-64 years old
- ☐ 65 – 74 years old
- ☐ 75 – 84 years old
- ☐ 85+

(3) What is your country of birth?

- ☐ China
- ☐ Mexico
- ☐ India

- ☐ Iran
- ☐ England
- ☐ Canada
- ☐ Other (specify) _____

(4) How long have you been in Canada?

- ☐ < 5 years
- ☐ 5-9 years
- ☐ 10 – 19 years
- ☐ > 20 years
- ☐ Born here

(5) What class of immigrant are you?

- ☐ Family Class (sponsored)
- ☐ Economic class (applicant)
- ☐ Economic class (family of applicant)
- ☐ Investment/retirement class
- ☐ Not applicable

(6) Are you currently

- ☐ Never married
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Other (specify) _____

(7) How many children do you have & where do they live?

In Canada	In U.S.	In country of origin	Elsewhere

Insert # of children under each location

(8) Please, check the option that applies to you.

- ☐ Staff
- ☐ Volunteer

(9) Around how many hours do you work or volunteer per week? _____ hours

(10) Did you receive some training BEFORE becoming a staff or volunteer here?

- ☐ YES
- ☐ NO

(11) Did you receive some training to AFTER becoming a staff or volunteer here?

- ☐ YES
- ☐ NO

(12) Income per year

- ☐ > $20.000
- ☐ $20.000 - $30.000
- ☐ $30.000 - $40.000
- ☐ $40.000 - $50.000
- ☐ Other

(13) How many years did you go to school?

Insert # of years

- ☐ Primary School
- ☐ Secondary School
- ☐ Post-Secondary School
- ☐ Other (specify) _____

(14) Did you speak or understand any English before coming to Canada?

- ☐ YES
- ☐ NO (If NO, skip question 13)
- ☐ Not applicable

(15) How much?

- ☐ Few words
- ☐ Enough to hold a simple conversation
- ☐ Fluent

(16) What languages do you speak?

- ☐ English
- ☐ Chinese
- ☐ Italian
- ☐ Spanish
- ☐ Farsi
- ☐ Others (specify) _____

Appendix F.

Semi-Structured Interview Protocol – OVMI

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

1. You've been in Canada X years, and you've been coming to the Neighbourhood House for Y years now. Can you tell me a little about your life before coming here? How did you spend your time?

Prompts:

Social network – who, when, where, how?

Activity participation – what, when, where, how?

How did it make you feel?

2. So tell me about the Neighbourhood House, how did you hear about it?

Prompts:

How often do you come?

Who do you come with?

Have you met new friends here – staff/other participants?

In what programs do you participate; what does that involve, what do you do?

Do you do anything else here, outside of scheduled programs?

Would you like to see any changes to programs you attend, or the way the Neighbourhood House is run?

3. When you come here, how does it make you feel?

Prompts:

Do you like how it makes you feel?

Do you feel your opinion/concerns are taken into consideration?

What is it about the Neighbourhood House that makes you feel that way? People/programs/combo

Have other places/programs made you feel that way?

Is there anything that could be changed here to improve how you feel about it?

4. Is there anything that makes it difficult for you to come to the Neighbourhood House?

Prompts:

Proximity of home

Transportation

Busy with childcare/household chores/family obligations

Busy with activities at other sites

Cost

Things you do not like about the Neighbourhood House

5. How does it make you feel when you cannot come here?

Prompts:

How would it make you feel if you could not come any more? (e.g., if something changed for you or for the Neighbourhood House)

6. Can you tell me what a ‘good old age’ is like, in your opinion?

Prompts:

Are these beliefs just your own, or are they shared by others who share your cultural background?

How does the life you are living now compare with this ideal?

IF DIFFERENT

How do you feel about that?

Why do you think that is?

7. People often talk about health in terms of physical health and wellness, although not everyone sees these things as separate. What is your view of wellness?

Prompts:

Can we separate physical and wellness?

What kinds of things help us to be mentally healthy?

Physical health

Family

Engagement

Volunteering

Knowing people

Having friends

Having opportunities to learn

Having a purpose in life

Freedom from discrimination

8. What does it mean ‘good old age’ in your original country and ‘good old age’ here in Canada?

Prompts:

Physical health

Wellness

Family

Having friends

Financial resources

Access to health care

9. Has coming to the Neighbourhood House had any influence on your opinions or your feelings about aging or wellness?

Prompts:

Negative feelings

Positive feelings

10. What kinds of information or activities have been important in changing how you think about these things?

Prompts:

Think about information you received here that made you change these feelings.

Think about activities that you participate here that made/helped you change these feelings.

11. What is it about coming to the Neighbourhood House that has changed how you feel about old age?

Prompts:

Feel included?

Feel excluded?

12. Is there anything about the Neighbourhood House that has improved or supported your wellness?

Prompts:

Freedom to express your culture?

Opportunities do participate?

Feeling part of something/group?

Welcoming environment?

13. Is there anything about the Neighbourhood House that has challenged your wellness?

14. How could activities be different or improved to support your wellness?

Prompts:

Think about things that you believe you need for your wellness that we could add here in this Neighbourhood House.

Things that you would have in your original country that we could add here.

More activities? Health, wellness, social.

Workshops about health/wellness?

15. Is there anything else you want to tell me about the Neighbourhood House that is important to you?

Appendix G.

Semi-Structured Interview Protocol – Staff Members and Volunteers

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

1- How do you understand the Neighbourhood House mission statement?

Prompts:

What is your role?

Does your role enable you to deliver on this mission statement?

If so, can you give me examples of home you address the various components of the mission statement?

Diversity	Engaging community	Openness
Accountability	Volunteerism	Compassion

2- Can you tell me about your programming?

Prompts:

How many clients do you serve?

What percentage of participants are:

Seniors	Immigrants	Visible Minority Immigrants

Is this taken into account in your programming?

3- What services does the Neighbourhood House provide to seniors?

Prompts:

Are programs culturally sensitive?

Do programs help people to connect with additional resources/connect with the wider community?

Do services provide clients with tools to understand/address discrimination?

4- What gets in the way of your being able to plan or deliver services that meet all the needs of your senior clients, especially the immigrants/visible minorities?

5- So, let's focus in on the mental health/wellness of visible minority older adults.

6- First of all, it would helpful if you told me what, in your view, is mental health/wellness? What kinds of things are important to keep people mentally healthy?

7- Considering everything you've told me so far, does the Neighbourhood House do anything to support or promote the mental health of immigrant/VM seniors?

Prompts:

IF YES, can you give me examples?

Capacity building

Social inclusion

Behaviour changing

8- Is there anything you would like to change to be able to do this better?

9- Is there anything else that you would like to tell me about in relation to the Neighbourhood House s role in the lives of OVMI?

Appendix H.

Recruitment Poster (English Version)

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

PARTICIPANTS REQUIRED FOR RESEARCH STUDY

Are you 55 years old or over?

Did you immigrate to Canada from a Chinese, Spanish-speaking country or any other country that does not speak English?

Have you been coming to the Neighbourhood House for the past 6 months?

We would love to chat with you to learn about if and how Neighbourhood Houses promote wellness in immigrant seniors.

Participants will receive a gift card to compensate for their time, and childminding will be offered for the period of the interview.

Where: The Neighbourhood House

When: Summer 2018

How: contact Glaucia 604- […]

Appendix I.
Recruitment Poster (Chinese Version)

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

我们正在招募研究参与者

您有55岁了吗？

您是从中国或西班牙语国家移民到加拿大的吗？

您在过去6个月来过Neighbourhood House 吗?

我们期待与您聊聊天，并了解社区对老年移民者健康是否有帮助。

参与调查访问的人将获得一个礼品卡。如有需要，我们可以在调查访问期间提供看护小孩的帮助。

地点: Neighbourhood House

时间: Summer 2018

如何参与：请联系 Glaucia 604-[…]

Appendix J.

Recruitment Poster (Spanish Version)

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

PARTICIPANTES REQUERIDOS PARA ESTUDÍO DE INVESTIGATION

¿Tienes 55 años o más?

¿Inmigró a Canadá desde un país donde si habla español o chino?

Has estado viniendo a Neighbourhood House desde hacía 6 meses o más?

Nos encantaría conversar con usted para conocer si y cómo Neighborhood Houses promueve el bienestar de los adultos mayores inmigrantes.

Los participantes recibirán una tarjeta de regalo para compensar por su tiempo, y se les ofrecerá cuidado de niños durante el período de la entrevista.

Donde: The Neighbourhood House

Cuando: Summer 2018

Cómo: contact Glaucia 604-[…]

Appendix K.

Invitation Letter Staff Members and Volunteers

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

INVITATION TO PARTICIPATE IN RESEARCH STUDY

Title: "I Belong to Canada: The Role of Neighbourhood Houses in the Mental Health of Older Visible Minority Immigrants"

We are reaching out to invite [*name of the Neighbourhood House]* to participate in our study that aims to understand the benefits of Neighbourhood Houses services and programs in the mental health of older visible minority immigrants.

Research has shown that community-based seniors' services like Neighbourhood Houses play important roles in maintaining and promoting mental health of seniors (Kadowaki & Cohen, 2017). We believe that [*name of the Neighbourhood House*] is the ideal organization to be part of this study because of [*name of the Neigbourhood House*] services are focused on mental health and older visible minority immigrants.

Our goal is to understand the perception that Neighbourhood Houses' participants have about programs and services provided. Also, we would like to understand the factors existing in this organizational model that promotes mental health of visible minority older immigrants.

In order to gather data for this study, we would like to observe, and document programs and services delivered at [*name of the Neighbourhood House]* and do semi-structured interviews with staff/volunteers' members and participants. Therefore, we would like to ask your permission to proceed with this study at [*name of the Neighbourhood House]*.

I would sincerely appreciate your participation in this study because this type of inquiry can help to improve and acknowledge the role of Neighbourhood Houses in the mental health sector.

This study is being conducted as part of the requirements for a graduate thesis in the Department of Gerontology at Simon Fraser University.

Sincerely,

Glaucia Salgado, Master's Candidate

Department of Gerontology, Simon Fraser University

[…]@sfu.ca or 604 […]

Appendix L.

Receipt for Research Participants

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

Confidential

This is to confirm that the undersigned has received a payment for participation in an interview for the above-named research project.

Date: _____

Location (city): _____

Amount Received: _____

Payee Name (please print): _____

Payee Signature: _____

Signature of Person Responsible: _____

Appendix M.

Consent Form

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

PURPOSE

The purpose of this pilot interview is to refine the semi-structured questionnaire which will be used in a study that intents to understand what individuals think about wellness programs that they participate at the Neighbourhood House model of Community-based seniors services. This research will partially fill the requirements for the degree of Master of Arts in the Department of Gerontology in the Faculty of Arts and Social Sciences at Simon Fraser University, and will be published as a thesis. Your participation in this project will include ***one*** meeting.

PROCEDURES

If you agree to take part in this study, you will take part in ***one pilot semi-structured interview***. The pilot interview will be conducted in English, and it will include a series of questions related to wellness services and programs provided by Neighbourhood house wellness seniors' programs.

The pilot interview will last for approximately 45-60 minutes. The purpose of the pilot interview is to understand if any changes should be made to the interview questionnaire that will be used in the study.

During the interview, I will check in with you to make sure you are comfortable with going on.

Also, I would like to make notes during the pilot interview to allow me to go back to the questionnaire and make improvements when needed. Any information you provide will **only** be used to improve/refine the semi-structured questionnaire, and your answers cannot be used in any other way.

At the end of this meeting, you will receive a $20 gift card as an appreciation for your time.

The ***interview*** will take place in a location of your choice, possibly your own home. We can arrange an alternate meeting space in a community space like Neighbourhood House, or library, if you prefer. The location will be private, so that you will not be overheard by others (e.g., other visitors or staff). Anything that you tell us will not be shared with anyone (e.g. staff members/volunteers, your family members) in a way that would allow them to identify you.

Your participation in this research project is completely voluntary. Refusal to participate does not affect your right to use services and programs that you already are involved or plan to do so in the future. Participation or non-participation in the study will not affect the services you receive.

You can withdraw from this pilot interview at any point without penalty or consequences. If you withdraw from the study, any information you provided will be destroyed immediately. The term “information” refers to any suggestion you will be providing in order to improve the semi-structured questionnaire.

CONFIDENTIALITY

Although this is a pilot study and your answers will not be included in the study, we will assign a pseudonym to your identity file. This file will only contain information related to your suggestions to improve the semi-structured questionnaire protocol.

Your answers to the pilot interview will not be recorded in any way. Therefore, there will be no raw data collected from this process. The only information collected will be related to the refinement of the semi-structured questionnaire.

RISKS AND BENEFITS

This pilot interview will give you the opportunity to support a study about wellness and services older immigrants use in the community. Your insight will be important to make questions more appropriate to visible minority immigrants or staff/volunteers who will later participate in the study. Although your role in this pilot interview is to refine the questions in the interview questionnaire, it is possible, that participation in this project may bring up sensitive and personal areas of your life. So, you may choose to ask to stop your participation in the study at any point during the process.

Also, you might feel the need to speak with someone about these sensitive and personal issues, therefore, a list of resources in the community is provided below.

WELLNESS RESOURCES IN THE COMMUNITY	
Mental Health/Geriatric Outreach Coast Mental Health	1-877-602-6278
Seniors Distress Prevention	604-872-1234
Anxiety BC	604-620-0744
Crisis/Suicide Line	604-872-3311
Suicide Prevention	1-800-784-2433

E. HOW WILL THE RESULTS OF THIS STUDY BE USED?

The results of this study will be reported in a graduate thesis. At the end of the study, if you would like a copy of the thesis, a digital copy will be available to you upon request. Who can you contact is you have questions about this study? If you have any questions regarding this study, please contact either the principal investigator or the faculty supervisor.

Principal Investigator: Glaucia Salgado, MA Candidate [...] @sfu.ca | 604-[...]| Dept. of Gerontology, Simon Fraser University

Faculty Supervisors:

Sharon Koehn, PhD | […] @sfu.ca | 778-[…] | Dept. of Gerontology, Simon Fraser University

Habib Chaudhury, PhD | […] @sfu.ca | 778-[…] | Dept. of Gerontology, Simon Fraser University

Please send me the report and/or summary by

Email at _____

OR By mail to

_____

_____

I have signed this form on this date _____ (year, month, day)

_____ _____

Participant Name (or initials) Signature

_____ _____

If you have any complaints about your rights as a research participant and/or your experiences while participating in this study, you may contact Dr. Jeffrey Toward, Director of the Office of Research Ethics
at SFU: […] @sfu.ca or 778-[…]

Please keep one signed copy of this form for your records.

Appendix N.

Ongoing Consent Script

STUDY TITLE: I Belong to Canada: The Role of Neighbourhood House in the Mental Health of Older Visible Minority Immigrants - PRINCIPAL INVESTIGATOR: GLAUCIA SALGADO MA CANDIDATE [...] [...] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY FACULTY SUPERVISORS: SHARON KOEHN, PHD | […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY Habib Chaudhury, PHD | […] […] | DEPT. OF GERONTOLOGY, SIMON FRASER UNIVERSITY

[Participant's name], I will ask you throughout the whole interview, if you are feeling okay and if you would like to proceed with the interview.

If there is anything making you uncomfortable, or if you do not want to talk about something that I will ask you here, please do not hesitate to let me know and we can change the subject or stop the interview. We can also take a break at any moment if you feel tired or for any other reason. Participation in this study is completely voluntary and you have the right to withdraw at any point. If this is the case at any moments, please feel free to let me know.