

Mental Health Needs of Immigrant and Refugee Populations

Location: Pine View Golf Course

Date: October 19th, 2018

Facilitators: Aamna Ashraf

camh

Agenda

- 1:00** Welcome and Introductions
- 1:10** Immigrant and Refugee Populations
Myths and Facts
Special Populations
- 2:15** Trauma Informed Care
- 2:45** Self Care
- 3:15** Discussion
- 3:30** Wrap up and Closing Remarks

Refugees and immigrants: background and context

Currently there are approximately **7 million Canadians** living with mental health problems and illnesses and this is projected to grow to around **9 million** by the year **2041**.



Refugees and immigrants: background and context

Mental illness is common, and has a significant impact on Canadians:

- In any given year, 1 in 5 Canadians experiences a mental health or addiction problem
- 70% of mental health problems start during childhood or adolescence
- Mental illness is a leading cause of disability in Canada
- Mental illness costs Canadian society about \$50 billion each year
- At least 500,000 employed Canadians miss work weekly due to mental health problems.

Refugees and immigrants: background and context

- A person's **immigration category** determines the services and resources he or she has access to (e.g., health services, language classes, work, study) and also has implications for mental health.
- Refugees compared to their Canadian-born counterparts, are at a higher risk of experiencing mental health problems, including depression, anxiety, and PTSD. Asylum seekers with unresolved legal statuses are at especially high risk for these problems.
- **Post-migration factors**, including the quality of reception and support in the country of asylum, are important predictors of long-term outcomes.

Healthy Immigrant Effect

- There is a large amount of evidence that suggest that new immigrants and refugees are healthier, both physically and mentally, than the native-born population upon initial arrival to their new country.
- With more time spent in Canada, the immigrants' health advantage tends to diminish and the physical and mental health of immigrants and refugees begins to deteriorate.

What the data tells us?

- Rates vary considerably
- Common mental health problems in first generation migrants:
 - > Depression
 - > anxiety
 - > posttraumatic stress disorder (PTSD)
- Highest risk of PTSD associated with the post-migration experience in Canada

What the data tells us?



Prevalence rates of depression, anxiety and PTSD of **refugees**

Refugees and asylum seekers experience higher prevalence of **anxiety at 40%; 28%** among migrants in general.

Postpartum depression among women asylum seekers is about **14%;** refugees **12%**

What the data tells us?

- Immigrants overall report **lower rates** of mental health problems than longer-term immigrants and Canadian-born counterparts.
- Generally **lower rates** of depression than Canadian population; but **matches** population with longer stay.
- Psychosis rates among **first-generation** immigrants similar to Canadian population.
- Postpartum depression is **5%**

Impact of mental illness

Some things that cause stress for immigrants and refugees:

- > not being able to do the work they used to do;
- > feeling that they are not welcome in Canada;
- > experiencing racism and discrimination;
- > learning that Canada does not value their skills and education; not being able to speak English;

Impact of mental illness

- having to take on a different role in their family or community; being separated from their family and friends;
- not having the support of people from their community;
- having post-traumatic stress because of something that happened before they arrived in Canada.

Situational differences between immigrants & refugees

Immigrants	Refugees
Choose to leave home and settle in country of choice	Flee in response to crisis with little choice on where they go and means of travel
Time to prepare emotionally for departure and say farewell to friends and family	Unprepared emotionally for leaving due to hurried, often secret departure
Usually well-prepared and motivated to settle in new country	Arrive in new country ill-prepared and often
Leave country knowing they can return for visits or stay permanently	Often affected by pervading sense of loss, grief, worry and guilt about family left behind

A photograph of a man and a woman looking at a laptop screen together. The man is standing behind the woman, pointing at the screen. The woman is sitting at a desk, looking at the laptop. The image has a purple tint. The text 'Activity: Myth & facts' is overlaid on the left side of the image.

Activity: Myth & facts

Myths

- 1. Immigrants are a burden on Canadian economy**
- 2. Immigrants bring crime to Canada**
- 3. Immigrants take away jobs from Canadians**

Facts

- Immigration policies attract highly skilled immigrants, educated in different fields.
- Gives Canada an economic edge. For every 10% increase in immigration, Canada's exports increase by 1%.
- Immigrants have lower overall crime rates than Canadian-born populations.
- Less involved in criminal activity.
- Although highly skilled, immigrants often do not get to compete for Canadian jobs due to barriers with credential recognition.

Myths

- 4. Real refugees wait in refugee camps. Those who make a claim in Canada queue jump and are not as deserving**
- 5. Refugee claimants pose threats to Canada's security**
- 6. Canada does more than its share to assist refugees and asylum seekers when compared to other countries**

Facts

- All refugees have a right to protection, wherever they are.
- Cannot wait on others to assist.
- Canada has legal obligations towards refugees in Canada.
- Refugees are seeking security and protection from threats to their own lives.
- Refugee determination process involves security checks. Claim rejected if claimant pose security risk.
- Only a small minority of refugees and asylum seekers make claims in the world's richest countries, like Canada.

Special Populations

List of special populations

- Certain **sub-groups** within the immigrant and refugee populations are at **increased risk** of mental health problems/illness:
 - > **Women**
 - > **Children**
 - > Older adults
 - > Lesbians, gay, bisexual, transgender and queer (LGBTQ)
 - > **Survivors of torture**
 - > Persons living with disabilities

Immigrant and refugee women: risk factors

- Refugee women more likely to be impacted by gender-based violence (GBV) through acts such as rape, trafficking
 - > Sex used as a form of survival for necessities* of life, food, shelter, etc.
- Trauma may reduce a woman's sense of control over her life. May feel either emotionally numb or suddenly alert and panicky



Immigrant and refugee women: risk factors

- Intimate partner violence (IPV) occurs across **all** cultures but cultural context for IPV may differ for immigrant and refugee women.
- Migration may reduce women social connections and supports
- Mental health impacts include:
 - > trouble sleeping and nightmares
 - > feelings of self-hate and low self-esteem
 - > depression
 - > self-harm

Supporting immigrant and refugee women

- Adequate social and emotional support can help survivors of sexual trauma cope and distress decrease over time
- Trauma informed care is a promising approach

Immigrant and refugee children

- Children are **vulnerable**
- Children are **dependent**
- Children are **developing**



Immigrant and refugee children: Risk and protective factors

- Circumstances of their family's migration
- Parents' adaptation to Canada, ability to speak English or French
- Parents' mental health and wellbeing
- Family functioning; key role of family as a source of resilience
- Level of hospitality in Canada

Immigrant and refugee children: Risk and protective factors

- Stage of physical, cognitive, social and emotional development
 - > Pre-school children (aged 2-5)
 - > School-age children (aged 6-11)
 - > Older children and adolescents (aged 12-17)

Mental health issues in immigrant and refugee children

- Rates of psychiatric disorders among immigrant children are **not higher** than that of native-born children; whereas refugee children have **higher rates** of distress and depression.
- Children are particularly vulnerable; they need the support of adults for their psychological and social well-being. There are many risk and protective factors for children, at the level of the individual, family, school, and community.
- Symptoms of children's trauma vary based on their age. Trauma can show up in emotional, cognitive, physical, and behavioural ways.

Mental health issues in immigrant and refugee children

It's important to distinguish between mental distress and mental disorders. Mental distress is often a normal reaction to upsetting and stressful events. Unfortunately, the line between distress and disorder is not always clear, but some important considerations include:

- > whether the parents are concerned and see a significant change in their child
- > whether there is a significant disturbance in functioning in the areas of school, friendships/play and family relationships
- > whether there are safety concerns.

Mental health issues in immigrant and refugee children

- Schools play a very important role in supporting refugee children's mental health. Focus on a strengths-based approach.
- Refugee children with more severe mental health problems should be referred to appropriate treatment. A variety of different treatment options, including individual, family, community and school-based interventions, should be considered.

Signs of trauma in children

Younger children (ages 5 and under)	Older children (ages 6 to 12)
<ul style="list-style-type: none">• Recurring nightmares and night terrors• Repetitive play on traumatic themes• Problems distinguishing fantasy from reality• Increased aggressive behaviour• Anxiety expressed by dependent behaviour	<ul style="list-style-type: none">• Withdrawal and quietness• Decreased concentration and/or attention• Decreased school performance• Regressive behaviour• Aggression, fighting, disobedience• Difficulty sleeping, nightmares• Increased physical complaints

Recently in the news – October 2018

- **Highlights:**

- > Immigrant youth are more likely to present with a mental health crisis to the emergency department than non-immigrants
- > Likely due to barriers in accessing and using outpatient mental health services
- > Interventions to improve access to the mental health system should consider the needs of specific immigrant populations

- **Links:**

- > <http://www.cmaj.ca/content/190/40/E1183>
- > <https://www.thestar.com/news/gta/2018/10/09/refugee-and-immigrant-youth-more-likely-to-end-up-in-er-during-mental-health-crisis-study-shows.html>

Recently in the news – October 2018 – CAMH response

“There’s a bit of the impact of poverty, there’s a bit of the impact of culture, there’s a bit of the impact of where the services are, and then there’s the impact of who offers the services and whether they speak your language.”

- Dr. Kwame McKenzie, Director, Office of Health Equity

<https://globalnews.ca/news/4529750/immigrant-mental-health-care-canada/>

Supporting immigrant and refugee children

- Enhance the factors that promote children's mental health and wellbeing.
- Provide appropriate help to those children experiencing severe mental health problems to ensure a full recovery.

Strength and resilience

- Many immigrant children do exceptionally well upon arrival, some surpass Canadian-born peers in aspiration and academic achievement.
- Many refugee children coping with a history of exposure to war and political violence manage to have relatively good mental health, due to their resilience factors.

Immigrant and refugee older adults: risk factors

- Mental health problems/illnesses can be serious issues for older immigrants within first few years after arrival.
- Racialized immigrant men more likely to report poorer health than Canadian-born men; recent immigrant racialized older women less likely to report poorer health than Canadian-born senior women
- Some risk factors for mental health problems are:
 - > Loss of social status

Immigrant and refugee older adults: risk factors

- Chronic physical health problems
- Social isolation
- Language barriers
- Feeling of “aging in the wrong place”
- Loss of independence



Supporting immigrant and refugee older adults

- Help older adults establish and maintain contact with people from similar cultural backgrounds.
- Provide recreational opportunities and other activities to stimulate older adults mentally, physically and socially.
- Recognize of the central role of family and community is the best approach to meet the needs of this population.
- Places of worship are an important sources of support provides a sense of belonging to a community.

LGBTQ: risk factors

- For LGBTQ newcomers, uncertainty about the future and post-migration difficulties interact.
- Prolonged exposure to various forms of violence may cause LGBTQ refugees to suffer from depression, anxiety, and complex trauma.



LGBTQ: risk factors

- May not benefit fully from the support of their ethno-cultural diaspora communities during resettlement due to stigma.
- Social isolation may be even more of a problem for LGBTQ immigrants and refugees who also experience marginalization due to race ethnicity, which can negatively affect mental health.
- Claimants must navigate a complex claims process, which can be highly intrusive and traumatizing

Supporting LGBTQ populations

- Formal and informal supports may help promote the wellbeing of LGBTQ newcomers.
- Due to discrimination, service providers should build an accepting, empowering and compassionate relationship with LGBTQ clients.
- Considerations when working with LGBTQ services users:
 - > Encourage clients to find community support.
 - > Offer same quality of services like others, including access to services in multiple languages.
 - > Refer to appropriate community organizations.

Survivors of torture: risk factors

- Torture includes beating, burning, electric shocks, sleep deprivation, Goal - make victim powerless.
- Produces guilt, destruction of mental and psychological capabilities and loss of dignity.



Survivors of torture: risk factors

- Psychological and emotional consequences considered to be the devastating and most difficult to repair
- Survivors at high risk of depression, anxiety and PTSD
- An estimated 20% of all refugees believed to be either survivors of torture or family members or close intimates of a survivor.

Supporting survivors of torture

- Apply principles of trauma informed-care when working with this population.
- Survivors need support in understanding their experiences and rebuilding their identities.

Supporting survivors of torture

- Emotional and social support help serve as protective factors
- Effective programs:
 - > acknowledge and validate the person's experience of torture
 - > provide safety
 - > recognize that individuals may need specialized assistance
 - > help survivors deal with practical resettlement issues

Immigrants and refugees with disabilities: risk factors

- Precarious position because support structures break down during displacement.
- Experience stigma and discrimination, limited/no access to health care and psychosocial support, which increase isolation when compared to other refugees.

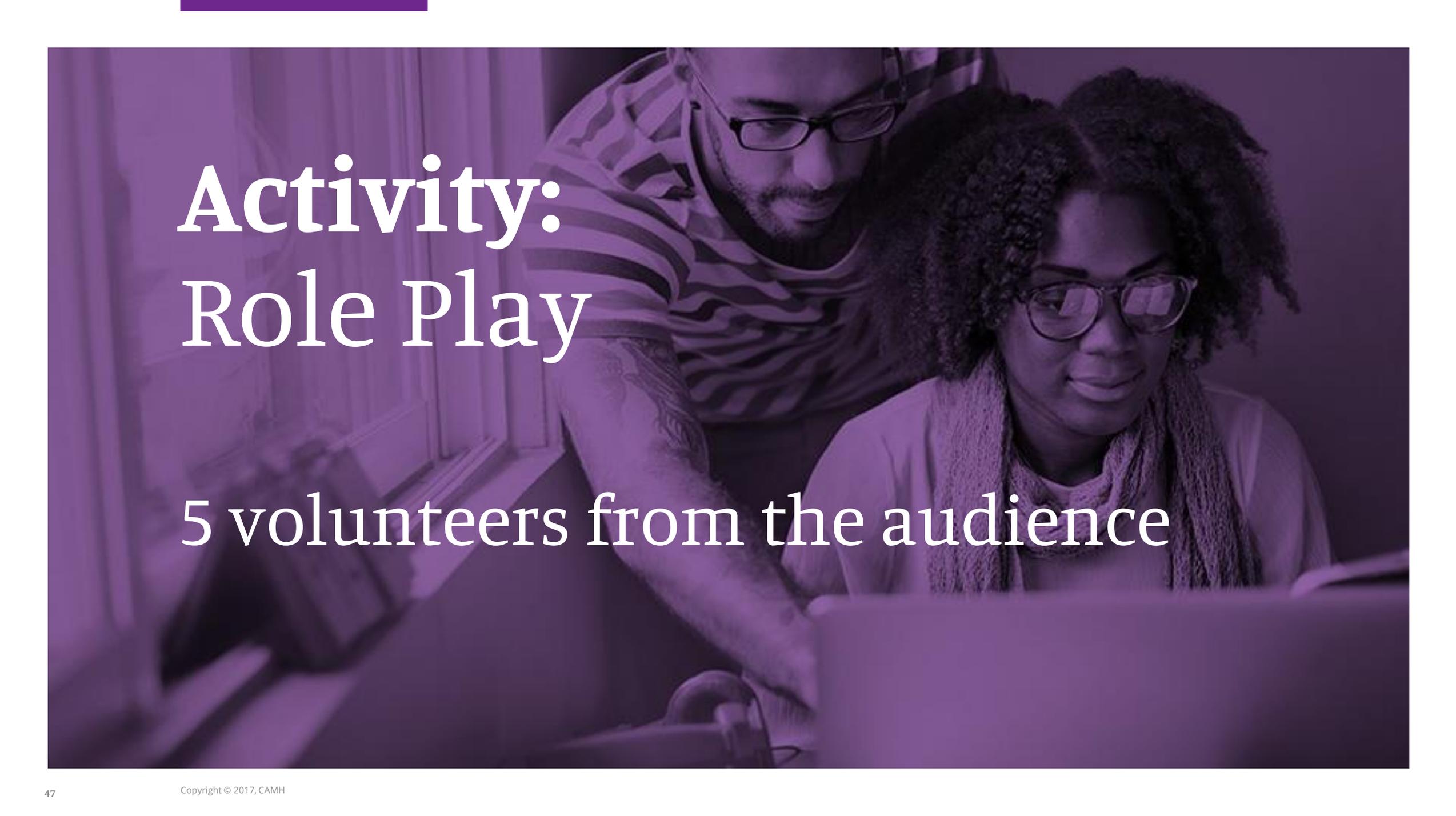


Immigrants and refugees with disabilities: risk factors

- Encounter loss of social ties due to migration.
- Limited awareness of disability rights and resources often disability related needs go unmet.
- Winter can be challenging especially for visually or physically impaired.

Supporting immigrants and refugees with disabilities

- Facilitate full and equal access to services and information.
- Provide services, such as support groups and case management, that are culturally appropriate or safe for individuals.
- Connect individuals and their families with community-based agencies to reduce social isolation and access to other services.
- Partner with other agencies and connect immigrants and refugees living with disabilities to other resources to support their rights and access services.

A photograph of a man and a woman looking at a laptop screen together. The man is wearing glasses and a striped shirt, and the woman is wearing glasses and a white top. The image is overlaid with a purple tint. The text 'Activity: Role Play' is written in white on the left side of the image.

Activity: Role Play

5 volunteers from the audience

Trauma Informed Care

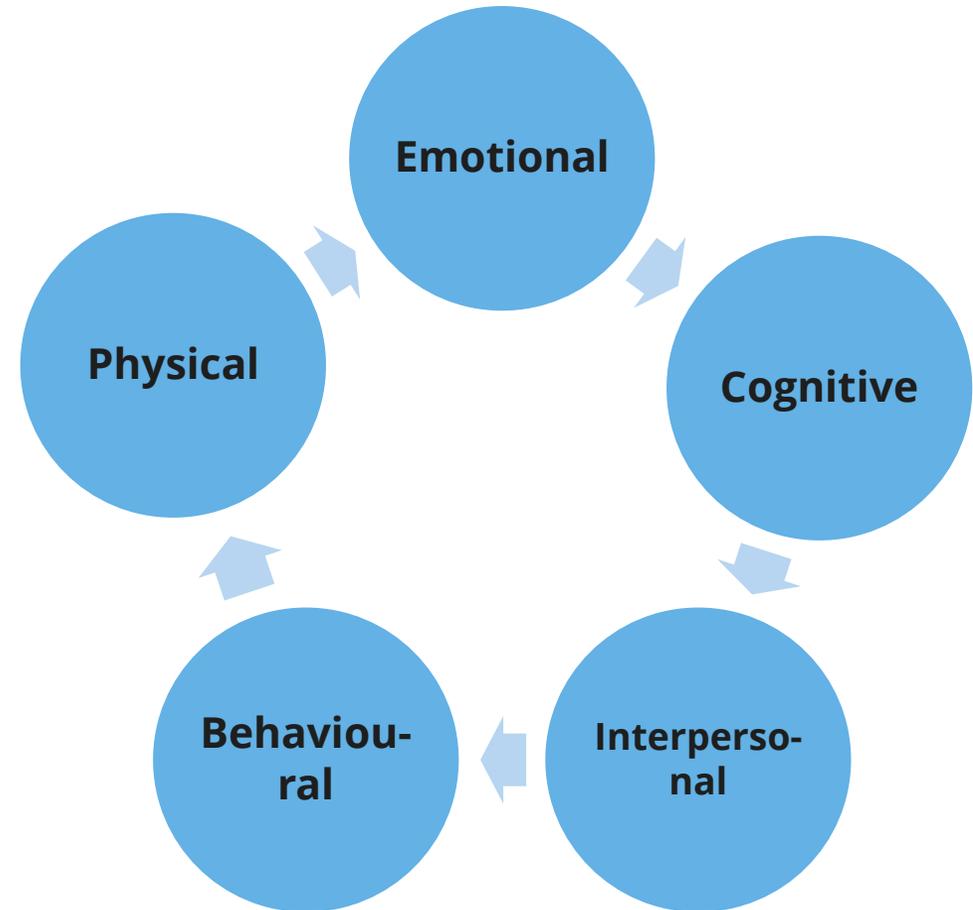
What is trauma?

Trauma =		
EVENTS	EXPERIENCE	EFFECTS
<p>May occur once or be repeated over time</p> <p>Can include:</p> <ul style="list-style-type: none">▪ Actual or threatened harm▪ Severe withholding of resources for healthy development	<p>Same event may be experienced as traumatic by one person and not another</p> <ul style="list-style-type: none">▪ Subjective experience may be influenced by a host of factors including culture, social context and developmental stage	<p>Adverse effects may occur immediately or over time</p> <ul style="list-style-type: none">▪ The connections between traumatic events and the impact of trauma may not be clear

Impact of trauma

Affects many areas of development and functioning:

- Emotional
- Cognitive
- Interpersonal
- Behavioural
- Physical



Trauma-informed approach

- Realizes the widespread impact of trauma.
- Recognizes the signs and symptoms of trauma.
- Responds by fully integrating knowledge about trauma into policies, procedures and practices.
- Seeks to actively resist re-traumatization.

Common Responses to Trauma

- Trouble sleeping
- Aches and pain (headaches, stomach aches)
- Changes in appetite and eating
- Panic attacks and anxiety
- Worrying or ruminating (intrusive thoughts of the trauma)
- Nightmares and/or flashbacks (as if reliving traumatic events)
- Tendency to isolate oneself
- Diminished interest in everyday activities or depression
- Irritability, restlessness, outbursts of anger

Common Responses to Trauma

- Drinking or taking other drugs
- Feeling like you don't want to live or you can't go on with your life
- Feelings of shame, self-blame and low self-esteem
- Fearing people and relationships
- Trauma responses are normal reactions to abnormal events (abuse, neglect, war/conflict, violence, etc.)
- Trauma affects people physically and emotionally
- It may take weeks, months and, in some cases, many years to regain equilibrium

Approaches when meeting with survivors of trauma

- Introduce yourself clearly and be explicit about your role.
- Explain confidentiality and its limits.
- Attend to immigrant/refugee's comfort.
- Try to guide the conversation in a way that does not lead the person to feel overwhelmed.

Approaches when meeting with a trauma survivor

- Do not probe into trauma – it can lead to re-traumatization.
- Listen and validate the person's feelings in a way that feels genuine and comfortable.
- Encourage the service user to share only what he/she feels safe sharing.

Guiding questions when working with survivors of trauma

- What is my purpose during this meeting?
- What information is truly necessary to obtain in order to fulfill my role and make decisions?
- When can I stop going for details about a traumatic experience?
- What do I do with information I obtain? What resources can I access?

Considerations when working with survivors of trauma

- Many are reluctant or emotionally unable to share their traumatic experiences.
- May have difficulty remembering certain events.
- May fear persons in authority.
- May break down and/or become incapable of coherent expression.
- May have a mental health problem or illness.

Case scenarios: Discussion



Cases study #1: J. Ansari

J. Ansari is a 35 year old male who fled his home country 2 months ago due to persecution for being gay. He tells you he arrived in Canada two weeks ago. J has come to you for treatment for his Type 2 diabetes because he has run out of insulin and he knows he needs it. (He hasn't been testing). You have a portable A1C machine and you find that his A1C is 12.

He is not seeing anyone for any other kind of mental and physical care. He's just asking for insulin because he doesn't have any and he's feeling lousy. As he talks you notice he is edgy, agitated, unable to sit still, speaking rapidly. You suspect from his body language and his demeanor that he has been emotionally and physically abused. When you talk to him about getting lab tests, a complete physical, changing his diet, he gets more agitated.

J tells you he just wants you to give him insulin so he'll feel better.

What do you do?

Cases study #2: F. Khan

F. Khan is a 69 year old man who came with his wife to Canada on a visitor's visa one year ago, from Pakistan, via Germany. He tells you he has mild diabetes that doesn't need medication – he can control it through his diet. He says that he used to take medication for hypertension but he doesn't think he needs it, and he is having trouble seeing (cataracts). He doesn't mention arthritis but you can see the signs.

He tells you he feels tired and weak and he cannot stay awake for very long – he sleeps a lot. His wife “made” him come to the clinic to get “help”. He has come to your clinic because he can see a doctor without an OHIP card.

You learn that the family fled Pakistan due to threats against them and their family from the Taliban – threats that had been escalating over the past two years. Several of their family members have been killed by the Taliban. F and his wife sent their children out of the country to attend high school a year ago and they haven't seen the children since. They are trying to get their children to Canada. They are alone, other than one brother in Toronto who is dying of cancer.

What do you do?

Cases study #3: B. Fatya

B. is a 27 year old Yemeni woman, who came to Canada as a university student with her husband before the violence started in Yemen. All of her family is back home. No one can leave because of the international blockade and hundreds of thousands of people are going to starve in the coming year. She is in touch with her family and they are losing hope. B is pregnant with her first child. She has recently left her husband for unspecified reasons. She is experiencing chest pain and tells you that her family has a history of heart disease so she is worried that she may have angina or worse, being having a heart attack.

What do you do?

Self Care

What is compassion fatigue?

- Refers to profound emotional and physical exhaustion that can affect helping professionals over time.
- Described as the “cost of caring” for others in emotional pain.
- Related to work stress and regular exposure to the trauma and suffering of the people they work with
- Characterized by physical, emotional, cognitive, spiritual and mental symptoms.

Compassion fatigue

- Conditions that can affect professionals working with trauma survivors.
- Being able to recognize the signs is the most effective way to implement strategies before things get worse.



Warning signs and symptoms of compassion fatigue

- Feeling estranged from others
- Difficulty falling or staying asleep
- Irritability
- Physical or emotional exhaustion
- Depression
- Inability to maintain balance of empathy and objectivity
- Gradual desensitization to client stories
- Diminished sense of personal accomplishment

True or false?

Compassion fatigue can affect someone quite quickly, coming on with little warning.

What is secondary or vicarious trauma?

- Refers to the range of psychological, emotional and physiological effects seen in professionals working with the survivors of trauma
- Associated with cumulative exposure to survivors of violence or disaster/being repeatedly exposed to traumatic content
- A process that unfolds over time

Vicarious trauma

- In part related to the professionals' empathic engagement with the person while telling their traumatic story
- Listening to the stories that resonate with someone on a personal level plays a crucial role
- Can affect a wide range of professionals assisting trauma survivors: humanitarian workers, social service workers, justice system professionals, health care providers, journalists, police officers, etc.

(Pearlman & McKay, 2008; UNHCR, n.d.)

Risk factors

Individual	Work	Community
<ul style="list-style-type: none">• Poor self-care• Poor work habits• Previous trauma• Inadequate training or experience• Other life stressors to deal with	<ul style="list-style-type: none">• High frequency of exposure to trauma and narratives of suffering• Work overload• No opportunities / few opportunities to debrief• Unsupportive work environment	<ul style="list-style-type: none">• Working with a high need community• Lack of social support• Lack of resources to respond to the needs of clients

Protective factors

Individual	Work
<ul style="list-style-type: none">• Self-awareness• Balance between personal and work life• Ability to ask for help and/or get support• Self-care	<ul style="list-style-type: none">• Early Identification of workers dealing with stress• Open communication• Professional support systems

Signs & symptoms of vicarious trauma

- Often parallel those of the trauma survivors
- Repeated thoughts or images of the stories heard
- Difficulty managing emotions
- Irrational fears regarding safety
- Feelings of alienation
- Difficulty concentrating
- Sleep disturbance
- Feelings of sadness
- Generalized despair and hopelessness
- Loss of interest or pleasure
- Physical symptoms

Self-care

- Physical exercise
- Good nutrition/balanced diet
- Rest
- Relaxation techniques
- Good social network
- Hobbies & interests
- Humor
- Boundaries/limit setting



Self-care: multiple levels

Personal	Professional	Organizational
<ul style="list-style-type: none">• Maintain life balance• Contact with nature• Skill development• Establish boundaries	<ul style="list-style-type: none">• Limit work hours• Pace the day for breaks, nutrition & reflection• Set limits• Confirm rewards that come from your work	<ul style="list-style-type: none">• Peer support• Debrief• Formalized self care plans

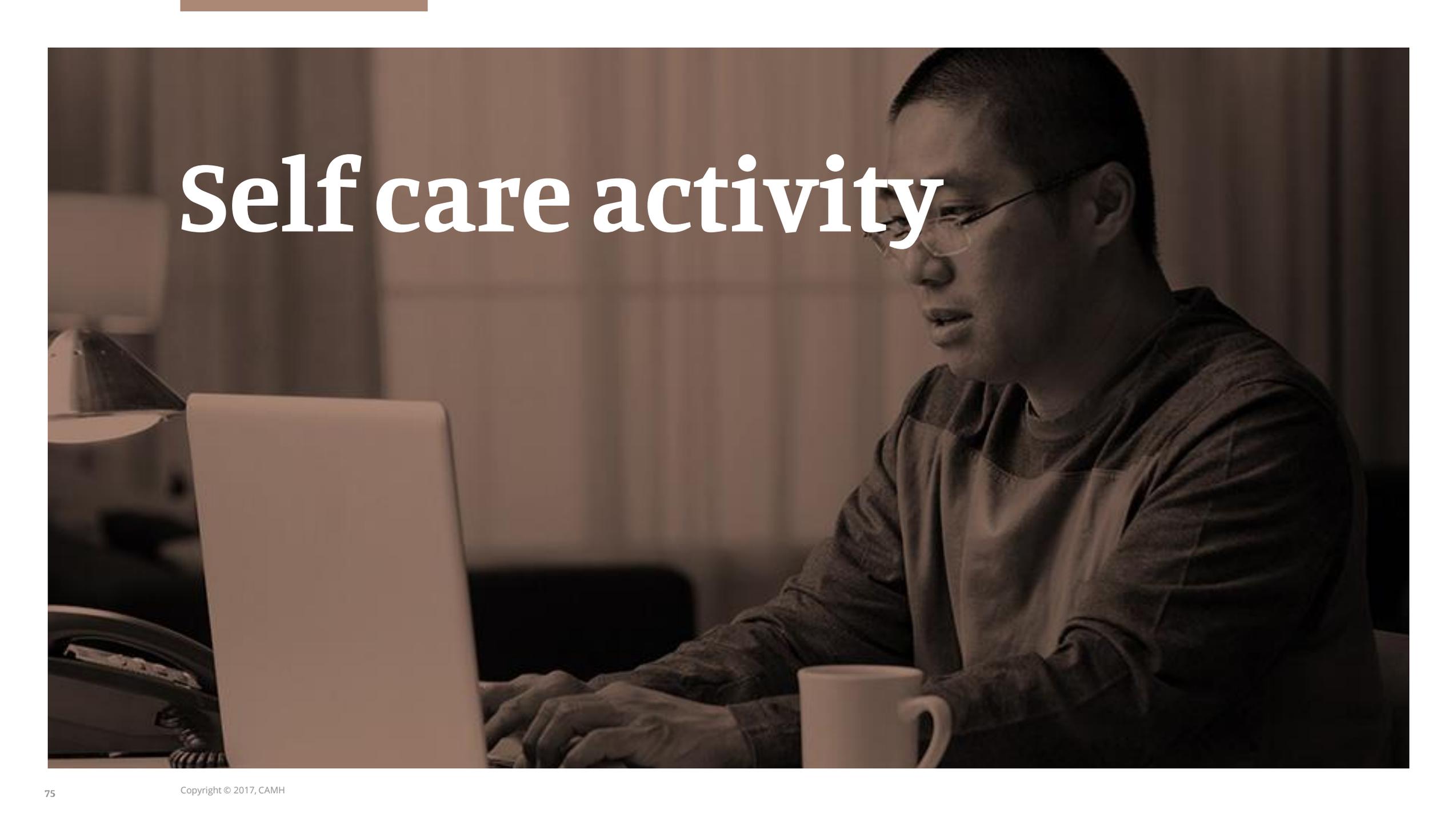
(Hamilton, n.d.)

When to seek help?

Persistent and severe symptoms of distress that impair your functioning:

- Not sleeping
- Not eating
- Crying often
- Not able to perform at work

Self care activity

A man with glasses is sitting at a desk, focused on his laptop. The room is dimly lit, with a desk lamp providing light. A white mug is on the desk next to the laptop. The overall mood is quiet and concentrated.

Self care plan

Physical Health	Emotional Health
<ul style="list-style-type: none"> • Take the stairs instead of escalators/elevators 	<ul style="list-style-type: none"> • Talk to a friend
<ul style="list-style-type: none"> • Meal plan and shop for healthy foods 	<ul style="list-style-type: none"> • Listen to music
Spiritual Life	Work Life
<ul style="list-style-type: none"> • Go for spiritual talks 	<ul style="list-style-type: none"> • Take breaks
<ul style="list-style-type: none"> • Meditate 	<ul style="list-style-type: none"> • Debrief with a colleague when things are tense
Social Life	Other
<ul style="list-style-type: none"> • Attend a festival, neighborhood event, outdoor market 	<ul style="list-style-type: none"> • Increase awareness of nature e.g. birds and flowers in the day, stars and solitude at night
<ul style="list-style-type: none"> • See friends regularly 	<ul style="list-style-type: none"> • Pamper oneself

Immigrant and Refugee Mental Health Project

Immigrant and Refugee Mental Health Project

- The Immigrant and Refugee Mental Health Project offers **online training, tools** and **resources** to settlement, social and health service professionals
- Project leads:
 - > Dr. Kwame McKenzie
 - > Aamna Ashraf



Immigrant and Refugee Mental Health Course

Self-directed

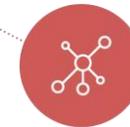
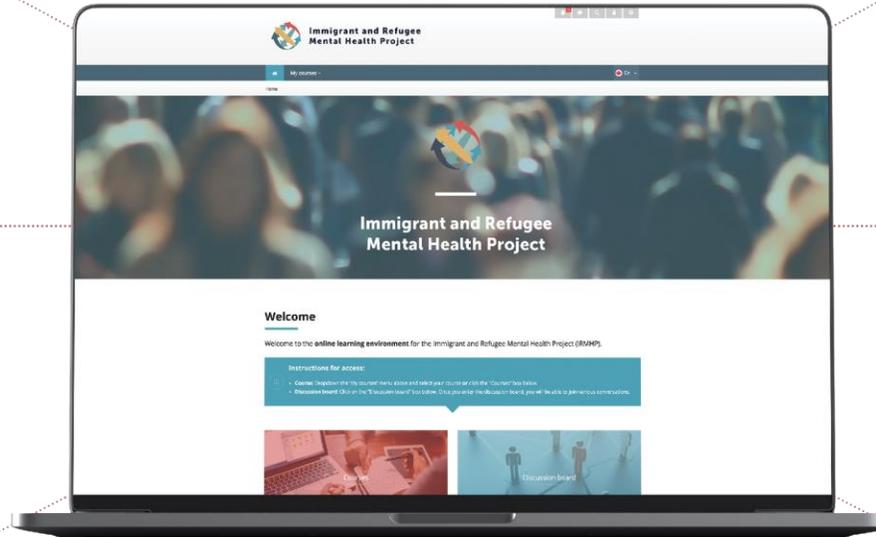
Students have six weeks to complete the course at their own pace

Essential information

- background information
 - promising practices
 - tools and resources

Evidence-based

Based on current research, built with subject matter experts and informed by a national advisory committee



Expert videos

40+ videos on various topics from experts on immigrant and refugee mental health

Interactive

Interactive quizzes and activities that explain complex topics

Networks

Opportunities to develop a national network of service provision through the community of practice discussion board

Evaluation

Ongoing evaluation gives us an opportunity to continuously improve and update the course

Definitions & References

Definitions

- **IRER:** Immigrant, Refugee, Ethno-cultural and Racialized (IRER) populations
- **Immigrants:** Immigrants as persons born outside of Canada who have been granted the right to live in Canada permanently.
- **Refugees:** Refugees are people who are unable to safely remain in their own country, or are outside their country, on account of a fear of persecution due to their ethnicity, nationality, religion, or social or political affiliations.

Definitions – terminology

- **Racialized:** The Ontario Human Rights Commission describes people as “racialized person” or “racialized group” instead of the terms “racial minority”, “visible minority”, “person of colour” or “non-White” as racialized expresses race as a social construct rather than as a description based on perceived biological traits (Ontario Human Rights Commission, 2005).
- **Health Equity:** Health Equity is the principle underlying a commitment to reduce and, ultimately, eliminate disparities in health and in its determinants (Braveman, 2014).

Definitions – terminology

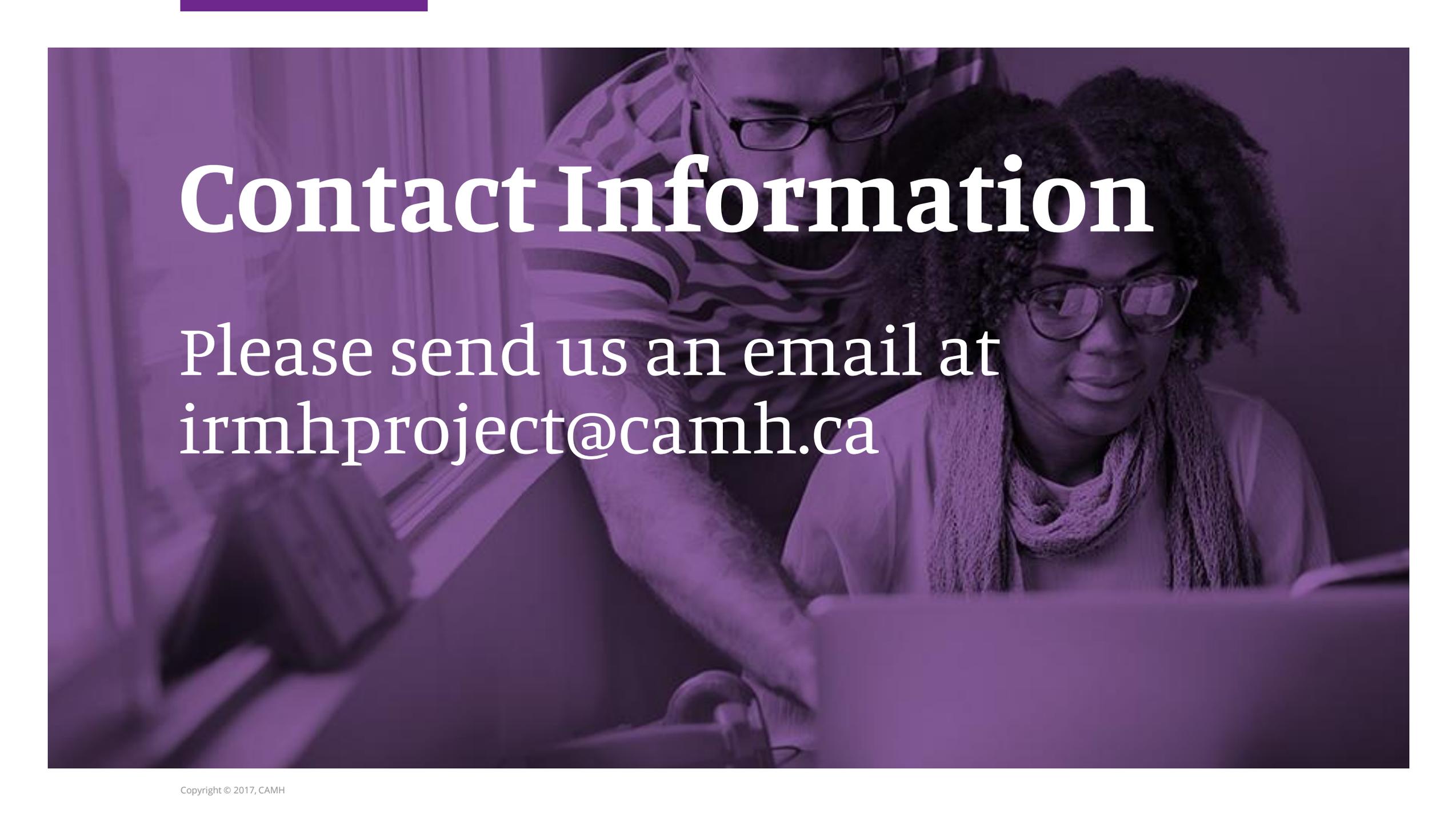
- **Cultural competency:** A “culturally competent” health care system has been defined as one that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs.” (Betancourt et al., 2003:294)

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A photograph of a man and a woman looking at a laptop screen together. The man is on the left, wearing glasses and a striped shirt. The woman is on the right, wearing glasses and a scarf. The image is overlaid with a purple tint. The text is white and centered over the image.

Contact Information

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