Refugee Mental Health

Promising Practices and Partnership Building Resources

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About this Guide

This guide is for people who work with refugees in Canada, particularly those who provide settlement, health and other social support services. The material is written for front line workers, program managers and the leaders of agencies, and is informed by their ideas and expertise.

What is the Purpose of this Guide?

1. To help settlement workers learn how they can meet some of the mental health needs of refugee clients.

2. To help mental health workers better understand the complex settlement needs of refugee clients, and how mental health services can support settlement needs.

3. To support settlement agencies, mental health and health service providers in the process of forming strong, lasting partnerships with one another, so that refugee clients can have seamless access to a range of services.

4. To suggest how settlement and mental health service providers can develop knowledge exchange activities that meet local needs.

5. To share what was learned from a Canada-wide study on what helps to promote refugee mental health, resiliency and recovery.

Where did the Information Come From?

The content of this guide comes from the findings of the Refugee Mental Health Practices study, a research project at the Centre for Addiction and Mental Health in Toronto. The research team included people with experience researching refugee mental health, as well as working in adult education, in the settlement sector, and in clinical counselling. This study was funded by Citizenship and Immigration Canada to learn about what service providers across the country are doing to support refugees' mental health, and what resources settlement workers need in order to better support their clients' mental health. Data collection methods included an environmental scan, in-depth interviews, case study site visits and literature review.

The research team spoke with over 150 participants in nine provinces across Canada, during 2009 and 2010. Participants include refugee clients, settlement workers, program managers, policy-makers, and clinicians.

The two key findings about training and education needs of people who work with refugees are:

- **Providing refugee-centred mental health and social care**
  Settlement service providers would like, in partnership with mental health professionals, to provide services to refugee clients that are timely, culturally competent and responsive to complex adaptation needs during resettlement.

- **Building better inter-professional working relationships**
  Many settlement workers and agencies would like to learn more about better supporting their clients' emotional needs. But, they also need strong working relationships with professionals and agencies with mental health expertise.

The knowledge does exist on how to serve refugees and on how to support their emotional well-being, and often the most important thing that we can do is bring different experts together. This guide offers some suggestions on how to do that.

Part 1: Findings from the Mental Health Practices Study

This section of the guide presents excerpts of research evidence to illustrate service providers' perceptions of refugee mental health needs, service gaps and promising practices.

The Current Situation

The Refugee Mental Health Practice study spoke with service providers, program coordinators, clinicians and other support workers, during in-depth interview (see **Appendix 7** for more details on the participants). While there is variation across regions and in different settings (for example, in larger or smaller cities), service providers describe their situations similarly. This section highlights the words of participants.

Higher needs among recent refugees

Many service providers perceived mental health needs among recently-arrived refugees to be very high. For example, they reported:

> *Because of the way in which we select people to resettle now, we are seeing a great deal more individuals, refugees, who could very much benefit from therapeutic counseling.*
> — Alberta 02

> *With the changes in immigration, what I'm observing – and we have a lot of clients, actually-- that certainly some have symptoms of untreated mental illness.*
> — British Columbia 07

> *Among GARs, you will see many who are 'high needs' or 'special needs' refugees simply because most of them have spent a large part of their lives in refugee camps. There are kids, teenagers, young men and women who have spent their entire lives in refugee camps.*
> — Ontario 16

Refugees' needs are complex

Service providers recognize the complexity of refugee's mental health. As the following comments illustrate, social needs compound mental distress, and coping with trauma may be only one among many challenges that refugees face. While trauma is a distinct concern, service providers report seeing more refugees who suffer from depression.

> *Within six months, they experience depression, culture shock, longing to go back home, language barriers and some of them are suicidal and display psychosis and paranoia…. Mental health problem such as depression and PTSD in conjunction with substance abuse and domestic violence. [And] loneliness without family support, violence, child abuse, traumas in the past.*
> — Saskatchewan 02-06

> *The majority of the refugees we receive are not textbook clinical cases. These are just people who had a really tough time in their own refugee camps, and as they arrive here, they're having a really tough time resettling in a completely different [environment]… it doesn't make them crazy, it doesn't make them significantly challenging from a clinical perspective, but we need to be able to provide services that complement those needs.*
> — Alberta 03

Service providers also understand that mental health problems are caused by social factors in Canada, such as isolation, loss of social support, family separation, unemployment, and adaptation challenges, in addition to pre-migration trauma.

Importance of timing of services and interventions

According to service providers, refugees' needs for mental health care vary and change over time. Some clients need services or interventions immediately upon arrival and others require follow-up after many months or years.

> *My goal as a health coordinator was to try to have a psychiatrist or a psychologist accessible to clients because when they come…MY perception is that the best time to work with the clients is when they come here for the first six months or year, because that is when they experience the mental health issues, because of the dislocation and leaving the family behind, the culture shock. …people don't want to go where everybody goes but they want to go to places where they feel safe..*
> — Saskatchewan 01

> *…[after two to five years] they get worse. Because then you really see the person. At the beginning they still have the hope that they are going to find a job and all that and then they realize they won't. Usually--because some of them are professionals--finding out that you are not going to be able to work in your field here really puts you down. I went through the same issue myself….it is really shocking. If you don't have a*

*good self esteem, it is overwhelming. Even if you have self
esteem, it is still shocking, right?*
          – Ontario 10

*As soon you get employment, your life becomes more stable and
they can become independent. They still are dependent on the
services that we provide but in a different perspective. People
are beginning to put their lives together, and THEN is when the
counseling issues start coming up, because they miss the
country, they are homesick, they are having difficulties
understanding the system, or they get sick, because the urgency
is over and then they can realize the physical ailments that come
in, because they have been stressed out for two, three, four,
even more years. This is a place to recover.*
          – Ontario 09

Service providers face challenges in meeting their clients' needs

Service providers struggle to meet refugees' mental health needs for a number of
reasons, including heavy workload, waiting lists for services, lack of funding, and their
own experiences of vicarious trauma.

*A lot of the settlement workers are immigrants and refugees
themselves and so their CLIENTS often trigger THEIR stuff in
them and it becomes not as effective and they become
traumatized over and over again. There are actually no services
for THEM. That's the gap as well in terms of addressing the
question, "How do THEY best practice and provide these services
for the clients and not destroy themselves in the process?" It is
such a glaring need.*
          – British Columbia 06

*We have been struggling A LOT to get funding to respond to
refugees' mental health.*
          – Nova Scotia 01

*I really do not think that a settlement counselor, with all the
other responsibilities that they have, can realistically provide the
level of support and the time that is needed to give newcomers
what they need in this area.*
          – Manitoba 02

*Some of our clients, most, have post-traumatic stress. We are
trying to help them, but with mental health, there is a big issue,
because …we have some access to some counseling, but the
waiting list is very long.*
          – Saskatchewan 01

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Challenges of linguistic diversity and service gaps for specific groups

Service providers report ongoing problems with lack of language and cultural interpretation services, which are critical in dealing with sensitive mental health issues. As well, they see that there are many mental health care gaps for sub-groups within the current refugee populations arriving in Canada: special services are needed for women, for men, for children and youth and often for specific ethnocultural groups.

We started noticing, especially with a lot of the government assisted refugees, and some of the more vulnerable, more traumatized groups of people coming in, the kids are entering school, probably have never seen anything remotely like it coming out of a camp, and all of a sudden, they are in this zero tolerance environment at the school and they don't know what the heck, what is expected of them. They don't even understand really what they are doing wrong, and they are EXPELLED! So you have kids in grade one being EXPELLED and there is just something so absurd about that.
        – Ontario 07

African refugees have this really difficult time when they arrive. They are put up in a room; they have all the basic necessities. And then they are kind of left. Here, in our country, we prize privacy. Back at home, these people were never alone. …So they feel extremely lonely. I heard this from SO many of the African and Haitian refugees-- they had everything materially that they never had in their country, but they were very depressed because of loneliness.
        – British Columbia 08

I would say in some areas…about 80% of the women have been raped. …They already have PTSD….Unless there is a place with qualified clinicians who can assist them through this, not only are they going to be depressed and non-functional, but also they will have a real difficult time parenting their children.
        – British Columbia 08

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Identified Service Needs

This section discusses particular service gaps and concerns that participants identified.

Children and youth services

Service providers report the need for services for school-aged children and for unaccompanied children. They request trauma and early intervention services children who have witnessed violence. Preventive initiatives and supports for youth are also needed.

> *[Youth] are getting very, very quickly attracted to gang activity. Not for the sake of violence, but because it's what they know. They understand non-family connection. They're being attracted to that lifestyle. The earlier those kinds of things can be assessed, and determined, earlier interventions and supports can be put in place.*
> *— Manitoba 01*

> *There is still a lot room for development around services to children and youth. We do not have the same level of support if there is a situation where a child or youth is going to be receiving supports when there is no adult connected to them.*
> *— Manitoba 02*

> *Specialized resources targeting refugee children and youth between the ages of three and 18. I continue to see that as a significant gap.*
> *— British Columbia 04*

Early assessment of mental health needs and services upon arrival

Many service providers requested some type of screening or early identification and intervention for mental health problems in order to prepare and assist with refugee mental health needs upon arrival in Canada. Having mental health information prior to refugees' arrival and mental health services in place upon arrival would be helpful.

> *We receive the information on the client when they are coming from the Matching Centre from CIC. That Notice of Arrival Transmission sometimes contains some medical information. …If someone needs a wheelchair or something like that. But they don't tell us, [what we could use] like maybe people already assessed some mental issue. At least if we KNOW that, then we could prepare… We could be at least ready for the issue.*
> *— Ontario 02*

> *Now I think there's a much greater sensitivity to the trauma needs of refugees. Even to the point where I think we just ASSUME that because a person is a refugee they've been traumatized. Because, you know, how do we define trauma? Realistically, I think early intervention and early assessment of trauma and the scale to which a person's been traumatized is very important. In order to be able to plug them into appropriate clinical resources. Assuming they exist.*
> *— Manitoba 01*

The other recommendation is around Government Assisted Refugees and the need for systematic screening and assessment. ….This systematic undertaking of primary health care including mental health screening support to Government-Assisted Refugees is needed across the country.
– British Columbia 04

I honestly think that's where it needs to start, the mental health piece. Could it start, probably, in the initial assessment? Especially with children, if they've witnessed… I think we might start too late with mental health issues.
– British Columbia 03

Service-bridging for consultation and counselling

A common need reported by service providers is having ways to link settlement workers with mental health service providers, mental health counselors and other service providers for consultation. Such linkages would help refugee clients and service providers alike.

Specific services for the needs of refugees….part of these services could be services for victims of torture. Absolutely. ANYBODY WHO NEEDS IT SHOULD BE ABLE TO ACCESS IT. Also, have a psychiatrist connected with that service. That's very important, because some people WILL need some medication. And I think they are fearful of accessing the mainstream services.
– British Columbia 08

A settlement provider in a town in British Columbia recounts the challenges of developing a circle of care around a teenage girl. She had witnessed the murder of her mother, and also needed extensive surgery which was only available in Vancouver, hundreds of kilometers away.

There really wasn't anything in place. [The counsellor] was willing at least to work with the two family members that had witnessed the murders of the parents, and for this young girl to continue to have these surgeries. It's just really tragic. … I know that if things were in place, at least to start… they must have professional counselors in hospitals that could refer to [this agency], but that [this agency] could come to the hospital. But we're not the major player here, and it's hard to bring everyone together.
– British Columbia 03

Integrating customized, holistic mental health care

Service providers would like to be able to integrate in their practice customized and holistic mental health care that is culturally appropriate for diverse refugee clients with a broad range of needs.

While service providers emphasized that trauma and clinical services are very much needed, they also emphasized the need to provide mental health prevention and care that does not only focus on trauma and mental illness, but also builds resiliency.

> *A major gap is people not being 'sick enough' to be admitted to mental health services, but needing care. As an intake worker, I was encountering this problem all the time…. Physicians can prescribe medications, but people don't need just a pill. They need to talk.*
> — British Columbia 05

When asked what is needed to support incoming GARs, a physician who holds clinics at a reception house replied:

> *Culturally appropriate mental health services, having people who are not just competent language-wise, which they don't even have, but also people who are really culturally knowledgeable, knowledgeable in terms of medical systems in both places and views of mental health. … if we were able to get our dietitian involved, that would be very useful. If we were able to get an exercise program going. If we were able to do other things that promote general resiliency. I don't really like a sort of trauma model of mental health.*
> — Ontario 17

Improving information, communication and mental health education

Many service providers requested that more attention be given to information, communication and education about refugee mental health in order to make mental health counseling and supports accessible and effective. Issues in need of attention include:

- Improving trust and safety
- Improving interpretation services
- Improving mental health literacy

> *CIC could … work together with the provinces to be able to have mental health workers who do speak the languages. It's sort of like an interpreters and translators phone line or hotline, that they would be available to do that kind of work on line or on the phone. [There are] interpreters and translators for the RCMP, and [Law Line,] why couldn't they do it?*
> — British Columbia 03

> *Not many North American trained counselors have ever had to have the language bridged. We are trying all the time to get a multi-lingual counsellor but that is a pretty hard thing to find, because we are very aware that the best way to deliver mental health services is in first language, because then you are using the terms that someone would recognize. I mean, as we banter out our mental health jargon, I am sure we are throwing out all kinds of terms that people have never even heard of…*

> *We are hoping … to have one of the counselors come in and provide a couple of education sessions to our client base, to talk*

about the field of therapeutic counseling, to talk about the issues of mental health in Canada, to unpack some of those mysteries. So the people realize that while it is still stigmatized, it is certainly not as stigmatized as it is in the other societies. People realize that, 'Hey, going to counseling is not necessarily a bad thing. I am in trouble right now and I need some help. Doesn't mean I am sick for life, just means that right now, I need some help and these people can do it for me.' So we are very gently trying to go about it that way.
        – Alberta 02

Promising Practices

The next two sections of this guide focus on "promising practices," or what some of the solutions to these problems might be based on what we learned from the experiences and expertise of the service providers who participated in the study.

Front line service providers

Settlement workers and agencies often do creative work and strategize on ways to make their clients' transition to Canada easier. The Refugee Mental Health Practices team asked study participants to share what they think is working well. This section and the next one outline "promising practices" that emerged. These are not "best practices", because it is understood that what is "best" for one agency, city or region may not be feasible or equally useful in another location.

The first set of promising practices relates to the individual service providers, and the second addresses practices of agencies or organizations. These two sets of practices are related, and some items could overlap in practice.

Taking time to build trust

Service providers report uncertainty about how to work with affected refugees who are emotionally fragile, but they know that establishing rapport and trust are priorities. They also understand that it takes time to address any mental health needs.

> *When they first arrive, it's not uncommon for people to be quite discreet about who they want to talk to. Particularly within their own community of origin, because they don't yet know who's who, who they can trust, what links people here may have to people back home.*
> — Québec 02

> *You can't push them to talk, but it is true that they need longer processes than other clients because sometimes they just need more time to trust you.*
> — Ontario 10

> *They often find this hard to trust anybody, especially if they come from more of a police-state, where it's not acceptable to talk; mental illness in some of these countries are horrifying to people. They get shut into mental hospitals. So there are a lot of these issues to overcome ... Often they don't come for help if they are fearful of these things.*
> — British Columbia 08

Listening to clients

All the service providers that participated in the scan felt that refugees are the best sources of information about their mental health distress. Sometimes, listening to a client is the only "intervention" that is needed, and being listened to can in and of itself be therapeutic. For example, a family therapist in Manitoba begins sessions with her immigrant and refugee clients by asking, "how do you heal?" or "what is it that helps you feel better?"

> *Right now I only have one client, so SHE'S teaching me. Of course, I am reading, I am in school, but the CLIENT has something to say, and I'm always listening.*
> — Ontario 08

> *We found that, in every culture – whether it's Africa, Asia, Europe – they was REALLY very little difference. It is very easy to connect with people if you have listeners who can accept what they have gone through.*
> — British Columbia 08

Using case management approaches

Service providers report that refugees' mental health needs are ongoing, and often intertwined with larger settlement issues. Given the complex nature of these needs (see section "Identified Service Needs"),service providers advocate ongoing access to counseling services, prevention, and mental health promotion in order to reduce the risk of stress becoming more serious. Case management models can be used to support clients who may need to access many different services, over a long period of time.

> *Over the past five years now, we have been receiving clients with more high needs, with all different aspects. So that requires a lot of interactions with the clients and some of them, we may contact them on a daily basis for the first two months. Some of them will be in a weekly basis. It may depend on different factors, maybe because of traumas, maybe because of high level of education. It varies because sometimes one person who may have a good level of education will require a lot MORE assistance and will be more dependent into the new settings in Canada. … And then we do the first quarterly review depending on how the client feels at that point. … Then we will decide, "okay the client doesn't need us to be there as a bridge anymore", so they can slowly go wherever they need to go. If they don't, then we will keep them for another quarter, and if they need another review…as I said, the program is for up to one year. …We will not do ALL the settlement services by ourselves. We WILL work in partnerships with all different organizations.*
> — Ontario 14

Participants who used case management approaches described the need for flexibility when working with refugee clients, and how important it is for refugees to trust service providers. Boundaries between work responsibilities and personal desires to respond emotionally to refugees' needs may become blurred, and this is a part of the process of

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building trust. They suggest that providing referrals for refugees includes transferring a personal relationship of trust and care, and an "active" referral process is often required. Active referrals can involve accompanying clients when they have appointments with new service providers, and acting as a personal bridge or support to accessing the new service.

What does it mean to be a service provider? Is it just providing an apartment? Does it mean providing some care, some concern, spending some time with the person? When we have, let's say, a family support worker assigned to a teenager … what they DO is they spend a couple of hours every week with the youngster. Take the youngster places. Go out to lunches. That's part of the job. So, there is an interesting fine line. Because that's what people need most. Somebody who CARES about them. That they can share those joys and sorrows. We ALL need that. …Amongst the refugees, many of them became our translators; they were trained also as counselors, so the lines very often got blurred. …to me, it's very important that people DO care about the refugees.
— British Columbia 08

Speaking to clients in their own language and learning about their culture

Service providers report three points relevant to language. First, they report that mental health service providers are less likely to provide quality interpreter services than are settlement or primary service providers.

We have volunteer interpreters who are not always available. When I referred a client to the mental health clinic, they indicated that it would be too difficult to provide counseling to the client because of the language barriers. If we would not have advocated for her, she would have been turned away. Many other community services, such as insurance companies, are not able to provide services to our clients due to their language barrier … they don't have funding to provide interpreters.
— Saskatchewan 02-06

Secondly, service providers report that being "equipped" for constantly changing and diverse client groups is challenging.

[The] need of service changes all the time, depending on what happens in the world.
— Manitoba 03

Now we have Arabic, we have Farsi. Lots of people are coming from Nepal, Bangladesh and India. We have the Bhutanese refugees coming. We have the Karen refugees from Burma. We work in a multilingual, multicultural environment. Lots of clients are coming from Africa now and there is scarcity of people who have knowledge in that area.
— Ontario 09

Finally, service providers report that most refugees have little or no experience of formal therapy or mental health services as in the Western medical tradition, but they do have their own cultural views of mental health that that service providers need to understand.

Many clients come from cultures that know nothing about what we do, but they have their own wisdoms, of course. And so we listen, we look at what they do, we encourage them or help them, even, to find supports in their community, if there is somebody who can help support their cultural way of healing.
– Manitoba 03

Not many North American trained counselors have ever had to have the language bridged. We are trying all the time to get a multi-lingual counselor but that is a pretty hard thing to find, because we are very aware that the best way to deliver mental health services is in first language, because then you are using the terms that someone would recognize. I mean, as we banter out our mental health jargon, I am sure we are throwing out all kinds of terms that people have never even heard of … When we are talking about therapeutic counseling, we are still only looking at things from a Western diagnostic model, and we need to incorporate others.
– Alberta 02

Agencies

There is no simple dividing line between the agency and individual employees. Some of the promising practices which are categorized at the agency level may be the work of one or two individuals. The practices below are ones which agencies as a whole can often apply. Each promising practice includes examples with some quotes from the study participants.

Fostering strategic partnerships

While settlement agencies do the best job possible, sometimes under severe resource limitations, the care of refugees goes beyond one sector. Settlement agencies need not take on the task unsupported. Settlement agencies often described what they do in the context of the agencies that they work with.

Fostering strategic partnerships was a theme throughout the study, and it is the foundation of many other promising practices at the agency level. Three examples of strategic partners are illustrated below:

A specific faculty or faculty member of a local university

In Windsor, fifth-year Ph.D. students in counselling psychology at the University of Windsor provide one-to-one trauma counseling to clients from the local settlement agency. By the time these doctoral students are in their final year, they have already completed practice on campus, and have elected to do a further practicum with refugee clients. As part of their course-work for this practicum, the students receive training in working with interpreters and in providing trauma therapy, as well as ongoing clinical supervision from their professor and support from their peers. This new partnership has

been very well received by the agency, refugee clients, the Ph.D. students, and the faculty alike. The settlement agency reports,

> *The first year was AMAZING, and this second year, apart from maybe some attendance problems, with our clients, it also went excellently.*
> – Ontario 15

A specific service provider from a health or mental health agency

This form of partnership is quite common, though the stability and formality of the collaboration differs. There are many examples from across Canada that could illustrate this promising practice.

> *Oh, my god!—it was one week, and another, and another week of pregnancies. So we started to see there was a need of sexual health education. We contacted the Public Health Sexual Health Clinic, and now we have a monthly sexual health workshop, not only for the Karens but for everyone.*
> – Ontario 14

> *Apart from these direct services, from these [vulnerable] group services, we do offer in terms of emotional support, we do offer regular workshops, usually for specific ethnic groups. For example, to deal with alcoholism, to deal with AIDS, if we have clients who have AIDS. We call the AIDS Society of Windsor, and they deliver workshops for them. Or, later on, they deliver very intensive one-on-one services with them, too.*
> – Ontario 15

A Clinical Social Worker who works for a family counseling agency describes her work and relationship with the reception house.

> *What I'm actually doing now is that—I think this is the most ABSOLUTELY ideal situation. [My agency] is LITERALLY in the BACK YARD of Reception Centre. Part of my "hat," while Clinical Social Worker, I'm also Community Developer… so I believe in forging partnerships. I used to work in an immigrant settlement agency, and I'm also a controversial person who doesn't believe that immigrant serving agencies are the SOLE provider of all things. I think that there NEEDS to be strategic partnerships, especially in this day of limited resources and funding. So, I literally walk through the parking lot, through the grass, every Tuesday morning, and I go into Reception Centre, and I do clinical counseling, 1 on 1, with the refugees, right there. It's THEIR context, it's THEIR location, it's THEIR familiarity.*
> – Ontario 01

An agency with a broader human services or protection mandate

Human service agencies often form relationships with one another in response to a local need. These relationships may end when the need is no longer there. The quality and structure of each relationship is unique, and this example of a service provider in Ottawa is just one of many:

The Karen refugees who were resettled in Ottawa came with many challenges, and some believed rumours circulating in the refugee camps that their children would be taken away from them upon arriving in Canada. The settlement agency formed a reciprocal training program with the local Children's Aid Society (or CAS, referred to as Child Welfare or Child Protection in some provinces). A settlement worker in Ottawa explained how the relationship was initiated, and how it has evolved:

> *There are a lot of issues… It could be traumas because of the war, because of persecution, spousal abuse, you name it. But there are a lot of kids who we needed to get seriously involved with. This started escalating at some point, and we didn't want to have the kids taken away by CAS, because it would become a more stressful situation for the parents. Then we thought, "how can we do it?" So we contacted them, and they didn't know much about the type of clientele that we were serving in our program.*
>
> *… We called CAS and they invited us at some point to do some staff training for them. They were so pleased. We had about twenty different departments involved and they were pleased to know who we are and who the clientele are that we serve. So then THEY CAME to deliver information from them to us, to OUR staff.*
>
> *… And then we came up with a coordinated series of workshops that we are going to start soon. The workshops are to explain to the new refugees who CAS is. It is not take their kids away only but they will do it in serious situations. As well, they are to support you if you have teenagers with bad behaviours, you know with problems with discipline, things like that. They can provide [support] or they can send you to different programs that they have.*
> – Ontario 14

The final section of this report offers suggestions on how settlement agencies can form partnerships with health and mental health providers, ideally to the benefit of both. In doing so, the goals of service bridging and achieving some of the promising practices may be accomplished.

Using the reception house as a hub

A second promising practice at the agency level is specific to the cities or towns that have a reception house (sometimes called a welcome house or reception centre) for Government Assisted Refugees (GARs). However, this promising practice is not exclusively directed to those agencies that run the reception house.

The services and "feel" of reception houses vary, and some agencies provide many different services within one building. Sometimes the people who work in the reception house are paid by different employers, but residents may experience the interactions with different service providers as more "seamless." Services available can include:
- Physical health screening and ongoing primary care
- Social workers, counsellors and psychiatrists

- Pre-and post-natal care
- ESL conversation classes

In some places, GAR clients are welcome to continue to go to the reception house after they have moved out. This often works best in smaller cities, where clients will be able to get to the reception house easily, without having to pay too much for public transit.

We probably have about five General Practitioners. They all work irregular hours, depending on their own schedule. …They're actually physically housed in the centre [the reception house] here, but they jump in their own cars, and they drive over here and they would work in the clinic during that time. That same model applied to a lot of our specialists. We have a pediatric specialist, an obstetrician/gynecologist, a psychiatrist.

Those individuals would be coming for just a brief moment in time during that week, to help out. Our psychiatrist, for example, comes for one full day each week. That's FANTASTIC for us, it really really is. We have very conventional models outside of the clinic service, which we would describe as more health prevention and promotion. … For example, we have a post-partum session for new mothers every Monday, and they help to support us in that endeavor. I think it's a very healthy collaboration. So we have that kind of a model. At different times of the day, you'll see different individuals sitting in different places around here.
        – Alberta 03

Serving clients where they live or settle

In larger cities, and in ones with complicated transit systems, another promising practice is to go to where the refugees live, rather than ask them to go a single site. The affordable housing where refugees often live may be poorly served by public transit, and zoned transit fares may make accessing a centrally-located agency prohibitively expensive, especially for larger families. The challenge is to offer the full range of services that they would receive in a central location.

In Winnipeg, we have Neighbourhood Immigrant Settlement Workers who are connected to specific geographical areas of the city. One of the things that we do at our agency is that when one of our clients move into one of those neighbourhoods, we try to facilitate a meeting with the worker in that area so that the client can benefit from the services provided by that worker in the community. They do not lose the contact with us but we talk together about what the progress has been for the client, what the needs might be, and what that particular neighbourhood worker might be able to offer that client. So we have a bit of a hand-off there. Similarly, in some of the schools, there are people kind of like the SWIS [Settlement Workers in Schools] program in [Ontario]. We also work very closely with those people as kids go into the schools.
        – Manitoba 02

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Promising Practices and Partnership Building Resources

Providing intensive, consistent and predictable service

Because they have already experienced so much stress, refugees need predictability and consistency in their settlement support. Refugees may prefer the same person to pick them up from the airport, bring them to the reception house, help them find an apartment, and support them in the upcoming months and years when they still need help. Not all programs are able to provide the intensive, consistent and predictable services that they would like, but the ones who are able to find that is the best way to work with refugees.

> *Through the front-line staff coordination we can assure to the best or our ability that clients are seen — they don't fall through the cracks — and we can better help clients navigate the system from behind the scenes, versus them being tossed around to various providers. 'Cos we have taken the time to create systems and tools to help us coordinate what we're doing for clients. So it's very client-centered in that regard.*
> – British Columbia 03

A settlement manager in Ontario describes the Health component of a systematic program for Government Assisted Refugees who are resettled in this smaller city:

> *[The health program] is also one of our big successes. It's very intensive. It's almost like case management, but only under health services. We offer information about their health conditions, if they have any specific health conditions. We offer escorts to medical appointments. We offer interpreters at medical appointments. We offer consistency AND predictability in medical services. I think that's the most important thing with Government Assisted Refugees: They want consistency and predictability. So, what happened before, with ISAP, when they offered health services, they would tell them, for example, "Okay, I've got an appointment for you. Go to this and this address." Well, unfortunately, many of my clients do not know, even after a year or two, how to take a bus to that address. They're afraid to take a bus, because they have previous issues with transportation in the country of refuge, or they have a fear of [domestic] people… it's another issue.*
> – Ontario 15

Training and reaching out to mainstream service providers

This promising practice is about increasing the ability of non-settlement providers to work with refugees and other vulnerable newcomers. Ways to do this involve training university students who will become practitioners in the future; collaborating with other human service agencies, and advocating for mainstream health and mental health services to do a better job of working with refugees.

Some agencies have been actively involved in training medical, nursing, counselling, and social work students. The students may do a practicum or course work at the settlement

agency or in the reception house, while they are supervised by their professors. In Newfoundland, a resettlement agency explains their partnership with the local university, Memorial University of Newfoundland (MUN):

> *We also have a partnership with the Memorial University medical school, and that project is called the Gateway Project. It's a wonderful partnership, because MUN medical students have the chance to interview and take a full medical history for newcomer families or individuals. Then, they match new clients with a family doctor, and then forward the medical history. So this is kind of a streamlined entry into the medical system with a GP, because the medical students can take MORE TIME to do a full medical history. They can take maybe an hour and a half to talk with the family, whereas sometimes family doctors either don't have the time, aren't interested, or are reluctant to take that amount of time to a full, in-depth history.*
> *– Newfoundland 02*

Another strategy is to actively support mainstream medical and social service providers to be more "culturally competent". Strategies include offering formal consultation and case reviews to mainstream agencies, hosting workshops and seminars, and providing "brokers" or liaisons to work more closely with them.

A further outreach strategy, often borne of desperation, is pushing mainstream providers to not use the settlement sector or agency as a "dumping ground" for clients/patients that they are not serving well. This often involves advocating for clients' needs, and making it very clear to other service providers what the limitations are of the settlement agency. A service provider in New Brunswick explains:

> *Our past immigration was mostly from England, Scotland…so White English-speaking Canadians. Even though New Brunswick is officially a bilingual province, French and English, Fredericton is not as French as English. So French is there but it's kind of a minority. So really there is a huge culture shock for people when they come here. And it's also that the service providers are not used to working with diversity. Most of the service providing organizations here, if you look at the mental health clinic, they have no capacity to serve people in different languages…. They don't have a budget to pay for interpreters if they need it. There's no acknowledgement that there is need for services in other languages than French or English. If somebody arrives and they don't speak English or French, if they need to be seen by either any health care professional or any other service that we have in our community, we, as service providing organizations have to accompany them and help with the translation. And if we don't do that, if we don't go all the way, then we see that our clients will suffer.*
>
> *So, we make it clear for service providing organizations that it is not our job to provide interpretation once our clients access their services. Once we take somebody to the emergency room and we take them with an interpreter or, if it's their first time, we show them how to get there, we make it clear that it's not our mandate and we don't have funds, we don't have resources to continue providing this interpretation service. Once they are in the health care system, we would rather the health care system*

take that on because we don't want to replace any of the
services, we just want to enhance them. We want to make sure
that there is acknowledgement of this community.
— New Brunswick 02

Tailoring services to clients' evolving needs

As different refugee populations are supported to come to Canada, agencies may periodically need to adjust their services and delivery model to better meet their clients needs.

I think we should customize our services to our clientele. There
are immigrants who come with higher education, and who do not
need more systematic service, right? But my clients, I feel,
would benefit from a system. That system would include, yes,
everyday LINC classes, but that would actually incorporate
something that, for example, gives them information about their
health. How to manage their health, how to STAY healthy in
Canada. About their MENTAL HEALTH.

…What we as a team came up with is that Pre-LINC concept. It
IS focused on language, but not entirely. It's also settlement
teaching. With that you actually achieve two things: they do
learn English, but on the other hand, they do also learn some
settlement skills, some personal skills, like what is emotional
wellbeing, things like that. That was our idea. And incorporated
into that, we also thought about Pre-ISAP. ISAP is very general;
they only inform and refer, so they don't offer very intensive
support. What we thought that our clients need, because of their
background, they need a Pre-ISAP program that would offer
more intensive settlement services, more intensive escorting,
interpretation. ISAP does not do escorting, and most of the time
they don't even do interpretation.
— Ontario 15

Flexibility in administration

Procedures that agencies have developed may not work well with some client groups, and the ability for staff to be flexible in the execution of administration is a promising practice.

A number of agencies have worked to eliminate the barrier of a form-based intake procedure. In some cases, individual employees are permitted to not use forms with their particular clients, while in others, special programs have been developed which address conventional administrative barriers.

While such an idea may seem intuitive and commonplace for settlement agencies, this practice may be novel and need management support and sponsorship at "mainstream" and mental health agencies. A manager at a mental health agency in Manitoba describes how they came to create a program specifically for refugees and immigrants:

_____ 23

We just were realizing at some point that … a lot of the people who live in the area [of the agency] were not coming to see us. So we started looking at how we could change our services, to make them more appropriate and accepted by immigrant and refugee populations. We realized, we need to make a lot of changes. And, as a result of those changes, we developed a special program. … Some of the changes we made, included the different intake procedure where – in our general agency, the client has to call, nobody can call for you, you have to call and they will send you the forms, you fill out the forms, and once we receive the forms the therapist gets assigned and then you go from there. With the immigrant program, that procedure doesn't work. So anybody can call. And most of our clients come through referrals. So anybody can call for the client, as long as they have their permission to phone
        – Manitoba 03

Often, proactive programming is required, as another service provider described:

I think the issue that we were all facing was that we had kids in temporary accommodation and did not have any programming for them. Part of the struggle was that the temporary accommodation was right downtown and there were quite a few efforts on the part of gang members and others to recruit these kids right out of the front porch, so-to-speak. And we thought there had to be a better welcoming committee. {laughs} So that is where it came from.
        – Manitoba 02

Flexibility in service delivery: Alternative healing and social support

Participants in this study echo scientific literature which argues that psychotherapy is premised on Western values that often do not translate across cultures. Cross-cultural evidence supports the use of healing practices that do not rely exclusively on talk-based therapeutic encounters with single individuals, but rather include families and communities. "Alternative" modalities used by study participants include visual art therapy, drumming, choral singing, leisure activities and social gatherings. Settlement and mental health professionals agree that alternative healing modalities should be available. Extending healing practices and enhancing community social supports has also proven successful, because these prevent mental health problems and enable problem solving.

In settlement agencies there needs to be more support for the group stuff that actually consciously facilitates building community,… because it is the lack of community in our minds that is actually hindering progress on a number of fronts. It would be great to see more of that, because that will support larger aims and will keep depression at bay. If you can do that, then you have better health.
        – Ontario 07

Don't stay isolated. … When they connect with their own community, it makes it much better. You see when people start going to mass or Spanish or they join the choir or they join dance, whatever the group, they have some kind of connection, people to talk to, to have fun. If they are afraid of meeting their community, that makes it more difficult. It depends … but if they don't isolate, and they start connecting with the community, things change.
          – Ontario 10

Things like peer support groups; capacity building training for youth leaders… we have a number of programmes that are capacity building, that train immigrant women, refugee women, youth, to go back in their community to facilitate peer support groups and other activities, that we would consider as part of the informal mental health system.
          – British Columbia 04

As many service providers have said, simply being with other people, and not necessarily with the intent of engaging in a "healing" practice, is itself therapeutic. Some settlement agencies feel that hosting social activities is as important to refugees' wellbeing as any formal program that they offer.

We had a group of forty or fifty Somalis. They had been living in, if I am not mistaken, in an Eritrean camp for fourteen years…. Sometimes it becomes difficult …to gain trust. We've been successful. We called all the different Somali ethnic organizations …we all got together…. We managed the issue pretty well. We met, shared experiences, and together we are trying to find solutions, one by one. Things are working pretty well, not perfectly, but really well.
          – Ontario 14

When we realized that, that we can't just open this can of worms and leave it unaddressed, we started focusing more on the educational part, on self-help. Together with Victim Services, we organized two group sessions, and that was our first effort in that direction. One was for Somali women who suffered some kind of trauma or torture or rape… We had two Somali women's groups: one was for younger, one was for older women.
          – Ontario 15

We also have a Somali Fathers' group that has been meeting for about 10 years now. Most of them don't express their feelings and this is manifested in the way they behave and they have relationship issues…. We were trying to go from the perception of how the migration is affecting their fatherhood, their parenting role. From there, there were a lot of discussions and questions. They, themselves, decided to have a group that meets and supports the community.
          – Ontario 12

We are going to a new initiative called Mom to Mom Mentor and Companionship. This is for new mothers that are coming in the country. They don't know how the health system works, they don't know about where to take the babies. So we have a mentor that is a mother that will accompany her, and these are our volunteers….. People need parenting training, they might

need psycho-educational [support]…if it is an issue that they are not ready to talk about on an individual basis but they can do in groups, we would like to have some therapeutic groups and some groups for youths…. So our new approach would be towards community building.
          – Ontario 09

Every year I do trainings for the Immigrant Services Society. They have the group called Cross-Cultural Peer Support Group. They train women from different ethnic communities to be group facilitators. One of the parts of the curriculum is learning about mental health and mental illness. That's very good. You cannot imagine – the groups are amazing. Because they are women from different countries who come with so much education, they are really resources to their communities. …I present, but also I open the time for questions. They have so many good questions about mental health, mental illness, how do deal with this… This type of training session is really valuable. It's also good to give them some written materials.
          – British Columbia 05

An initiative in Edmonton combines these principles. Staff in the language instruction, family literacy and child minding services started a choir with their clients, which grew out of the family literacy program. This program includes some singing activities, where parents are taught children's songs in English. Since its inception, this choir has grown to welcome clients of all ages (the youngest member is three years old!), and ones who were never participants in the original family literacy program.

As the choir has received invitations to perform all over the city and province, staff have noticed a remarkable improvement in some of their clients. They report that clients/ choir members are less isolated, more confident and have an increased ability to meet their own basic needs. Some have formed deep friendships, whereas previously they were isolated and somewhat despondent. The language and family literacy instructors report that some clients come from oral cultures that lack a written form, and they were having a great deal of difficulty in their ESL class.

These clients have increased their basic literacy skills and comprehension of literacy principles through being in the choir, because they wanted to teach their new friends songs from their own culture: suddenly, there was a tangible immediate need to communicate with written form, which was largely abstract before. While the choir was never intended as a therapeutic intervention, staff have no hesitancy is saying that it has had that effect.

Having Easily Accessible Mental Health Services and Professionals

Many agencies are very busy places, and central sites may host many programs, with staff on and off-site in ways that can feel irregular to clients. Clients often talk to whomever they are working with and may not know how professional roles are divided, and who is "supposed to" take care of their specific needs. It is important for all staff to

be able to provide a minimum level of emotional support; some staff may require training and ongoing mentoring to do so.

> *Para-counseling means that we would listen to their concerns, and sort be their "pin-cushion," if I can say it that way. We would NEVER try to counsel them; we would automatically refer them on.*
> — British Columbia 03

> *What would be ideal would be to have a position like mine, in each of the centres--let's say attached to the SWIS or one attached to the refugee centre – [to offer] consultation on individual cases. A person that the settlement worker could come to and say" I have this family that I am working with, here is the story and what do you think, what should I be doing, what should I be looking out for, what do they mean when they say this?" This is quite different from pulling out a pamphlet and looking at what PTSD is because, it is not as PERSONAL I know the SWIS workers in the schools really look forward to the meeting I have with them once a month. It would be nice if we can have more than that.*
> — British Columbia 06

Dedicated Mental Health Support for Clients

Where it is not possible to provide dedicated mental health workers for clients, agencies can enter into partnership with one another. These partnerships can be via informal networks and communities of practice, or very formalized contractual relationships.

> *Sometimes we get a heads-up. We had a family moving here, they had a 19-year old son living with schizophrenia. We were able to connect him very quickly here with a mental health worker, connecting him with self-help resources. His English wasn't bad. Connected him with a psychiatrist immediately.*
> — Manitoba 01

In Vancouver, a consortium of five agencies has been formed to provide the Refugee Trauma Program. Participants in the consortium include the Bridge Clinic, where refugees can receive primary and secondary care, and the Vancouver Association for Survivors of Torture, where a holistic model of social and emotional support is used. The consortium is led by Immigrant Settlement Services of British Columbia (ISS BC), who provide the coordination services to all the consortium members, including Settlement Organization Services (SOS) and Family Services of Greater Vancouver. ISS BC also runs the reception centre in Vancouver, so all incoming GARs are able to access the various health and mental health supports that each of the agencies operates independently as part of the Refugee Trauma Program.

<u>Support for Non-Mental Health Staff</u>

Training should be available for part time and contract staff, particularly for those agencies who mainly employ part time workers to deliver services. The better trained all staff are to handle clients needs, the better clients will be served.

> *Another thing we've done were workshops for service providers about war trauma. So, even though they cannot provide trauma therapy, we provided them with some basic skills about what they can do, what not to do. What they can talk about. How they can be helpful? How they shouldn't really probe and ask questions… So, some really basic stuff about how to talk to trauma survivors. …open to all sorts of service providers who came; it was a one-day workshop. And then we did a large workshop that 140 attended; we brought in people who provide training in self-regulation therapy, and the workshop was specifically focused on war and survivors of war and political violence.*
> — Manitoba 03

However, "training" is not a one-time event. Staff need on-going support, particularly staff who work with refugees and vulnerable clients, and especially if they do not have a background in counselling, therapy, social work, or something similar. These workers may need on-going support in order to prevent vicarious trauma, that is, being so deeply affected by their clients' stories that it is difficult for them to work. Vicarious trauma may lead staff to burn out and leave the agency, which compromises the predictability and consistency of the care that refugee clients receive.

On Vancouver Island, a child and youth counsellor who works for a regional health authority does much of her work in schools and wherever youth feel comfortable meeting with her. The therapist has provided some formal training to SWIS workers, but she also provides informal support and mentorship. The SWIS workers are invited to go to her when they are working with a child or family whose needs they are struggling with. There have been a few cases where the support that the therapist has offered the SWIS workers has resulted in issues being resolved before they became problems severe enough to warrant a referral to the therapist. In these cases, the SWIS workers have benefited by increasing their skills through informal on-the-job learning, and they have become more confident in handling such situations independently.

Training Needs and Suggestions

Settlement workers can benefit from formal and on-the job training to recognize the mental health and emotional wellbeing needs of their clients, how to make referrals and identify existing resources, and how to alleviate their clients' stress. Health and mental health workers can benefit from pre-service and in-service training on cross-cultural communications and culturally competent practice. Participants in the Refugee Mental Health Practices study identified both the specific topics that settlement workers might need to learn, and the preferred ways to provide training.

Training needs and suggestions for settlement workers

Participants identified that settlement workers could benefit from learning specific clinical skills, management skills, and general information.

Clinical Skills
- Recognize signs of posttraumatic stress and depression
- Counteract the stigma of mental health; this stigma may be on the part of refugee clients, settlement workers, or both
- Deal with panic attacks in clients
- Recognize and reduce the risk of suicide
- Develop skills in informal/ supportive counselling

Management Skills
- Share inter-professional practices and knowledge
- Share cases and engage in case management with more than one service provider
- Develop protocols (or standard rules) for the agency when they work with refugees who are in crisis
- Find and access mental health resources for clients

General information
- The mental health system: how it works, who works in it, and what they do
- Parenting, the law and child discipline
- The pre-migration living conditions and life experiences of refugees

Challenges to training settlement workers

The current professional development opportunities that are available to settlement workers (e.g. ISAP conferences) often only support the attendance of full time staff. Some agencies employ large numbers of part time and contract staff who cannot attend, but who could benefit from training.

Because there is currently no set of minimum standards or certification body, settlement workers have different levels of familiarity with the issues. Thus, no training should be rigid or take a "one size fits all" approach.

Training needs and suggestions for health and mental health workers

Suggestions in this section come from the participants of the Refugee Mental Health Practices study. Some of these participants are themselves health or mental health workers; however, most are settlement workers (including managers and directors) who offered opinions about what health and mental health professionals can do to better serve refugee clients.

Health care providers and institutions should:
- Engage in outreach to refugee communities
- Work to expand their interpretation resources
- Enhance their cultural competence skills

Mental health care providers and institutions should:
- Learn about refugee mental health issues
- Learn about the circumstances of clients' countries of origin, and where to find this information
- Improve provision of culturally appropriate care
- Enhance cultural competence skills

Two additional recommendations to expand refugee mental health practice, capacities and cultural competencies include:
- Train refugees who are more settled to be peer mental health workers or navigators
- Involve more professionals with trauma expertise

Delivery preferences

The consensus is that the ideal form of training would be personal and interactive, with tele- and video-conferencing as acceptable methods. There is resistance to using exclusively print and DVD-based instruction, though these are welcome in the absence of other resources. Settlement workers want content that is:
- Problem-based and applied (i.e. based on needs of participants)
- Targeted to the needs of a particular location, in preference to generic conferences

Additional delivery considerations include:
- Providing training and resources that are free or moderately priced
- Using materials that are practical and applied, rather than overly theoretical
- Incorporating different learning styles
- Allowing time for participants to ask questions
- Providing materials in lay language (i.e. not clinical)
- Avoiding exclusive reliance on books, manuals and DVDs
- Inviting visiting experts to smaller, more remote places to train staff
- Training and conference support that is extended to part-time workers as well as full time staff

Part 2: Putting the Findings to Work

Resources to Address the Mental Health Needs of Refugees

This section presents some of the common situations that settlement workers may encounter in working with refugees, and resources. The suggestions for ways to deal with these problems come from service providing organizations across Canada, and from mental health-related resources that are widely available. This document cannot provide comprehensive professional knowledge, nor can a printed guide teach skills such as counselling that are often acquired through supervised practice. **Appendix 4** is a list of on-line resources and courses that are available Canada-wide. Some of the print resources are in multiple languages, which settlement counsellors can print for their clients.

These resources should be considered introductory, as a starting point for further professional training and development, and are neither complete nor conclusive. Some suggestions may not be appropriate for all contexts.

When in doubt about how to respond to a client who is experiencing emotional distress, consult with more experienced colleagues, mental health professionals and/or knowledgeable service providers who are part the client's cultural community.

Sources for pre-arrival information

Agencies receiving RAP funding to work with Government Assisted Refugees in the early stages of their resettlement wish to know more *personal* information about their in-coming clients, in order to put in place any specialized psychosocial supports, and to best match clients with counsellors. It is recommended that service providers be in touch with the CIC matching centre to request more detailed information on incoming GARs.

Settlement providers may also wish to know about the pre-settlement conditions of refugee populations. The following resources, which are updated regularly, could be consulted.

UNHCR: The UN Refugee Agency (UNHCR)
www.unhcr.org

International Organization for Migration (IOM)
www.iom.int

CIA World Factbook
https://www.cia.gov/library/publications/the-world-factbook/

The CIA World Factbook offers basic background information on the political and social history and geography about the country or region.

What to do when...

This section outlines some concerns settlement workers report that they see most frequently in their work with refugees and information about ways which they have found are helpful in responding to those concerns. Please note that this is not an exhaustive list. A more complete list and description of the resources referred to here can be found in **Appendix 4**, "Other resources".

Common concern: **Client does not directly express mental health needs, or the "culture" of mental health is different.**

How to help: Try to understand different idioms of distress that the client may use to express mental distress indirectly. For example, service providers have reported hearing clients say that they have a 'heavy heart,' a 'heart that hurts,' a 'mind full of troubles', or that 'it is difficult to sleep'. Talking about what this means to the client can be helpful. It builds rapport, conveys to the client that you understand what they are saying, and specifies understanding of the need. It also helps model a vocabulary for the client to use in Canada, to advocate for their needs.

Understanding the context and the nuances of the refugee's culture enables more competent service delivery. It is important to consider the refugee's cultural perspectives on mental health and illness. For example, what may be considered a sign of good mental health in the Western context (e.g. individual independence) may not be in others. Similarly, how people express and cope with distress varies by culture. For overviews of cultural considerations in mental health service delivery, the following sources can be helpful:

- The chapter "Mental Health Practice" (Lo and Pottinger 2006), in *The Healthcare Professional's Guide to Clinical Cultural Competence* (pp 247-263),
- *Asking for Help When Things are Not Right* (2-page fact sheet for clients, available in 17 languages).

Common concern: **Client feels mental health is less important than other concerns or that mental distress cannot be helped.**

How to help: Service providers reported multiple barriers to identifying the need for mental health services. First, the types of services or supports available are not always explained to the client. It takes time to build trust and establish familiarity with the Canadian service delivery model. It can be helpful to explain to clients the ways that they can be helped, the resources that are available, and the range of services that they can access. The booklet *Asking for Help When Things are Not Right* is a 2-page fact sheet for clients, available in 17 languages, and can be used as part of a supportive conversation.

Second, refugees may not prioritize mental health. For example, service providers noted that refugees tend to pay more attention to 'here and now' and to immediate settlement needs than on resolving the past or planning for the future. They also noted that refugees may express preference for relying on spiritual resources rather than individual

therapy, or traditional medicine rather than pharmaceuticals. Each of these considerations is relevant to addressing any client's psychosocial needs.

Third, refugees' historical, political, social, and spiritual experiences are important. A person's customary help-seeking behaviours and beliefs about and responses to sickness should be considered in this context. The additional resources provided above may be helpful in this regard.

Common concern: Social isolation or lack of like-ethnic community

How to help: Find out if the client knows people from his or her own cultural community locally who can provide social support. If there is no cultural match, ask the client what involvement they do have in the local community that provides social support, and which people in the community they can trust. Phone calls to distant relatives and friends can provide support, but be sure the client is aware of how long-distance phone costs can be difficult to manage. Inform clients about confidential formal professional services that are available, should they be desired or needed in the future.

Social support is vital to prevent isolation and mental distress. Continue to follow up with clients if they miss appointments; check in with telephone calls even if there is no appointment scheduled. Extend invitations to community events (whether from the agency or more broadly in the community), and encourage the client to participate in English language-learning programs. Ensure services are easy to attend, and 'friendly' in delivery: This can include providing transportation assistance, or accompanying clients to events or activities. It could also include creating programming at the agency or in the community where language and a common culture are not needed, for example artistic expression groups, choirs, or informal sport activities. The booklet *Alone in Canada: 21 Ways to Make it Better* may be helpful (available in 18 languages).

Common concern: Sadness

How to help: Being homesick is not a mental illness, but serious mental distress may develop. Be aware of changes in clients. Learn to recognize signs that may indicate bigger problems, such as depression, which can co-exist with post-traumatic stress: sleeping too much, sleeping too little, changes in eating patterns, irritability, withdrawal or a loss of interest in activities that they previously enjoyed. *Asking for Help When Things are Not Right* may be helpful to walk through with a client (2-page factsheet, available in 17 languages); also the guide *Depressive Illness: A Guide for People with Depression and their Families* (28-pages, English) may be helpful for workers who want to learn more about depression.

Some service providers reported that clients felt despondent to the point of considering suicide. Concerns about suicide must be addressed promptly. Immediate assistance is available at 1-800-SUICIDE, or, for service according to region, a Canada-wide list may be accessed at the Centre for Suicide Prevention at http://www.suicideinfo.ca. Services for children and youth are available through www.kidshelpphone.ca or 1-800-668-6868. A helpful English resource for workers, *Coping with Suicidal Thoughts* (Simon Fraser University, 2007) can be downloaded here.

Common concern: **Fear / Worry**

How to help: Many fears and worries are normal responses to adversity. Be aware of the refugee's history as much as possible, including political and social contexts, for both the individual refugee and his or her immediate family. These contexts may shape the refugee's help-seeking behaviour and responses.

Service providers reported seeing four major areas of fear and worry in refugees. Understanding each of these concerns is both important and relevant in any service delivery.

First, service providers noted refugees were frequently worried due to the uncertainty of their immigration status. The waiting process in a refugee claim can be lengthy, preventing stability in settlement. To help address the worry about uncertainty in status, service providers reported it essential to provide links or partnerships to legal services specializing in immigration law, as well as explain all the steps the refugee may expect throughout the legal process. Service providers also noted that having translators accompany refugees to appointments for legal services was very helpful.

Second, clients experience high levels of fear and worry for family members left behind in their country of origin. To help address family concerns, connect the client with social supports. Assist the client with his or her participation in community events, social programs and activities. Encourage engagement in creative pursuits, continued meditation, or spiritual commitments to their present (Canadian) community.

Third, there may be fear of institutions or organizations in general. In places where there have been repressive regimes, fear could have resulted from previous encounters with bureaucracy. Service providers noted that a refugee client may in some instances be hesitant, reluctant, or mistrustful of receiving services because of the personal information that is sometimes required to open a client file. It may thus be helpful to spend time transparently discussing, explaining, and reviewing reasons behind any agency interventions, referrals, or supports.

Last, many people stigmatize mental illness and newcomers are no exception. Many refugees fear being thought of as 'crazy', or being isolated from their communities, if they request or receive mental health services. The brochure noted above, *Asking for Help When Things are Not Right,* may also be helpful here (2-page fact sheet, available in 17 languages).

Common concern: **Changed family dynamics.**

How to help: Ask families about their values, gender roles and expectations and discuss how these may differ in Canada from their countries of origin. Spouses may have to rely on one another more in Canada in the absence of extended family; parents may also experience stress in their partnership with having to negotiate multiple responsibilities. Consult with the School Settlement Worker about stressors that youth may be facing in the classroom: these may include adjusting to learning in a new language, peer pressures that are likely different than those experienced before, and having had some interruptions in schooling.

Additionally, children who have more fluency in English than their parents often face some reversal of responsibility in needing to act as translator or mediator. As much as possible, provide translators who are not friends or family members; this will help ease pressures that may affect or contribute to the changes in dynamics, or permit discussion with less tension about the changes. Work with the entire family, rather than just one or some of the members.

Common concern: **Anger from unmet expectations.**

How to help: Talk to the client about their expectations, hopes, and achievements. Help the client identify where they have had success since arriving, what challenges remain, and the areas where they can make plans and set goals. Focus on where the client has demonstrated resiliency or strength. Approaches such as strengths-based therapy may be helpful. For those moments of loss or perceived failure, work with the client on strategies for coping with the accompanying stress and anger; also encourage the client to engage in creative outlets, or activities that they enjoy.

Common concern: **Developing addictions or gambling problems**

The following CAMH brochures have useful information and links on understanding responses to drugs, alcohol, and gambling, including self-assessment tests, substance-specific brochures, and ways families can help.
Understanding Addiction (17 languages)
Problem Gambling (16 languages)
Coping with Stress (19 languages)

Common concern: **Lack of activities for children and youth**

How to help: Contact agencies that provide recreation and leisure activities in your area: for example, YMCA, YWCA, Public Libraries, and departments of Parks and Recreation. Find out if services exist for low-income families or if there are foundations that can support children's participation in after school, weekend and summer leisure and social activities. Service providers reported that sometimes clients did not feel they could participate or were entitled to participate in these community activities, so informing the client that these services are available to them might be helpful.

See also Active Healthy Kids Canada, http://www.activehealthykids.ca/ : There is a "Provincial/Territorial Pages" link on the website, with promising strategies and resources that are available across Canada.

Using Knowledge-sharing Events to Form Partnerships

The following section of the guide is about bringing together the promising practices and the training needs in such a way so that strong, lasting partnerships can be formed amongst settlement, health and mental health agencies. The goal of the partnerships is to create structures so that refugees receive comprehensive, seamless services. In **Appendix 1**, you will find an example of a workshop plan, and **Appendices 2 and 3** are resources that can be distributed to participants at your own, locally-produced events.

Knowledge-sharing events speak to some of the following promising practices:
- Fostering strategic partnerships
- Training and reaching out to mainstream service providers
- Having easily accessible mental health services and professionals

In designing local events, the organizing team could consider how the other promising practices could also be integrated.

What is a knowledge-sharing event?

It is an opportunity for experts in different fields and sectors to learn from one another.

Examples include the following:
- a one or two-day long conference. A small number of people present to a larger audience
- a one or two-day long fair. A larger number of people are stationary at tables or in rooms, and other participants are free to walk around at their own pace and talk to people
- seminars or meetings on the same afternoon every week, or on the same afternoon every month (such as on the last Friday of every month). These could be for a defined period (such as 3 months) or on-going
- presentations on the work of one agency, which are made at the staff meetings of other agencies
- interactive presentations on the work of one agency or on a particular topic, offered at a specific time, on the internet (sometimes called "webinars").

What is important is that these are *events*: they are occasions when people gather, have the opportunity to meet (electronically in the case of the last example), talk, ask questions and learn about the other people and the work they do.

No format of a knowledge-sharing events (or series of events) is "right" or "wrong." Each has many variables to consider. Some knowledge-sharing events offer more opportunities for informal interactions than others. Small-scale meetings and seminars can be less intimidating than conferences. Some settlement workers rarely attend conferences, and might feel uncomfortable sharing what they know in that setting, even though they are experts that other professionals can learn from! In remote communities that have well-established distance-learning facilities, people may feel quite comfortable using internet technologies to learn about other people; in a large city, workers might

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benefit more from having a calmer, low-tech interaction with professionals whom they are meeting for the first time.

Every agency and professional network must independently decide what will work best for them, using whatever resources are available.

In **Appendix 1**, you will find an example of a knowledge-sharing event. This 2.5 hour workshop assumes that settlement workers are the first line of support for one another, and helps to define what the specific training needs are of the workers who are present. The appendix includes a plan for the first session, suggestions for facilitation and an invitation letter for guest speakers.

<u>Why host knowledge sharing events?</u>

In the Refugee Mental Health Practices study, settlement and mental health workers repeated the belief that the mental health system needs to become more "culturally competent," and that settlement workers have limits to what they can provide. Local knowledge sharing events can help to foster strategic partnerships, and increase the skills of both settlement and mental health workers.

1. Because settlement workers can learn from each other

Settlement staff need to feel supported by their peers and their agency, particularly those staff who do not have a background in the mental health professions and who work with more emotionally troubled newcomers. The informal support that settlement staff can offer each other is as important as learning new things, and may help prevent burnout.

2. Because settlement workers can learn from mental health workers

Settlement workers do an excellent job in working with refugees and newcomers in general. However, there are some roles for which they often have received little training or support. These include working with refugees' complex emotional needs, for example, understanding what can emotionally trigger their clients, and how to react when a client has been triggered. Some settlement workers were refugees themselves, and find themselves re-living their own difficult past when their clients need their support. There is no denying that settlement workers can often benefit from training and being formally supported by mental health professionals.

As a service provider in New Brunswick said, "We've had clients who have threatened suicide, and we all have university degrees, but we don't have any experience with that kind of thing."

3. Because mental health workers can learn from settlement workers

There exists a whole system of social service and mental health professionals, people who are trained to work with people who have complex emotional needs. This includes social workers, clinical counsellors and therapists, psychologists and psychiatrists. However, these professionals may not have had any experience working with refugees. There may also be administrative barriers to refugees seeking professional mental health

support, for example refusing to take referrals by a third-party, or not knowing how to work through an interpreter.

A knowledge-sharing event, or series of events, is intended to bridge these two worlds. Both sectors are experts in what they do, and if they can learn from one another, two important things can happen:
- Professionals from both sectors may learn things that help them serve refugees better
- Relationships can develop which bridge the sectors, and allow for clients to receive more holistic and integrated care.

Suggested goals and timelines

Knowledge sharing events are intended to serve both a pragmatic, immediate function, as well as a longer term, strategic function. In the short term, professionals are brought together, and learn new skills and information that results in improved service delivery. In the longer term, partnerships are formed across sectors, so that all refugee clients and patients can experience service and care which is as seamless as possible. The following goals and timelines are suggestions for local organizers to consider.

Short-term goals (6-18 months)
- form a local partnership, network or a coalition of people who work with refugees
- define what your staff and refugee clients need from mental health service providers
- research what local mental health service providers could learn from settlement workers about working with refugees
- decide on a knowledge-sharing project to work on together
- apply for funding to support the knowledge-sharing activities your group has decided on
- start organizing this event or series of events

Medium-term goals (1-3 years)
- host knowledge-sharing events with staff from settlement agencies (including part time staff who may not always be supported to go to these kinds of events) and health and mental health workers
- evaluate the events, for example, what was learned and what more needs to be learned
- decide if more or ongoing knowledge-sharing events are needed
- provide opportunities for the participants from different sectors to stay connected

Long term goals (2 years +)
- continue to provide opportunities for the participants from different sectors to stay connected
- strategize on ways to ensure that the informal relationships become sustainable (for example, so that the partnership will not break off if one person leaves the agency) so that local agencies and service providers can provide more holistic and integrated services for their refugee clients or patients.

Organizing a knowledge sharing event

This section addresses some of the logistical and conceptual questions around creating knowledge sharing events that meet the specific needs of workers in your agency or area.

Who should organize the knowledge sharing event(s)?

The first decision to make is whether training or knowledge-sharing events should happen within one settlement agency, or be for the staff of many agencies. This section assumes the latter. An example of a smaller scale training program, primarily for staff within one agency, is provided in **Appendix 1.**

Local and regional networks of immigrant service providers already exist in many areas. Some are formal, such as the Communities of Practice in the Prairies, and the Local Immigration Partnerships in Ontario, while informal connections exist between service providing agencies everywhere. If agencies wish to create larger knowledge sharing opportunities with one another and with the mental health sector, then a few members of these networks can form a local organizing committee. Where they exist, a provincial umbrella agency or council might be able to support the local efforts.

How can the event(s) be funded?

Settlement workers and agencies would not be able to attend events that involve considerable cost. Organizers can consider government and foundation funding, donations from private companies, and a sliding scale registration fee.

Government funding

Citizenship and Immigration Canada has been changing the way it supports settlement programs, through its "modernized framework." One of the objectives is to "foster partnerships and the participation of municipal, community and private stakeholders in immigration."[1] One of the "streams" of this new approach is Program/ Policy Development, where possible activities include:

- Conferences and consultations
- Development of curriculum and assessment tools
- Development of online resources and capacity for training
- Professional development for service providers
- Training and capacity building
- Partnership development for planning and program/service development and implementation[2]

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[1] Ontario Ministry of Citizenship and Immigration: *Modernizing Settlement: Working in CIC's New Outcomes and Stream Approach 2009*

[2] Citizenship and Immigration Canada: *Settlement Program: Implementation of the Modernized Approach (for External Stakeholders)*, Fall 2009

The Modernized Approach accepts proposals that are jointly written by more than one agency or applicant, and a recent House of Commons report, *Best Practices in Settlement Services*, recommended CIC prioritize such proposals.[3]

The federal and provincial ministries of citizenship are not the only source of government funding. Some partner organizations may be well-placed to apply for funding from municipal, provincial and federal ministries and departments of health, public health, training and adult education.

Private sector funding

Approaching the private sector for funding may seem non-traditional for settlement agencies. Yet, private sector businesses may very willing to support some events. For example, in Calgary, a one-day event for knowledge sharing around multicultural health was funded in part by a pharmaceutical company, so that attendance fees were kept very moderate. While it was a "health" event, mental health and emotional wellbeing needs were well-represented.

For-profit agencies may be able to donate resources, make in-kind contributions (for example, around project management, or printing costs) or financial donations, and may be happy to be approached. Larger private sector companies often have a charitable foundation and community engagement departments that can help facilitate accessing and using the funding.

What could knowledge exchange look like? Who could deliver training?

Knowledge exchange and knowledge sharing does not mean that there needs to be a defined instructor or trainer. But, it may be a place to start, so that relationships can be formed between a few key individuals, which could then grow into more stable inter-sectoral relationships.

This section presents some options for training that is directed towards either settlement or mental health workers, and concludes with options on how the two sets of professionals can teach one another

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[3] Standing Committee On Citizenship And Immigration: *Best Practices In Settlement Services: Report of the Standing Committee On Citizenship And Immigration*, March 2010

Teaching settlement workers about mental health

Some options and cost consideration are given in the table below.

Cost	Training Option
0	*Self-directed reading with group facilitation* Similar to a journal or book club, participants could select, read and discuss some of the resources linked to this document, in the **Other Resources** document in **Appendix 4** or from the **Literature Review**, **Appendix 5.**
0 to $	*Mental health professional who works for a local agency* Staff from, for example, the local Canadian Mental Health Association (CMHA), a health centre, or a government unit may be able to deliver standard or personalized workshops as part of the community work that they do.
0 to $$	*Instructor from a local college or university* There may be instructors in translation, social work, child development, or other topics that settlement staff would benefit from learning about. Contact the community relations department of your local colleges and universities to learn about these options.
$ to $$	*Professional trainers* Some trainers deliver "off the shelf" workshops and course, such as with Mental Health First Aid Canada. Some can create workshops on topics of interest to local settlement staff, for example, on compassion fatigue and self-care.

Teaching mental health workers about refugees

Participants in the Refugee Mental Health Practices study were clear in their feelings that health and mental health workers, in general, can learn more about serving refugees and ethnically diverse groups. Medical and nursing students across Canada may already be receiving some of this information in their training, but long-time practitioners also need to be targeted. Settlement agencies may be able to support the training and professional development of clinicians, at little or no cost to the agency.

An advantage of doing knowledge exchange with health and mental health professionals is that their regulatory bodies usually require them to participate in professional development activities on a regular basis, and the infrastructure to deliver the PD is often well-established. The challenge can be making the right connections. Consider

using the following activities:

- Offer tours and workshops to students from local faculties of medicine, nursing and social work;
- Offer the agency's services as consultants to mainstream services, when they are working with clients whose needs are not being met because of cultural hurdles. Some provinces now allow nonprofit charities to engage in such revenue-generating activities.
- Request the inclusion of refugee health and mental health at local Continuing Medical Education (CME) events; learn how additional CME credits can be granted for health and mental health workers to attend tours and workshops on site at the settlement agency.

Mental health and settlement workers teaching one another

This could take the form of health fairs, conferences and regular series of workshops. There may be more cost, administration and work involved in organizing them, but they can also bring together people who wouldn't normally meet. If this is the direction that is decided upon, then consider having some informal networking opportunities within the events.

Events could be administered by:
- Agency staff combining paid and in-kind labour
- Placement students and interns working under supervision
- Professional event organizers (likely only for larger events and multi-day conferences)

Appendices

Appendix 1: Example of a Settlement Worker-Directed Training Program

Introduction and Overview

This example training program is based on the assumption that some settlement workers already know about local mental health resources and strategies for working with clients in distress, and can serve as a first line of support for their colleagues. Time and space is allocated for one or two facilitated initial sessions to elicit successful strategies for working with refugee clients who need more support, and to define what additional training is required. Subsequent sessions would bring together settlement and mental health workers.

Duration

The number of sessions is not defined at the outset, but is to be agreed to by the training sponsor and by settlement workers. The number of sessions can be defined by:
- stated needs of the settlement workers who are present
- availability of local mental health professionals who can present on the desired topics
- ability and desire of settlement workers to engage in self-directed reading
- time and space that training sponsors are able to obtain for training purposes.

Facilitation

This program assumes that there is one facilitator, perhaps two. The facilitator may be an administrator or an adult educator from within the organization, or a consultant and trainer retained for the training. The training starts by making explicit what the participants already know. The first session involves little preparation, and is designed to provide a scope and definition for subsequent sessions. Following the first session, external mental health professionals are invited to present on specific topics. These presentations should meet the needs that the providers themselves have identified

Pedagogy

The pedagogy consists of a mixture of more didactic presentations, question and answer, opportunities for self-reflection, and problem-based learning. Mental health professionals are invited to make presentations, engage in question and answer sessions, and do problem-based learning activities with the settlement workers. The

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problem-based learning activities are case studies that have been written or presented by the settlement workers.

Invitation Letter

The sample letter which follows the "Day 1" material is one that you are welcome to use and adapt. This letter is more for mental health professionals who are presenting about the work that they do, or that their agency does, rather than professionals who are teaching a particular skill (for example, dealing with panic attacks) or providing region-specific information (such as children, youth and the school system).

Day 1

Time: Approximately 2.5 hours

Goals:
1. To orient participants to the concept of mental health
2. To share local resources and successful strategies
3. To share mental health-related difficulties that participants have encountered, in particular when working with refugee clients
4. To discuss and define some of the more concrete skills and longer-term strategies that participants would like further instruction in.

Materials Needed:
- Flip-chart paper and/ or white or black board
- Paper or notebook for each participant.

Task 1	Introductions
Time	10-20 minutes (depending on the size of the group)
Actions	The facilitator can introduce her/himself to the group, if she/he is previously unknown to them.
	State the purpose of the session: • To talk about the mental health and emotional wellbeing needs of clients and refugees in particular. • To define what training or further information the assembled group would like to have
	The facilitator can use any standard ice-breaker or introduction activity they prefer.

Task 2	Define multiple meanings of "mental health"
Time	20 minutes
Actions	Ask participants to discuss what the term "mental health" means to them.
	Ask what meanings they know it to have in different cultures.
	Discuss ways that conflicting understandings of the term may have an impact on clients that they work with.
	Present the World Health Organization's definition of "health", and discuss: **"A state of complete physical, mental and social well-being, and not merely the absence of disease"**
	As part of this discussion, the WHO's definition of "mental health" can be invoked: **"Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."**

Task 3	Discuss examples of mental health needs among refugee clients
Time	20 minutes
Actions	Ask participants to elaborate on any stories that came up in Task 1, regarding clients' mental health needs
	As a group, create a list (on a large piece of paper or on the white/ black board) of the mental health needs of refugee clients
	The facilitator may wish to add to this list, using the *Findings* section (Part 1) of the Refugee Mental Health Practices report.

Task 4	Defining one's own skills and needs in working with refugee clients
Time	20 minutes
Actions	Ask each participant to privately create their own list of the topics from Task 2, grouping them under the headings: "I think I can handle this on my own" "I need some support in handling this" and "I need a lot of support in handling this."
	Ask participants to volunteer particular topics from their lists, and discuss them, only if they are comfortable doing so. The facilitator may wish to be the first one to start this example.

Task 5	Where to get support, locally
Time	30 minutes
Actions	Using the list created in Task 2, make it into a table with two additional columns, titled "who can help with this problem, locally" and "how they have helped."
	Ask participants to volunteer the specific agencies and individuals that they have connected with in order to address that specific problem.
	Ask those who have worked with the agencies or individuals mentioned to give concrete examples of how clients have been helped, and if they do or do not have any concerns about referring to them again.
	For any mental health needs where participants do not know a local support, place a "*****" or "**?**"

Task 6	Defining what the group would like to learn more about
Time	30 minutes
Actions	Start a new list or table, entitled "To learn more about" (or something similar)
	Use the items marked with a * or ? to start the new list.
	Ask participants if there are other items they would like added to the list.
	Tell participants that in a study done of settlement workers across Canada, they identified a number of topics that they would like to learn about. Read (or distribute or post) the list of topics, and ask if any of them are ones that they would like added to the list in development.
	Topics
	- Refugee process, both for claimants and GARs - Who does what in the mental health professions - Refugees and trauma - Social and environmental factors affecting the mental health of

refugees
- Isolation and depression
- Panic and anxiety attacks
- Parenting and changes in family dynamics
- Children, youth, the law and the school system
- Working with an interpreter/ Working as an interpreter
- Care for settlement workers

Task 7	Creating case studies
Time	5 minutes in the session + 10-30 minutes outside of the session
Actions	Tell participants that in subsequent training, we will address some of their stated needs and will engage in detailed discussion of particular problems.
	Each participant is requested—but not required—to write a short (1/2 to 2 pages) story from their experience. The story, or "case study," should be about a time that they struggled to help a client or a group of clients. They should leave out any specific identifying information, such as proper names, but include as much information as possible so that everyone else understands the problem. Describe the problems, what you could and could not do, and any personal feelings you had about the situation.
	These case studies can be written down, and emailed to the facilitator if possible, within a specified period of time.

Task 8	Wrapping up
Time	5-10 minutes
Actions	Define future activities: guest speakers will be sought out to present on the topics that were identified today.
	The speakers will be asked to present on their agency and services they offer, or on the specific skills strategies and knowledge that were identified today. At the end of each presentation, there will be opportunity to engage in questions and answer and to have a detailed discussion on one of the case studies.
	Distribute (hard copy or email) some of the resources in the Refugee Mental Health Practices guide, as requested or relevant

Information Letter for Guest Speakers from Mental Health Agencies

Date
Agency Contact Information

Dear_____:

Thank you for agreeing to participate in our training! This two-page letter will provide you with some information about who you are presenting to, the kind of information we are requesting, and how you will be participating in our training.

What is this training program about?

The settlement workers at our agency are receiving training to increase their comfort in addressing their refugee and newcomer clients' mental health and emotional wellbeing concerns. We will learn about topics such as:
- The social and environmental factors that affect the mental health of refugees
- The refugee process, for both claimants and Government Assisted Refugees (GARs)
- Refugees and trauma: recognizing the signs and referring appropriately

… and others!

Who are the participants in this training session?

Participants include:
- Settlement counsellors. Their role is to support newcomers in finding housing and jobs, enrolling their children in school, and helping them integrate into their new community.
- SWIS (Settlement Workers in Schools) program workers.
- English as a Second Language (ESL) instructors.
- Other people who support newcomers' wellbeing and integration.

Some of the participants will have professional designations such as Social Worker, Social Services Worker, Psychologist or Medical Doctor, either from Canada or from their country of origin. Other participants may need a more comprehensive introduction to how mental health services are organized and offered.

How will I be participating in their training?

During the training, please prepare to do the following:
1. Give a 30-minute presentation on your agency and the work that you do there
2. Answer questions about you and your agency
3. Sit down with participants after your presentation, and engage in small groups problem solving and case study activities.

These activities will take **90 minutes in total.**

After the training, you are encouraged to take what you have learned from the training and participants, and incorporate that into your work by:
- Taking client referrals from the participants and the agencies they come from
- Considering ways that your agency and its practices can be more responsive to the needs of specific newcomers, and newcomer communities in general

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Refugee Mental Health:
Promising Practices and Partnership Building Resources

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What kind of information should I provide in the 30-minute presentation?

Please answer the following questions in your presentation:
1. General information about your agency, and who is served there
2. General information about your role
3. What services—if any—does your agency offer for ethno-racial minority groups? For women? For senior? For children and youth?
4. What does "making a referral" to your agency entail?
   a. What is the step-by-step administrative process?
   b. What does the referral and admission process look like for new clients?
   c. What expectation does your agency have about communicating with the person or agency that initially referred a client?
5. Are there waiting lists? How long are they? Are waiting lists managed in any particular way?

Please end your presentation by asking participants the following questions:
1. Did you know about our services before today?
2. Have you ever thought about referring your clients to a service such as the one I am here talking about today?
3. If you have referred, were there any questions or comments you had about how our centre/ service has worked with refugee and other newcomer clients?
4. What are ways that our centre/ service could become more responsive to the needs of your clients?

What is the case study activity at the end? Why am I being asked to participate in it?

Our settlement staff have lots of experience working with newcomers, but sometimes have been challenged by the complex emotional needs of our clients. Participants in this training have been asked to submit a personal story about a client or a family that they have worked with, where they were uncertain about what to do, or how to best work the client or the family.

The case study exercise is an opportunity for you, the mental health professional, to learn more about the work that the settlement staff are doing, and to help one another find creative strategies for working with refugee clients who have complex needs.

What happens after the training?

We hope that we can stay connected with you and your agency. We hope that our relationship with you and your agency can continue beyond training or education, so that we can work together to bridge the gaps that our clients face when they need mental health and social support services.

Thank you for agreeing to participate in our educational events, and we look forward to see you on *date,* at *time*, at *location.*

Sincerely,

Agency contact person/ group

Appendix 2: Who does what in the mental health professions: A quick reference guide

Type of professional who helps[1]	Credential / Designation	Level of Education	Qualified to Administer:			Where do they work?	Qualifying body?	Cost?	Local service providers
			Medication	Diagnosis	Treatment[2]				
Psychiatrist	MD	Medical	✓	✓	✓	Hospitals; Private practice.	Royal College of Physicians & Surgeons of Canada (RCPSC)	None[3]. Requires referral by Doctor / Legal Aid.	
Psychologist	Dpsy / PhD / Cpsych	Doctoral	✗	✓	✓	Hospitals; Private practice; Broadly in the community.	Canadian Psychological Association (CPA)	None / Sliding scale[4].	
Chaplain	CCP	Master's	✗	✗	✓	Broadly in the community.	Canadian Association for Pastoral Practice and Education (CAPPE)	None.	
Counsellor	CCC	Master's	✗	✗	✓	Broadly in the community.	Canadian Counselling and Psychotherapy Association (CCPA)	None / Sliding scale.	
Psychological Associate	Psych Ass.	Master's	✗	✗[5]	✓	Broadly in the community.	Canadian Psychological Association (CPA)	None / Sliding scale.	
Social Worker	BSW / MSW / RSW	Bachelor / Master's	✗	✗	✓	Broadly in the community.	Canadian Association of Social Workers (CASW)	None / Sliding scale.	
Therapist / Psychotherapist	CCC or other	Usually Master's	✗	✗	✓	Broadly in the community.	Canadian Counselling and Psychotherapy Association (CCPA)	None / Sliding scale.	
Community leader	Varies	Varies	✗	✗	✗	Broadly in the community.	None / Varies	None.	

NOTES & TERMS:

1. The authors would like to thank Dr. Lisa Andermann, the Parkdale Community Legal Clinic, the Parkdale Intercultural Association, and the Toronto Catholic District SchoolBoard: Settlement Workers for their assistance, feedback, and review of this document.

2. Treatment:
Each professional who 'treats' may do so differently, through a variety of methods or techniques. These vary not so much by profession, as the individual professional. They may include, but are not limited to:

Theoretical orientation	Kinds of techniques used	Kinds of meeting formats
cognitive	art	Couple
cognitive-behavioural	behavioural modification	Dyad (for example, Parent-child; Siblings)
existential	dream analysis	Family
family	expressive modalities	Group
gestalt	meditation	Individual
group	music	
humanist	play	
psychoanalytic	pscyhoeducation	
psychodynamic	self-assessment	
psychoeducational	talk / verbal	
strength-based		
systems		

3. Psychiatric services: Referrals are required to cover payment for psychiatric services, either by a GP or the client's family doctor, or by Legal Aid
(if writing a refugee report for the hearing).

4. Sliding scale": Fees generally depend on the client's income; this is called a "sliding scale". Sliding scales may range anywhere from $40 per session to $150 per session, or higher. There is no set sliding scale.

5. A **Psychological Associate** may diagnose a mental health condition (such as anxiety, depression, learning difficulty, PTSD) when supervised by a licensed, registered Psychologist.

"Broadly in the community": This category may include Community organisations, Health clinics, Schools, Prisons, Settlement organisations, Specialised police or court units, and / or Places of worship.

Appendix 3: Who does what in the settlement sector: A quick reference guide

Title	What they do? / How they can help?	Where do they work?	How do I refer to them?	Is there a cost?
Life Skills Worker	They help refugees learn to how to live in Canada, for example ▪ Basic cultural information ▪ Living in a Western-style home (how to use the kitchen, do laundry, etc.) ▪ Using the bus system ▪ Going grocery shopping Life Skills Workers can also apply for services on the refugee's behalf.	They are employed by settlement agencies, but their work place includes the homes of refugees, libraries, grocery stores, etc.	Call: settlement agency	No. All Government Assisted Refugees have access to life skills workers, although some may need more support
Settlement Counsellor	They connect newcomers up with the more complex services that they need, for example: ▪ Opening a bank accounts ▪ Getting a health card ▪ Enrolling children in school They also provide information, make referrals, and can interpret.	They are employed by settlement agencies, and usually work in an office.	Call: settlement agencies	No.
Settlement Worker in Schools (SWIS)	They can be a liaison between teachers, principles and newcomer children and parents. They can support newcomer families, and perhaps counsel them on how the school system works	They are employed by settlement agencies. They can work in an office at the settlement agency or school, and also in places that youngsters and parents are comfortable talking, such as the school library or cafeteria.	Call: The child's school and ask to speak with a settlement worker OR: Call settlement agencies.	No.

Health Broker/ Liaison	They provide a human link between agencies and institutions. They can help bridge not only linguistic barriers, but also the cultural ones that may prevent newcomers from getting the care that they need.	Varies. In some places, they have their own agency. In others, they are employed by settlement agencies or community-level health clinics.	It depends on if your city/ region even *has* them. Contact a settlement agency and your regional health authority. The later are in better the position to fund and support brokers/ liaisons.	Some regional health authorities cover their costs
Medical Interpreter	They can interpret for patients when they are being seen by a health provider with they do not share a common language. Some medical interpreters also provide *cultural interpretation*, which can assist the care-giver to know how better to bridge the cultural gaps between her or himself and the patient.	Varies. Some are employed by: ▪ settlement agencies ▪ interpretation firms ▪ hospitals	It depends on if your city/ region even *has* them. Contact a settlement agency and your regional health authority. The later are in better the position to fund and support medical interpreters.	Some regional health authorities subscribe to medical interpreter services offered by agencies over the telephone. *Enquire if this exists in your region.*

Appendix 4: Other Mental Health Resources and Courses

Links active and material accurate as of November, 2010.

Centre for Addiction and Mental Health (CAMH)
www.camh.net

CAMH is Canada's largest mental health and addiction teaching hospital.
Brochures of interest available on the CAMH website include: Posttraumatic Stress and refugees, and an article from Cross Currents magazine on trauma in refugee children.

CAMH materials are available in a number of languages, including:

English	French	Amharic	Chinese	Farsi
Greek	Hindi	Italian	Polish	Portuguese
Punjabi	Serbian	Somali	Spanish	Tagalog
Tamil	Urdu	Vietnamese		

@ http://www.camh.net/About_Addiction_Mental_Health/Multilingual_Resources/index.html

Other information available for download on the CAMH website includes:

- Addiction
- Alone in Canada
- Depression
- Immigrant women
- Post-traumatic stress

- Aggression in children
- Anxiety
- Drugs and pregnancy
- Mood problems
- Psychosis

- Alcohol
- Dementia
- Drugs and youth
- Post-partum depression
- Sexual orientation

Alone in Canada: 21 Ways to Make it Better
http://www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/alone_in_canada.html

A publication / self-help guide for single newcomers to Canada, about adapting to life alone in a new country. Available in the following languages:

Arabic	Bengali	Chinese	Dari	English
Farsi	French	Hindi	Korean	Punjabi
Russian	Serbian	Somali	Spanish	Tagalog
Tamil	Twi	Urdu		

Culture Counts: Best Practices in Community Education in Mental Health and Addiction with Ethnoracial/ Ethnocultural Communities
http://www.camh.net/About_CAMH/Health_Promotion/Community_Health_Promotion/Best_Practice_MHYouth/Culture_Counts/index.html

"Culture Counts" is a guide about alcohol use in ethno-cultural minority communities. Download the brochure *Low-risk Drinking Guidelines* in the following languages:

Polish	Portuguese	Punjabi
Russian	Tamil	Serbian

CAMH KnowledgeX portal
http://knowledgex.camh.net/Pages/default.aspx

Online tutorials for anyone who wants to learn more about mental health and addiction topics, including:
- Stigma of mental health
- Mother-daughter relationships (Audio recording)
- How to stop smoking

Canadian Council for Refugees http://www.ccrweb.ca The Canadian Council for Refugees is a non-governmental organization committed to the rights and protection of refugees, and to the settlement of refugees and immigrants in Canada.	Conseil canadien pour les réfugiés Canadian Council for Refugees

Settlement.org
http://www.settlement.org

This website provides answers to common questions about moving to Ontario and settling into your new home in Canada. This website offers useful, practical information in a number of languages, including:

Amharic	Arabic	Bengali	Chinese (Simplified)	Chinese (Traditional)
Croatian	Dari	Farsi	French	German
Greek	Gujarati	Hindi	Hungarian	Italian
Korean	Pashto	Pilipino (Tagalog)	Polish	Portuguese
Punjabi	Romanian	Russian	Serbian	Somali
Spanish	Tamil	Turkish	Ukrainian	Urdu
Vietnamese				

Click here for a listing of settlement services in provinces / territories across Canada.

Centre for Refugee Studies
http://www.yorku.ca/crs

A research hub and educational institute for researchers, students, service providers and policy makers concerned about refugee and forced migration issues. Publishes **Refuge**, a journal of research on refugee issues.

The Canadian Centre for Victims of Torture
http://ccvt.org

The Canadian Centre for Victims of Torture aids survivors in overcoming the lasting effects of torture and war. Publications of interest available on the CCVT website include the annual publication First Light; The Trauma of Exile and Resettlement; and Befriending: Creating a Therapeutic Bond with the Community.

Integration-Net
http://integration-net.ca

Integration-Net is a communications, information and research tool to support the work of settlement agencies across Canada.

Mental Health First Aid Canada
http://www.mentalhealthfirstaid.ca

Provides courses throughout Canada on how to help someone developing a mental health problem or experiencing a mental health crisis. Available in French and in English.

Diversity in Action
http://www.psychologyfoundation.org/diversityinaction.php

A project developing new ways for service providers to help newcomer children and their families receive better mental health services.

Fédération des familles et amis de la personne atteinte de maladie mentale
http://www.ffapamm.qc.ca

La Fédération des familles et amis de la personne atteinte de maladie mentale est un réseau québécois dédié au mieux-être des membres de l'entourage d'une personne atteinte de maladie mentale.

Here to Help BC
http://www.heretohelp.bc.ca

This website provides a number of resources on common mental health difficulties, available in multiple languages including:

Arabic	Simplified Chinese	Traditional Chinese	English	Farsi (Persian)/ Dari
French	Korean	Punjabi	Russian	Spanish
Japanese	Vietnamese			

Health information translations
Quality translations in multiple languages

Health Information Translations
http://www.healthinfotranslations.com

Health information on a number of health subjects, including cancer, head lice, and stress, translated in the following languages:

American Sign Language	Arabic	Bosnian	Chinese Simplified
Chinese Traditional	English	French	Hindi
Japanese	Korean	Marshallese	Portugese Brazillian
Russian	Somali	Spanish	Tagalog
Ukranian	Vietnamese		

Best Start
www.beststart.ca

Best Start is a newborn and early childhood development Resource Centre in Ontario. Information on maternal health and parenting is available in the following languages:

Arabic	Bengali	Simplified Chinese	Traditional Chinese	Cree - N Dialect
English	Farsi	Filipino	French	Greek
Hindi	Italian	Korean	Polish	Portuguese
Punjabi	Russian	Severn Ojibwe	Somali	Spanish
Tagalog	Tamil	Urdu		

Mothercraft
www.mothercraft.ca

Mothercraft provides information and direct services for parents and families, and child care providers in healthy child development.

Minnesota's Refugee Health Program
http://www.health.state.mn.us/refugee

This website offers screening tools, resources for health care providers, and links to online-learning specific to refugee issues. Some resources are available in Spanish,

Problem Gambling.ca
http://www.problemgambling.ca

Information for people who may have a problem with gambling, and for professionals. A Translated Resources page offers a number of resources in languages including:

Arabic	English	Cambodian	Chinese
Dari	Farsi	French	Greek
Hindi	Italian	Korean	Macedonian
Pashto	Polish	Portuguese	Punjabi
Russian	Serbian	Somali	Spanish
Tagalog	Tamil	Ukrainian	Urdu
Vietnamese			

Appendix 5: Literature Review

Forthcoming in <u>Canadian Issues</u>, Special Issue on Immigrant Mental Health, July 2010

Title:
A Review of the International Literature on Refugee Mental Health Practices

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Biljana Vasilevska is the research coordinator of the Refugee Mental Health Practices study.
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Abstract:

This article is a summary of the literature review for the Refugee Mental Health Practices study. The goal of the study is to fill the gap in empirical research on services that are available for refugees to Canada which supports their mental health, emotional wellbeing, resiliency and recovery. The review is organized according to themes relating to three levels: the individual (refugees); the level of social systems (medical care and service provision), and policy-level decision-making.

A Review of the International Literature on Refugee Mental Health Practices

Since 2000, Canada has supported the resettlement of approximately 7,500 refugees annually. With the introduction of the Immigrant and Refugee Protection Act (*IRPA*) in 2002, the criteria for eligibility for government-assisted resettlement softened to give greater consideration of refugees' needs. With less emphasis being placed on their ability to integrate quickly, "many refugees now have different settlement needs that include special requirements arising from years of trauma or torture followed by years in camps"(Pressé & Thomson, 2007).

The mental health of refugees has received more attention in the academic literature than have studies of refugee economic integration, social identity or adaptation (Ryan, Dooley, & Benson, 2008). While there is some existing data on the mental health concerns and needs of refugees, there is a greater gap in empirical research on mental health services for refugees in Canada (Yu, Ouellet, & Warmington, 2007). This article is a brief summary of a literature review from the Refugee Mental Health Practices study, a project which seeks to fill this gap in empirical research.[1] The review is organized according to themes relating to three levels: the individual (refugees); the level of social systems (medical care and service provision), and policy-level decision-making.

Refugee-Level Themes

Explanatory Models

Recent work has sought to understand how refugees and other ethno-minority groups conceptualize and express emotional distress and how these cultural conceptions may differ from the Western medical perspective or vocabulary. Studies have sought to understand the gaps between clients and mental health services, and how differences may be bridged. Arthur Kleinman's concept of *explanatory models* [EMs] is heavily invoked in this literature. Explanatory models are "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process. …The study of the interaction between practitioner EMs and patient EMs offers a more precise analysis of problems in clinical communication" (Kleinman, 1980). Mental health professionals who work with refugee clients must be aware of differences in explanatory models, that is, notions of cause, course and treatment for mental distress.

Conceptual Models of *Health* and *Care*

The Western or *biomedical* model of health care is understood to be one where the client, as an individual, seeks professional care. The professional may have no other relationship with the client than that of diagnosis and treatment, and the relationship is unidirectional: the patient changes, while the medical practitioner goes about her or his work. It is important to bear in mind that the biomedical explanation of health and illness, which is common to Canadian and many other medical professionals in the Western tradition, is itself an explanatory model, one which may not be comprehensible to all clients, particularly refugees

who are also ethno-cultural minorities (Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006).

In many traditional cultures, the model of care emphasizes the connection of self and one's community, with a preference for social forms of intervention when mental health support is needed. The interconnectedness of self and society is taken to be axiomatic; therefore, responsibility for care of the individual rests with the family or community. *Psycho-social* or *social-ecological* models of health care are conceptual frameworks for understanding the health of individuals within society and include social determinants of mental health, such as income, social support, employment, housing, and education (Public Health Agency of Canada, 2005; World Health Organisation, 2001) .

Among Southeast Asian refugees, the most important factors contributing to positive mental health in the post-migration period were being in a stable, significant personal relationship, and having stable employment (Beiser, 1999). Having ethnic or ethnic-like community supported mental wellbeing initially, but was not necessarily supportive in the long term. An interactional model is put forth to explain the more complex relationships between an individual and social resources that contribute to mental health (Beiser, 1999).

Trauma Discourse

Many refugee mental health studies have sought to determine the prevalence of Post Traumatic Stress Disorder (PTSD) and other mental illnesses. Meta analyses of research findings on the extent of trauma and emotional distress and associated social factors in specific refugee populations is presented in Table 1.

Table 1: Results of Meta-Analyses

Reference	Total Articles	Total Refugees	Key Findings and Conclusions
Mental Health Status in Refugees: An Integrative Review of Current Research (Keyes, 2000)	n = 12	n = 2,065	▪ At least one negative mental health state present in populations studied ▪ Only one-third of studies used culturally sensitive measurement instruments ▪ Psychological concerns *and* physical complaints present in all the studies that used culturally sensitive diagnostic tools
Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis (Porter & Haslam, 2005)	n= 56	n = 22,221 refugees and 45,073 non refugees	▪ Post-migration economic, social and housing conditions influenced mental health. ▪ Worse outcomes experienced by refugees living in institutional accommodation and experiencing restricted economic opportunity. ▪ Refugees who were older, more educated, female, had higher pre-displacement socioeconomic status and rural residence also had worse outcomes.

Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review (Fazel, Wheeler, & Danesh, 2005)	n=20	n= 6,743	▪ 9% to 11% of refugees resettled in Western countries were diagnosed with post-traumatic stress disorder (PTSD). ▪ 4 % of resettled refugees experienced a generalized anxiety disorder, and about 5% suffered from major depression.

Concern has been expressed about the lack of culturally sensitive diagnostic tools used in academic studies (Keyes, 2000). Moreover, the application of the concept of PTSD to refugees and other marginalized communities has been challenged for pathologizing individual responses to events which often have a social and political origin (Bracken, Giller, & Summerfield, 1995; Burstow, 2005; Friedman & Jaranson, 1994).

While medical care for acute mental disorders should be available upon resettlement, refugees' psycho-social needs must also be addressed. As Porter and Haslam (2005) suggest, humanitarian efforts to improve the post-migration social and material experiences of refugees would likely have a positive influence on mental health outcomes.

Social Support

Support networks are known to protect refugee mental health, and resettled refugees in Canada may engage in seemingly counter-intuitive secondary migration in order to be nearer to family and their own ethno-cultural community (Simich, 2003; Simich, Beiser, & Mawani, 2003). Qualitative data show that the affirmation of shared experiences through community-level support is a strong determinant of refugee wellbeing (Beiser, Simich, & Pandalangat, 2003; Simich et al., 2003). These findings corroborate epidemiological data showing that post-migration conditions matter to refugee mental health (Fazel et al., 2005; Porter & Haslam, 2005).

Refugee or ethno-cultural communities may not have the capacity to address acute mental illnesses without the help of medical professionals, yet they may be well-equipped to support mental wellbeing and prevent emotional distress. Programs in Canada (Li, Koch, & Angelow, 2008) and in the United States (Weine et al., 2003) have sought to formally encourage social support through multi-family group-therapy types of programs. Some agencies match clients with volunteers in a befriending program or foster mutual supports groups with a goal of breaking down isolation (Canadian Centre for Victims of Torture, 2009). Many formal programs are offered through settlement and social service agencies, which do not often have the capacity to engage in evaluation and reporting of their activities. Therefore there is a need for more empirical research.

Systems-Level Themes

Program Accessibility and Barriers

Refugees face many barriers to accessing mental health services, both in Canada and internationally. In Canada, the challenge is in part due to the difficulty of finding culturally appropriate care and the lack of interpretation services in the health care system in general (Gagnon, 2002; Scheppers et al., 2006; White, 2008). Similar under-usage of health services has been found by ethnic minorities in other industrialized Western nations (Chow, Jaffee, & Snowden, 2003; Guerin, Abdi, & Geurin, 2003; Scheppers et al., 2006; Ten Have & Bijl, 1999). While mental health service providers in Canada are working to eliminate systems level barriers, perceptions of barriers may persist. Perceived accessibility of a service influences attitudes towards seeking help. If the perception of access to mental health services is improved through outreach programs, then more refugees and ethnocultural minorities may be encouraged to use services (Fung & Wong, 2007).

Ingleby (2009) puts forth three components to accessing services: entitlement to care (a question of legality and status), ease of accessibility, and the level of trust one has in a service and expectation of positive results (Ingleby, 2009). Scheppers and colleagues categorize barriers to services according to a three-level model of interaction: patient level, provider level, and system level (Scheppers et al., 2006). While differently directed, both models emphasize a dynamic and systemic understanding of access and barrier, rather than focusing on the individual in need of care.

Models of Service Delivery

A number of approaches and models of service delivery have been described. These include inductive models based on the qualitative input of clients and service providers, a model of a specific service or program being piloted, and broad approaches or schools of thought which influence service provision. Ingleby and Watters (2005) use the following groupings: mainstream health care approaches; multicultural health care approaches; sociological health care approaches; managed care, and service provision which has been influenced by the users' movement.

Currently in Canada, there is a focus on client-centred care, which should include refugees and ethno-cultural minorities. Ryan, Dooley and Benson (Ryan et al., 2008) advocate a *resource-based model*, in which resources are personal, material or social. Services premised on such a model would acknowledge that refugees are not passive victims of trauma; they are active survivors in a new environment which affects their mental health and adaptation as well (Birman et al., 2008; Birman & Tran, 2008) Services that capitalize on refugees' resources should be considered in future policy and programming decisions.

Bridging Primary Care and Mental Health

The importance of bridging primary care and mental health systems is underscored often by the World Health Organization (World Health Organisation and World Organization of Family Doctors (Wonca), 2008; World Health Organization, 2009). Upon arrival in Canada, refugees' primary health care needs often have not been met for many years, and it is through primary care that most refugees experience their first contact with the Canadian medical system. Mental health concerns are often raised in primary care settings, in the context of dealing with physical problems. Headaches, fatigue, difficulty sleeping, and difficulty breathing are physical complaints that may be expressions of psychological disturbances (Patel, 2002; Summerfield, 2005).

To increase capacity in primary care settings to better work with clients from diverse cultures, holistic, anthropological perspectives may aid in medical training and practice (Gozdziak, 2004; Kleinman, 1980). Some practitioners have promoted the need for recognizing the roles of spirituality (Collins, 2008; Mollica, Cui, McInnes, & Massagli, 2002) and the family (Stepakoff et al., 2006) in refugee mental health care. Given the barriers refugees and ethno-cultural minority groups face when accessing mental health services, some initiatives have sought to bridge services from multiple sectors, including mental health and social services, and to foster informal, community supports. Success has been demonstrated in programs that bridge gaps among services and build the internal capacity of agencies to better work with cultural minority clients (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003; Yeung et al., 2004).

Policy-Level Themes

Lack of Policy

The World Health Organization's 2001 Annual Report, "Mental Health: New Understanding, New Hope," states that most countries do not have a national mental health policy. This statement applies to Canada, with different levels and breadth of service coverage across the country, compounded by a lack of policy to address the needs of low English/French proficiency clients (Abraham & Rahman, 2008). There has been movement towards filling this gap in recent years. The consultation activities of the new Mental Health Commission and publication of a discussion paper on Ontario's mental health care strategy (Ontario Ministry of Health and Long Term Care, 2009) are examples.

While mental health is a concern for all Canadians, refugees are especially vulnerable. They have experienced significant pre-migration stress and likely need services immediately upon entering Canada, yet they cannot be expected to know how to access those services. However, it is the post-migration conditions that potentially have the greatest moderating effect on refugee mental health and which the Canadian policy environment is most able to address. Current pre-settlement health screening practices in refugee camps are narrowly focused, and leave insufficient opportunity for mental health promotion and prevention (Gushulak & Williams, 2004).

Multi-Level Governance

The Canadian context of health policy and programming is affected by the constitutional division of power of the federal and provincial governments. Health—including mental health—falls within the domains of the provinces and territories, and the transfer of federal health funds to the provinces and territories occurs when the latter have met the conditions of the federal Health Act. Thus, any discussion of pan-Canadian mental health policies is also a discussion of multi-level governance. In case studies of settlement programming and administration, the most successful cases are those in which all levels of government meaningfully work with local service providers, and where the later participate in the design and implementation of the programs (Leo & August, 2009; Leo & Enns, 2009). As noted above, economic opportunity and quality of housing are important predictors of emotional wellbeing in refugees. This is a strong argument for coordinating supports and services across traditionally separate sectors—in this case, housing, the labour market and health—when designing refugee resettlement policy and programming.

Conclusion

Current resettlement programs do not meet the mental health and wellbeing needs of Canada's newcomers, in particular refugees. Displaced people who have sought refuge in Canada face real challenges in obtaining culturally appropriate services for mental health problems that may not be understood well by medical practitioners. Given Canada's humanitarian commitment to refugee resettlement and the more acute needs of today's refugees, there is a need for culturally inclusive and appropriate mental health care practices for refugees. In particular, practices should be based on models which are more likely to be understood and accepted by clients from diverse cultural backgrounds, and which do not take the individual as the sole unit of care, but which included the family, the community, or the broader population. At the program or service level, more culturally competent care is needed. Programs may have no obvious institutional barriers, but because there has been little outreach to refugee and ethnic minority communities, the perception of accessibility needs to improve, as well as the quality of care. While some mental health service and settlement service providers are working to provide more comprehensive care at the local level, the lack of integration of sectors and services is most appropriately addressed at the provincial and national policy or systems level.

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Appendix 6: Data Collection Questions
Service Provider Questions: Environmental Scan Phone Interview

General

1. Can you tell me a bit about your agency and your role there?

2. What are the immediate mental health challenges that refugee clients face when they arrive in Canada?

3. Do these mental health challenges change over time?

4. How does your agency meet the mental health needs of refugees?

5. To what extent does your agency try to meet the needs of specific groups (e.g. women or youth) or classes of refugees [GARs (government-assisted refugees) or LCRs (landed-in-Canada refugees)] ?

6. What recommendations would you make?

7. How would you like service provision to change?

8. How would you like training to look?

For External Referrals

1. How are the clients identified for referral?

2. What are the referral pathways?

3. How did the relationship between you and (the other agency/ service provider) start?

4. What does your relationship with (the other agency/ service provider) look like?

5. Do you continue to coordinate services or communicate with (the other agency/ service provider) after you've made the referral?

6. What would your ideal working relationship with (the other agency/ service provider) look like?

7. What services would you like to see offered in your community, that currently are not?

8. Do you have any suggestions for how you would like to see service provision outside of your agency change?

For Internal Referrals

1. How are the clients identified for referral?

2. What are the referral pathways?

3. How often, and for how long, does the client meet with the mental health worker?

4. When did this set-up start? What motivated it?

5. How has this set-up evolved?

6. How is this internal (team/ service) administered?

7. Do you know where your funding for those positions comes from?

8. What is the relationship between the front line staff and these mental health workers?

9. Are there any changes you would like to see?

Refugee Mental Health Practices--Case Study Questions for Agency Staff

Description of services

1. What mental health issues are the refugee clients being seen for?
2. What is your role?

Cultural diversity and mental health concepts / cultural competence / client perceptions

1. How do mental health issues arise with refugee clients?
2. How do the clients understand or perceive those issues?
3. How do you explain mental health issues to your clients?
4. What makes services comfortable for refugees?

Clinical encounter / gaps / challenges

1. Tell us about your therapeutic relationship with clients. What is it like??
   a. What is the formal structure/ relationship?
   b. How does it evolve?
   c. How do the clients understand or perceive your relationship?
2. What successes have you had in delivering mental health services?
   a. What factors contributed to this success?
   b. What things have you learned from that experience, that you would like to see replicated elsewhere?
3. What difficulties you had in delivering mental health services?
   a. Where are there gaps?

Linking clients with needed services / accessibility issues

1. If there are gaps in your services, how do you liaise with other services?
   a. How do the clients react to the transfer?
2. Do you know of any obstacles that your clients tend to encounter that prevent them from accessing these external services?

Sources of social support / empowerment / resiliency factors for clients

1. What is the role of peers and family in helping? (i.e., informal "social support")?
2. What kind of formal social support is being offered in the agency?
3. Where do your clients find social support? (e.g. Work? Religious groups? Schools?)
4. Are there any other strategies your agency would like to try?
5. What is empowering about this for your clients?
6. Are clients involved in any advocacy efforts that may contribute to mental health?

Service provider appraisal of good practices / suggestions for evaluation & training

1. What do you think is good about your services? What is working well?
2. What have your clients expressed satisfaction about?
   a. Has any data been collected on clients use of services and their satisfaction
3. If you were going to evaluate services, what would you look for?
4. What kind of training would be best for your staff?
5. Would the recognition of foreign credential be helpful for your staff?
6. Other suggestions and comments

Client Focus Group Questions

When refugees come to Canada, sometimes the pain is in their heart, or in their mind, not in their body. Being sad, feeling alone. Missing family, missing their country. Sometimes, being angry. Or, the relationship with the family changes. Sometimes, the sadness and pain or anger in the heart and in the mind is very strong, and the person can become ill.

1. Do you know people in your community who have sometimes felt like this after they came to Canada?
2. What are some ways to help people who are feeling this way?
3. What are some things that ___{this agency}___ has done to help people who feel this way?
4. How did they learn about these services? Where else did they go?
5. Why were those things helpful?
6. What other help did they get?
   Probes: Community, formal, school, religious, medical
7. What other things can we do to help people feel better in this way?

Demographic

- Age+ Gender
- How long have you been in Canada? Yrs/months
- Did you come to Canada with family? Or alone?
   0=Alone;   Sp=Spouse,   #=Number of children;
- Did you apply to Canada from a refugee camp or a visa post?
   C=Camp, V=Visa

Demo*Participant*	1	2	3	4	5	6	7	8	9	10
Age (approx)										
Gender										
Time in Canada										
Family status										
Origin										

Appendix 7: Overview of Project Participants

Table 1: Environmental Scan Participants by Province

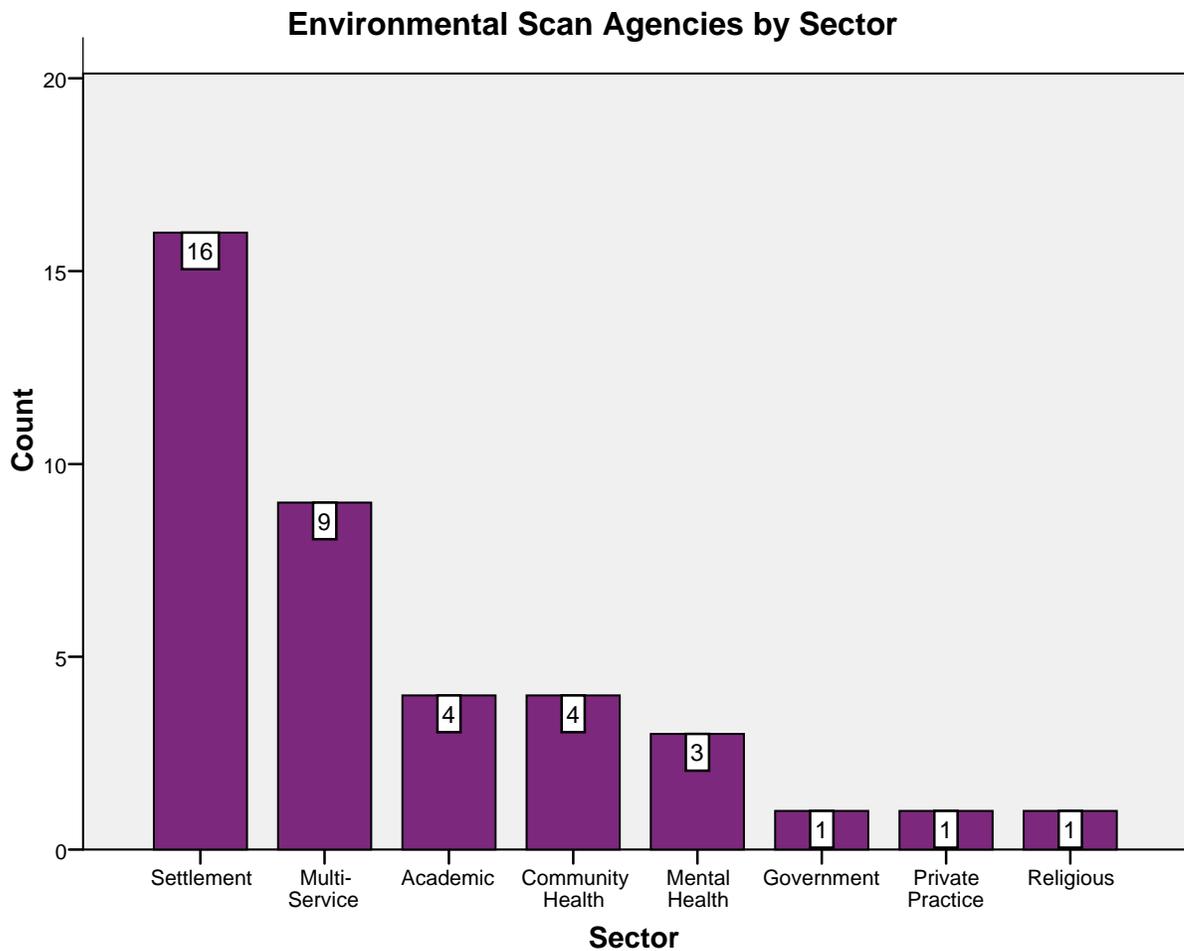| Province	n Agency Participants (includes private practice)	n Interview participants
British Columbia	8	9
Alberta	4	5
Saskatchewan	2	6
Manitoba	3	3
Ontario	14	17
Quebec	3	4
New Brunswick	3	4
Nova Scotia	1	2
Newfoundland and Labrador	1	2
Total	39	52

Figure 1: Environmental Scan Agencies by Sector

Figure 1: Environmental Scan Agencies by Sector

Figure 2: Community Size of Environmental Scan Agencies

Environmental Scan Agencies' Community Size

- Large City
- Medium City
- Small City
- Town or Rural
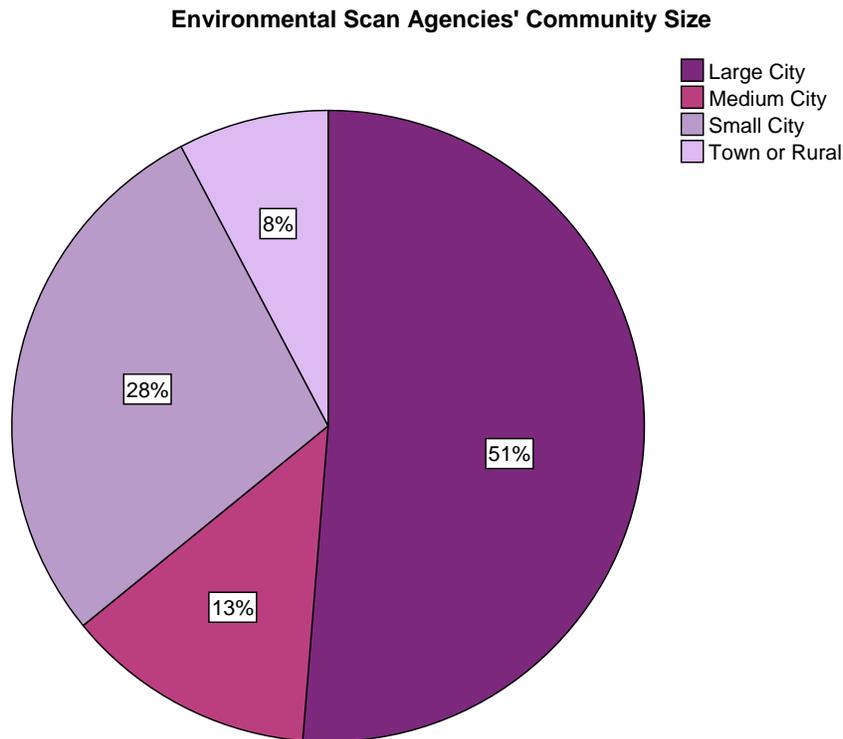
Large City= 1Million+
Medium City= between 500,000 and 1Million
Small City = between 100,000 and 500,000
Town or Rural = less than 100,000

Table 2: Case Study Participants by Role, Gender and Site

Case Study Site	Staff			Clients			Volunteers			Total Agency
	Male	Female	Total Staff	Male	Female	Total Clients	Male	Female	Total Volunteers	
Toronto	1	5	6	6	5	11	0	0	0	17
Windsor	2	2	4	1	2	3	3	2	5	12
Edmonton	4	15	19	5	7	12	0	0	0	31
Calgary	3	7	10	3	6	9	0	0	0	19
Vancouver	4	10	14	4	3	7	0	0	0	21
Total	14	39	**53**	19	23	**42**	3	2	**5**	**100**

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[i] The full review will be available with the final report, in spring of 2010.