



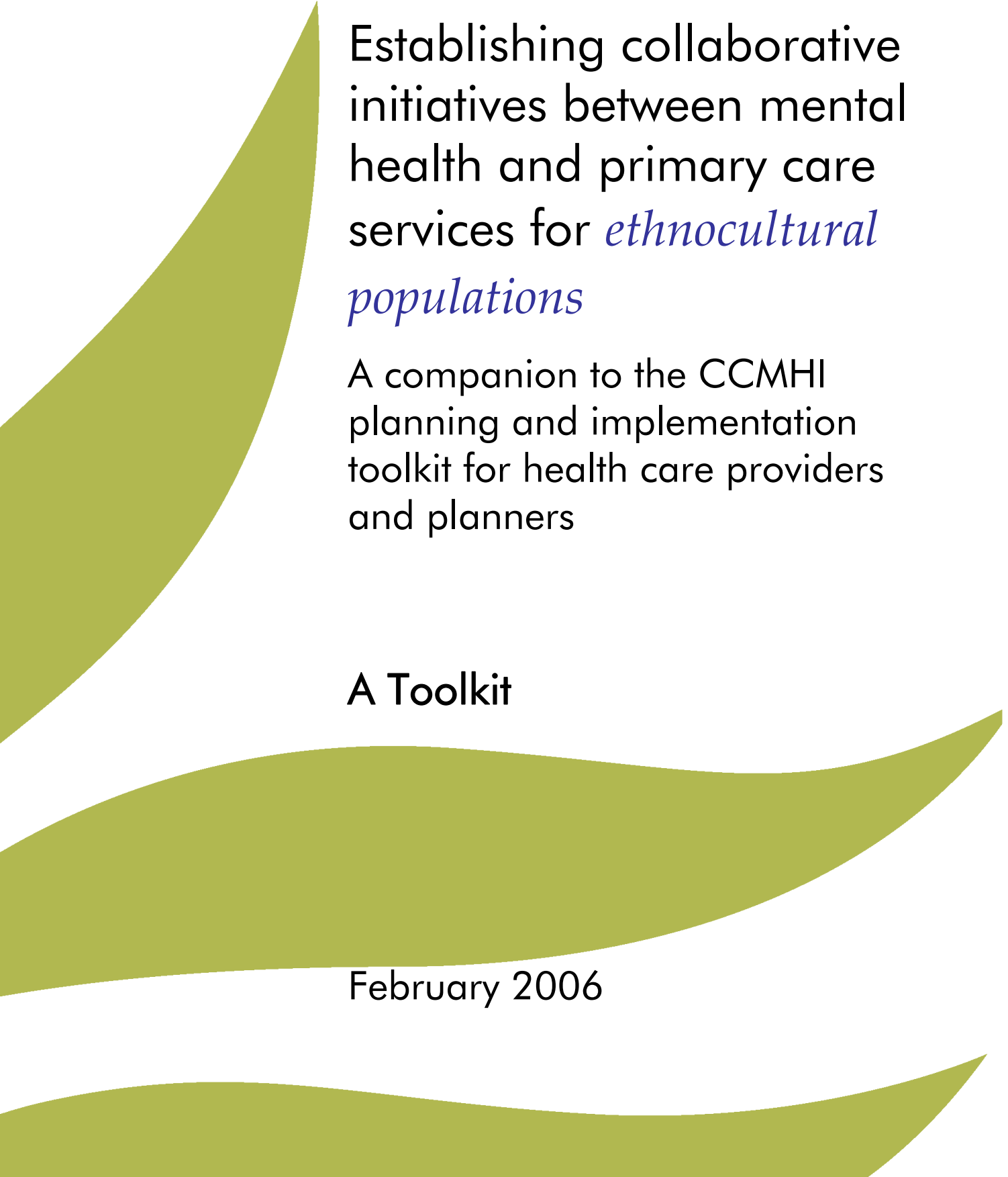
Canadian
Collaborative
Mental Health
Initiative

Initiative
canadienne de
collaboration en
santé mentale

Establishing collaborative initiatives between mental health and primary care services for *ethnocultural populations*

A companion to the CCMHI planning and
implementation toolkit for health care
providers and planners

PROVIDERS AND PLANNERS



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initiatives between mental
health and primary care
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and planners

A Toolkit

February 2006



OUR GOAL

The Canadian Collaborative Mental Health Initiative (CCMHI) aims to improve the mental health and well-being of Canadians by enhancing the relationships and improving collaboration among health care providers, consumers, families and caregivers; and improving consumer access to prevention, health promotion, treatment/intervention and rehabilitation services in a primary health care setting.

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Ethnocultural populations



Preface

Welcome to the CCMHI toolkit series!

The Canadian Collaborative Mental Health Initiative (CCMHI) is led by 12 national organizations representing community services; consumers, families and caregivers; self-help groups; dietitians; family physicians; nurses; occupational therapists; pharmacists; psychiatrists; psychologists; and social workers. Funded through Health Canada's Primary Health Care Transition Fund, the goal of the CCMHI is to improve the mental health and well-being of Canadians by increasing collaboration among primary health care and mental health care providers, consumers, families and caregivers.

The CCMHI toolkits contain practical tools to:

- Assist providers and planners in the implementation of collaborative initiatives
- Help mental health consumers and their family members understand mental illness and work with other members of the care team
- Inform educators of the benefits of interprofessional education (IPE) and provide tools to teach about collaborative mental health care.

Each toolkit was developed with an interprofessional Expert Panel and guided by a Working Group representing a number of key stakeholder groups. We hope that readers of any of the toolkits in the series will recommend them to others (e.g., consumers referring toolkits to their providers and vice versa).

In addition to this series of 12 toolkits, the CCMHI has developed a Charter of principles and commitments that will influence the future of mental health care in Canada and a series of reports that capture the current state of collaborative mental health care. The reports highlight health human resource issues, provide an annotated bibliography, summarize best practices, review initiatives from across the nation and summarize provincial and territorial mental health and primary care reform. These documents guided the development of the toolkits and are available at www.ccmhi.ca.

Implementation toolkits

Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners is a guide for providers wishing to establish or enhance the mental health services they provide through collaboration. This general toolkit offers readers a guide to all aspects of planning, implementing and evaluating a collaborative mental health care initiative, including assessing need, setting goals and objectives, developing a budget, building a team, maintaining a well-functioning team, managing change and monitoring the initiative.

Eight population-specific toolkits, entitled *Establishing collaborative initiatives between mental health and primary care services*, are designed to be used in conjunction with the general toolkit. They offer tips on adapting the general toolkit for Aboriginal Peoples,

children and adolescents, ethnocultural populations, rural and isolated populations, seniors, individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. There is some overlap in the toolkits; for example, information about collaborative mental health care and the homeless may be found in at least three toolkits: individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. Readers are encouraged to consider all the toolkits that may be relevant to their needs.

The general and population-specific toolkits are not intended as clinical practice guides but offer practical advice on different aspects of establishing successful collaborative initiatives.

Consumer, family and caregiver toolkits

Consumers, families and caregivers developed both of these toolkits for consumers and their loved ones.

Working together towards recovery: Consumers, families, caregivers and providers is intended for all consumers, families and caregivers wishing to know more about mental health and mental illness, how to access services and the type of professionals that can assist them in their recovery. This toolkit also offers an outline of complementary therapies and self-care as well as the contributions and needs of caregivers. Finally, this toolkit includes a guide to “getting involved”, describing how government and boards of directors work, and why consumers and families should participate.

Pathways to healing: A mental health guide for First Nations people is a toolkit that offers a basic overview of mental health and mental illness along with a contextual section outlining the impact of history, social, economic and political conditions on the mental health of these peoples. There are tools in this toolkit to foster holistic care.

Education toolkit

Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators serves as an educational resource to assist in the implementation of educational initiatives and programs that promote collaborative mental health care in primary health care settings. The toolkit is targeted to education program developers in regulatory agencies, professional associations, regional health authorities, family health teams, governmental departments, and educators within both academic (universities and colleges) and care delivery settings.

This toolkit highlights the importance of interprofessional education in promoting collaborative care. It offers four case studies and several activities accompanied by a sample lesson plan and other useful tools to aid educators in the implementation of educational events.

Executive summary

Introduction

Ethnocultural groups are not in essence a ‘special’ population but rather a population at risk because of poor access to the specific and/or unique services they may require. Consumer and community consultation with this population is paramount to determine if potential approaches are culturally appropriate and relevant, and to assist with providing appropriate linguistic supports. There remains significant stigma within some ethnocultural populations in approaching mental health services or admitting to their potential need. In addition, the concept of mental health will vary among cultural groups, and guidance from its members is necessary.

The purpose of this toolkit is to assist service providers and other key stakeholders to work collaboratively to meet the mental health needs of ethnocultural populations. Highlights of the toolkit include: ten key issues for consideration when planning and implementing an initiative; descriptions of two positive practice initiatives; and a list of key websites.

Defining the population

Included in the working definition of this ‘special’ population are immigrants, refugees, and second- and third-generation Canadians of minority groups.

Consultation process

The Expert Panel employed several strategies in the development of this toolkit, including conducting surveys, questionnaires and interviews with a range of service providers, health care providers and consumers; involving settlement organizations and interpreters; and consulting community representatives.

Key issues for consideration

- **Accessibility is a key issue.** Services must be culturally and linguistically appropriate; translators must be available; information needs to be in multiple languages and formats; service providers must understand racial and systemic barriers; having one location for multiple services is beneficial.
- **Primary health care providers need to develop an increased awareness of somatization of complaints as individuals may not express mental health issues as such.**
- **Cultural competency is pivotal for services to be useful.** Cultural competency involves providing equal access, removing barriers and being inclusive (Sue, 2001). It also refers to an awareness of contextual and nonverbal signals; differences in communication styles; and power, role, gender and age factors (Gorman, 2001).

- **Awareness of poverty issues and how they may affect those receiving services is important.** These issues could include cost of transportation, cost of medication, cost of basic items such as food and clothing, and availability of appointments outside of regular working hours.
- **One major barrier to gaining access to successful and appropriate services is a lack of awareness (on the part of providers and consumers) of culturally specific services.**
- **Involvement of consumers requires greater attention.** Consumer centredness means there are formal avenues of review, revision, consultation and feedback. The right to self-determination must be respected and there must be education regarding decision-making and options.
- **A greater understanding of the policies and legislation that impact ethnocultural populations is required.** The issues are vast and include numerous disparities and lack of awareness of the needs to be addressed.
- **It is necessary to secure funding for interpreters, advocates and culturally appropriate material and financial supports for immigrants and refugees during resettlement.**
- **There are no valid measurement or evaluation tools applicable to this population as a whole,** nor any significant evidence-based research upon which to develop guidelines for ethnocultural services. Evidence-based screening and health maintenance guidelines relevant to the patterns of illness in different immigrant groups should be developed.
- **Service providers involved in collaborative care** may include physicians, settlement workers, advocates, religious and community groups, nurses, physiotherapists, psychologists, clinical counsellors, health brokers, interpreters, psychiatrists, lawyers, mental health workers, dietitians, addictions counsellors, pharmacists and community liaisons. Provisions should be made for interpreters and health brokers to act as liaisons in the community.
- **Collaborative care structures must include rapport-building and establishment of trust before any significant issues can be addressed.**
- **Two types of collaborative models currently exist for this population:**
Ethnocultural-inclusive models address the needs of multiple ethnicities and cultures in one setting, while ethnocultural-specific models address and provide services to a particular cultural group or ethnicity.

Introduction

Defining the population

Statistics Canada (2005) projects that by 2017, roughly one out of every five people in Canada, or between 19% and 23% of the nation's population, could be a member of a visible minority, up from 13% in 2001. As the Minister of State for Multiculturalism said, "The Canadian population has always been evolving. We're a land of immigrants, so diversity is not something new to us" (Mahoney, 2005, p. A1). Jeffrey Reitz, head of the ethnic studies program at the University of Toronto, Toronto, Ontario, similarly stated: "The Canadian identity can't be changed by increasing diversity because that's what the Canadian identity is" (p. A7). Ethnocultural individuals are not, in essence, a 'special' population but rather a population at risk because of poor access to the specific and/or unique services they may require.

Included in the working definition of this population are immigrants, refugees, Protected Persons and second- and third-generation Canadians of minority groups. The following definitions are based on Canada's Immigration and Refugee Protection Act, 2002.

Immigrants are persons who, of their own volition or desire, leave their country to settle permanently in another.

Convention Refugees are persons who are outside of their country of nationality or habitual residence and who are unable or unwilling to return to that country because of a well-founded fear of persecution for reasons of race, religion, political opinion, nationality or membership in a particular social group.

Persons in need of protection are persons in Canada whose removal to their country of nationality or former habitual residence would subject them to the possibility of torture, risk to life, or risk of cruel and unusual treatment or punishment.

Protected Persons can either be Convention Refugees or persons in need of protection.

Factors specific to ethnocultural populations

- There is an overall need for health care providers to develop an awareness of the special needs and appropriate manner in which to serve ethnocultural groups. This can include not only language and cultural sensitivity, but awareness of and respect for religious and spiritual traditions, differences in roles and family relationships, and dietary and other lifestyle choices.
- Service providers must understand what the needs of the individual are on multiple levels as well as the racial and systemic barriers that some of this population may face.

- There is a need to understand the disparities and regionalization of services to this population as well as the vastness of the issues faced by this group.
- The concept of mental health will vary among cultural groups, and guidance from its members is necessary. Collaborative care must include rapport building and establishment of trust before any significant issues can be addressed.
- Primary care providers may come into contact with Protected Persons, Convention Refugees or persons in need of protection through the federal government-funded Interim Federal Health program, self-referral or as referred by the community and/or settlement workers. Presentation of these individuals may be confounded by trauma experienced abroad. The trauma should be addressed slowly with attention paid to rapport building in a casual and friendly environment with a goal of working towards the establishment of trust.
- Many ethnocultural individuals will present either with linguistic differences, as a visible minority or express that they consider themselves to be such.
- Individuals may present with somatic complaints (e.g., headaches, non-organic body pains, etc.), which may be manifestations of mental health issues that cannot be expressed as such. Therefore, physicians and other health care providers working with ethnocultural groups may want to inquire into mental health, anxiety and depression when such physical symptoms are reported.
- Due to linguistic limitations, many consumers may present with family members acting as interpreters. Many seniors, for example, use children or grandchildren as interpreters with health care providers. This can lead to conflict-of-interest situations as well as limitations on what individuals will be able to disclose. The care provider will need to address confidentiality, the level of comfort of the consumer (e.g., are the issues being discussed appropriate with a family member interpreting?) as well as other issues that may arise.

Lessons from the literature

- The role of interpreters is crucial to working with ethnocultural groups. Providing services in a linguistically appropriate manner makes services accessible. Language barriers can make services inappropriate (Ganasen, 2002).
- Cultural competency is pivotal for services to be useful. This type of competence refers to services that are aware of contextual and nonverbal signals. It suggests the consideration of communication styles, the significance of self-disclosure and expression of feelings, power and role differentials, gender and age factors, physical settings and the multiple ways in which people give and receive help (Gorman, 2001).
- Cultural competence includes whether providers are able to gather information from the community and those they are serving without putting their own framework of understanding first. The ability to work from various points of view becomes important as well as the ability to educate consumers on the service provider's point of view and explore the consumer's point of view regarding health services. This will be influenced by consumers' experience in their country of origin (British Columbia Ministry of Health, Mental Health Services Division, 1996).
- Sue (2001) suggests that multicultural competence "must be about social justice - providing equal access and opportunity, being inclusive, and removing individual and systemic barriers to fair mental health services" (p. 801).
- Safety and trust are fundamental to establishing a working relationship. Professionals that could take time with consumers were seen to be more helpful. Additionally, persons who could meet multiple needs were valued more highly. Settings that included multiple service providers (e.g., settlement workers, interpreters, counsellors, mental health workers, community leaders, school counsellors, clergy, nurses, physicians and dietitians) eased/reduced barriers to services, making them more accessible (Behnia, 2001; Watters, 2001).
- The social determinants of health, including age, social isolation, language barriers, separation from family, change in family roles and norms, lack of information about available resources and unemployment are of paramount importance with immigrant and refugee populations (Fowler, 1998).

For additional information on lessons from the literature consult two CCMHI reports available at www.ccmhi.ca:

- *Annotated bibliography of collaborative mental health care*
- *Better practices in collaborative mental health care: An analysis of the evidence base*

- Cross-cultural differences in diet, smoking rates, information-seeking patterns, communication styles and ideas about prevention of disease have been identified (Fowler, 1998).
- Refugees who are older, more educated, and female and who have higher predisplacement socioeconomic status and rural residence have worse mental health outcomes (Porter & Haslam, 2005).
- There is a growing amount of grey literature and anecdotal evidence that many organizations outside the formal mental health system stretch their mandates to provide mental health services without funding (Ganesan, 2002).
- In a 2001 refugee health survey which collected information from immigrant and refugee agencies, schools, church groups/ sponsorship groups, health services, social services and others, all identified having contact with persons with mental health problems. The most common types of mental health concerns were depression/suicidal behaviour, anxiety, post-traumatic stress, alcohol and/or drug misuse, psychosis and adjustment problems (Ganesan, 2002).

Collaborative models and initiatives

Two types of models currently exist for ethnocultural groups: ethnocultural-inclusive (addressing the needs of multiple ethnicities and cultures in one setting) and ethnocultural-specific (addressing and providing services to a particular cultural group or ethnicity). See Appendix B for descriptions of positive practice initiatives.

For additional information on positive practice initiatives in Canada, consult the following document available at www.ccmhi.ca:

- *Collaborative mental health care in primary health care. A review of Canadian initiatives: Volumes I and II*

Key elements and fundamentals of collaborative mental health care



Figure 1 Framework for collaborative mental health care

Accessibility

- Two primary factors affect accessibility of services to this population: Services must be culturally and linguistically appropriate.
- If the service provider does not speak or understand a consumer's first language, translators must be available.
- Having information about services in multiple languages as well as in multiple formats is helpful. For persons of limited literacy, plain-language explanations and a clear context should be provided.
- Providers must be aware that there remains significant stigma for consumers in approaching mental health services or admitting to their potential need.
- For both service providers and consumers, lack of awareness of services is a major barrier to successful and appropriate services. Mainstream service providers may be unaware of culturally specific immigrant and refugee services in the community.
- Consumer awareness of services is most often successfully achieved through community members or agencies serving the community.
- Using trained peers (e.g., immigrant women) to provide counselling, support and information can be effective in health promotion activities (Fowler, 1998).

- Consumers must know what can reasonably be expected from a service. A clear presentation of what will and will not be included can help reduce miscommunication and loss of trust.

Collaborative structures

- The establishment of a national network of providers of health care services to ethnocultural groups is recommended. The goal of such a network would be to collaborate, review and share information.

Richness of collaboration

- Collaboration between service providers is essential. Having one location in which multiple services can be addressed was consistently cited as beneficial (Bellows, 2004).
- Service providers may include:
 - Physicians
 - Settlement workers
 - Advocates
 - Religious and community groups
 - Nurses
 - Physiotherapists
 - Psychologists
 - Dietitians
 - Clinical counsellors
 - Health brokers
 - Interpreters
 - Psychiatrists
 - Pharmacists
 - Lawyers
 - Mental health workers
 - Peer support workers
 - Addictions counsellors
 - Community liaison
- When working with Protected Persons, providers would do well to collaborate with lawyers and advocates, as well as familiarize themselves with the refugee claim process and its procedures. Providing information regarding timelines of processing as well as how the government in Canada may operate differently from one's country of origin will also be useful.
- It is important to co-ordinate and collaborate with settlement service providers who can address primary needs (i.e., where to find food, clothing, shelter, financial supports), secondary needs (i.e., language classes, understanding of society and

employment) and primary health care. The co-ordination of these services allows for ongoing stabilization and support for newcomers throughout the resettlement period.

- Provision should be made for interpreters and health brokers to act as liaisons in the community.
- The development of partnership programs for newcomers with Canadians who can act as cultural liaisons is suggested, especially with groups such as law enforcement, where issues of cultural diversity may need to be made explicit and perceptions of newcomers may be different.

Consumer centredness

- Consumer and community consultation with this population is of paramount importance to determine if potential approaches are culturally appropriate/relevant and to assist with providing appropriate linguistic supports.
- There is a need for formal avenues of review, revision, consultation and feedback. Similarly, rights to self-determination must be respected and, when appropriate, there must be education regarding decision making and options.
- The primary needs of the consumer (food security, clothing, shelter) must be met before secondary needs (such as mental health services) can be addressed (Watters, 2001).
- “After the Door Has Been Opened” (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988), a Canadian report on immigrants and refugees, identifies both seniors and youth as special sub-populations. As such, special attention should be paid to what their needs may be and how they may present differently from other members of their ethnic community.
- Women who are pregnant or breastfeeding may present as another special sub-population with unique health care needs.
- For some, lack of financial resources may be critical in the establishment of services. There needs to be an awareness of poverty issues and how they may affect those receiving services. These issues could include cost of transportation, cost of medication, cost of basic items such as food and clothing, and availability of appointments outside of regular working hours to accommodate work and family schedules.

Policies, legislation, regulations

- Familiarity with the following legislation will afford service providers a greater understanding of consumers' experiences:
 - Convention Relating to the Status of Refugees (United Nations, 1951)
 - Canadian Multiculturalism Act
 - Immigration Act
 - Governance and Guidelines of the Canadian Immigration and Refugee Board
 - Canada Health Act
 - Interim Federal Health program
- There is currently a lack of unified theory and approach to guide ethnocultural services and research. This confirms the importance of cross-cultural and multicultural awareness.
- There is a need to establish guidelines and training in cultural competency for service providers. This may include a type of credentialing process to create a standard for interpreters as well as including cultural competency in university, college and professional training centres.

Funding

- Funding for interpreters, advocates and culturally appropriate materials are all needed as are financial supports during resettlement for immigrants and Protected Persons.

Evidence-based research

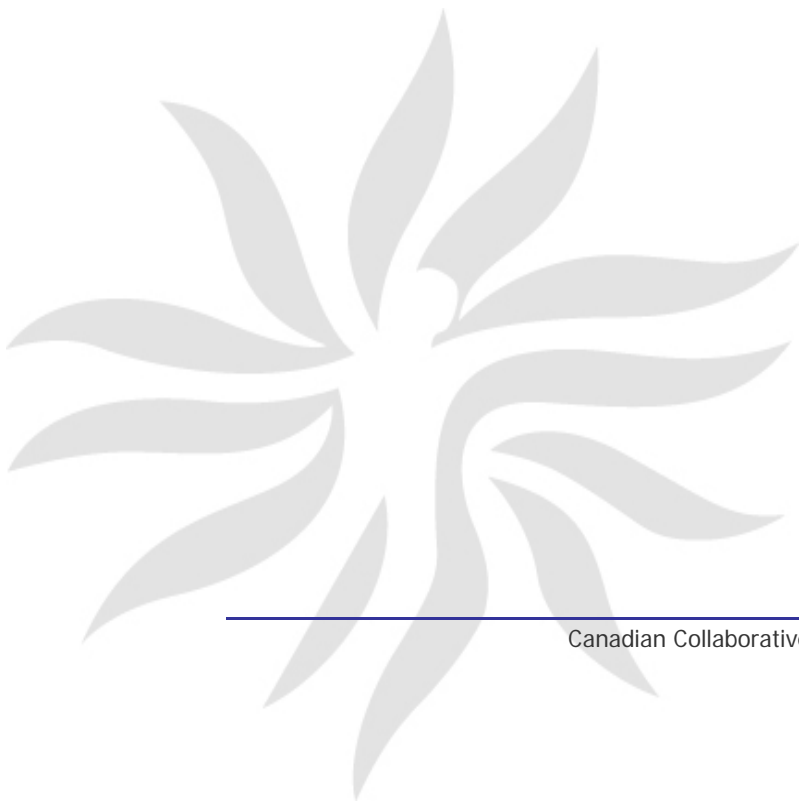
- There is a paucity of literature concerning this population and currently no significant evidence-based research.
- Evidence-based screening and health maintenance guidelines relevant to the patterns of illness in different immigrant groups should be developed.

Community needs

- These include the ongoing need for culturally appropriate supports and services to address multiple issues.

Evaluation

- A significant barrier to evaluation may be consumers' hesitancy to critique services. Service providers' lack of available resources and time may be a barrier to evaluation; for consumers, transportation may be an issue.
- Currently, there are no valid measurement tools applicable to this population as a whole. Outcomes will vary depending on the goal of collaboration; evidence of usefulness and accessibility will be vital to success.



Key issues for consideration

1. When working with ethnocultural groups, it is pivotal to have appropriate interpretation services available. They must be competent in addressing mental health issues and respect confidentiality. In addition, training for interpreters and translators in basic counselling skills would be greatly beneficial.
2. Due to the constantly changing demographics of newcomers in Canada, it is important to create a system for ongoing training for organizations and front-line workers to become aware of varying resettlement dynamics. Community, immigrant and refugee agencies need to develop a mechanism for updated education and ways of gathering culturally relevant information on the changing dynamics of those they serve.
3. The development of formal cultural competency training in professional training programs and the inclusion of para-professional health care providers within education centres would help improve overall care.
4. Inclusion of immigrant agencies as partners in federal, provincial and municipal funding structures is important. This would allow for more appropriate delivery of mental health services.
5. Exploration of the possibility of implementing a diversity co-ordinator in community health centres is recommended. The role of this position would be to be linked with resources in the community, provide (or liaise to provide) culturally specific health services, co-ordinate with immigrant agencies and possibly develop self-help groups on various topics.
6. There is an overall need to develop awareness by all health care workers of the special needs and appropriate manner in which to serve ethnocultural groups. This can include not only language and cultural sensitivity, but awareness of and respect for religious, cultural and spiritual traditions, differences in roles and family relationships, and dietary and other lifestyle choices.
7. There is no 'cookbook' model for development of care and collaboration with ethnocultural groups. Each model of delivery must be tailor made for the unique community in which it will be situated.
8. Funding agencies need to be flexible allowing for 'bottom-up research' and investigation and the development of more collaborative research opportunities. This is necessary to address the lack of formal and longitudinal research in this area.

9. The creation of a national network for service providers to share information and collaborate is recommended.
10. The development of a credentialing process would facilitate foreign-trained mental health professionals' access into the Canadian system.

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Appendix A: Consultation process

Service providers, including community health brokers, social workers, nurses, family physicians, psychiatrists, physiotherapists, mental health workers, clinical counsellors, administrators, settlement co-ordinators, interpreters and academics, were contacted by direct interview as well as by survey.

A detailed survey for health care providers, a plain-language health care provider survey and a plain-language consumer survey were adapted for this population from the questionnaires created by the Expert Panel for another of the toolkits in the Canadian Collaborative Mental Health Initiative series: the Rural and Isolated Populations Toolkit. These documents were e-mailed to individuals, organizations and advocacy groups throughout Canada for feedback and input. As well, individuals who voiced the desire to be involved but felt they did not have time for survey completion were interviewed face-to-face or by telephone.

Due to the need for culturally and linguistically appropriate services for ethnocultural groups, many settlement organizations and interpreters were contacted. Ethnocultural care providers, such as organizations catering to the needs of specific ethnocultural groups, were included in the survey. In addition, psychiatrists from the Vancouver General Hospital's unique Cross-Cultural Psychiatry Division were consulted. The division provides ethnically matched psychiatrists who diagnose, treat, medicate and assess. The mandate of the clinic is to provide culturally sensitive and language-specific comprehensive psychiatric assessment for psychotic and non-psychotic individuals.

Once a first draft of this document was created, it was sent to all members of the Expert Panel as well as to community service providers (school worker, cultural broker and health care provider) for their review and input prior to the creation of the final draft. Based on recommendations or identification of missing aspects, appropriate changes were made in the document.

The following persons or organizations were contacted during the consultation process:

- AIDS/HIV Educator, BC Multicultural Health Service
- Alberta Health and Wellness
- Association of Multicultural Societies and Service Agencies of BC
- BC Multicultural Health Services Society
- BC Nurses Association
- British Columbia Cancer Society
- Centre Hospitalier Universitaire de Quebec
- Cross-Cultural Psychiatry Department of Vancouver General Hospital
- Ecole de Nursing, Université de Montreal
- Fraser Health Authority

- Hamilton School of Nursing
- Healthcare Interpretation Network
- Hong Fook Mental Health Association
- Immigrant Services Society (BC)
- Les Centres Jeunesse de Montreal
- Metropolitan Immigrant Settlement Association
- Michael Rachlis Consulting
- Nova Scotia Department of Health
- Ontario College of Family Physicians
- Ontario Family Practice Nurses
- ResoSante Colombie Britannique
- Somerset West Community Health Centre
- Task Force on Newcomer Access to Health Care in Nova Scotia
- The Bridge Community Health Clinic (Vancouver)
- Toronto Public Health
- Dr. Barbara Tully (family physician)
- Université du Québec en Outasouais
- University of Toronto
- Vancouver Association for Survivors of Torture
- Vancouver Coastal Health Authority
- Winnipeg Regional Health Authority
- Yellowknife Health and Social Services Authority

Appendix B: Positive practice initiatives

Vancouver Model (ethnocultural-inclusive)

This collaborative setting (Ganesan & Janze, 2005) addresses the needs of multiple ethnocultural groups, Convention Refugees, Protected Persons and immigrants as well as second- and third-generation Canadians. The program includes the Vancouver Association for Survivors of Torture (VAST) which was created in the mid-1980s as a non-profit organization. VAST's mandate is:

- To provide services to people who have survived war and torture
- To research the consequences of torture
- To educate other groups and organizations
- To educate the public on the importance of preventing torture

For additional information on positive practice initiatives in Canada, consult the following document available at www.ccmhi.ca:

- *Collaborative mental health care in primary health care. A review of Canadian initiatives: Volumes I and II*

Referrals to VAST are made from various community services including settlement agencies, schools, lawyers, physicians, mental health workers and ethnic community centres. Intake is done in a non-clinical, casual setting, helping the individual identify needs and options to meet those needs. Settlement and social support programming is available as well as psychological supports.

VAST collaborates with the Bridge Community Health Clinic (Bridge). Bridge has provided immediate access to primary and preventative health services for refugees (with and without legal status) and immigrants since 1994. The clinic's services include:

- Primary health care
- Screening for infectious and/or chronic disease
- Nutrition screening
- Immunization
- Pediatric consultation
- Immigration medical examinations
- Mental health services (from both specialized physicians and a Masters- level psychologist)
- Settlement services

The clinic offers well-trained, experienced teams of professionals including

- Physicians
- Nurses
- Interpreters
- Settlement workers
- Dietitians
- Physiotherapists
- Respiratory therapist
- Speech language pathologists
- Psychologist
- Psychiatrist

The collaboration in Vancouver also includes the Vancouver General Hospital's Cross-Cultural Psychiatry Division, established in 1988, which includes inpatient and outpatient services. The focus of the outpatient clinic is to provide culturally responsible and language-specific assessment and treatment. Staff psychiatrists speak a combined total of 22 languages and dialects. For languages not provided by the current staff, a hospital-based interpreter for mental health is available.

Patient referrals come from family physicians, social services, school boards and immigrant settlement organizations from across the province of British Columbia. The clinic provides comprehensive psychiatric assessment including diagnosis, medication recommendations and consideration of other resources available in the community. Treatment includes a psychoeducational component for patients and family members and the provision of group therapy in conjunction with the Outpatient Psychiatry Program at Vancouver General Hospital. Five beds in the general inpatient psychiatry unit have been designated as flex beds for cross-cultural patients who require culturally competent and sensitive services.

VAST, Bridge and the Vancouver General Hospital all collaborate in mental health and primary health services in culturally and linguistically appropriate ways. In addition, the Vancouver Coastal Health Authority has co-ordinated the following complementary services under a single administrative structure:

- Multicultural Liaison Worker Program at Vancouver Community Mental Health Services
- Cross-Cultural Program in the Department of Psychiatry at the University of British Columbia
- Annual Cross-Cultural Mental Health Symposium and Workshop
- Cross-Cultural Inpatient Psychiatry at Riverview Hospital
- Interpreter training services for the Vancouver Coastal Health Authority
- Telehealth

Hong Fook Model (ethnocultural-specific)

Located in metropolitan Toronto, Hong Fook serves the Chinese and Southeast Asian populations. It is designed to provide services to individuals, groups and the community at large. It provides professional development activities for mainstream health care providers and extensive interagency linkages, collaboration and advocacy (Lo & Chung, 2005). Contact person: Dr. Ted Lo.

Other examples of ethnocultural-inclusive and ethnocultural-specific programs include: Across Boundaries, an ethnoracial mental health centre in Toronto; the Asian Clinic in Toronto, which serves Mandarin, Cantonese, Vietnamese, and Korean populations; cultural consultation services at Mt. Sinai Hospital in Toronto; the Canadian Mental

Health Association which has workers of various ethnicities; and the CLSC (Centre Local des Services Communautaires) Côte-des-Neiges, a community-based centre which provides medical and social services to the culturally diverse population in the Côte-des-Neiges region of Montreal. This is not an exhaustive list of services but rather a sampling of some of the work currently being done within Canada.



Appendix C: Websites

<http://www.amssa.org/>

Association of Multicultural Societies and Service Agencies of BC

<http://www.ercomer.org/wwwvl/>

The world wide web virtual library migration and ethnic relations

<http://www.edchange.org/multicultural/>

The Multicultural Pavillion

<http://integration-net.cic.gc.ca/>

Integration Net Government of Canada

<http://www.ocasi.org/index.asp>

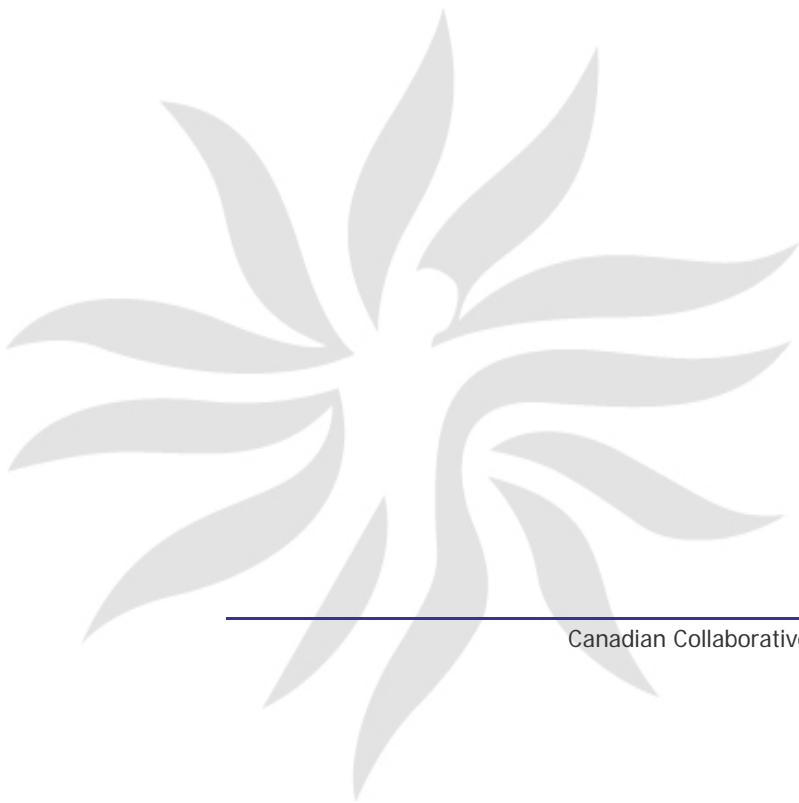
Ontario Council of Agencies Serving Immigrants

<http://dsp-psd.communication.gc.ca/Collection/H21-149-1999E.pdf>

Health Canada. Canadian Research on Immigration and Health

http://www.camh.net/about_camh/

Centre for Addiction and Mental Health



Appendix D: Glossary of terms and Index of acronyms

Glossary of terms

Best practices – Activities and programs that are in keeping with the best possible evidence about what works [Interchangeable with ‘Better Practices’, ‘Positive Practices’ and ‘Good Practices’] (Health Canada, 1998).

Chronic disease management (CDM) - A systematic approach to improving health care for people with chronic disease that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection and management of chronic conditions (British Columbia, Ministry of Health Services, 2004).

Collaborative primary health care - The delivery of services at the first point of contact with the health system by two or more different stakeholders (health professionals, consumers, families, primary health care organizations, community agencies) working together in a partnership that is characterized by:

- Common goals or purpose
- A recognition of and respect for respective strengths and differences
- Equitable and effective decision-making
- Clear and regular communication

in order to:

- Improve access to a comprehensive range of services (treatment, health promotion, disease and injury prevention and management of chronic diseases and self-help), delivered by the most appropriate provider in the most suitable location
- Deliver high-quality and effective health care
- Make the most efficient use of resources
- Improve outcomes for the consumer

Determinants of health - Factors in an individual’s living and working environment that can affect their health (e.g. housing, education, income, employment, culture, physical environment, equity).

Health promotion – The process of enabling people to increase control over and to improve their health (WHO, 1986).

Interdisciplinary – A range of collaborative activities undertaken by a team of two or more individuals from varying disciplines applying the methods and approaches of their respective disciplines.

Mental health promotion - The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health (Health Canada, 1998).

Mental health specialist – An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment or rehabilitation

Prevention – Interventions that target risk factors for specific illnesses in order to prevent the initial occurrence of a disease, arrest or retard an existing disease and its effects or reduce the occurrence of relapses.

Primary health care - An individual's first contact with the health system characterized by a spectrum of comprehensive, coordinated and continuous health care services such as health promotion, diagnosis, treatment and chronic disease management.

Primary mental health care – Mental health services provided in a primary health care setting. Settings where primary health care can be delivered include the offices of health care providers, community clinics, workplaces, schools, homes, health care institutions, homes for the aged, nursing homes and day care centres. Primary mental health care may also be available by telephone, health information services and the Internet.

Recovery – A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Index of acronyms

CCMHI	Canadian Collaborative Mental Health Initiative
VAST	Vancouver Association for Survivors of Torture
WHO	World Health Organization

Toolkit Series

This toolkit belongs to a series of twelve toolkits.

Implementation toolkits for providers and planners

1. Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners

A series of companion documents to the CCMHI planning and implementation toolkit for health care providers and planners. Establishing collaborative initiatives between mental health and primary care services for:

2. Aboriginal peoples
3. Children and adolescents

4. Ethnocultural populations

5. Individuals with serious mental illness
6. Individuals with substance use disorders
7. Rural and isolated populations
8. Seniors
9. Urban marginalized populations

Toolkits for consumers, families and caregivers

10. Working together towards recovery: Consumers, families, caregivers, and providers
11. Pathways to healing: A mental health guide for First Nations people

A toolkit for educators

12. Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators

A series of documents examining aspects of collaborative mental health care support these toolkits:

- | | |
|----------------------------|---|
| 1. Barriers and strategies | 7. International initiatives [unpublished] |
| 2. A framework | 8. Health human resources |
| 3. Annotated bibliography | 9. Mental health prevalence and utilization |
| 4. Better practices | 10. Interprofessional education |
| 5. Canadian initiatives | 11. Aboriginal mental health [unpublished] |
| 6. A policy review | 12. The state of collaborative mental health care |

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