



# **Building capacity to support the mental health of immigrants and refugees: A toolkit for settlement, social and health service providers**

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# About the project

## Project website:

[Visit our project website >](#)



“As an employer, the Immigrant and Refugee Mental Health Project provided me with a list of resources, something that we can lean on in order to build our own internal capacity. It also gave the opportunity for all kinds of learners to grasp the content of the course as the information is available through different learning activities, everyone is able to learn and build their skills. I also think being able to use the discussion board gave my employees a sense of the network.”

### **Belma Podrug**

Executive Director at the Global Gathering Place (Saskatchewan)

The Immigrant and Refugee Mental Health Project was developed by the Centre for Addiction and Mental Health’s (CAMH) Health Equity Office, with funding from Immigration, Refugees and Citizenship (IRCC) and in collaboration with experts in the field. It is an evidence-based, capacity-building initiative, designed to enhance your knowledge and skills as a settlement, social or health service provider to appropriately respond to the unique mental health needs of immigrants and refugees, and to foster inter-sector and inter-professional collaboration. Building on the success of the award-winning Refugee Mental Health Project, this project provides five different avenues to enhance knowledge, develop skills, and build networks. These avenues include online courses, webinars, monthly e-newsletters, a community of practice, and this toolkit.



The Immigrant and Refugee Mental Health Project examines the mental health problems and disorders of different groups of immigrants and refugees along with services, treatments and supports that have been effective. This project offers a comprehensive overview of immigrants’ mental health, along with expanded knowledge on the particular needs of refugees. It outlines different pathways to mental health and mental illness among various subgroups of immigrants, addresses the role of culture and context, and provides examples of promising practices and innovative approaches to service delivery.



# About us

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## The Centre for Addiction and Mental Health

CAMH is Canada's largest mental health teaching hospital and a world leader in mental health and addiction research. As such, CAMH sets the standards for care, research, education and leading social change.

With a dedicated staff of more than 3,000 physicians, clinicians, researchers, educators and support staff, CAMH offers outstanding clinical care to more than 34,000 patients each year. The organization conducts groundbreaking research, provides expert training to health care professionals and scientists, develops innovative health promotion and prevention strategies, and advocates on public policy issues at all levels of government. And through our Foundation, we are working to raise tens of millions of additional dollars to fund new programs and research and augment services.

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## The Health Equity Office

The Health Equity Office has created ongoing collaborations and internal initiatives in the pursuit of health equity. The Health Equity Office makes a continuous effort to reduce disparities in mental illness and treatment through work with Immigrant, Refugee, Ethno-cultural and Racialized Populations, data collection, policy-related activities, research and training programs. These programs aim to consider the causes of health inequities and disparities, and specifically the social determinants of health. These programs pay particular attention to obstacles associated with socio-economic, race, immigration, education and gender status—with the goal of promoting equal opportunities for all and distributing resources to reduce disparities and avoidable inequities.

CAMH has been a leader in diversity and equity. We have been working to eliminate disparities in health status to enable each and every individual to lead a healthy life. Health equity means that we all have equal access to opportunities to attain a higher level of health through timely, appropriate and high-quality care independent of social, economic and demographic status.

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## The Immigrant and Refugee Mental Health Project

### Project leads:

- » Dr. Kwame McKenzie, Director of Health Equity
- » Aamna Ashraf, Manager of Health Equity

### Team:

- » Arda Baykal, bilingual communications specialist
- » Chantel Spade, communications coordinator
- » Jewel Bailey, project coordinator
- » Erin Lee, communications associate



# Our partners



“Before taking part in the Immigrant and Refugee Mental Health Project, where we were lacking was having that **intersectional approach**. So, what it's really done is **enhanced our collaboration** with different sectors, including education, Alberta Health Services, settlement agencies, and the police, so that we are able to work together to be able to **address the mental health needs of our immigrant and refugee populations.**”

## **Dr. Annalee Coakley**

Physician Lead at Mosaic Refugee Health Clinic (Alberta)

CAMH served as the connective tissue bringing multi-sectoral experts from all over Canada together to produce this successful project. The Immigrant and Refugee Mental Health Project demonstrates CAMH's leadership in the community and is a celebration of community and national partners making a joint commitment to provide equitable access to services for immigrant and refugee populations. It would not be possible without the support of our Advisory Committee, Subject Matter Experts, community partners and course contributors. Partnerships include:

### **Advisory committee**

- » **Centre for Addiction and Mental Health, Ontario**  
Branka Agic, director, knowledge exchange
- » **YWCA Hamilton, Ontario**  
Denise Christopherson, chief executive officer
- » **COSTI Immigrant Services, Ontario**  
Yasmine Dossal, director, social services
- » **Canadian Centre for Victims of Torture (CCVT), Ontario**  
Teresa Dremetsikas, programs manager
- » **Association for New Canadians, Newfoundland and Labrador**  
Suzy Haghighi, settlement social work coordinator
- » **YMCA of Greater Toronto, Ontario**  
Nicoleta Monoreanu, national programs, manager client support services
- » **New Brunswick Multicultural Council, New Brunswick**  
Alex LeBlanc, executive director
- » **Ottawa Local Immigration Partnership, Ontario**  
Hindia Mohamoud, director
- » **Immigrant Services Association of Nova Scotia (ISANS), Nova Scotia**  
Juliana Pelinsom Marques, coordinator, newcomer community wellness program
- » **Manitoba Association of Newcomer Serving Organizations**  
Vicki Sinclair, executive director
- » **Global Gathering Place, Saskatchewan**  
Belma Podrug, executive director
- » **Across Boundaries: An Ethnoracial Mental Health Centre, Ontario**  
Aseefa Sarang, executive director



- » **Calgary Catholic Immigration Society**  
Božana Šljuka, Case Manager, Calgary Catholic Immigration Society, Alberta
- » **Polycultural Immigrant and Community Services, Ontario**  
Nadia Sokhan, director, monitoring, reporting and partnerships
- » **Multicultural Council of Windsor and Essex County, Ontario**  
Kathleen Thomas, executive director
- » **Vancouver Association for Survivors of Torture (VAST), British Columbia**  
Mariana Martinez Vieyra, coordinator, provincial refugee mental health
- » **Ontario Council of Agencies Serving Immigrants (OCASI), Ontario**  
Eta Woldeab, associate executive director

## Community partners

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- » Canadian Centre for Victims of Torture (CCVT)
- » The SickKids Centre for Community Mental Health
- » Hong Fook Mental Health Association
- » Mental Health Services Program, COSTI Immigrant Services
- » New Beginnings Clinic, Centre for Addiction and Mental Health
- » Psychological Trauma Program, Mount Sinai Hospital
- » Women's College Hospital's Crossroads Refugee Health Clinic
- » Centre for Refugee Studies, York University
- » YWCA Hamilton
- » Ottawa Local Immigration Partnership
- » Polycultural Immigrant and Community Services
- » Multicultural Council of Windsor and Essex County
- » Ontario Council of Agencies Serving Immigrants (OCASI)
- » Across Boundaries: An ethnoracial mental health centre
- » Lethbridge Family Services » Calgary Catholic Immigration Society
- » Multilingual Orientation Service Association for Immigrant Communities (MOSAIC)
- » Vancouver Association for Survivors of Torture (VAST)
- » Association for New Canadians
- » Immigrant Services Association of Nova Scotia (ISANS)
- » Global Gathering Place
- » Fédération des Francophones de Terre-Neuve-Et-Du Labrador
- » Conseil Multiculturel de Nouveau-Brunswick
- » Accueil Francophone » Réseau de développement économique et d'employabilité du Nouveau-Brunswick : RDÉENB
- » Conseil scolaire mon avenir
- » Réseau des services de santé en français de l'Est de l'Ontario
- » Réseaux en immigration francophone



# Subject matter experts

Project participants can draw on the knowledge and expertise of the SMEs, who are leaders from the settlement and health care sector. SMEs inform project content, have participated in webinars, and are accessible to participants through the CoP.

**Vanessa Wright**  
Nurse Practitioner,  
Crossroads Refugee  
Health Clinic



**Dr. Clare Pain**  
Director, Psychological  
Trauma Program,  
Mount Sinai Hospital;  
Associate Professor of  
Psychiatry, University of  
Toronto



**Sangeeta  
Subramanian**  
Lead Consultant,  
The Inclusion Project



**Dr. Ghayda Hassan**  
Psychologist, Université  
du Québec à Montréal  
(UQAM)

**Vince Pietropaolo**  
General Manager,  
Mental Health Services  
Program, COSTI



“The Immigrant and Refugee Mental Health Project has tremendous impact in that it builds knowledge for service providers and settlement workers. It builds capacity in the sectors and it also builds community for all.”

**Vince Pietropaolo**



**Bonnie Wong**  
Executive Director,  
Hong Fook Mental  
Health Association



**Dr. Debra Stein**  
Staff Psychiatrist  
(children and  
adolescents), SickKids  
Centre for Community  
Mental Health



# About the toolkit

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## Objectives

The toolkit is designed to provide a snapshot of essential information, tools, resources and examples of promising practices that can be integrated into the daily work of settlement, social, and health service providers across Canada, with the aim of building the capacity to better support the mental health unique needs of immigrants and refugees.

The toolkit provides a repository of evidence-based research; information on key models of care and frameworks; and an outline of components that are pertinent to service delivery.

## Who is it for?

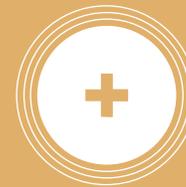
The toolkit is intended to be used by settlement, social and health service providers across Canada who work to support the mental health of immigrants and refugees.



### Settlement and Social Service Providers

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This stream is intended for settlement workers or social service providers in Canada, who in their current training or role conduct needs assessments, provide settlement/social service information and facilitate referrals. Participants in this stream may include service providers such as: **community outreach facilitators, housing counsellors, employment facilitators or family support workers.**



### Health Service Providers

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This stream is intended for health service providers in Canada, who in their current training or role conducts mental health screening/assessment, diagnosis or treatment/therapy, and are comfortable with basic clinical language. Participants in this stream may include service providers such as: **physicians, nurse practitioners, or psychologists/psychiatrists.**



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## How to use

Read through this toolkit at your own pace and use it as a reference point when needed. It is a downloadable document that you can print for easy-use or you can navigate it online and visit external links for additional information. We encourage that you share and discuss it with other service providers in your organization and with partners in the community to foster collaboration. It can be used as complementary to other Immigrant and Refugee Mental Health Project learning initiatives as well.

# Setting the context

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Immigration contributes to the vitality of communities across Canada. Whether through economic immigration, family reunification or the protection of refugees, immigration is a central pillar of Canada's prosperity. The Government of Canada has set a multi-year Immigration Levels Plan that commits to welcoming an increasing number of permanent residents to Canada in the coming years.

Immigrants and refugees may have different reasons for migrating. In general, immigrants come to Canada hoping for a better life, while refugees seek protection from war, organized violence and persecution. However, immigrants and refugees tend to experience similar challenges during post-migration.

Newly-arrived immigrants have better mental and physical health than the Canadian-born population. Many refugees have undergone difficult and traumatic pre-migration experiences that constitute salient risks to their mental health. With time in Canada, however, both immigrants' and refugees' mental health and physical health declines (MHCC, 2016). Evidence suggests that this is more apparent for some immigrant populations – in particular, immigrants from racialized groups, low-income immigrants and refugees (MHCC, 2016). Furthermore, immigrants and refugees tend to experience disparities in their access to services, quality of care and health outcomes (MHCC, 2016).

The rates of mental health problems and illnesses vary considerably among and within different populations. These variations are likely attributable to differences in exposure to and effects of social determinants of health on specific populations. In addition, research shows that these populations are less likely than the Canadian-born population to seek mental health services due to various barriers, and are more likely to end up in emergency rooms if they experience a mental health crisis. This means that one size does not fit all: a blanket approach to service models is simply not effective (MHCC, 2016). In response, the need for timely, culturally responsive, safe and accessible mental health service provision has been well-recognized.

CAMH's Immigrant and Refugee Mental Health Project aims to help fill this service need by providing settlement, social and health service providers across Canada with the knowledge, skills and networks to support the mental health of immigrants and refugees. By providing evidence-based online training, the project is well-positioned to build the capacity of service providers who are in a key position to support the mental health of immigrants and refugees during this crucial post-migration period.



# Key considerations

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This section highlights key considerations that are major themes throughout this toolkit. These key considerations are based on evidence and are continuously recognized as essential components of improving service provision when addressing the mental health of immigrants and refugees.



**“We often look for pathology by associating the terrible things that people have gone through with the inevitability of being mentally ill...but there’s a difference between distress and disorder”**

**Dr. Clare Pain**  
Mount Sinai Hospital

## Mental distress versus mental disorder

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There are many stressors that accompany immigrating to a new country, which may in turn, cause mental distress and symptoms of distress. These are normal responses to stressful situations. At times, service providers may not properly consider the migratory stressors an individual may be dealing with. Rather than being associated with an existing mental health problem or disorder, the symptoms of distress are often a result of settlement issues or the social determinants of mental health.

In addition, while refugees, and in some cases immigrants, may have suffered trauma, a diagnosis of post-traumatic stress disorder, depression or anxiety based on solely on this history may be problematic. The mental distress that an individual may be experiencing is often a normal response to a horrific event. The stressors associated with the migration experience do not necessary result in newcomers developing a mental disorder. In reality, most refugees, and immigrants, will not develop a diagnosed mental health problem (MHCC, 2016).

## Social determinants of mental health

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The social determinants of health are the conditions in which people are born, grow, live, work and age (WHO, 2018). Evidence shows immigrant and refugees groups are more likely than the Canadian-born population to experience disparities in the social determinants of health that result in poorer health outcomes. Furthermore, immigrant and refugee groups, compared



to the Canadian-born population, more commonly experience specific factors such as those relating to pre- and post-migration, language difficulties and racism (Hansson et al., 2010; MHCC, 2016).

The social determinants in the post-migration context are consistently identified as the most important factors affecting the mental health of immigrants and refugees. As a service provider, it is important to acknowledge the impacts of social determinants and to inquire about such factors as housing, income and socioeconomic status, employment, education, experiences of racism and discrimination, among others.



**“Evidence suggests that some subgroups are at greater risk for deteriorating mental health than others. A one-size-fits-all approach to service models is not effective.”**

**Dr. Kwame McKenzie**  
CAMH

## **One-size-fits-all approach**

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Immigrants and refugees are diverse populations and their rates of mental health problems and illnesses vary considerably between and within these groups. They differ based on gender, race, country of origin, age at arrival, length of time in Canada, socioeconomic status, immigration status and circumstances surrounding migration (MHCC, 2016).

As a service provider, when considering mental health problems and illnesses in immigrant and refugee populations it is important to recognize that these groups are not homogeneous and therefore a one-size-fits-all approach to mental health care should not be employed. Newcomers’ histories before coming to Canada, their migration journey to Canada, and their post-migration and integration experiences in Canada, as well as other factors, create unique situations that may influence mental health problems and illnesses for some immigrants and refugees more than others (MHCC, 2016).

## **Connecting to primary care**

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It is important to connect immigrants and refugees to primary health care as soon as possible after arrival. Research has found that newcomers are more likely to use health services in an acute manner as opposed to a preventative manner, meaning they are more likely to use the emergency room as the first point of contact with the health care system rather than seeing a general practitioner (Tiagi, 2016). In general, immigrants and refugees are less likely than





**“People should be connected to primary care early on in the migration process, even if they are doing well. If things do fall apart, it is much easier to work with someone you already know than to seek out primary care when you are feeling ill”**

**Dr. Meb Rashid**

Crossroads Refugee Health Clinic, Women’s College Hospital

their Canadian counterparts to use a mental health service in primary care or specialty health care settings (Chen et al., 2009; Durbin et al., 2014, 2015). Being connected with a primary care provider is essential as primary care providers have a better understanding of the needs of their patients compared to the shorter-term, problem-specific interactions clients encounter in acute care.

The primary care connection allows for the development of rapport and a relationship that may better allow refugees and immigrants to feel comfortable disclosing any potential physical and/or mental health concerns, leading to the provision of appropriate diagnosis and treatment. For example, a client’s description of particular symptoms may indicate a major psychiatric disorder, but only a health service provider with an adequate amount of time, connection and understanding of the client can properly screen and assess for this (Abbey, 2010). In addition, newcomers are less likely to seek care for mental health distress on their own and may be more likely to seek mental health services through their primary care provider (Hansson et al., 2010; Kirmayer et al., 2011; MHCC, 2016).

## **Resilience**

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Post-migration resettlement and integration is associated with processes of dynamic adapting, where individuals demonstrate active ways of coping (Simich & Roche, 2012). The role of a service provider entails supporting and facilitating access to protective factors that contribute to resilience. A strength-based approach emphasizes resilience and a shift away from vulnerability and pathology, and instead focuses on the strengths and solutions that immigrants and refugees bring with them (Simich, 2014).

Resilience is often described as an individual attribute, but emerging evidence highlights the significance of contextual, cultural and social factors that may support individuals and communities in adapting as well (Simich & Roche, 2012). Thus, resilience is not only the outcome of individual psychological processes, but also involves the “social process that reside in relationships among people, systems and institutions at the level of families, neighborhoods, communities, and organizations, governments and transitional networks” (Kirmayer, 2014, p.vii).



# Promising practices, tools and resources

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This section highlights promising practices, tools and resources in the settlement, social and health care sectors to inform the work of service providers and organizations. It provides evidence-based research to build your knowledge; information on key models of care and frameworks to inform your work; and, an outline of components that are pertinent to effective service delivery. It also discusses innovative strategies for offering appropriate and adequate care and support to better the mental health outcomes of immigrants and refugees.

## Evidence-based research

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This sub-section provides evidence-based research on the mental health of immigrants and refugees and reports on immigration trends. This section is to be used as background reading, with the aim of providing service providers with a baseline of knowledge of the current immigration context and the mental health needs and considerations for supporting immigrants and refugees.

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### Immigration trends

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#### **2019 Annual report to parliament on immigration**

*Immigration, Refugees and Citizenship Canada*

This report provides offers key information on the successes that have been achieved as they relate to welcoming newcomers to Canada. It sets information and statistical details regarding temporary resident volumes and permanent resident admissions. It also provides the projected number of upcoming permanent resident admissions in future years, beginning in 2020. [Access online >](#)

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#### **World Migration Report 2020**

*International Organization for Migration*

This report presents key data and information on migration as well as thematic chapters on emerging migration issues globally. [Access online >](#)



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## **Global trends: Forced displacement in 2018**

*United Nations High Commissioner for Refugees*

This annual report analyses statistical trends and changes in the UNHCR's populations of concern and seeks to deepen the public's understanding of ongoing crisis. UNHCR reports on the numbers of refugees, internally displaced people, people who had returned to their countries or areas of origin, asylum-seekers, and stateless people. The information in this report is important in ensuring there is an appropriate and adequate humanitarian response in place to meet the needs of refugees and other populations of concern.

[Access online >](#)

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## **Mental health of immigrants and refugees**

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### ***Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups: Issues and options***

*Mental Health Commission of Canada*

Improving mental health services and outcomes for immigrant, refugee, ethno-cultural and racialized (IRER) groups is a common challenge for mental health systems in high-income countries. This report, which is the result of a number of different lines of investigation and consultation, outlines the plan for service improvement. This includes the identification of key issues that policy makers, health planners and service providers across Canada may consider when developing strategies to improve mental health services for IRER populations.

[Access online >](#)

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### ***Changing directions, changing lives: The mental health strategy for Canada***

***Mental health Commission of Canada***

This report outlines the first mental health strategy for Canada. Drawing on the best available evidence and in consultation with people living with mental problems and illnesses, families, stakeholder organization, governments and experts across Canada, translates the gathered information into broad recommendations for action. As a result, improved mental health services and support for immigrants, refugees, ethno-cultural and racialized (IRER) groups was identified as a key priority. [Access online >](#)



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***The case for diversity: Building the case to improve mental health services for immigrant, refugee, ethno-cultural and racialized populations***

*Mental Health Commission of Canada*

Building on the Issues and Options report, this report builds the case – economically and socially – for investing in culturally and linguistically appropriate and diverse mental health care for Canada’s Immigrant, Refugee, Ethno-cultural and Racialized (IRER) populations. This report offers: an examination of Canadian published research on IRER peoples mental health in Canada, promising practices to better serve IRER populations and an economic evaluation of IRER mental health service use. [Access online >](#)

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***Immigrant, refugee, ethnocultural and racialized populations and the social determinants of health***

*Mental Health Commission of Canada*

This report discusses select sociodemographic trends and issues related to Immigrant, refugee, ethno-cultural and racialized (IRER) populations’ mental health and well-being, identified from 2016 Census Data. It highlights a number of key social determinants that influence mental health, including language, income, education, unemployment and underemployment, discrimination, and hate crimes. The data shows that immigrants experience a range of equity-related issues after settling in Canada – with many having an impact on health outcomes – and it speaks to an increasingly urgent need for action.

[Access online >](#)

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## **Models of care and frameworks**

This sub-section outlines key models of care and frameworks to inform your work when supporting the mental health of immigrants and refugees. It provides a brief overview of each, and directs you to helpful tools, resources, and promising practices. While this is not intended to be an exhaustive list, these models of care and frameworks are selected based on evidence that shows that these are appropriate when working with immigrant and refugee populations.



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## Trauma-informed care

Although different people respond to traumatic experiences in different ways, most people who have been exposed to organized violence do not require trauma treatment. Nevertheless, trauma is an experience that can overwhelm an individual's emotional and psychological ability to cope. It often results in lasting mental and physical effects. It is important to acknowledge clients' feelings and the courage it takes to disclose trauma. However, probing into trauma can cause survivors to feel overwhelmed and can sometimes lead to re-traumatization. As trauma counselling falls outside the scope of the settlement and social service provider's role, they should refer clients to appropriate services.

Organizations that provide services to newcomers should be aware of trauma-informed services. Service providers should be sensitive to the effects of organized violence and plan programs in a way that recognizes there are many paths to recovery.

- » When service providers are trauma-informed, they do not automatically assume, for example, that every client seeking services has a biological mental illness or needs psychiatric services.
- » When programs are trauma-informed, clients are not inadvertently re-traumatized by policies or procedures that recreate or resemble previous traumatic events. As such, all clients can benefit from services, whether or not they choose to identify themselves as trauma survivors (Blanch, 2008).

### Resources:

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#### **Trauma-informed practice guide**

*BC Provincial Mental Health and Substance Use Planning Council*

The Trauma-Informed Practice Guide is intended to support the translation of trauma-informed principles into practice. Included are concrete strategies to guide the professional work of service providers assisting clients with mental health and substance use concerns. [Access online >](#)

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#### **Trauma-informed: The trauma toolkit – A resource for service organizations and providers to deliver services that are trauma-informed**

*Klinic Community Health Centre*

This toolkit aims to provide knowledge to service providers working with adults who have experienced or been affected by trauma. It will also help service providers and organizations to work from a trauma-informed perspective and develop trauma-informed relationships that cultivate safety, trust and compassion. [Access online >](#)



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## **Guidelines on trauma and violence informed approaches: For agencies serving immigrants and refugees**

Ontario Council of Agencies Serving Immigrants

The purpose of this guide is to foster an organizational commitment to acknowledge and understand the role that trauma and violence play in the lives of people and to support a culture of learning, and building strength, resilience and capacity to create safe environments for both service users and staff.

[Access online >](#)

### **Promising practices:**

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#### **Centre for Canadian for Victims of Torture (CCVT)**

CCVT is a community-based organization that helps victim of torture, war, genocide and crimes against humanity. They provide treatment, tools and support that allow refugees to heal from trauma and become active community members. [Access online >](#)

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#### **Vancouver Association for Survivors of Torture (VAST)**

VAST provides trauma-focused psychological counselling to refugees, group support to document symptoms of psychological trauma to support a refugee claim, referrals to health, housing and settlement services, and capacity building and education workshops on refugee mental health. [Access online >](#)

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### **Anti-oppression and anti-racism frameworks**

It is important for service providers to be aware of what it means to work within an anti-oppression and anti-racism framework, and how these frameworks translate into mental health and service delivery for immigrant and refugee populations (Corneau & Stergiopoulos, 2012).

Anti-oppression can be a difficult concept to understand and is a widely debated concept. In general, an anti-oppression framework is based on the following premises (Larson, 2008):

- » promotion of egalitarianism and power sharing
- » understanding of one's social location and how it informs relations and practice behaviours
- » challenging of existing social relationships
- » participation in practice behaviours that minimize power imbalances and promote equity and
- » empowerment for service users



## Resource:

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### ***Building champions of anti-racism and anti-islamophobia: A practice guide for Alberta's settlement community***

*Alberta Association of Immigrant Serving Agencies*

Recognizing that the issue of racism and Islamophobia is complex, this practical guide aims to simplify, deepen understanding and provide practical support for those working on the frontline with immigrants or refugees. It reflects on both ongoing promising practices and seeks to share learnings from different sectors or systems to enhance practice. [Access online >](#)

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### ***An integrated anti-oppression framework for reviewing and developing policy: A toolkit for community service organizations***

*Springtide Resources and United Way Greater Toronto*

This toolkit was created to support community service organizations to consistently integrate their anti-oppression learning into practice. The aim of the toolkit is to help organizations review and consider changes to policies to ensure that they are equitable for all employee and members, and for their community. It includes suggestions and checklists designed to help foster discussions allowing for an application of an anti-oppression analysis to current policies.

[Access online >](#)

## Promising practice:

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### ***Anti-racist, holistic service delivery model Across Boundaries***

This report describes the elements as well as generates a common language to discuss and define an anti-racist holistic service delivery model. It demonstrates how Across Boundaries has successfully integrated this framework in various aspects throughout the organization in order to address the impact of racism and discrimination on mental health and well-being. [Access online >](#)

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## **Cultural humility and safety**

Cultural humility is a lifelong process of self-reflection and learning to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience (First Nations Health Authority, 2019). Cultural humility is a building block for cultural safety. It is an overarching principle that is threaded through our learning and acts as the process by which change can occur (Northern Health Indigenous Health, 2019).



Originating in New Zealand in the field of nursing education, cultural safety has become an influential perspective in developing better health care for Indigenous people (Ward, Branch & Fridkin, 2016). Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care (First Nations Health Authority, 2019). People are supported to draw strengths from their identity, culture and community (Northern Health Indigenous Health, 2019).

Although the resources and promising practices do not speak directly to service provision specific to immigrant and refugee populations, the same principles can be integrated into your work and practice.

## Resources:

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### **Policy statement on cultural safety and humility**

*First Nations Health Authority*

This document outlines the First Nations Health Authority's view on creating cultural safety and humility in the health care system. It builds a common understanding of cultural safety and humility, communicates its views with health partners and provides recommended actions to embed cultural safety into the health system across multiple levels. Although this is specific to supporting First Nation's populations, its principles are applicable to service provision with immigrants and refugees. [Access online >](#)

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### **Cultural safety and humility: Key drivers and ideas for change**

*First Nations Health Authority*

This document is intended to support service providers in achieving culturally safe health services. It offers practical tips and ideas for enhancing cultural safety in five areas: values and attitudes, structures and policy, evaluation and research, training and development, and leading practice. [Access online >](#)

## Promising practice:

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### **Battered Women's Support Services, Indigenous Women's Program**

The Indigenous Women's Program currently offers support programs and groups at in partnership with other organizations. The Indigenous Women's support workers use traditional healing practices while working with women survivors of trauma and colonization. [Access online >](#)



## Service delivery

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This sub-section identifies key components that can be improved and implemented in order to make service delivery seamless, timely, and appropriate for supporting the mental health of immigrants and refugees. This includes a one-stop hub model of service delivery; ensuring a connection is established to primary care soon after arrival; the establishment of community partnerships; information and resources on the promotion of mental health; the need for interpretation services; health care coverage for immigrant and refugee populations; and, the importance of self-care for service providers.

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### One-stop hubs

Immigrants and refugees often experience various barriers in accessing adequate and timely mental health services. In many cases, services are fragmented and compartmentalized, which results in service users being transferred back and forth across systems (CDCD, 2010). This becomes inconvenient, time consuming and costly for the service user, ultimately resulting in their needs going unmet (CDCD, 2010).

A good model of service delivery follows an integrated approach, whereby organizations collaborate to deliver programs and services in the form of joint programming or co-location (CDCD, 2010). This model allows for: a single point of access for a variety of services; a space that can be accessed easily by public transit; flexible hours of operation; a space for child-care if needed; and, a place to build a social network. A one-stop hub facilitates integration between programs and services that have traditionally been implemented independently, resulting in seamless service provision (CDCD, 2010).

### Promising practices:

**Community hubs:** these public spaces allow local residents to access programs, services and community spaces in a single location.

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### Youth Wellness Hubs

This initiative consists of integrated service hubs across Ontario to address the existing gaps in the youth mental health service system. Ten hubs are now being established to serve as fully integrated “one-stop-shops” for youth aged 12-25, to address their needs related to mental health, substance use, primary care, education/employment/training, housing and other community and social services. [Access online >](#)

**Community Health Centres:** these centres deliver primary care services through a collaborative team approach, and integrate health promotion programs, illness prevention programs, community health initiatives and social services focused on housing, food security, employment etc.



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### **Mount Carmel Clinic**

The first Community Health Centre, established in Winnipeg, continues to provide not only primary care services, but also programs that seek to address the social determinants of health. This centre works to adapt its programs to respond to the unique needs of its service users. [Access online >](#)

**Welcome Centres:** these hubs are based on a service delivery model that is holistic and flexible – providing a broad range of cross-sector services and expertise to new immigrants and refugees under one roof.

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### **Immigrant Services Society of BC**

A one-stop support centre, located in Vancouver and Surrey, offers a wide variety of services to meet the immediate needs of newcomer immigrants and refugees. immigrant services hub located in Vancouver It also partners with organizations in order to provide a unique avenue for connecting newcomers with local and broader communities. [Access online >](#)

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## **Connecting to primary care**

It is important to connect immigrants and refugees to primary health care as soon as possible after arrival. Being connected with a primary care provider is essential as primary care providers have a better understanding of the needs of their patients compared to the shorter-term, problem-specific interactions clients encounter in acute care. In addition, prompt access to appropriate mental health interventions improves outcomes and decreases the need for more costly interventions later on, such as hospitalization (Gardner, 2008).

### **Resources:**

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#### ***Innovations to champion access to primary care for immigrants and refugees***

*Wellesley Institute*

To promote good health and address their health care needs we need to ensure immigrants and refugees to Canada have the best possible access to primary care and preventative care services. This article outlines three promising practices and strategies to improve access to primary health care.

[Access online >](#)



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***Women’s College Hospital Crossroads Clinic***

The Crossroads Clinic complements the long-standing work being done in neighbourhood community health centres. They provide comprehensive medical services to newly arrived refugee clients for their first two years in Toronto. The medical team has previously worked with hundreds of newly arrived refugees and is very familiar with the refugee process and all the stresses and challenges that it involves. They provide a range of services and connect clients to a family physician after two years. [Access online >](#)

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***Mosaic Refugee Health Clinic***

The Mosaic Clinic in Calgary provides primary and multi-speciality care services including women’s, children’s, and family health, mental health and transition services. They recommend other health services as needed, and they connect clients to a family physician in the community after two years. [Access online >](#)

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***Community Airport Newcomers Network: Vancouver International Airport***

This network strives to facilitate the pre-settlement of all immigrants arriving in Canada at the Vancouver International Airport by offering individualized reception, orientation, information, and referrals. The one-time service offered at the airport aims to help newcomers gain a better understanding about the first steps to take to settle in Canada by providing them with information and referring them to other organizations. If immigrants and refugees are unable to connect immediately with primary care, initiatives such as these, ensure that these populations are at least able to connect to services that can then make appropriate referrals as soon as possible. [Access online >](#)



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## Partnerships

Establishing strong partnerships can promote wellness and prevent illness among immigrant and refugee groups in Canada. Partnerships can help by increasing early recognition of mental health problems, adopting a variety of treatment modalities and improving the retention of clients in treatment (Rogers & Robinson, 2004; Trainor et al., 1999). The barriers faced by immigrants and refugees in accessing and receiving appropriate and timely mental health services are largely systematic. In addition, the social determinants of health affects individuals at and across different levels of society (Dahlgren & Whitehead, 1991). Similarly, programs for promoting mental health and preventing mental illness that intervene at multiple levels have a greater change for success (Strader et al., 2000). In response, partnerships between organizations are essential in increasing the capacity to respond to needs and issues faced by immigrants and refugees.

For example, for individuals and groups to whom religion is important, it may be helpful to consider partnerships that include faith leaders. Partnering with religious and faith leaders can help establish connections with hard-to-reach immigrant and refugee communities. Places of worship are trusted, easily accessible and often prominent in the lives of immigrant and refugee groups (Chaze et al., 2015; Lee et al., 2008; Williams et al., 2014). They can provide spaces for people living with mental health problems as they are seen as sacred and offer physical, social, and spiritual/emotional support (Agyekum & Newbold, 2016; Griffith et al., 2016; Lee et al., 2008; Williams et al., 2014).

## Resources:

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### **Local immigration partnerships handbook**

*Citizenship and Immigration Canada*

This handbook is intended to assist communities, organizations and governments in establishing Local Immigration Partnerships (LIPs) as a means of planning and coordinating at the local level with municipal, provincial/territorial and federal involvement. [Access online >](#)

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### **Faith and settlement partnerships: Setting immigrants and Canada up for success**

*Centre for Community Based Research*

This report outlines a two-year project that aimed to study the partnerships among faith-based and government-funded settlement organizations. The aim is to determine how these partnerships can better lead to positive settlement outcomes for newcomers, and ultimately benefit Canadian society.

[Access online >](#)



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### **Peel Service Collaborative**

Many youth seek help from informal supports such as faith leaders when experiencing mental health or substance use issues; however, these supports indicated that they needed to build their skills and knowledge to better understand mental health issues and help youth seeking assistance. The Peel Service Collaborative designed an intervention designed to bridge the gap between formal and informal mental health and addiction supports and build a system that better serves the needs of a diverse population. [Access online >](#)

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### **The Ottawa Local Immigration Partnership (OLIP)**

The OLIP is a multi-sectoral partnership involving 60 local organizations working on a shared vision and common priorities designed to build local capacity to attract, settle, and integrate immigrants in five sectors: education, economic integration, health and well-being, language and socio-civic integration. Partners include the City of Ottawa, local universities and colleges, the four school boards, employers and employer associations, settlement, social, and health service providers, and regional planning bodies. [Access online >](#)

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### **West-End Non-Insured Walk-In Clinic**

Established in response to the increase of vulnerable populations not having access to appropriate and adequate health services, this partnership of seven Toronto community health centres and local midwives offers confidential health care services at no charge. [Access online >](#)

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## **Mental health promotion**

The mental health needs of immigrant and refugee communities are diverse, and mental health promotion strategies and solutions need to account for this diversity. Growing evidence shows that the best results are achieved by initiatives that target specific groups and settings, including in the home, school, workplace and community (MHCC, 2012).

The Ottawa Charter for Health Promotion (Government of Canada, 1986) identifies five action areas that are essential for health promotion strategies. A mental health promotion strategy should:

- » build healthy public policy
- » create supportive environments
- » strengthen community action
- » develop personal skills
- » reorient health services.



## Resources:

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### **Culture counts: A roadmap to health promotion**

*Centre for Addiction and Mental Health*

This guide is intended for service provider working agencies or organizations who are undertaking health promotion initiatives with ethnocultural communities. It focuses on breaking down the barriers between ethnocultural communities and effective health promotion in mental health and substance use. It provides basic steps and background with links to other online resources. [Access online >](#)

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### **Best practice guidelines for mental health promotion programs:**

#### **Refugees**

*Centre for Addiction and Mental Health*

This resource provides health and social service providers with current evidence-based approaches in the application of mental health promotion concepts and principles for refugees. It is intended to support practitioners, caregivers and others in incorporating best practice approaches to mental health promotion initiatives or programs directed toward refugees. [Access online >](#)

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### **Mental health promotion guide for agencies serving immigrants and refugees in Ontario**

*Ontario Council of Agencies Serving Immigrants*

This guide will help agencies in the immigrant and refugee serving sector to develop a common set up policies and practices that promote refugee client's mental health. It explores the role of settlement agencies and the role of front-line staff at settlement agencies in promoting client's mental health, as well as makes recommendations for policies and practice to optimize this promotion. [Access online >](#)

## Promising practices:

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### **The Opening Doors Project**

*Canadian Mental Health Association*

This program uses unique story-telling techniques in presenting workshops to agencies and the community, which are aimed at strengthening, fostering and cultivating healthier communities in Ontario. It is particularly beneficial to newcomers in Canada, mental health survivors and mental health service providers. [Access online >](#)



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## **Prevention and promotion program**

*Hong Fook Mental Health Association*

The overall goal of the Prevention and Promotion Program is to build community capacity through empowering individuals with the knowledge of mental health and resources so that they can play a more active role when it comes to their mental health. As well, the suite of programs aim to build community capacity by providing accurate information to reduce stigma, by advocating equal access to mental health services, and by encouraging community participation.

[Access online >](#)

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## **Mental health promotion within immigrant and refugee communities**

*Here to help*

A coalition of seven agencies developed the website that provides information about mental health promotion initiatives. A number of these resources are dedicated to the mental health needs of immigrants and refugees.

[Access online >](#)

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## **Interpretation**

Communication is paramount when it comes to accessing mental health care services, communicating symptoms of distress and receiving adequate support and treatment. Compromised communication can have an impact on a client's mental health. The client can receive inappropriate treatment, may not have a clear understanding of their diagnosis, may use mental health services less often, and may be less satisfied with the care they received. As many studies indicate, the use of trained interpreters is the most effective approach in improving access to care, the accuracy of diagnosis, and treatment outcomes (Brisset et al., 2013).

### **Resources:**

**British Columbia:** MOSAIC coordinates over 300 language specialists working in more than 80 languages to provide public and private sectors with professional interpretation and translation services. [Access online >](#)

**Alberta:** The Language bank at Immigrant Services Calgary provides translation and interpretation services offered to individuals and organizations in over 50 languages. [Access online >](#)

**Manitoba:** Language Bank services at Immigrant Centre Manitoba has over 400 translators registered with them, with over 50 different languages.

[Access online >](#)



**Nova Scotia:** Nova Scotia Interpreting Services offers consecutive in-person and telephone interpreting services to hospitals, government departments and other organizations. [Access online >](#)

**Ontario:** Access Alliance Language Services provides translation services, and face-to-face and remote interpretation services to a diverse range of public sector organizations. [Access online >](#)

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## Health care coverage

As a service provider, it is important to be aware of health care coverage options for different immigrant and refugee populations you may work with. In different provinces and territories, eligibility and waiting periods for coverage may differ.

### Resources:

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#### ***Interim federal health program: Summary of coverage***

*Government of Canada*

This website provides information on the Interim Federal Health Program – the federal healthcare coverage initiative for refugees in Canada. It provides details about overseas coverage, in-Canada coverage, and has links where you can consult the IFHP benefit grids. [Access online >](#)

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#### ***Health insurance for immigrant and refugee families***

*Kids New to Canada*

This website provides detailed information on health insurance for permanent residents, refugees and refugee claimants, and uninsured children. It also provides external links where you can gather information tailored to your specific needs. [Access online >](#)



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## Self-care

To manage their mental health and well-being, service providers should be aware of the conditions that may affect them, and how to avoid these conditions and/or mitigating their effects. Service providers may experience compassion fatigue, burnout or vicarious trauma – all of which have varying risk factors and signs/symptoms. If persistent and severe symptoms of distress are experienced, to the degree that functioning is impaired, it may be time to seek help for burnout, secondary trauma or compassion fatigue. Self-awareness and self-care strategies are key to preventing and managing burnout, compassion fatigue and secondary trauma.

### Resources:

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#### ***Guidebook on vicarious trauma: Recommended solutions for anti-violence workers***

*Health Canada*

This guidebook is written to promote individual, professional and organizational solutions to support service providers in a helping profession. All service providers who are exposed to the trauma inflicted on others may benefit from the solutions proposed in this guidebook. [Access online >](#)

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#### ***Taking care of yourself: A brief guide for UNHCR fieldworkers***

*United Nations High Commissioner for Refugees*

This document outlines what responses to stress may look like and identifies key coping strategies that can be implemented. Although this is designed for UNHCR fieldworkers, all of this information is transferrable to the settlement, social and health service sector. [Access online >](#)

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#### ***Professional Quality Of Life Scale***

This is a validated, 30-item self-report designed for those in the helping professions. It provides ratings for compassion satisfaction/fatigue, burnout and secondary trauma.

Note that the ProQOL assessment is a screening tool, not a diagnostic test. It presents a snapshot of the user's situation at a particular moment and can be repeated over time to provide insight into how the user is coping with the psychological challenges of work. [Access online >](#)



# Evaluation

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The growth of any program requires the honest assessment of where that program is at the present, and that is where evaluation comes in. Program evaluation is the process of looking at the goals and desired outcomes of a program and critically assessing how well it is reaching those goals. Evaluation is an iterative process that any program can benefit from throughout virtually any stage of that program's life.

## Why Evaluate?

**Evaluation tells the story behind your success.** Even if your program has met its goals, the pathway of that success is valuable knowledge for improving the efficiency of your program. By pinpointing the most impactful components of your program and eliminating components that have little to no impact, you can improve the services being offered to your target population while optimizing use of your resources. Further, understanding what components make a program successful will allow you to replicate that success in other projects and share that knowledge with others in the community.

**Evaluation is essential for improving Equity.** The World Health Organization defines equity as, “the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically” (WHO, 2017). At the heart of equity is ensuring that there are no differences in the accessibility, quality and outcomes of your program for different people groups. Evaluation enables equity by equipping you with the necessary knowledge on who is accessing your services, what their experiences are like, and the outcomes of your services for the population you serve. This information will tell you if your programs are not serving a particular sector of the population you serve. For instance, if you have no one from the LGBTQ community accessing your service, but they account for 5% of the population in your service area, it is worth considering why that is the case and how you could increase the accessibility of your services for that group. If people are having differential experiences when accessing your services, then it would be worth finding out why. For instance, perhaps clients who do not speak English rate having a poorer experience when accessing service; it might then be worth considering interpretation services or translating materials.

**Evaluation demonstrates impact.** Evaluation allows you to see the impact and progress of your program, which can be shared with staff, shareholders, and the public. This will allow you to attract and retain good staff, keep stakeholders and funders engaged, and grow in your public support.

## What makes good evaluation?

A good evaluation will capture multiple stakeholder perspectives, is adapted to your program needs, and can be replicated with the same findings.

**Good evaluation includes multiple stakeholder voices.** When it comes to evaluation, every voice matters and is useful for creating a holistic image of your project. It also protects your evaluation from the bias that can be created by more dominate or vocal stakeholders. Key stakeholder groups to think about when conducting your evaluation include: (1) those who are served or impacted by the program, (2) those involved in the day-to-day operations of your program, and (3) those who have an interest in the evaluation findings.



**Once size does not fit all.** Good evaluation is tailor fitted for your program. Your project will have unique goals, objectives and pathways to those goals/objectives. It can be useful to use evaluation plans from similar projects as a starting point, but it is important to then make adaptation based on how your program operates.

**Replicability is key.** Good evaluation aims at being specific, rigorous, and unbiased enough that it can be replicated with the same conclusions being reached. Designing your evaluation with replicability in mind requires high quality evaluation design, data-collection methods, and analysis so as to limit bias and potential inaccuracy. Rigorous evaluation that can be replicated can also garnish greater confidence in evaluation findings among stakeholders.

### Why collect information on the people we serve?

The Government of Canada collects a population Census every five years, why? It is essential to track changes in who are in Canada, where people reside, and properly inform communities for the planning of services. This need is also essential to organizations, programs and services, if you know who you currently serve, and whom you do not it can help you track changes in who access your programs, and to plan programs accordingly. If a service does not ask the questions, you cannot know whom you are serving and whom you are failing to provide support to with your programming. Proper collection of socio-demographic data can provide organizations with a wealth of information, allow them to provide targeted support services and implement changes to address inequities in access, and outcomes.

Despite knowing this the collection of socio-demographic information is scattered and fragmented, often because it is believed the public feels asking these questions is intrusive or discriminatory. However, research has found that the public see the value in collecting this information (Baker et al., 2005, 2007; Quan et al., 2006) especially when the reasons are explained and the person asking the questions is someone they trust (IOM, 2009), or if the person fills out the form themselves.

### An example

The TRI+ Study in Toronto found medical patients in 5 different programs across four healthcare organizations willingly provided socio-demographic information, especially when they understand the purpose of the survey (Wray et al., 2013). However, staff level of understanding and comfort are key to the success of data collection (Wray et al., 2013). Provide staff with the big picture of the purpose for this information, we need to know who we serve, we need to know how well we are serving the distinct different populations we provide services to, and are we failing/missing to serve people we expect we should be serving. Do the people we already serve need special programs that we could not have realized/know without collection this information? Talking to staff, laying this groundwork and providing training supports greater uptake of data collection, but ensure that you feedback the results of the collection as well as the changes implemented/planned as a result of the data collection (Wray et al., 2013). Research at St. Michael's Hospital using socio-demographic data has found disparities in the rates of cancer screening among lower income individuals (Lofters et al., 2017) and for trans people (Kiran et al., 2019). At the time of the publication St. Michael's was developing a new electronic management record form to summarize trans patients' cancer screening and integrate better monitor of trans peoples' screening rates (Kiran et al., 2019). Data can be a powerful tool to influence significant system changes.



# Glossary of terms

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## **Adjustment disorder**

The presence of emotional or behavior symptoms that occur within three months of the onset of an identifiable stressor.

## **Bisexual**

A person who is emotionally, physically, spiritually and/or sexually attracted to people of more than one gender, though not necessarily at the same time.

## **Cis/Cisgender**

A person whose gender identity is the same as the sex they were assigned at birth. The term also includes the understanding that a person's gender identity, role, expectations and expression conform to society's expectations of the gender associated with their biological sex and anatomy.

## **Client**

The term "client" is used throughout this course (instead of "patient", "consumer" or other terms).

## **Ethnic Origin**

Ethnic origin is generally used by the Government of Canada to refer to the ethnic or cultural origins of a person's ancestors. Ethnic origin does not refer to citizenship, nationality, language or place of birth.

## **Gay**

A person who is emotionally, physically, spiritually and/or sexually attracted to the same gender. The word can refer to men or women, although some women prefer "lesbian." It is sometimes used as an umbrella term for the LGBTQ community.

## **Gender Binary**

A social system whereby people are thought to have either one of two genders: "man" or "woman." These genders are expected to correspond to birth sex: male or female. In the gender binary system, there is no room for living between genders or for transcending the gender binary. The gender binary system is rigid and restrictive for many people whose sex assigned at birth does not match up with their gender, or whose gender is fluid and not fixed.

## **Genderqueer**

Individuals who do not follow gender stereotypes based on the sex they were assigned at birth. They may identify and express themselves as "feminine men" or "masculine women" or as androgynous, outside of the categories "boy/man" and "girl/woman." People who are gender non-conforming may or may not identify as trans or transgender.

## **Government Assisted Refugees (GARs)**

GARs are refugees, from the Convention Refugees Abroad Class, whose initial resettlement in Canada is supported by the Government of Canada or the Government of Quebec.



**High context culture**

In high-context cultures, such as Chinese culture, other communicative cues such as body language, the understanding of unspoken rules and even silence have a more important role to play in communication. The message is not as much in the spoken word as it is embedded in the context. There is more emphasis on what is left unspoken and more responsibility on the listener to interpret the meaning.

**Immigrant**

The Canadian government defines immigrants as "persons residing in Canada, who were born outside of Canada, excluding temporary foreign workers, Canadian citizens born outside Canada and those with student or working visas". There are times when the term "immigrants" is included in the "refugee" classification and vice versa. In this course, where possible, an effort has been made to clarify the above when referencing literature.

**Incidence risk ratio**

Refers to the risk of a new event of psychosis occurring during the timeframe for the population in question, compared to the risk of a new case of psychosis occurring in the comparison group.

**Intersex**

A person born with reproductive systems, chromosomes and/or hormones that are not easily characterized as male or female. This might include a woman with XY chromosomes or a man with ovaries instead of testes. Intersex characteristics occur in one out of every 1,500 births. Typically, intersex people are assigned one sex, male or female, at birth. Some intersex people identify with their assigned sex, while others do not, and some choose to identify as intersex. Intersex people may or may not identify as trans or transgender.

**Lesbian**

A woman who is emotionally, physically, spiritually and/or sexually attracted to women.

**LGBTQ**

This course uses the term LGBTQ (lesbian, gay, bisexual, transgender and queer). The use of this term is not intended to be exclusive; it is recognized that terminology for sexual orientation or gender identity (SOGI) can vary by region and community, and across time and place (Hall & Sajjani, n.d.).

**Low context culture**

In low-context cultures, such as American culture, communication occurs predominantly through explicit statements. The message is in the spoken word. Silence and pauses are usually perceived as either signs of agreement or a lack of interest.

**Mental Disorder**

Mental disorders (also called mental illnesses) are characterized by alterations in thinking, mood or behaviour (or some combination thereof) associated with significant distress and impaired functioning.

**Mental Health**

The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".



**Mental Illness**

Mental illnesses (also called mental disorders) are characterized by alterations in thinking, mood or behaviour (or some combination thereof) associated with significant distress and impaired functioning.

**Migrant**

A migrant is a person who is outside their country of origin.

**Newcomer**

In this course, the phrase “immigrant and refugee” may be used interchangeably with the term “newcomer,” and both will refer to immigrants and refugees who have been in Canada for less than five years.

**People with disabilities**

People with disabilities include “those who have long-term physical, mental, intellectual or sensory impairments [by illness, injury or wounds] which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (United Nations [UN], 2006).

**Permanent Residents**

A permanent resident is a person who has been granted permanent resident status in Canada, but is not a Canadian citizen.

**Queer**

Formerly, a derogatory slang term used to identify LGBT people. Some members of the LGBT community have reclaimed queer as an identity and use it to describe their sexual orientation and/or gender identity.

**Racialized**

The Ontario Human Rights Commission describes people as “racialized person” or “racialized group” instead of the terms “racial minority,” “visible minority,” “person of colour” or “non-White,” as “racialized” expresses race as a social construct rather than as a description based on perceived biological traits. The term “racialized” is used in this course, except when referring to sources which use different terminology (e.g., visible minority, South Asian, etc.). In those cases, the original terms from the literature are used.

**Refugee**

The United Nations Convention relating to the Status of Refugees defines a refugee as someone who, "owing to a well-founded fear or being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country". There are times when the term “immigrants” is included in the “refugee” classification and vice versa. In this course, where possible, an effort has been made to clarify the above when referencing literature.

**Temporary Resident**

A temporary residence is a person who has permission to remain in Canada on a temporary basis. The three main types of temporary residence are: (1) visitors, (2) students, and (3) workers.

**Transgender**

Umbrella terms that describe people with diverse gender identities and gender expressions that do not conform to stereotypical ideas about what it means to be a girl/woman or boy/man in society. “Trans”



can mean transcending beyond, existing between, or crossing over the gender spectrum. It includes but is not limited to people who identify as transgender, transsexual, cross-dressers or gender non-conforming (gender variant or gender-queer).

Trans identities include people whose gender identity is different from the gender associated with their birth-assigned sex. Trans people may or may not undergo medically supportive treatments, such as hormone therapy and a range of surgical procedures, to align their bodies with their internally felt gender identity.

### **Transsexual**

A person whose gender identity differs from their sex assigned at birth. They may or may not undergo medically supportive treatments to align their bodies with their gender identity, such as hormone therapy, sex reassignment surgery or other procedures or changes.

### **Two-spirit**

A term used by Indigenous Peoples to describe from a cultural perspective people who are gay, lesbian, bisexual, trans or intersex. It is used to capture a concept that exists in many different Indigenous cultures and languages. For some, the term two-spirit describes a societal and spiritual role that certain people played within traditional societies. They were often mediators, keepers of certain ceremonies and transcended accepted roles of men and women by filling a role as an established middle gender.

### **Violence against women**

The United Nations Declaration on the Elimination of Violence against Women (1993, Article 1) defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life.”

### **Visible Minority**

Visible minority refers to “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour”. This term is used by some researchers; however, the term “racialized” will be used throughout this course.



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