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Centre for Addiction and Mental Health
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Best practice guidelines for mental health promotion programs: Refugees

A joint project of the

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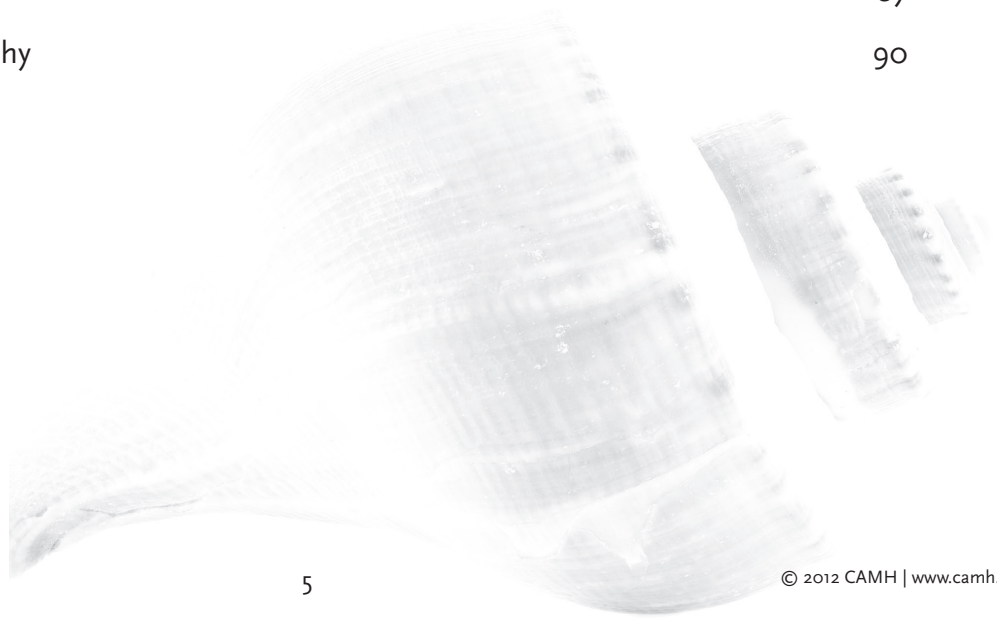
Contents



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This resource is a joint project of the Centre for Addiction and Mental Health; Dalla Lana School of Public Health, University of Toronto; and Toronto Public Health.

This resource reflects a literature review of articles published since 1997, including literature from Europe, the United States, Australia and Canada. Specific attention was given to finding examples of best practice in Canada from websites and reports, as well as from published articles. Managers and practitioners from agencies serving refugees from the Greater Toronto Area were interviewed by telephone after they had a chance to review the guidelines, and their feedback has been incorporated.

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We thank the many people representing the organizations and services listed below, who reviewed earlier drafts of this resource.

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Multicultural Council of Windsor-Essex County
Scadding Court Community Centre
St. Joseph's Health Centre
Toronto Public Health
Toronto Western Hospital
Woodgreen Red Door Family Shelter

Development of the resource

Kristin De Maeyer (Master of Social Work [MSW] student, Faculty of Social Work, University of Toronto) conducted a literature review to find examples of programs of best practice for refugees with respect to mental health promotion, and identified the major aspects of mental health and mental health promotion relevant to this population.

Uppala Chandrasekera (MSW student, Faculty of Social Work, Wilfrid Laurier University) conducted a pilot test to gather feedback from several community health and social service agencies on the usefulness and applicability of the guidelines. The guide was revised to reflect the input received from these agencies and Uppala's recommendations.

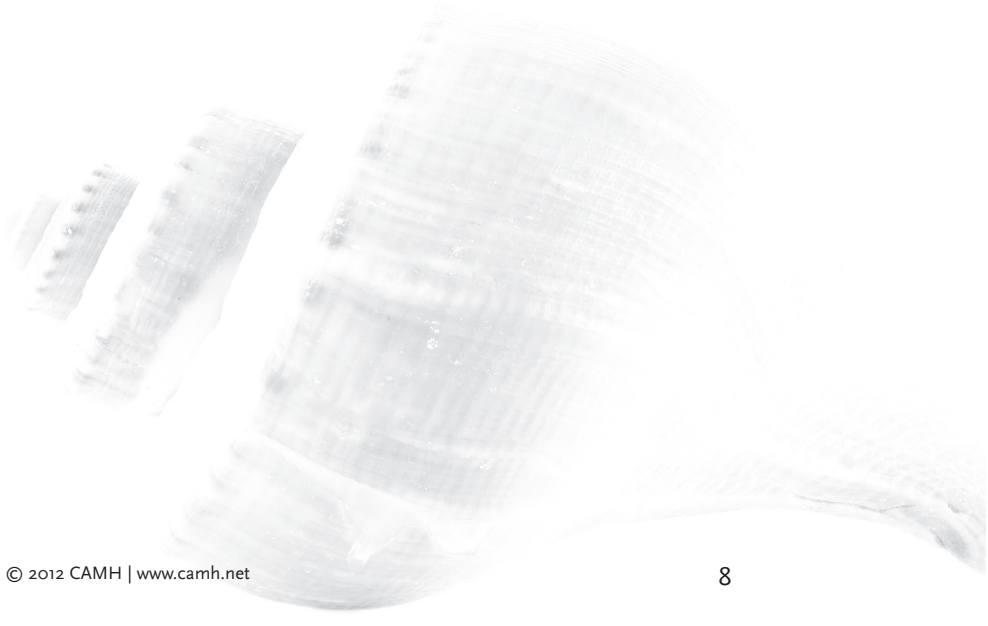
Holly Easlick (Master of Psychosocial Studies student, University of Brighton, U.K.) further contributed to the refinement of the content and design of this guide, and conducted a pilot study on the utility of the resource's worksheet. The worksheet was then redesigned to reflect the feedback provided by the organizations that participated in the review.

All three students worked under the direction of a working group from Toronto Public Health (TPH)—Angela Loconte; Centre for Addiction and

Mental Health (CAMH)—Marianne Kobus-Matthews, Branka Agic; and the Dalla Lana School of Public Health, University of Toronto—Suzanne Jackson.

Colin McKay, General Manager at the COSTI Ralph Chiodo Family Immigrant Reception Centre, provided the guide's sample worksheet that describes the Immigrant Reception Centre's programs for refugees to support positive mental health and demonstrates the worksheet's utility.

This resource has its origins in an adapted version for older adults (*Best Practice Guidelines for Mental Health Promotion Programs: Older Adults 55+*) developed by Anja Ziegenspeck, a visiting student from the University of Magdeburg at the University of Toronto, under the direction of a working group from TPH, CAMH, and the Dalla Lana School of Public Health, University of Toronto. The group worked from a previous draft document entitled "A Checklist: Guiding Principles of Best Practices in Mental Health Promotion across the Lifespan," developed by Maria Au-Yee Choi, Masters of Health Sciences student, University of Toronto. That document was based on findings of the research report, *Analysis of Best Practices in Mental Health Promotion across the Lifespan*, by Catherine Willinsky and Anne Anderson (2003) for CAMH and TPH. Anja updated the literature review in 2006 to refine the mental health promotion guidelines and checklist for older adults.



Introduction

This resource is the third in a series of online guides for promoting positive mental health across the lifespan. This resource provides health and social service providers ("practitioners") with current evidence-based approaches in the application of **mental health promotion**[1] 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**[2] directed toward refugees.

This resource includes:

- background on how Canada's foreign-born population is defined
- a theoretical context for mental health promotion, including definitions and underlying concepts, with a focus on promoting resilience
- 13 best practice guidelines for mental health promotion initiatives for refugees
- examples of mental health programs that illustrate the guidelines listed in this resource and therefore incorporate good practice
- examples of outcome and process indicators for measuring program success
- a worksheet that can be used by practitioners to plan and implement mental health promotion initiatives, a sample worksheet showing how it has been used in a mental health promotion initiative, a list of services and web resources, and a glossary of words commonly used in mental health promotion
- references used to develop these guidelines.

1 Each term in the glossary is boldfaced on first appearance throughout this document.

2 The terms *initiatives* and *programs* are used interchangeably in this resource.

1. Background: Refugees

Purpose

Although this information may not be new to some readers, the guidelines are intended to further promote the implementation of ideal mental health promotion practices within an array of organizations. This therefore serves as a useful resource for all mental health promotion service providers working with the refugee population in Canada.

These guidelines focus on refugees because many health promotion initiatives do not reach this population. These guidelines offer an opportunity to review current health promotion programs to improve their effectiveness for the refugee population. The guide addresses refugees from different countries of origin and experiences, recognizing that refugees should not be treated as a homogeneous group.

Refugees are defined as people who flee their country of origin to seek asylum in another host country. In other words, a refugee is a person in or outside Canada who fears returning to their home country (Citizenship and Immigration Canada [CIC], 2009). Reasons for fleeing may include "war, human rights abuses and persecution on grounds of politics, religion, gender, ethnicity, sexuality, genocide and ethnic cleansing" (Tribe & Keefe, 2007, p. 248).

Refugees in Canada

Canada's foreign-born population is unique and varied, with cultural groups represented from all over the world. For the majority (98 per cent), Canada is their only choice of country to migrate to (Statistics Canada, 2001). Some of the reasons why individuals choose to relocate to Canada include the opportunity to improve the future of their families, to join friends or family living in Canada, and/or for educational purposes.

Since 2002, Canada's immigration program has been based on the *Immigration and Refugee Protection Act* (IRPA) and its regulations. The IRPA replaces the *Immigration*

Act of 1976 and defines three basic categories of permanent residents (economic immigrants, family class and refugees), which correspond to three major program objectives: reuniting families, contributing to economic development and protecting refugees. Under the IRPA, Citizenship and Immigration Canada can also grant permanent resident status to individuals and families in cases where there are strong humanitarian and compassionate considerations, or for public policy reasons (CIC, 2009).

There are two main immigration categories in Canada:

- Permanent residents include immigrants and refugees who have been granted the right to live permanently in Canada.
- Temporary residents include those who are legally in Canada for a temporary purpose. This category includes foreign workers and students, individuals in the humanitarian population (primarily refugee claimants) and other temporary residents (CIC, 2011).

The Canadian refugee system has two main components (CIC, 2008):

- The Refugee and Humanitarian Resettlement Program is for people seeking protection from outside Canada. People in this category are granted permanent residence (landed status) when they arrive in Canada and are classed as "resettled refugees." Canada resettles 10,000 to 12,000 refugees annually through this program, or one out of every 10 refugees resettled globally.
- The In-Canada Asylum Program is for people making refugee protection claims from within Canada. The program provides protection to people at risk of torture or unusual punishment in their home countries. In 2007, 28,000 people came to Canada seeking asylum.

For more refugee statistics, visit www.cic.gc.ca/ENGLISH/refugees/outside/index.asp and www.ccrweb.ca/documents/state-of-refugees.pdf.

The main difference between immigrants and refugees is that immigrants choose to leave their country of origin, while refugees are forced to seek asylum in another country. Refugees usually come from areas of conflict or countries with limited resources for **health**, including shelter, clean water, food supply and education. They are more likely than immigrants to have certain health problems, such as anemia, malnutrition, neglected chronic health issues and mental health problems (Fowler, 1998; Hyman, 2007). By contrast, Canada's immigrants, particularly those from non-European countries, tend to have better overall health than the Canadian-born population when they first arrive (the "healthy immigrant effect"; Ali, 2002).

Demographic profile of the foreign-born population in Canada

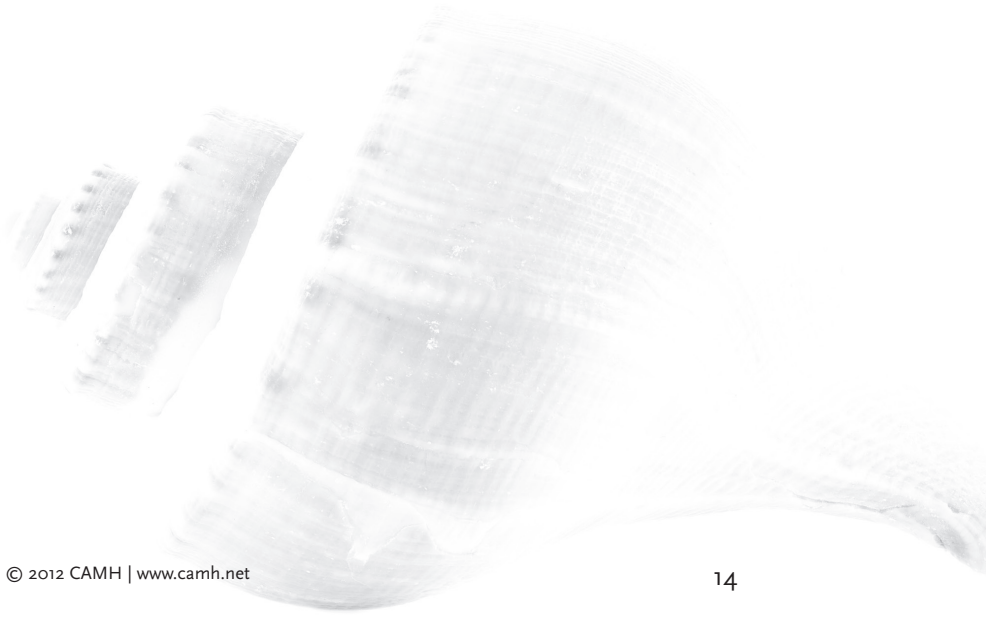
More than 13.4 million immigrants have arrived in Canada over the past century (Statistics Canada, 2003). Canada has the second highest proportion of foreign-born population in the world, after Australia (Statistics Canada, 2006). Based on the 2006 census, 19.6 per cent of Canada's population is foreign-born, the highest proportion in 75 years. Immigration has outpaced the birth rate, accounting for 53 per cent of overall population growth.

In the past 10 years, Canada has accepted approximately 240,000 immigrants annually, with refugees constituting about 10 per cent of this annual flow of newcomers. In 2006, Canada admitted 247,243 immigrants of which 21,860 were refugees (CIC, 2008). Until the late 1960s, the vast majority of newcomers to Canada were from Europe. Since the 1970s, an increasing number have been from other parts of the world, primarily due to the removal of national origin admission criteria that favoured the admission of people from the United States and European countries. In the past 10 years, almost 80 per cent of newcomers arrived from Asia, Africa, the Middle East, and South and Central America (CIC, 2009).

Citizenship and Immigration Canada (2009) reports that the top five source countries of refugees in 2008 were Mexico (17,937), Haiti (9,139), Colombia (6,254), China (6,223) and India (3,132). In 2007, Canada granted asylum to nearly 5,900 individuals, including more than 700 each from Colombia, China and Sri Lanka. At the end of the year, more than 37,500 asylum seekers had pending claims. Canada's refugee resettlement program accepted 11,100 refugees, including 2,040 from Afghanistan, 1,790 from Myanmar (Burma) and 1,650 from Colombia (U.S. Committee for Refugees and Immigrants, 2008). In 2006, the top five source countries for refugees selected under Canada's resettlement program were Afghanistan, Colombia, Ethiopia, Myanmar (Burma) and Sudan (Statistics Canada, 2009).

In 2008, Ontario received the greatest number of refugee entries, totalling 20,636 (CIC, 2008), followed by Quebec with 13,171, and British Columbia with 2,243. Ontario hosted 54.6 per cent of the refugee population, Quebec 34.8 per cent and British Columbia 5.9 per cent. According to CIC (2008), Toronto, Montreal

and Vancouver attracted 27.6 per cent (10,435) of the total number of refugees admitted to Canada in 2008. Toronto hosted 15.7 per cent of these refugees, Montreal 10.3 per cent and Vancouver 1.6 per cent.



2. Theory, definitions and context for mental health promotion

This section provides the practitioner with the theoretical context for mental health promotion through definitions and underlying concepts, with a focus on the promotion of resilience.

How is mental health promotion related to health promotion?

Health promotion

Health promotion is defined by the World Health Organization as a "process of enabling people to increase control over, and to improve, their health" (WHO, 1986).

The *Ottawa Charter for Health Promotion* (WHO, 1986) defines five key health promotion strategies:

- building **healthy public policy**
- creating supportive environments
- strengthening **community** action
- developing personal skills
- reorienting services toward promotion, prevention and early intervention.

Population health is an approach often used in health promotion and is based on interventions that target the entire population rather than smaller, select target groups. Population health in a Canadian context builds on public health, community health and health promotion traditions for which Canada has been recognized internationally since the groundbreaking work of the *Ottawa Charter*. Other key documents that have shaped the population health framework include the Lalonde Report, entitled *A New Perspective on the Health of Canadians* (Lalonde, 1974), and *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986).

Population health aims to address the health needs of a whole population. It is based on the tenet that health and illness are the result of a complex interplay between biological, psychological, social, environmental, economic and political factors. The goal of population health is to achieve the best possible health status for the entire population by fostering conditions that enable and support people in making healthy choices and by providing the needed services that promote and maintain optimum health.

Social Determinants of Health: Canadian Perspectives (Raphael, 2004) identified a range of factors that influence health (the determinants of health), which include:

- income and social status
- housing
- social support networks and social connectedness
- education
- employment and working conditions
- unemployment and employment security
- physical environments
- biology and genetics
- personal health practices and coping skills
- healthy child development
- health services.

Population health incorporates health promotion principles and strategies at all levels of society (e.g., individual, family, community) to address these determinants of health (Raphael, 2004).

Mental health promotion

The discussion paper *Mental Health for Canadians: Striking a Balance* (Health Canada, 1988) provided the driving force for placing mental health within a health promotion framework and viewing mental health on a continuum, ranging from optimal to minimal. The paper also provided a forum to define optimal mental health for the whole population, including people with a diagnosed mental health disorder. Further, this document supported the notion that promoting mental health is consistent with the health promotion process.

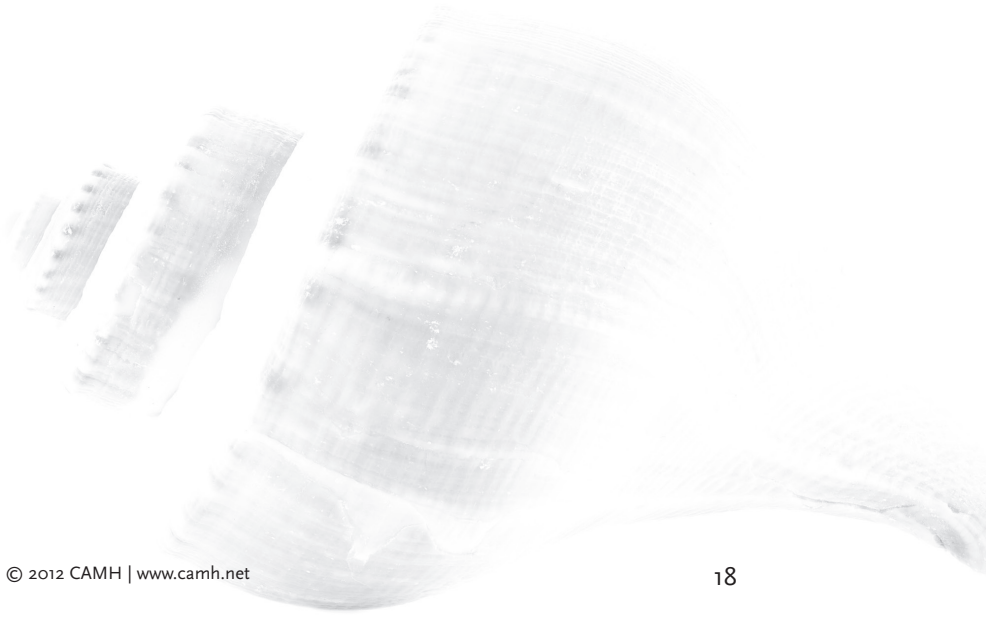
The field of mental health promotion is continuing to evolve, as is the definition of the term. A 1996 international workshop hosted by the Centre for Health Promotion at the University of Toronto and the Mental Health Promotion Unit of Health Canada defined mental health promotion as:

The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for **culture**, **equity**, social justice, interconnections, and personal dignity (Joubert et al., 1996).

This definition is very similar to the general concept of health promotion as defined by the *Ottawa Charter* (WHO, 1986). Similarly, strategies used in mental health promotion also parallel the strategies of health promotion more generally. Various interconnecting factors affect one's mental health. "[M]ental health status is determined by a complex interplay of individual characteristics, and cultural, social, economic and family circumstances at both the macro (society) and micro (community and family) levels" (Commonwealth Department of Health and Aged Care [CDHAC], 2000).

In summary, health promotion and mental health promotion have common elements, in that both:

- focus on the enhancement of well-being rather than on illness
- address the population as a whole, including people experiencing risk conditions, in the context of everyday life
- are oriented toward taking action on the determinants of health, such as income and housing
- broaden the focus to include protective factors, rather than simply focusing on risk factors and conditions
- include a wide range of strategies such as communication, education, policy development, organizational change, community development and local activities
- acknowledge and reinforce the competencies of the population
- encompass the health and social fields as well as medical services (Joubert et al., 1996).



What makes mental health promotion different from health promotion?

Mental health promotion emphasizes two key concepts: power and resilience. **Power** is defined as a person's, group's or community's sense of control over life and the ability to be resilient (Joubert & Raeburn, 1998). Building on one's existing capacities can then increase power and control.

Resilience has been defined as "the ability to manage or cope with significant adversity or stress in ways that are not only effective, but may result in an increased ability to respond to future adversity" (Health Canada, 2000, p. 8).

Resilience is influenced by risk factors and protective factors:

- **Risk factors** are variables or characteristics associated with an individual that make it more likely that he or she will develop a problem (Mrazek & Haggerty, 1994, cited in Commonwealth Department of Health and Aged Care [CDHAC], 2000). They are "vulnerability factors that increase the likelihood and burden of a disorder" (CDHAC, 2000). Risk factors can be biological or psychosocial and may reside within a person, his or her family or social network, or the community or institutions that surround the individual. They occur in innumerable contexts, including perinatal influences, family relationships, schools and workplaces, interpersonal relationships, media influences, social and cultural activities, the physical health of the individual, and the physical, social and economic "health" of the community.

- **Protective factors** buffer a person "in the face of adversity and moderate... the impact of stress on social and emotional well-being, thereby reducing the likelihood [that] disorders will develop" (CDHAC, 2000, p. 13). Protective factors may be internal (e.g., temperament and cognitive abilities) or external (e.g., social, economic or environmental supports). They enable a person to protect his or her emotional and social well-being and cope with everyday life events (whether positive or negative). Protective factors act as a buffer against stress and may be drawn upon in dealing with stressful situations.

Potential risk and protective factors for mental health problems are described on pages 27 – 33.

Some research has suggested that a person's resilience can be enhanced by improving his or her coping skills, reducing risks and improving protective factors. However, others suggest that resilience is more than simply improving these factors. Resilience is reflected in the ability to respond over time as various things change in one's life. It is a characteristic that is dynamic rather than static in nature and it has a direct effect on the coping process of an individual.

People who have high resilience (i.e., have the capacity to "bounce back" after adversity) are still vulnerable to adverse events and circumstances (CDHAC, 2000). However, a person's level of protective factors—regardless of the number of risk factors—has been shown to lower his or her level of risk (Resnick et al., 1997, cited in CDHAC). Protective factors also reduce the likelihood that a mental health disorder will develop, by reducing the person's exposure to risk, reducing the effect of risk factors or both.

Resilience consists of a balance between stress and adversity on one hand and the ability to cope and availability of support on the other. When stresses exceed a person's protective factors, even someone who has previously been resilient may become overwhelmed.

The relationship between risk and protective factors is complex: "[I]t is not the presence of risk or protective factors but rather the interaction and accumulation of these factors over time that affects the development of mental health problems" (CDHAC, 2000, p. 53).

In conclusion, mental health promotion efforts should start by:

- respecting people as they are at any given stage in their lives
- recognizing that people have the capacity to cope with life (regardless of whether they are currently coping well)
- acknowledging that they themselves are the best ones to know how to access their own intrinsic capabilities.

This increased sense of power and resilience is important not only as an outcome, but also as an integral part of the process—where the person truly feels that he or she is part of the process.

What are the goals of mental health promotion?

This section is adapted from: Canadian Public Health Association. (1998). *Documenting Projects, Activities and Policies in the Field of Mental Health Promotion in Association with CMHA.* Ottawa: Author.

The goals of mental health promotion are to:

- increase resilience and protective factors
- decrease risk factors
- reduce **inequities**.

Increasing resilience and protective factors

Mental health promotion aims to strengthen the ability of individuals, families and communities to cope with events that happen in everyday life by:

- increasing individual or community resilience
- increasing coping skills
- improving quality of life and feelings of satisfaction
- enhancing self-esteem
- enhancing a sense of well-being and belonging
- strengthening social supports and sense of identity
- strengthening the balance of physical, social, emotional, spiritual and psychological health.

Decreasing risk factors

Mental health promotion aims to reduce the factors that place individuals, families and communities at risk of diminishing mental health by reducing or eliminating:

- anxiety
- depression
- stress and distress
- sense of helplessness
- abuse, violence and social exclusion

- problematic substance use
- suicidal ideation or history of suicide attempts.

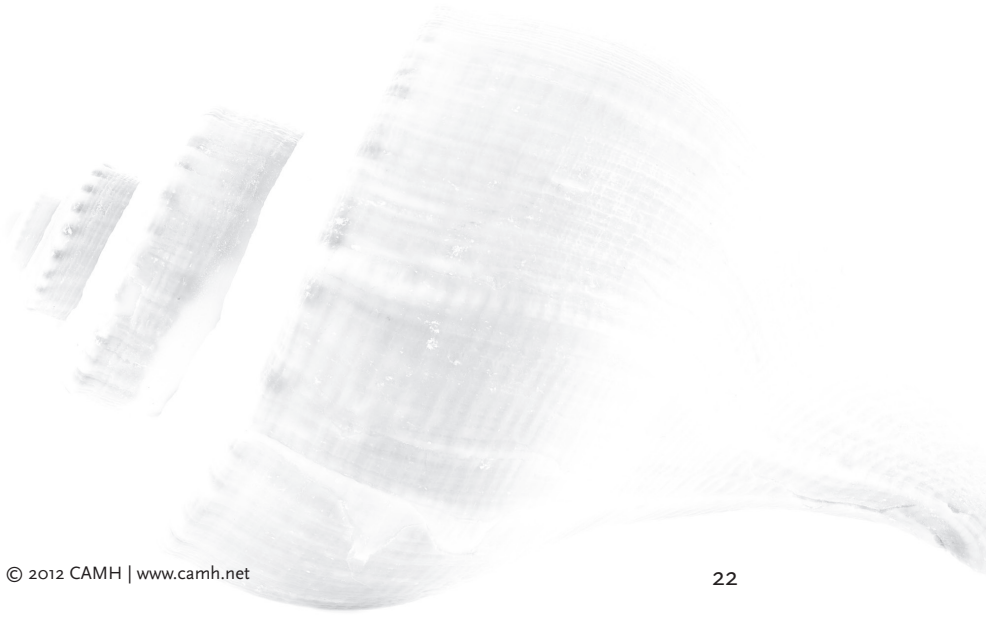
Reducing inequities

Mental health promotion aims to reduce inequities and subsequent effects on mental health. Inequities are often based on:

- gender
- age
- poverty
- physical or mental disability
- race
- employment status
- ethnic and/or cultural background
- sexual orientation
- geographic location.

Mental health promotion aims to reduce inequities by:

- implementing diversity and **equity** policies
- providing regular diversity and equity training and evaluating the results
- creating transitional programs for identified groups (i.e., tailoring programs to make them more inclusive or responsive to marginalized populations)
- promoting anti-stigma initiatives or campaigns that help to address the systemic barriers faced by refugees, such as **racism** and **discrimination**.



What factors influence the mental health and social well-being of refugees?

Determinants of health

Access Alliance, a multicultural community health centre in Toronto, produced the report *Advancing Knowledge, Informing Directions: An Assessment of Immigrant and Refugee Needs in Toronto* (2002) to highlight the key determinants of health specific to immigrants and refugees in Toronto. The report indicates that immigrants are typically healthier than refugees and the host population upon arrival, but that their health status declines over time. Refugees have more health concerns than immigrants because many have lived in war-torn countries and sustained physical injuries and mental trauma as a result. They are more likely to have experienced food and water deprivation in the migration process. And prior to entering Canada, many have lived in refugee camps that have substandard health conditions.

The report also indicates that both immigrants and refugees are at a heightened risk for poverty in the new host country. This is partially due to language barriers and racial discrimination, which pose difficulties for attaining employment and housing. A heightened susceptibility to poverty creates difficulties in accessing basic determinants of health, such as food and adequate shelter.

Determinants of mental health

A review of the literature indicates that the following factors have a predominant influence on the mental health of refugees.

Socio-economic status following migration

Many refugees experience a discrepancy between their social status prior to and after migration, which often leads to poverty. It is common for refugees to have lost many of their assets when forced to flee their host country. Many lose important documents certifying their education, training and credentials, which is a barrier to achieving employment. Discrimination and racism from prospective employers is also an often-cited barrier to employment. Foreign-trained

professionals have difficulty getting their skills accredited in Canada, and often have to undergo time-consuming and costly recertification processes. Difficulties in learning a new language also create barriers to employment. Recent cuts to funding for municipally run English as a Second Language (ESL) programs have compromised the **accessibility** and quality of these programs.

Sustained periods of underemployment and unemployment are therefore common among refugees. Many often wrongly blame themselves for their inability to get a job similar in status to what they did in their country of origin, especially because in their home country they may have developed unrealistic ideals of what refuge in Canada would involve. This self-blame can then lead to feelings of inferiority, helplessness, humiliation, anger, despair and nostalgia that can negatively affect mental health.

Isolation and absence of social support

Numerous factors contribute to the isolation of refugees and a lack of social support in the host country. Many refugees have been separated from their friends and family in the migration process. They may also experience an absence of similar ethno-cultural communities in the host country. Lack of language skills can make it difficult to form friendships with members of the host community. Unfriendly reception and racism from the host population also create barriers to forging support networks with the host population. Women and seniors are at heightened risk for isolation because they are more likely to be unemployed and to spend more time within the home than men, who are more likely to work, and children, who attend school. All these factors increase the risk for refugees' developing mental health problems.

Barriers to accessing mental health services

Because of language and cultural barriers, refugees are often unaware of how and where to access mental health services, and they may face financial barriers that prevent them from accessing treatment (e.g., refugee claimants awaiting a hearing do not have provincial health insurance coverage for mental health services).

Many refugees perceive mental health services in Canada as being culturally inappropriate because they reflect different beliefs about the origins of mental illness. Some refugees believe mental illness is a result of religious factors, whereas others believe it is a result of a lack of balance between mind, body and spirit. By contrast, Western methods of treating mental illness, which are insured under Canadian health plans, are based on an individualized, biomedical model that many refugees view as culturally inappropriate or ineffective. Traditional

healing methods that may be sought out by refugees are rarely covered by health insurance plans.

Stigma is another barrier to refugees' accessing mental health services. Stigma around mental illness in ethnoracial communities is often so severe that people will not seek help from mental health services. Stigma may perpetuate fear of seeking help outside of their own community or of being involuntarily hospitalized, and mistrust of Western medicine, service providers and the government.

Health Care Coverage

The Interim Federal Health Program (IFHP) provides temporary health care coverage for the non-insured, eligible individuals including refugee claimants, resettled convention refugees, persons detained under the *Immigration and Refugee Protection Act* and victims of trafficking in persons. The program is funded by Citizenship and Immigration Canada (CIC).

Eligible services include basic treatments covered by provincial/territorial health insurance plans plus supplemental coverage, such as dental and vision care similar to those provided by provincial/territorial social assistance plans (CIC, 2011).

For more information on IFHP, visit Medavie's website.

Traumatic life experiences

Many refugees have encountered traumatic life experiences prior to and during migration. Many flee countries because of war, torture, political persecution, economic devastation or natural disasters—sometimes sustaining injuries or experiencing prolonged hunger and dehydration as a result. Many have experienced separation from, or the death of, loved ones, as well as loss of property and other assets. In addition, detainment in refugee camps with substandard living conditions is becoming increasingly common. Traumatic experiences such as these put refugees at particular risk for mental health problems including posttraumatic stress disorder, other anxiety problems and depression, as well as suicide.

Difficulty in dealing with these traumatic experiences can often complicate legal processes of filing refugee claims. For example, impaired memory processing can impede the successful completion of claimant applications, and mental incapacitation can impede refugees' ability to successfully defend their claims to the Immigrant and Refugee Board (IRB). Refugees are assigned Designated Representatives (DR) by the IRB to represent them throughout the legal process.

However, it is important for DRs to be aware of the signs of poor mental health, and to advocate for their clients to receive psychiatric assessments if they are deemed unable to represent themselves due to mental health complications.

Two of the most common mental health issues affecting refugees who have encountered traumatic life experiences are depression and posttraumatic stress, which are discussed below.

Depression

Higher rates of depression among refugees have been found to be related to post-migration stressors such as **acculturation** difficulties, unemployment and isolation (Ehntholt & Yule, 2006). Refugee sub-groups at the greatest risk for depression are women, older adults, single adults, those who perceive a greater distance between their culture of origin and the host culture, those with low-level host language skills, and refugees who are unemployed (Barnes & Aguilar, 2007; CMHA, 2003). Focusing on these more vulnerable groups of refugees is a priority in promoting the mental health of the refugee population in Canada.

Posttraumatic stress disorder

Evidence suggests that refugees have higher rates of posttraumatic stress disorder (PTSD) than other Canadians due to their exposure to risk factors such as war and trauma (CMHA, 2003). PTSD "is characterized by exposure to an extremely stressful or catastrophic event or situation followed by three symptom clusters. These include repeated reliving of the trauma, e.g., through intrusive images or dreams of the event; hyperarousal, e.g., increased vigilance or disturbed sleep; as well as persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness" (Ehntholt & Yule, 2006).

There is some debate about the cultural specificity of the concept of PTSD, and the appropriateness of applying standard Western treatments for the disorder to refugees. While narrative therapy and cognitive-behavioural therapy have shown preliminary effectiveness for treating PTSD, these approaches have not yet been systematically evaluated. A need has now been established for culturally competent approaches that do not focus solely on trauma, but incorporate the resilient capacities of refugees (Lustig et al., 2004; Vaage et al., 2007): greater resilience can help protect refugees from further mental health problems.

Please see the following online brochure for more information on PTSD and refugees: http://www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/ptsd_refugees_brochure.html

What are the potential protective factors against mental health problems?

"Factors can be described as either protective or risky. Protective factors maintain 'mental well-being,' whereas risk factors may weaken 'mental stability'" (Solin, 2006, p. 4). The following lists provide examples of protective factors. The categories are based on U.K. Department of Health (2001), as well as those identified by Willinsky & Anderson (2003).

CA indicates guidelines specific to children and adolescents 18 years and under. UC indicates guidelines specific to unaccompanied children 18 years and under. AD indicates guidelines specific to adult refugees over 18 years old.

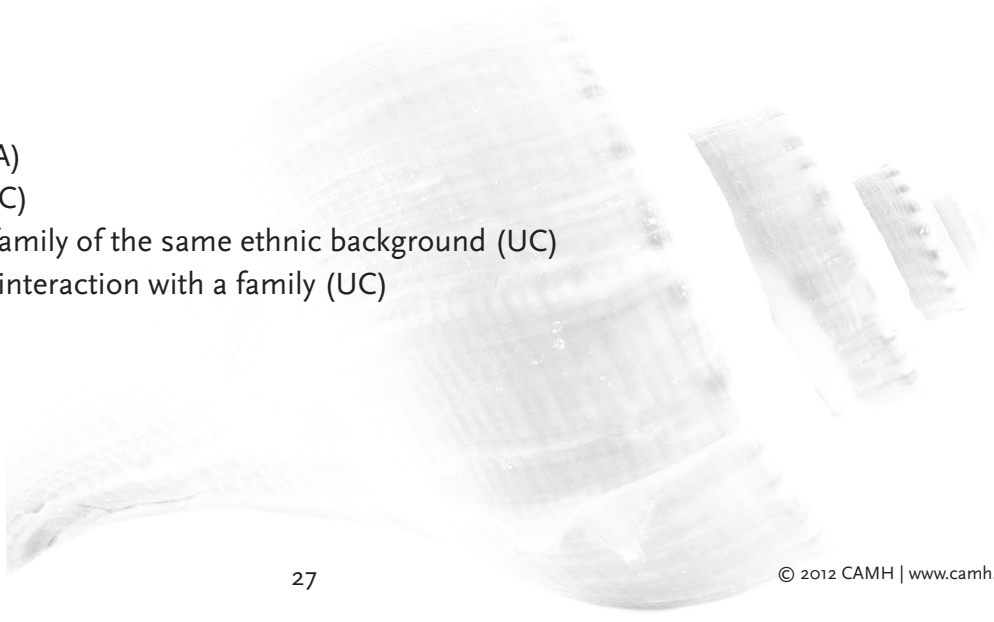
Social supports and networks

General population

- adequate social/emotional support
- nurturing environment
- social activity
- friendships
- living in close proximity
- having a good relationship with a partner or spouse

Refugee-specific

- enduring relationships
- family cohesion
- parental well-being (CA)
- family reunification (UC)
- residing with a foster family of the same ethnic background (UC)
- regular and sustained interaction with a family (UC)



Community factors

General population

- access to community support services
- institutional services
- supportive environment
- accessible and appropriate treatment

Refugee-specific

- adequate networks within the community (AD)
- volunteer participation (AD)
- sense of school belonging (CA)
- presence of interpreters and service providers with cross-cultural knowledge

Individual factors

General population

- self-efficacy
- engagement
- good coping skills, including good working skills
- interpersonal skills
- lifestyle
- resilience
- improved communication and conflict management skills
- high self-esteem and motivation
- empowerment
- life satisfaction
- health behaviour, nutrition, physical activity, physical exercise
- support systems
- reading skills
- control over one's life

Refugee-specific

- high self-esteem
- high cognitive ability
- education
- connection and commitment to original culture
- good temperament (CA)
- adaptability (CA)
- maintenance of religious beliefs

Life events or situations

General population

- economic security
- availability of opportunities at critical turning points in life
- general health and fitness
- well-being

Refugee-specific

- occupational success (AD)

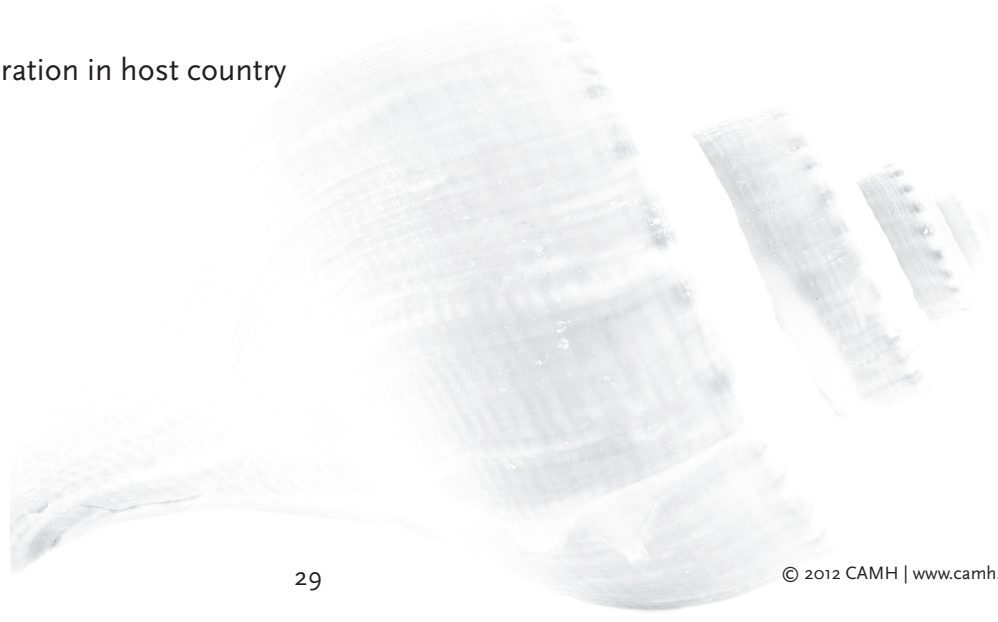
Social determinants of health

General population

- income and social status
- **social support networks**
- education and **literacy**
- employment/working conditions
- social and physical environments
- personal health practices and coping skills
- biology and genetic endowment
- health services
- gender
- culture
- housing (see Moloughney (2004) for more information on housing issues)

Refugee-specific

- adequate and prompt medical attention for injuries
- language training
- job training (AD)
- length of residence duration in host country



What are the potential risk factors for mental health problems?

The following lists provide examples of risk factors. The categories are based on U.K. Department of Health (2001), as well as those identified by Willinsky & Anderson (2003).

UC indicates guidelines specific to unaccompanied children aged 18 and under. CA indicates guidelines specific to children and adolescents aged 18 and under. AD indicates guidelines specific to adult refugees over 18 years old.

Social supports and networks

General population

- lack of family support
- limited social network

Refugee-specific

- social isolation
- family conflict
- family stigma against mental illness
- separation from family members (UC)
- poor maternal mental health (CA)
- family negativity (CA)

Community factors

General population

- low socio-economic status
- isolation
- lack of support services, including transport, shopping and recreational facilities
- limited mental health services
- social and environmental barriers
- poor housing

Refugee-specific

- discrimination
- language barriers and limited access to translators
- acculturation difficulties
- community stigma against mental illness
- shift in gender role expectations in new culture
- lack of culturally appropriate services
- lack of school integration initiatives

Individual factors

General population

- depression
- stress
- negative style of talking
- trouble handling disagreements
- difficult self-expectations
- grief
- physical illness/impairment
- chronic/severe mental illness
- substance and medication misuse
- heavy alcohol consumption
- smoking
- poor nutrition
- inactivity
- negative social comparison
- poor health status
- chronic illness
- lack of satisfaction with life
- anxiety
- sadness

Refugee-specific

- loneliness and isolation
- displacement from a rural area
- high pre-displacement education level (AD)
- high social status in pre-trauma stage (AD)
- impaired memory processing that impedes legal processes
- lack of trust in Western medicine
- poor medication compliance
- over 65 years of age at time of migration

- female
- difficulties with language/communication
- nostalgia
- feelings of dejection, humiliation and inferiority
- unprocessed trauma

Life events or situations

General population

- adverse life events
- death of family member
- stressful life events
- unemployment/job insecurity
- economic deprivation
- loss of roles and self-esteem
- pre-migration
- homelessness
- homesickness
- caring for someone with disability
- violence/abuse

Refugee-specific

- exposure to trauma (e.g., war)
- chronic physical injury sustained from torture or violence
- political persecution
- prior imprisonment
- extended residence in refugee detainment centres
- institutional accommodation
- involvement in front-line combat
- rape, torture, war injuries
- chronic physical illness
- insecure asylum status
- loss of property in leaving home country
- prolonged food/water deprivation
- frequent moves/resettlement

Social determinants of health

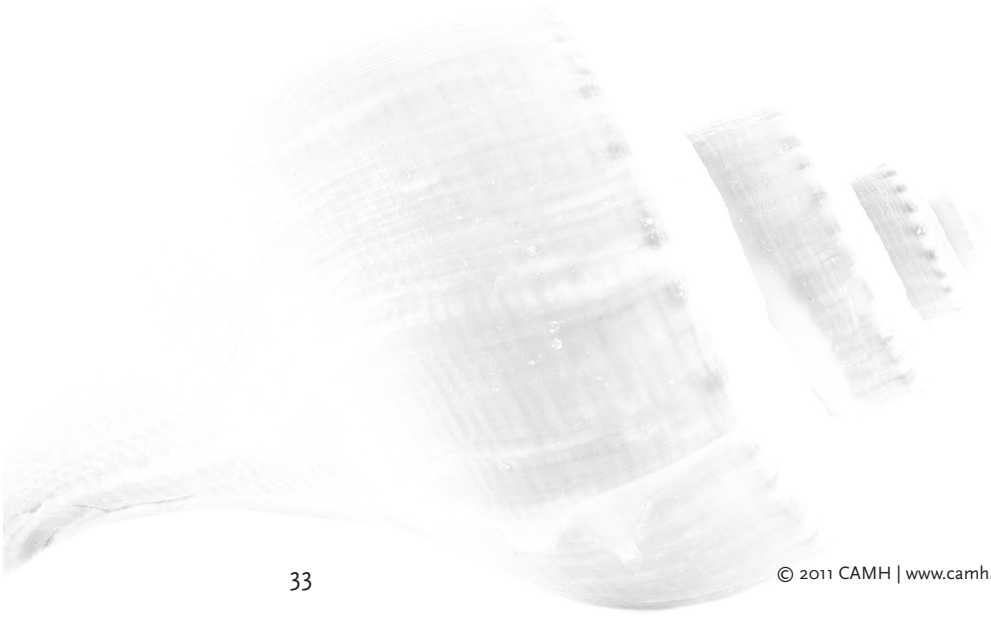
General population

- income and social status
- social support networks
- education and literacy
- employment/working conditions
- social and physical environments
- personal health practices and coping skills
- biology and genetic endowment
- health services
- gender
- culture

Refugee-specific

- unemployment (AD)
- inadequate housing
- parental unemployment (CA)
- uncertainty about asylum status
- ability to access health services (dependent on asylum status)
- neglected mental health problems
- infectious diseases
- lower education levels
- stigma, discrimination and **prejudice** in host society

Mental health promotion then aims to aid people in focusing on their positive aspects and potential in maintaining good mental health through increasing protective factors and reducing risk factors.



3. Guidelines for mental health promotion for refugees

What are the characteristics of successful mental health promotion initiatives?

Willinsky and Anderson (2003) found that successful mental health promotion initiatives include the following characteristics:

- clearly stated outcome targets
- comprehensive support systems with multiple approaches, including emotional, physical and social support, together with substantial assistance
- initiative in multiple settings (e.g., home and community)
- provision of screening and early initiatives for mental health problems in all lifespan groups
- involvement of relevant parts of the social network of the target group
- initiative over an extended period
- demonstrating a long-term investment in program planning, development and evaluation.

The **best practice** guidelines presented below aim to incorporate these characteristics that make for a more successful mental health promotion initiative relevant to the refugee population.

Best practice guidelines within mental health promotion initiatives

The terms "initiative" and "program" are used interchangeably and include a broad range of mental health activities, including services, information, campaigns, strategies, research and evaluation. These guidelines are based on mental health promotion principles that have been identified through critical analysis of literature reviews. The guidelines are not intended to be used as an evaluation tool, but rather to encourage health and social service practitioners to include mental health promotion principles in existing services and to assist in developing new initiatives. The guidelines may also assist in advocating with and on behalf of refugees.

Not all components will be applicable in all contexts because the guidelines are based on ideal mental health promotion initiatives. Health and social service providers ("practitioners") will have to consider their own level of resources and limitations, given the overall mandate of their organization. They can then apply what is relevant for their programming needs.

A worksheet incorporating these guidelines is provided in Appendix 1 to help service providers identify which guidelines should be further implemented within their initiative. The worksheet is a tool for the practitioner to use when planning and/or implementing mental health promotion initiatives for refugees.

CA indicates guidelines specific to children and adolescents 18 years and under. UC indicates guidelines specific to unaccompanied children 18 years and under. AD indicates guidelines specific to adult refugees over 18 years old.

Summary of guidelines

1. Identify the status and experience of members of the refugee population.

2. Continually involve individuals from the refugee population through meaningful community involvement.

3. Address and modify protective factors (including determinants of health) that can protect against mental health concerns for refugees.

4. Address and modify risk factors (including determinants of health) that could lead to mental health concerns for refugees.

5. Reduce negative attitudes about mental illness within the community.

6. Intervene in multiple settings using multiple approaches that are culturally appropriate.

7. Support both professionals and non-professionals in establishing caring and trusting relationships with refugees.

8. Focus on individual resilience, skill building, self-efficacy and **community capacity building** for refugees.

9. Provide comprehensive support systems that are easily accessible and culturally competent.

10. Ensure that information and services are culturally appropriate, holistic and accessible.

11. Involve multiple stakeholders.

12. Address opportunities for structural and organizational change, policy development and advocacy.

13. Demonstrate a long-term commitment to the development and evaluation of culturally relevant **programs**.

GUIDELINE

NOTES

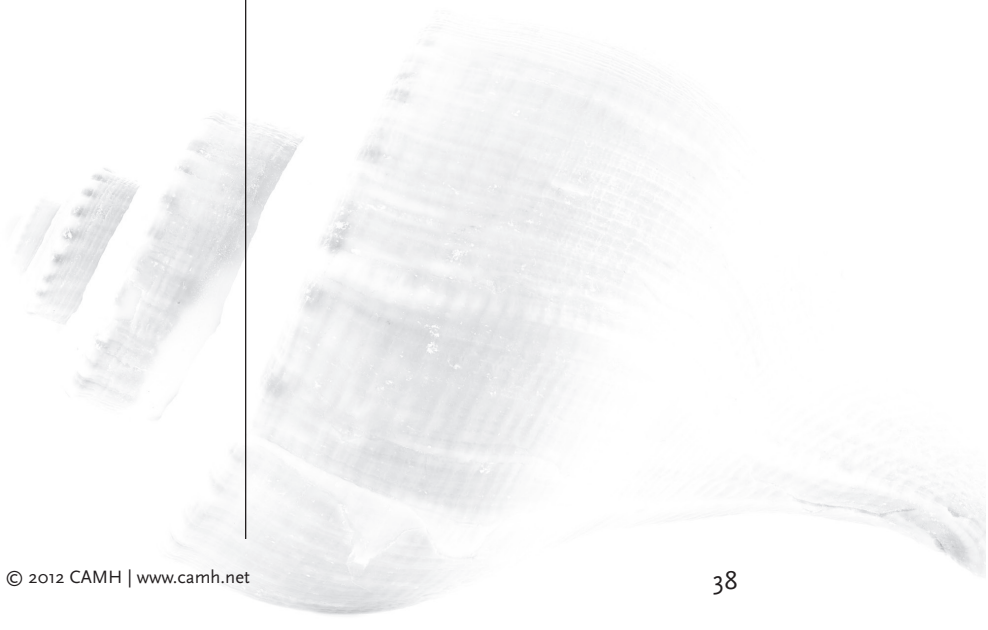
Guideline 1

Identify the status and experience of members of the refugee population by:

- identifying the refugee's legal status
- identifying the stage of the claimant process the refugee is currently in if applicable
- identifying if the refugee has been exposed to traumatic events
- classifying the needs of the refugee (consider mental health as well as physical health needs)
- determining the family support networks available to the refugee
- identifying how, when and where the group of interest can be reached.

Examples of refugees' status and experience include:

- refugees awaiting status approval
- refugees with a history of living in detainment
- unaccompanied refugee children
- refugees who have sustained injury and/or experienced food and water deprivation
- refugees who have witnessed the violent death of a family member or other violence.



Guideline 2

GUIDELINE

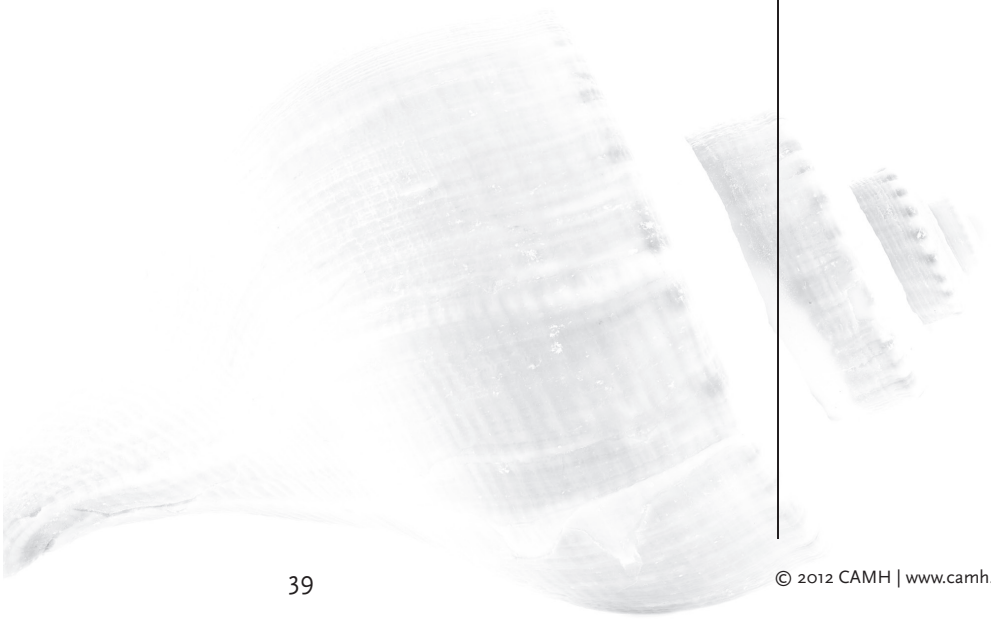
NOTES

Continually involve individuals from the refugee population through meaningful community involvement by:

- working with communities to understand how they define mental health
- identifying potential community partners
- defining the goals of these equal partnerships
- committing to achieving these goals
- working to build credibility and trust that will help to encourage community participation.

Examples of ways to involve community members include:

- initiating contact with refugee populations before making decisions about mental health promotion initiatives
- making sure all community members share the benefits
- being prepared to work with communities in non-traditional ways to address issues in their own terms.



GUIDELINE

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Guideline 3

Address and modify protective factors (including determinants of health) that can protect against mental health concerns for refugees by:

- identifying relevant protective factors and social determinants of health that could reduce the risk of experiencing a mental health problem
- assessing which protective factors and health determinants can be modified, and how
- developing a plan to increase or enhance the effects of protective factors for the refugee population.

Examples of *protective factors* include:

- family cohesion
- language and literacy competence
- good health
- high self-esteem
- adaptability
- positive temperament
- connection and commitment to original culture
- high cognitive ability
- resilience
- control over one's life
- volunteer participation
- school belonging (CA)

Examples of *protective determinants of health* include:

- adequate and prompt medical attention for injuries
- prolonged and stable social support
- family cohesion
- parental well-being (CA)
- family reunification
- adequate housing conditions
- job training
- language training
- occupational success
- presence of interpreters and service providers with cross-cultural knowledge
- freedom from discrimination, stigma, racism and oppression.

Guideline 4

GUIDELINE

NOTES

Address and modify risk factors (including determinants of health) that could lead to mental health concerns for refugees by:

- identifying relevant risk factors and social determinants of health that could negatively affect one's mental health
- assessing which risk factors and health determinants can be modified and how
- developing a plan to decrease the effects of risk factors for the refugee population.

Examples of *risk factors* or *determinants of health* to address include:

- exposure to or being a direct recipient of traumatic experiences (e.g., war, torture, rape)
- insecure asylum status
- history of political persecution, imprisonment or detainment
- loneliness
- isolation
- impaired memory processing
- nostalgia
- feelings of dejection, humiliation and inferiority
- language barriers and difficulties
- family negativity
- displacement from a rural area
- high pre-displacement social status
- lack of trust of Western medicine and service providers generally
- over 65 years of age at time of migration
- shifts in gender role expectations between old and new culture
- intergenerational conflict
- poor maternal health (CA)
- family or cultural stigma and discrimination surrounding mental illness
- separation from family members
- frequent moves and loss of property
- barriers to service access
- unprocessed trauma
- unemployment
- physical injuries sustained during torture or violence
- food and water deprivation
- inadequate housing.

GUIDELINE

NOTES

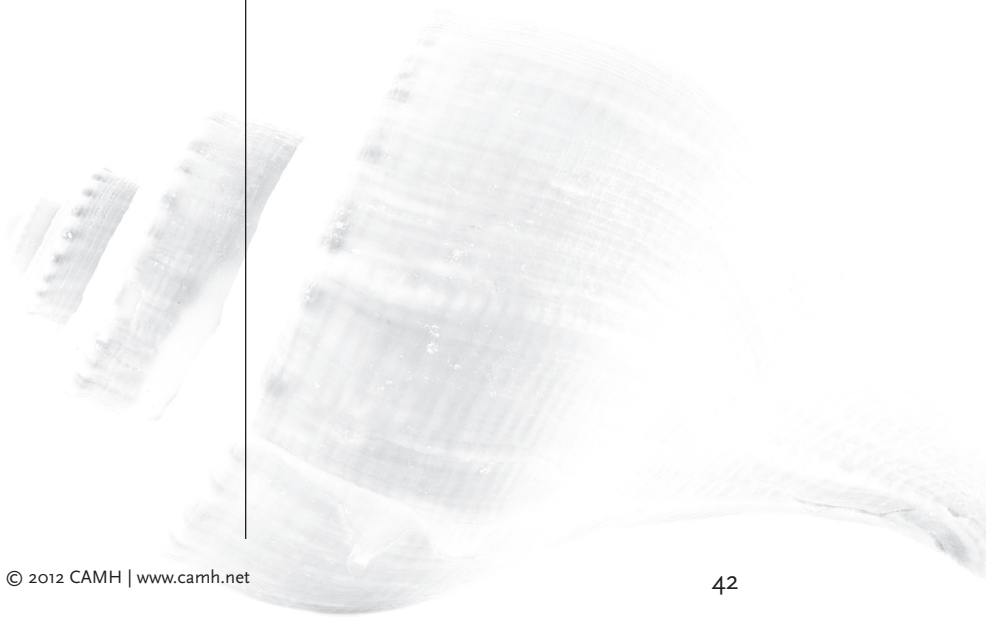
Guideline 5

Reduce negative attitudes about mental illness within the community by:

- educating organizations and professionals about cultural beliefs and **taboos** around mental health
- educating refugee groups about mental health mindfully and sensitively
- providing diversity and health equity training, for professionals and non-professionals, that incorporates a further focus on reflective practices, whereby the person reflects on his or her own personal biases and assumptions about the diverse population of refugees (Olavarria et al., 2005; Seah et al., 2002)
- working with communities to understand mental health.

Examples include:

- heightening awareness about the causes and effects of mental illness
- reducing stigma and raising awareness about mental illness, as outlined in the *Journey to Promote Mental Health* training manual (available at www.hongfook.ca/en/files/JourneyToPromoteMentalHealthManual-March2006.pdf)
- respecting confidentiality, and facilitating anonymity for refugees seeking services.



Guideline 6

GUIDELINE

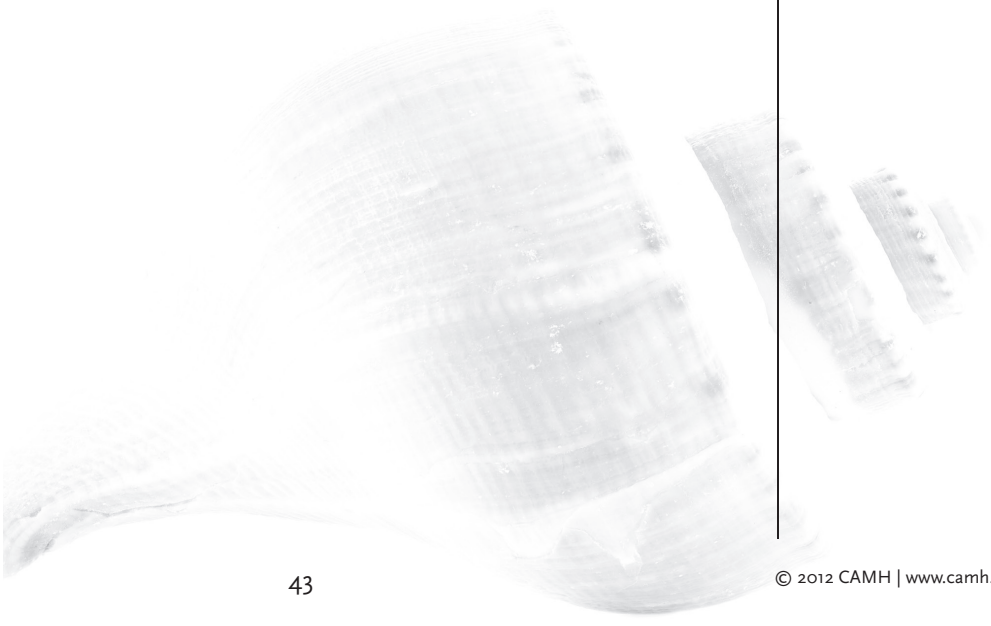
NOTES

Intervene in multiple settings using multiple approaches that are culturally appropriate by:

- developing strategies to intervene in different environments
- planning comprehensive approaches involving multiple methods
- using strategies to reach and engage refugees in formats appropriate to their needs and cultural preferences, while creating a safe environment
- identifying gaps caused by existing barriers, and working to close them
- encouraging professionals and non-professionals (e.g., family members) to work together to achieve goals.

Examples include:

- intervening in various settings (e.g., neighbourhood health centres, hospitals)
- engaging refugees in various programs (e.g., one-to-one consultations, family sessions, community based programs, ESL classes)
- adopting multiple strategies (e.g., building **healthy public policy**, forging ties between minority groups and organizations, developing personal skills, reorienting health services)
- making home visits to assess refugee living environments
- looking into ways to promote refugee children's sense of belonging in schools
- providing family support and education programs for refugees
- implementing outreach programs that seek out refugees.



GUIDELINE

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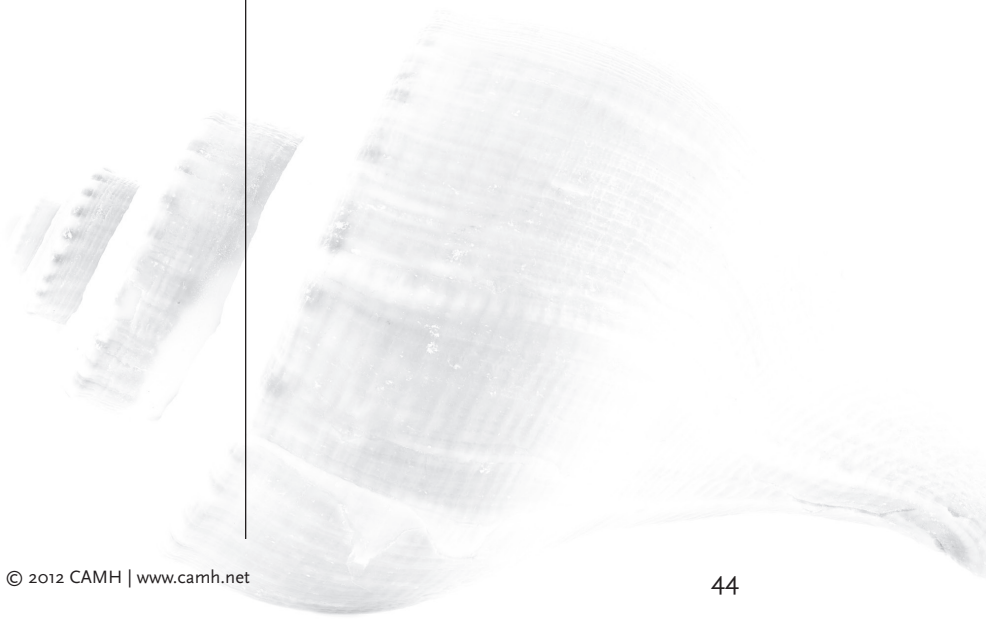
Guideline 7

Support both professionals and non-professionals in establishing caring and trusting relationships with refugees by:

- educating professionals about cultural taboos, cultural sensitivity and stigma within an anti-oppression framework
- encouraging professionals to foster trusting relationships with clients
- encouraging non-professionals to form relationships with refugee populations and get involved in promotion **initiatives**.

Examples of how to establish these relationships include:

- pairing refugees with others who have a positive outlook
- co-operating rather than competing with traditional healers
- training peer leaders to facilitate support groups for refugees
- providing cross-cultural competence training
- training designated representatives to understand signs of poor mental health manifested by culturally distinct symptoms, so they can effectively advocate for refugees in the claimant process
- training health and social service providers to recognize the behavioural indicators of mental distress (e.g., vague somatic complaints).



Guideline 8

GUIDELINE

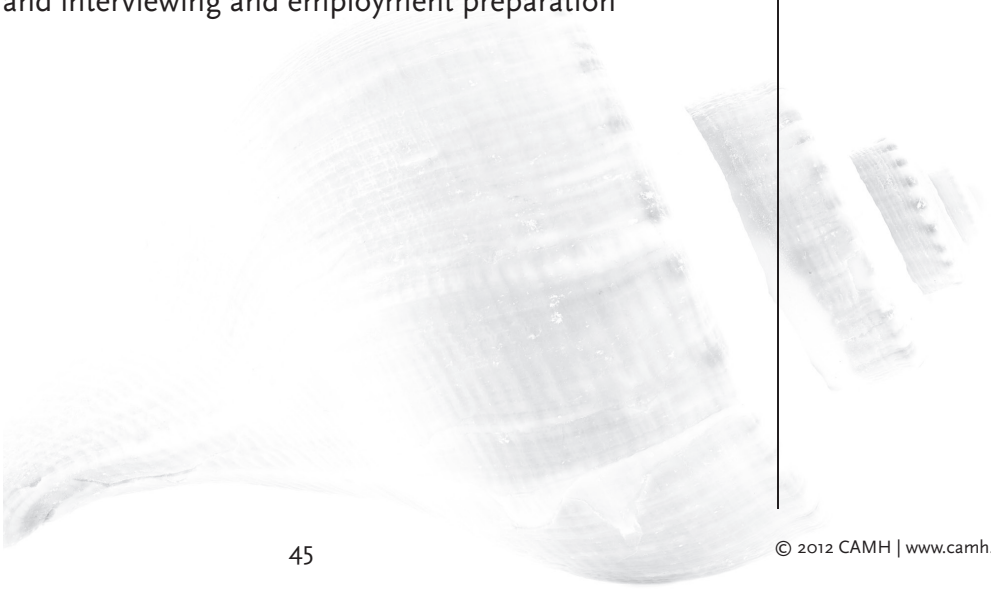
NOTES

Focus on individual resilience, skill building, self-efficacy and community capacity building for refugees by:

- providing an emphasis on skill building to enable refugees to increase control over their health and advocate individually and collectively for better resources and access to health services
- offering further skill-building opportunities for caregivers, family members and associated peers
- providing accessible opportunities for literacy, language and health care system navigation
- offering educational information to promote factual understanding of mental and physical health.

Examples include:

- providing stress management (e.g., breathing exercises, visual imagery, activity scheduling)
- improving problem-solving skills (e.g., involving unaccompanied children in finding their families)
- focusing on memory processing
- building support networks within the new community that may require an age-specific approach
- teaching ways to identify and challenge stigma about mental illness in the community
- providing workshops on navigating the health care system
- offering newcomer women's and men's health classes
- providing ESL classes, and interviewing and employment preparation counselling.



GUIDELINE

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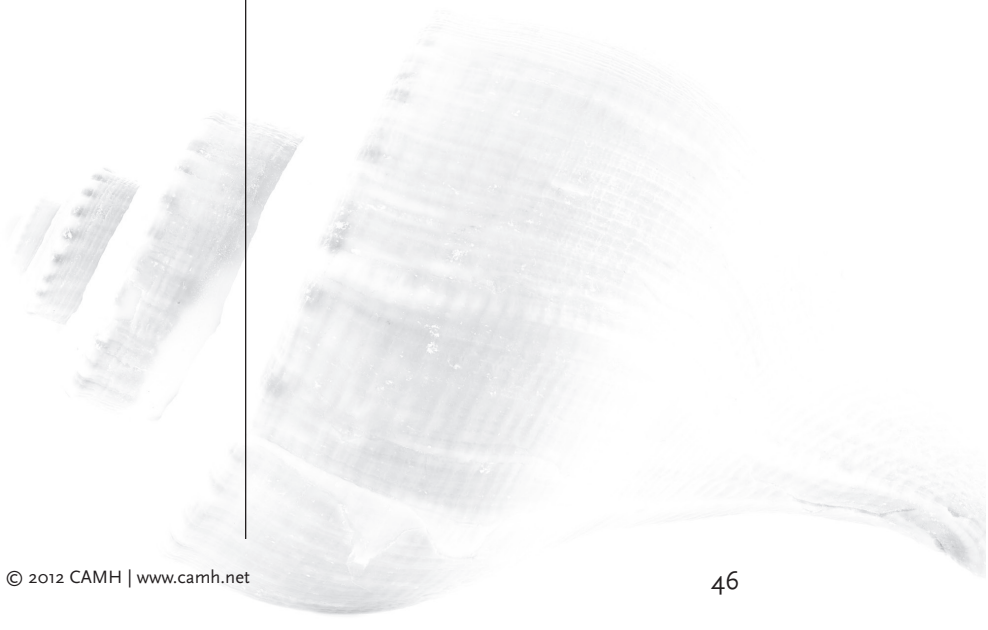
Guideline 9

Provide comprehensive support systems that are easily accessible and culturally competent by:

- forming ties between services, organizations and communities to establish a better support system for refugees in Canada
- facilitating the development of supports if none already exist
- understanding the impact of stigma, racism and systemic oppression while working toward their elimination
- facilitating the co-delivery of services with community partners
- forming referral networks specific to mental health promotion services for refugees
- providing **cultural competence** training for both professionals and non-professionals.

Examples include:

- offering professional development to service providers to improve their knowledge of services to offer refugees, and to increase their cultural sensitivity
- providing legal counselling and information in different languages
- developing school inclusion programs for refugee children
- improving links between refugees and services so that services can be accessed more independently
- facilitating co-delivery of programs.



Guideline 10

GUIDELINE

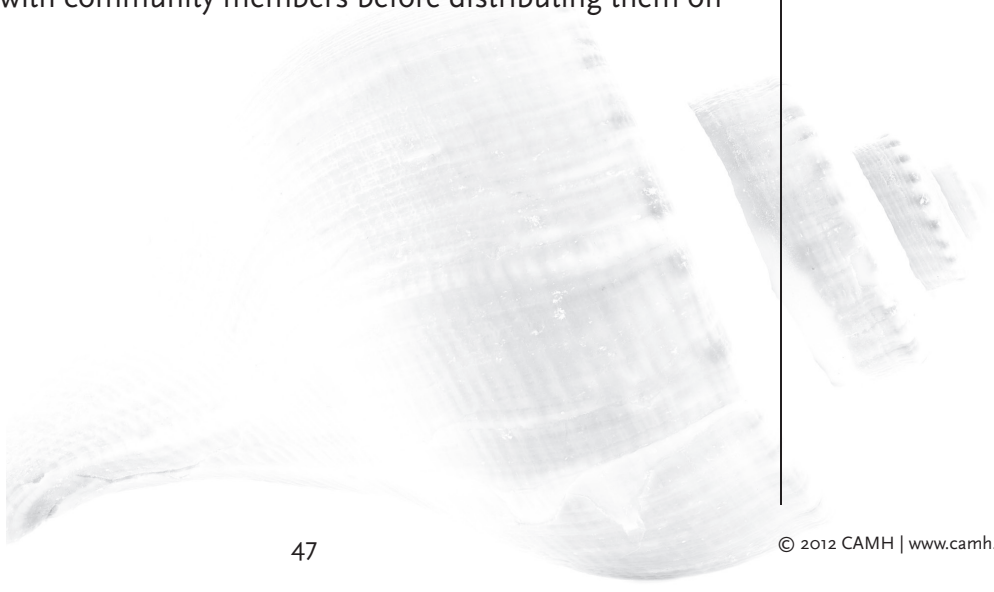
NOTES

Ensure that information and services are culturally appropriate, holistic and accessible by:

- working with community members to ensure that materials are correct and suitable
- developing materials in refugees' native languages instead of translating material from English
- using examples that people will be able to relate to
- providing services that match refugee populations' cultural values and beliefs.

Examples include:

- asking what words refugees of a particular culture use to describe various mental illnesses
- learning to recognize vague somatic complaints as potential indicators of mental illness
- asking specific questions about emotional symptoms, as many refugees don't report symptoms because of cultural stigma
- having peer educators lead refugee support groups
- matching refugees with service providers who speak the same language or are of the same ethnicity
- using simple terminology to orient refugees to the names of mental illnesses in the host culture
- reducing effects of stigma by respecting confidentiality
- collaborating with traditional healers
- ensuring that programs respect religious, cultural and familial values
- pilot testing materials with community members before distributing them on a larger scale.



GUIDELINE

NOTES

Guideline 11

Involve multiple stakeholders by:

- including both professionals and non-professionals
- forming ties and partnerships with people, agencies and organizations in the community who can offer valuable resources, knowledge, credibility and skills
- engaging multiple sectors.

Examples of stakeholders to involve include:

- professionals (e.g., social workers, physicians, psychologists, nurses, physiotherapists, dieticians, teachers, immigration lawyers, academia, other community social service providers)
- non-professionals (e.g., cultural brokers, family members, friends, traditional healers)
- practitioners of complementary medicine (e.g., herbalists, acupuncturists, shamans)
- religious leaders.

Examples of sectors to engage include:

- public health
- biomedicine
- traditional medicines
- government and policy-makers
- education
- immigration
- community organizations
- school boards
- legal services
- research institutions (e.g., Centre for Refugee Studies at York University: www.yorku.ca/crs)
- advocacy organizations (e.g., Canadian Council for Refugees: www.ccrweb.ca).

Guideline 12

GUIDELINE

NOTES

Address opportunities for structural and organizational change, policy development and advocacy by:

- engaging organizational, professional and community members
- mobilizing **ethnocultural** communities
- developing effective healthy public policies that focus on collaboration between refugee and mental health sectors.

Examples of public health policies to develop include:

- policies that support reducing the backlog of refugee applications through fair and equitable processes
- policies that facilitate quicker adjourning processes for claimants
- policies that facilitate timely family reunification
- equal opportunity and equal access policies.

Examples of unhealthy public health policy include:

- increased post-9/11 security measures that allow arrest, detention and deportation of landed immigrants on the suspicion they might be, or could become, a security threat
- the 2002 "Safe Third Country Agreement" between Canada and the United States under which refugees were only permitted to make refugee claims to the country of initial entry. The exceptions include having a family member in Canada or being an unaccompanied minor whose parents are not in the United States or Canada (Canadian Council for Refugees, 2009)
- funding cuts to English as a Second Language (ESL) programs that shut out the most vulnerable groups from attending lessons. ESL training plays a vital role in newcomers' successful settlement and integration in Canada.

GUIDELINE

NOTES

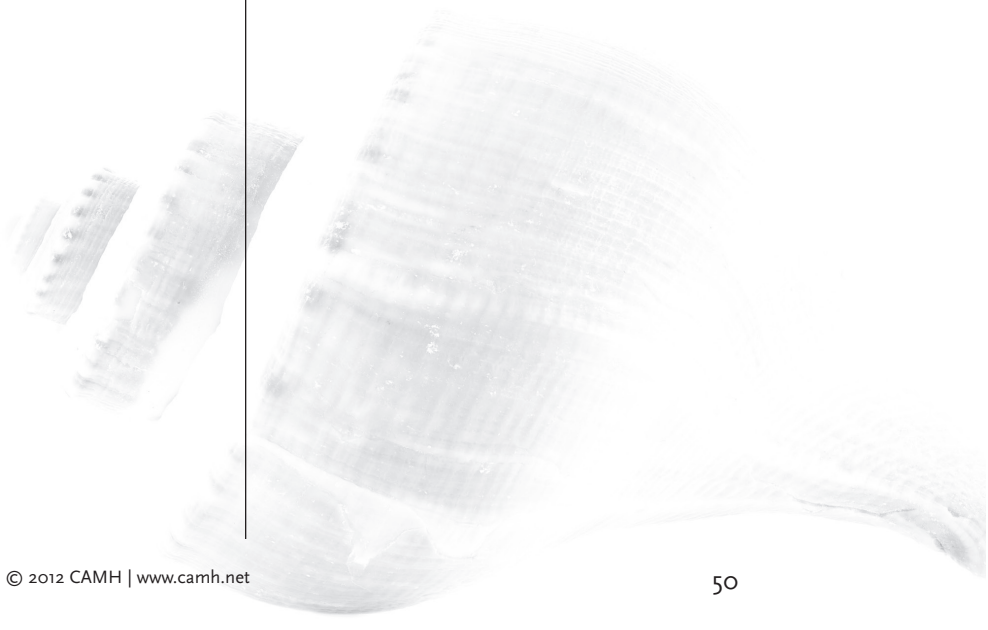
Guideline 13

Demonstrate a long-term commitment to the development and evaluation of culturally relevant programs by:

- continually involving members of the community
- assessing the strengths and needs of the community
- creating long-lasting partnerships between the community and outside sources
- setting a framework intended to support long-term initiatives
- ensuring that programs are continually being developed, evolving and being evaluated, with sufficient access to resources.

Examples include:

- creating program logic models and evaluation plans
- building trusting partnerships between community organizations and outside sources
- engaging and including members of the community at different points in the planning process
- publishing evaluative studies to strengthen the available body of knowledge surrounding refugee mental health promotion.



Outcome and process indicators

Outcome and process indicators are tools organizations can use to gauge the success of their work.

Outcome indicators

Outcome indicators measure how well your initiatives are accomplishing their intended results. They compare the result of an initiative to the situation beforehand.

The examples in the table below show how a well-chosen outcome indicator can measure an initiative's success:

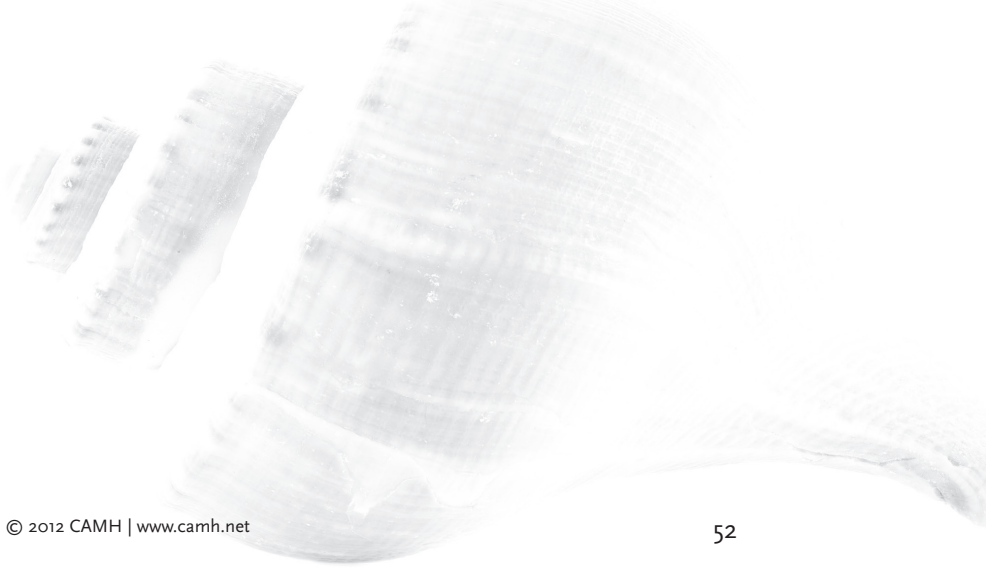
Intervention type	Possible outcome indicator
Changing a risk factor	Percentage of refugees reporting experiences of discrimination Percentage of refugees reporting a lack of social networks
Changing a determinant of health	Percentage of services available to refugees that are culturally relevant Percentage of refugees who have some form of employment
Intervening in multiple settings	List of essential services that are culturally appropriate and readily available to the refugee community
Building relationships	Percentage of refugees who report that they are satisfied with the relationships they have with professionals, family and friends

Intervention type	Possible outcome indicator
Building skills	Percentage of refugees who report being able to read, write and speak better English since their arrival
Policy change	List of policies introduced at the community level that reduce unemployment inequities for refugees
Overall change in mental health	Scores on self-perceived health and happiness measures Percentage of refugees reporting good to excellent self-esteem or well-being

Process indicators

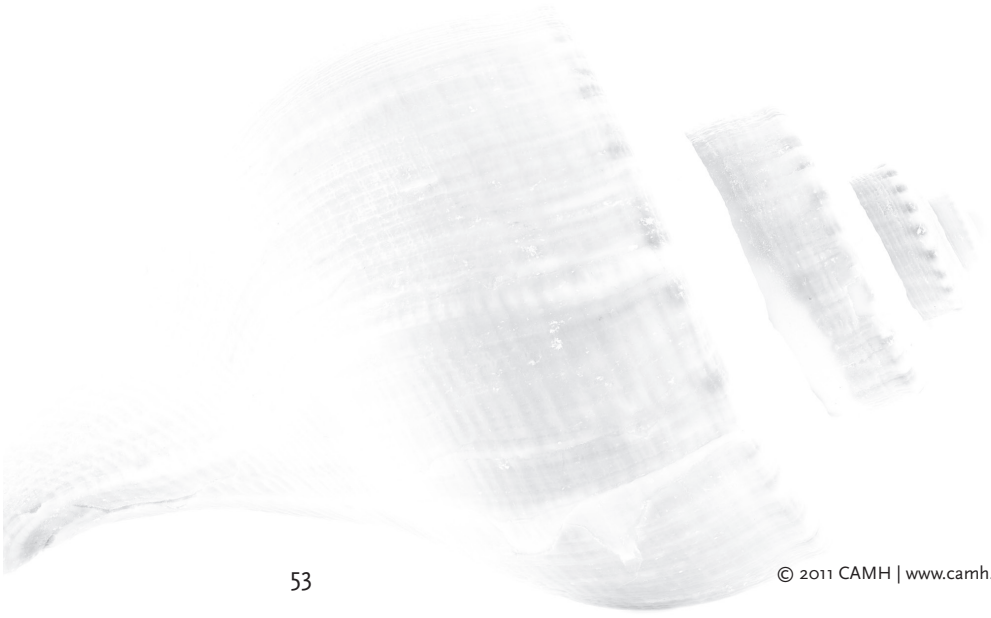
Process indicators measure how well you are running your activities. They track how much you are doing and how well people like it. Examples include:

- the number of people who attended your training sessions
- the number of times your organization offered diversity and equity training to staff and/or volunteers
- the number and variety of people from the refugee community who have collaborated with your organization to improve their own or others' mental health
- the number of meetings held to undertake a strengths-based needs assessment, and who attended
- participants' satisfaction rating of your training session(s).



4. Examples of mental health programs that incorporate good practice

Based on best practice guidelines, the following examples were found to follow some of the guidelines and have been deemed good practice. A brief description of the projects is provided, along with a reference or web link to access further information about the initiative.



Embracing Our Body, Mind and Spirit: Holistic Health Promotion for Women

Goals and objectives

- to increase knowledge about the health of body, mind and spirit
- to help women acquire increased skills and strategies that promote or maintain their mental health (Guideline 8)
- to foster understanding of how individual and societal factors interact to affect overall health
- to increase knowledge about mental health and related resources in the community
- to ensure that accurate information on mental and holistic health is accessible to everyone in the community (Guideline 10)
- to increase community awareness of mental health issues faced by women and their families
- to increase acceptance and comfort in talking about mental health issues in the community (Guideline 5)
- to reduce misconception and stigma about mental illness in the community (Guideline 5)
- to increase peer support and networking within the community to promote holistic health among women and their families (Guidelines 6 and 10).

Description

Embracing Our Body, Mind and Spirit: Holistic Health Promotion for Women in Toronto is a series of three workshops lasting between two and 2.5 hours. Sessions are led by trained peer leaders (Guidelines 7 and 10).

Start date

2002

Guideline 1: Audience, specific populations

Cambodian, Korean, Chinese (Hong Kong, mainland China and Taiwan) and Vietnamese immigrant and refugee women

Guideline 3: Protective factors

- social contacts
- friendships
- productive activity
- personal resilience

Guideline 4: Risk factors and determinants of health

Risk factors

- isolation
- physical illness
- extreme prolonged negative emotion

Determinants of health

- employment
- housing
- transportation
- safe physical environment
- access to health and social services
- social inclusion
- food
- income
- education
- healthy child development

Workshop 1 focuses on factors that promote health. Workshop 2 focuses on stress and negative emotions (Guideline 4) and their relationship to health. Workshop 3 focuses on building healthy relationships and support networks (Guideline 3). A full workshop manual is available online at www.hongfook.ca/en/files/PA-Workshop-E.pdf

Guideline 5: Reduce stigma

- raising awareness
- increasing acceptance and decreasing stigma about mental illness in the community
- educating about mental health
- decreasing misconceptions about mental illness
- increasing comfort in discussing mental illness

Guideline 6: Multiple approaches

- provides workshops, as well as information about resources and other services offered at the Hong Fook Mental Health Association and other health organizations
- facilitates peer networking

Guideline 7: Support non-professionals

- program manual is designed to train peer leaders from the community to lead workshops

Guideline 8: Skill building

- workshop 2 focuses on ways to cope with stress and negative emotions

Guideline 10: Culturally appropriate services

- ensuring information on holistic health is accessible through peer-led groups

Guideline 13: Evaluation

- ongoing; training manual provides procedures for participant evaluation

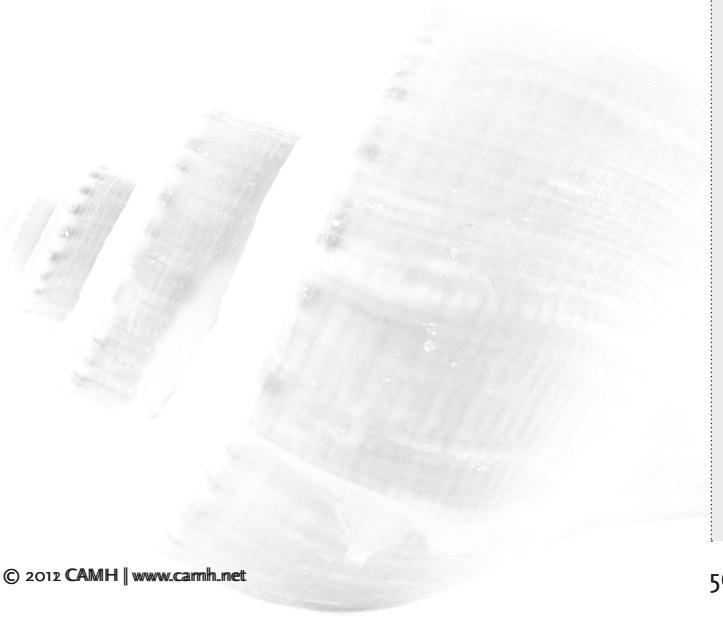
Learn more

Pui-Hing Wong, J. & Wong Y.L.R. (2002). *Embracing Our Body, Mind & Spirit: Holistic Health Promotion for Women Community Workshop Manual.* Toronto: Hong Fook Mental Health Association. Retrieved from www.hongfook.ca/en/files/PA-Workshop-E.pdf

Contact: Hong Fook Mental Health Association

Tel.: 416 493-4242 ext. 0

E-mail: jph.wong@sympatico.ca



The Child and Youth Mental Health Program

Goals and objectives

- to increase knowledge about mental illness as it relates to children and adolescents from immigrant and refugee families (Guideline 1)
- to increase access to culturally-appropriate outreach and education services (Guideline 10)
- to increase access to comprehensive support services (Guideline 9)
- to reduce stigma by dispelling myths and dealing with shame (Guideline 5)

Description

The Child and Youth Mental Health Program in Surrey, B.C., provides professional counselling to children and youth from immigrant and refugee families (Guideline 1) experiencing mental health issues. Counselling may involve individual, family or group therapy.

The childen and youth in the program deal with a range of issues, including depression, anxiety, suicide, posttraumatic stress disorder, attention-deficit/hyperactivity disorder and psychosis. The program also provides outreach and education services to immigrant and refugee communities (Guideline 6) with the hope of raising awareness and increasing knowledge about mental illness in children and adolescents (Guideline 5).

Start date
unspecified

Guideline 1: Audience, specific populations
immigrant and refugee families experiencing mental health issues

Guideline 3: Protective factors
- access to early detection services

Guideline 4: Risk factors
- stigma
- barriers to accessing services

Guideline 5: Reduce stigma
- raising awareness of warning signs
- dispelling myths
- dealing with shame

Guideline 6: Multiple approaches and settings
- community outreach and education
- service referral

Guideline 9: Comprehensive support systems
- referrals to other mental health services
- services offered free of charge

Guideline 10: Culturally appropriate services
- services available in different languages

Guideline 13: Evaluation
not specified

Topics addressed include warning signs, symptoms and early detection of illness, dispelling myths, dealing with shame (Guideline 5) and clients' and their families' right to access medical and counselling services. This program provides short-term counselling and support to clients, and subsequent referrals (Guideline 6 and 9) to child and youth mental health teams for long-term counselling. Services are available in Punjabi, Hindi, Urdu, Farsi and some African languages (Guideline 10), and are provided free of charge (Guideline 9).

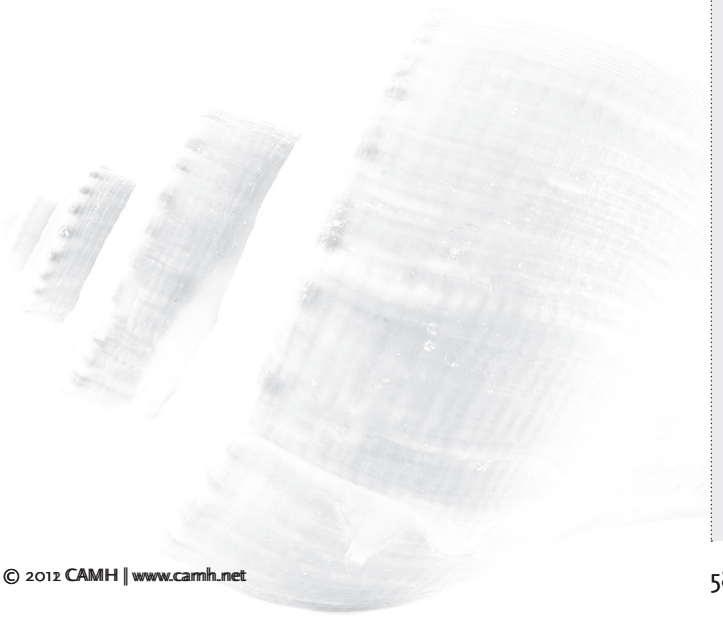
Learn more

Website: http://www.dcrs.ca/index.php? (see Child & Youth Mental Health under Services – Family Services)

Contact: DiverseCity Community Resources Society

Tel.: 604 597-0205

E-mail: counselling_programs@dcrs.ca



Changing Cultures Program for Refugee Youth

Goals and objectives

- to strengthen existing programs for refugee youth aged 15+ in the health, education and settlement sectors (Guideline 11)
- to conduct an audit of existing programs mapped against the social determinants of mental health (Guidelines 3 and 4)

Description

This Australian program focused on a needs assessment of refugee youth in order to influence program development and delivery, organizational development and capacity building, and **community development** and evaluation (Guidelines 6, 9 and 13). Data was gathered on needs pertaining to this refugee group, and consultations provided to teachers and service providers to inform program evaluation and modification (Guideline 11).

Programs that were modified in accordance with the Changing Cultures Program were school curriculum, peer support groups in schools, tertiary programs that provided vocational and language counselling, and programs provided by community agencies (Guidelines 6 and 9).

Start date

2001

Guideline 1: Audience, specific populations

refugee youth 15+ (post–compulsory school age in Australia) from Africa and the Middle East

Guideline 3: Protective factors

- language ability
- social integration
- employment
- access to recreation

Guideline 4: Risk factors and determinants of health

Risk factors

- low education level
- low English language ability
- unrealistic expectations about educational and vocational success
- trauma and physical injury
- family disruption
- acculturation difficulties
- tension over gender roles

Determinants of health

- social inclusion
- freedom from discrimination
- access to economic resources

Guideline 6: Multiple settings

- schools
- community organizations
- health services

A major outcome of the project was that it allowed many services to focus on strengthening and building networks, by:

- undertaking the professional development of teaching staff to improve their knowledge of what services to offer young people (Guideline 7)
- improving the links between students and services so that services could be accessed more comfortably and independently (Guideline 9)
- facilitating the co-delivery of programs (Guideline 9).

- two general intervention strategies based on:
  - individual needs
  - a structural level (intersectoral co-operation on community level)

Guideline 7: Support professionals and non-professionals

professional development of teaching staff

Guideline 9: Comprehensive supports

- assessing population needs to develop new programs in multiple sectors
- making programs more accessible
- co-delivering programs

Guideline 11: Multiple stakeholders

- education
- health
- settlement services
- refugees

Guideline 13: Evaluation

yes

Learn more

Bond, L., Giddens, A., Cosentino, A., Cook, M., Hoban, P., Haynes, A. et al. (2007). Changing cultures: Enhancing mental health and wellbeing of refugee young people through education and training. *Promotion and Education, 14* (3), 143–149.

Contact: Centre for Adolescent Health

E-mail: lyndal.bond@rch.org.au

Health Realization (HR) Program to Reduce Stress and Improve Coping in Refugee Communities

Goals and objectives

- to promote and enhance the use of internal and external coping resources while decreasing the negative outcomes of stress
- to improve individuals' understandings of psychological functioning
- to improve recognition of types of thinking that have a negative effect on mental health
- to help refugees recognize available external social supports

Description

Health Realization (HR) is a non-invasive, culturally adaptable (Guideline 10) community-oriented (Guideline 6), cost-effective educational approach that does not focus on the recall of past traumas. It is based on the holistic nursing principles that all people, regardless of their life experiences or psychological diagnoses, have innate internal coping resources to help them live a happier life (Guideline 3).

In this program from Minnesota, four to six three-hour group educational sessions are held in community settings. The sessions are highly interactive and teaching methods include the use of stories and illustrations (Guideline 10). Areas of content include the main principles of HR; the "thought cycle," or link between thought and life experience; recognizing levels

Start date
February 2006

Guideline 1: Audience, specific populations
refugee communities at risk for mental health issues

Guideline 3: Protective factors
- coping skills
- resilience
- social support
- self-efficacy
- positive outlook
- spirituality

Guideline 4: Risk factors and determinants of health
Risk factors
- stress
- negative outlook
- isolation
- issues with self-esteem
- limited or no social support
- trauma

Determinants of health
increasing knowledge of thought process and social support

Guideline 6: Multiple settings
individual and community settings

of mental and emotional well-being, and skills for raising personal levels of understanding; situational use of different modes of thinking; understanding that each individual creates a separate reality based on his or her thought patterns; skills for quieting the mind; recognition of moods and practical strategies for coping with low moods (Guideline 8).

Although external factors such as family and community support are acknowledged in HR education, the intervention focuses primarily on the internal environment and people's ability to access their internal resources and thereby shift their perception of external experience.

Guideline 8: Focus on skill building

- enhancing internal coping skills

Guideline 10: Culturally appropriate and holistic services and information

- culturally adaptable
- culturally appropriate teaching methods
- based on holistic principles

Guideline 13: Evaluation

No. This program is still largely based on theoretical findings.

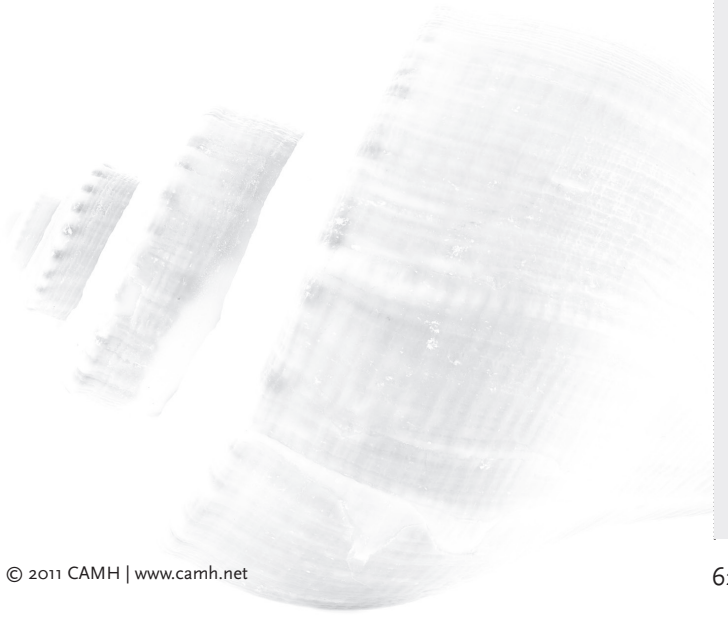
Learn more

Halcon, L., Robertson, C., Monson, K. & Claypatch, C.A. (2007). A theoretical framework for using health realization to reduce stress and improve coping in refugee communities. *Journal of Holistic Nursing, 25* (3),186–194.

Contact: Health Realization Training Center

Tel.: 612 823-5973

E-mail: claypatchc@puc-mn.org



Children and Youth Affected by War and Migration Coalition: Playing with Rainbows Group

Goals and objectives

- to develop resources designed to promote mental health and facilitate the healing process for children, youth, parents and care providers traumatized by war, political oppression, and pre-migration and post-migration stressors (Guideline 1)
- to play a role in educating service and care providers and educators about the impact of trauma on interpersonal relationships, mental and physical health, behaviour, academic success, employment and all aspects of one's life (Guideline 6)

Description

The coalition is a partnership between traditional, mainstream service organizations and a variety of ethno-cultural, ethno-specific service organizations and community members (Guideline 2). In 2004, the coalition received funding from the Ontario Ministry of Children and Youth Services's Children and Youth Mental Health Innovation Fund to provide and evaluate an innovative and much-needed group work service to Toronto refugee and immigrant children. Phase 1 of the "Playing with Rainbows" (PWR) group was developed for children, ages 5 to 13, and their caregivers, who have been affected directly or indirectly by war and migration trauma. Throughout winter 2005, 12-week

Start date

2004

Guideline 1: Audience, specific populations

children, youth, parents and care providers traumatized by war, political oppression and/or migration

Guideline 2: Continually involve community members

- members involved in development of programs and resources and in facilitation

Guideline 3: Protective factors

- support
- education
- normalization

Guideline 4: Risk factors

- stress
- isolation
- limited or no social support
- trauma

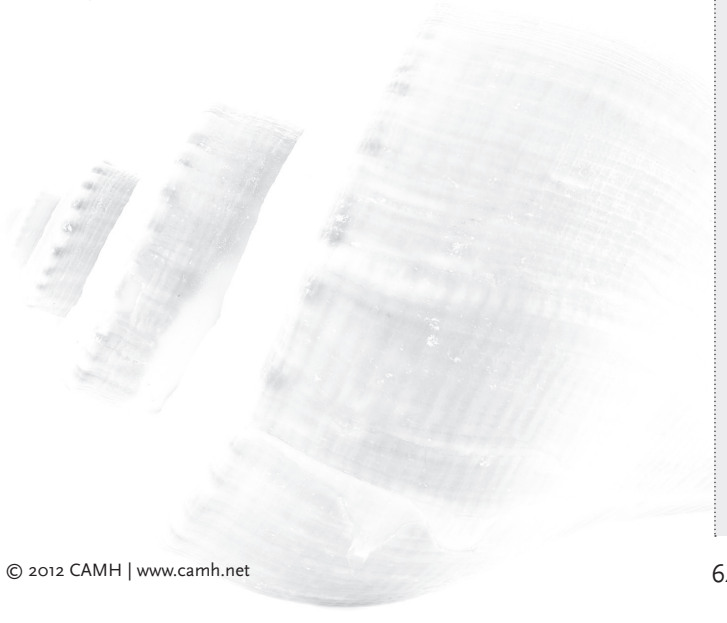
Guideline 6: Multiple settings and approaches

- education to service and care providers as well as educators
- play groups
- caregiver groups

PWR art and play groups were provided to identify and respond to trauma, and to provide normalization, support and education to the children (Guideline 3).

Accompanying the children's group was a three-session caregivers' group that provided information and support to enable parents to support their children's participation in the group, and connect them with appropriate community resources. Trained PWR facilitators delivered the groups to six ethno-specific communities: Afghan, Albanian, Iranian, Serbian, Somali and Tamil (Guidelines 2 and 10). A total of nine PWR groups were completed, and 95 children and their caregivers participated. Additionally, two PWR train-the-trainer workshops were provided to the group facilitators.

Phase 2 continues to advance this promising intervention, through a focus on developing specialized group work curricula for youth (ages 13 to 19) and parents.



Guideline 8: Focus on skill building

- enhancing coping skills
- normalization
- comfort with using community resources

Guideline 10: Culturally appropriate and holistic services and information

- training community members to lead groups
- involving ethno-specific service providers
- holistic mental health promotion principles

Guideline 13: Evaluation

No. This program is still being fully developed.

Learn more

Revell, B. (2000). *Playing with Rainbows: A Manual*. Toronto: YWCA Canada.

The Empowerment Program

Goals and objectives

- to create an innovative prevention and psychoeducational outreach program to address barriers to traditional Western mental health interventions for refugee and immigrant women

Description

The Empowerment Program in Kansas City, MO, was developed as collaboration among three partners: a university counselling psychology department and its clinic; a not-for-profit organization whose mission is to provide outreach and education to refugee and immigrant women concerning domestic violence and reproductive health, and providing shelter as required; and a local domestic violence shelter (Guideline 11). The program initially provided service to refugee women from Somalia, Sudan, Vietnam and Bosnia, and was expanded to include immigrant women from Russia, Afghanistan, India, Kenya, and Central and South America (Guideline 1). The program creators collaborated with community members from clients' native and host countries (Guidelines 2, 10 and 11) in order to meet personal and collective needs.

The program's services are broad, including psychoeducational workshops and home visits, counselling, advocacy and case management, informal meetings that provide one-on-one attention, and interpretation (Guideline 6).

Start date

2006

Guideline 1: Audience, specific populations

refugee and immigrant women from Somalia, Sudan, Vietnam, Bosnia, Russia, Afghanistan, India, Kenya, and Central and South America

Guideline 2: Continually involve community members

- both program development and delivery included community stakeholders

Guideline 3: Protective factors

- education
- coping skills
- resilience
- social support
- self-efficacy

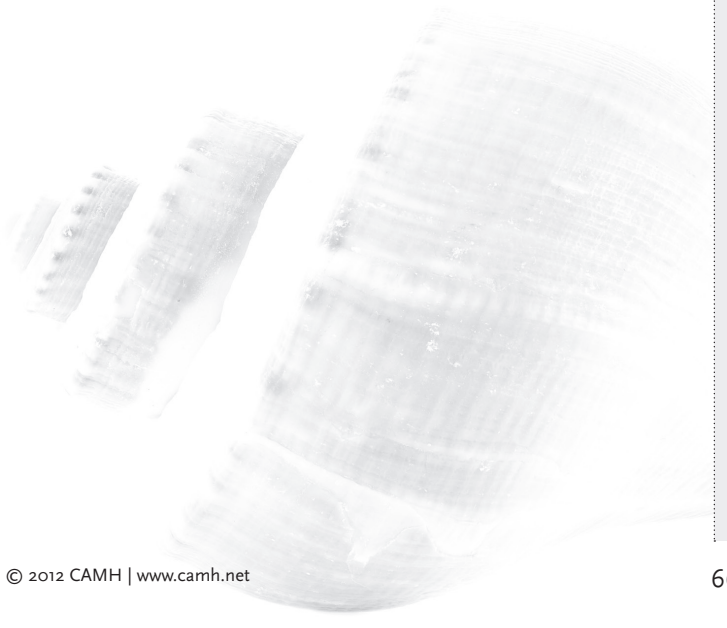
Guideline 4: Risk factors

- barriers to service access
- acculturation difficulties
- poor health
- unemployment

Guideline 6: Multiple settings and approaches

- multiple workshop topics
- workshops
- counselling
- home visits
- case management
- advocacy

Monthly two-hour workshops are offered to provide culturally sensitive (Guideline 10) psychoeducation in a group setting, focusing on topics such as mental health, acculturation and adjustment, physical health, family and gender roles, parenting, health, loss and grief, legal issues, unemployment and career barriers, and stress and self-care (Guidelines 6 and 8). Workshops are especially successful when they include presenters such as refugee women (Guideline 2) who have lived in the United States for an extended time, nurses and lawyers (Guideline 7). The program developers employed bilingual and bicultural paraprofessionals to serve multiple roles, including interpreter, translator, liaison, caseworker, resource specialist and community advocate (Guidelines 7 and 10). These advocates were refugee or immigrant women themselves and were active in their own communities (Guideline 2).



Guideline 7: Involve professionals and non-professionals

- refugee women
- nurses
- lawyers
- interpreters

Guideline 8: Focus on skill building

- skill building around legal and employment issues
- building coping abilities
- fostering support networks

Guideline 10: Culturally appropriate and holistic services and information

- solicited input from refugee community members
- culturally sensitive programming
- bilingual and bicultural service providers

Guideline 11: Multiple stakeholders

- university counselling psychology department and clinic
- non-profit service providers
- community members

Learn more

Khamphakdy-Brown, S., Jones, L.N., Nilsson, J.E., Russell, E.B., & Klevens, C.L. (2006). The Empowerment Program: An application of an outreach program for refugee & immigrant women. *Journal of Mental Health Counselling, 28* (1), 38–47.

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Pharos School-Based Education Program for Refugee Children

Goals and objectives

- to give attention to the difficulties refugee children face
- to strengthen peer support systems for refugee children by offering opportunities to share their histories and experiences with other children
- to foster teacher support for refugee children
- to strengthen coping ability and resilience among refugee children

Description

The Pharos program for secondary school students was originally developed and implemented in the Netherlands, and subsequently implemented in the United Kingdom. It has three components:

1. "The refugee lesson" is a series of eight lessons focusing on the experiences refugee children have in common (Guideline 1). The lessons are conducted by a teacher, together with a mental health care professional (Guideline 11), for a group of eight to 12 children. Examples of topics include living in the new country; where do I come from?; who am I?; important things and days; friendship and being in love; and prospects for the future. The aim is for students to share their experiences and develop skills that will enable them to cope more effectively with stressfull experiences

Start date

2002

Guideline 1: Audience, specific populations

refugee secondary school students
(also a separate program for primary students; see www.pharos.nl for more information)

Guideline 3: Protective factors

- access to support networks
- resilience

Guideline 4: Risk factors and determinants of health

Risk factors

- isolation
- issues with self-esteem
- limited or no social support
- acculturation difficulties

Determinants of health

- social supports
- ethno-cultural backgrounds

Guideline 7: Support professionals and non-professionals

- training manuals and educational tools for teachers and others involved in the group
- engaging non-refugee students in supportive activity

Guideline 8: Skill building

- coping skills

(Guideline 8), and not to explicitly bring up traumatic experiences for discussion. Emphasis is placed on the supportive factors in the social environment (Guideline 3).

2. The "Refugee youth at school" component is a training manual, accompanied by videotapes, for teachers and others involved with this group (Guideline 7). The themes are backgrounds of refugee youth, coping with loss, dealing with children who have been traumatized and preventive activities in the classroom.

3. "Welcome to school" is a series of 21 lessons emphasizing non-verbal techniques such as drawing and drama. The lessons aim to improve the well-being of youth seeking refuge or asylum and to prevent them from developing psychosocial problems by building bridges between the past, the present and the future. Classmates become companions and learn how to support each other (Guideline 7).

Themes include:

- getting acquainted
- where do I come from
- my school
- who are we
- important days or important people
- living in the new country
- important people
- friendship
- being in love and marrying
- leisure time
- feeling excluded
- on the road to the future.

Guideline 11: Involve multiple stakeholders

- teachers
- students
- mental health professionals

Guideline 13: Evaluation

yes—ongoing

Learn more

Watters, C. & Ingleby, D. (2002). Refugee children at school: Good practices in mental health and social care. *Education and Health, 20* (2), 43–46. Retrieved from http://www.sheu.org.uk/publications/eh/eh203di.pdf

Website: www.pharos.nl

Contact: Pharos (Netherlands)

Tel: 011 31 30 234 9800

Fax: 011 31 30 236 4560

E-mail: info@pharos.nl

Canadian Centre for Victims of Torture

Goals and objectives

The Canadian Centre for Victims of Torture (CCVT), based in Toronto, aids survivors to overcome the lasting effects of torture and war. Working with the community, the centre:

- supports survivors in successfully integrating into Canadian society, and advocates for their protection and integrity
- raises awareness of the continuing effects of torture and war on the mental health of survivors and their families (Guideline 5).

Description

The CCVT provides a range of services to improve survivors' mental health and empowerment. Its programs aim to promote mental health (Guideline 3) and reduce the impact of trauma, to prevent mental health problems from occurring (Guideline 4).

The Children's Program at CCVT aims to meet the specific needs of refugee children and their families through individual and family counselling, crisis intervention, and support groups for children, youth and parents that often include art therapy. This program also offers specialized settlement services and recreational and empowerment activities that incorporate conflict resolution, mentoring, peer support and storytelling (Guideline 9).

Start date

1977

Guideline 1: Audience, specific populations

refugees (claimants, convention refugees [CR] and government-assisted refugees [GAR]) and communities at risk of psychosocial trauma

Guideline 2: Involve community members

- more than 300 volunteers

Guideline 3: Protective factors

- counselling
- settlement services and skills training
- building social capital
- creating cohesion through networks of support

Guideline 4: Risk factors

- exposure to trauma (e.g., war)
- loneliness, isolation

Guideline 5: Reduce negative attitudes about mental illness within the community

public education and advocacy on issues of torture and its effects at a local, national and international level

Guideline 6: Intervene in multiple settings

- medical
- legal
- social support

In the CCVT's befriending program, volunteers are paired with a CCVT client and provide ongoing personal, non-professional support (Guidelines 2 and 7). They offer clients basic information, life skills and general help in adjusting to life in a new country (Guideline 8).

The centre also provides computer training and specially designed ESL classes to the refugee community, and is involved in numerous international projects related to mental health promotion for survivors of torture and war (Guidelines 9 and 11).

Guideline 7: Support professionals and non-professionals

- support group
- counselling
- volunteer services

Guideline 8: Skill building

re-empowering mental health services

Guideline 9: Provide comprehensive support

culturally appropriate approach when offering comprehensive support to clients

Guideline 10: Ensure information and services are culturally appropriate

materials produced in several languages and there is close involvement with a CCVT client advisory committee

Guideline 11: Involve multiple stakeholders

extensive network of agencies in education, public health and health services, and legal services

Guideline 12: Address opportunities for structural and organizational change

promoting circles of solidarity as an approach to mobilizing ethnocultural communities and engaging professionals and volunteers

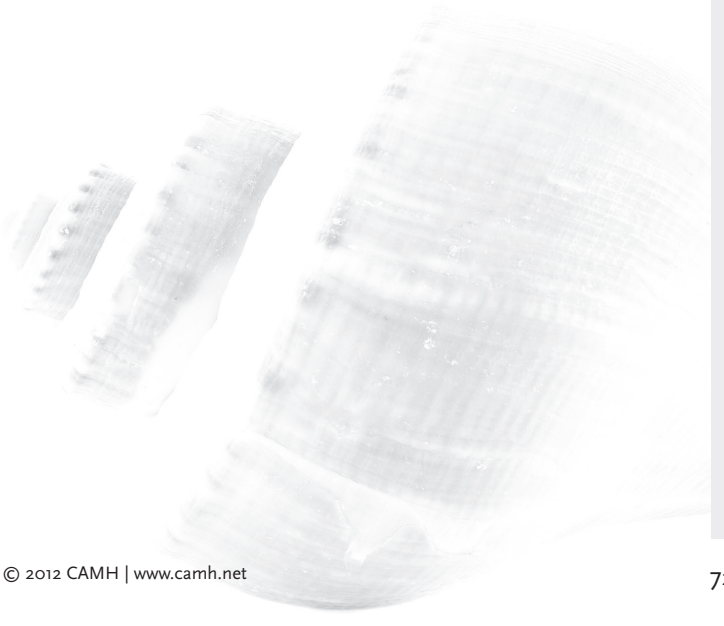
Guideline 13: Evaluation

outcome-based evaluations implemented twice yearly and regular focus groups held in the community. The planning is done with the input from all the centre's members (i.e., clients, board, volunteers) and staff

Contact: CCVT

Tel.: 1 416 363-1066

E-mail: mabai@ccvt.org



Appendix 1:

Worksheet

In this appendix you will find a worksheet that can be used by service providers to identify which guidelines could be implemented within new or existing mental health promotion initiatives for refugees. As some guidelines may prove a higher priority or, conversely, may not be relevant to your specific initiative, we recommend that you focus on the guidelines that relate best to your initiative when completing the worksheet. This worksheet is not meant as an evaluation tool, but as a referral resource for the planning, implementation and promotion of best mental health practices within your initiative.

Worksheet information

Why use the worksheet?

The purpose of completing this worksheet is to:

1. contribute to an evidence base that will help advance the field of mental health promotion for refugees

2. contribute to a better understanding of issues faced by refugees and what your initiative can do to further help them

3. provide information that could help other organizations and service providers apply similar practices to help refugees

4. recognize the full potential of your initiative to empower refugees and engage them in learning new skills

5. help you, through careful analysis of your effort, to better understand your strengths and pinpoint areas to improve, and thereby make your work more effective

6. communicate to others what you have accomplished

7. raise your organization's profile through describing the accomplishments of your initiative, which in turn could increase your possibilities for funding and other support.

How to use the worksheet

The worksheet has a user-friendly format to help you identify where your initiative is presently with regards to the guidelines and what you intend to further achieve.

The first column of the table includes the 13 guidelines relevant to promoting the mental health of the refugee population. They are posed as questions in order for you to think about how your intervention relates or does not relate to each.

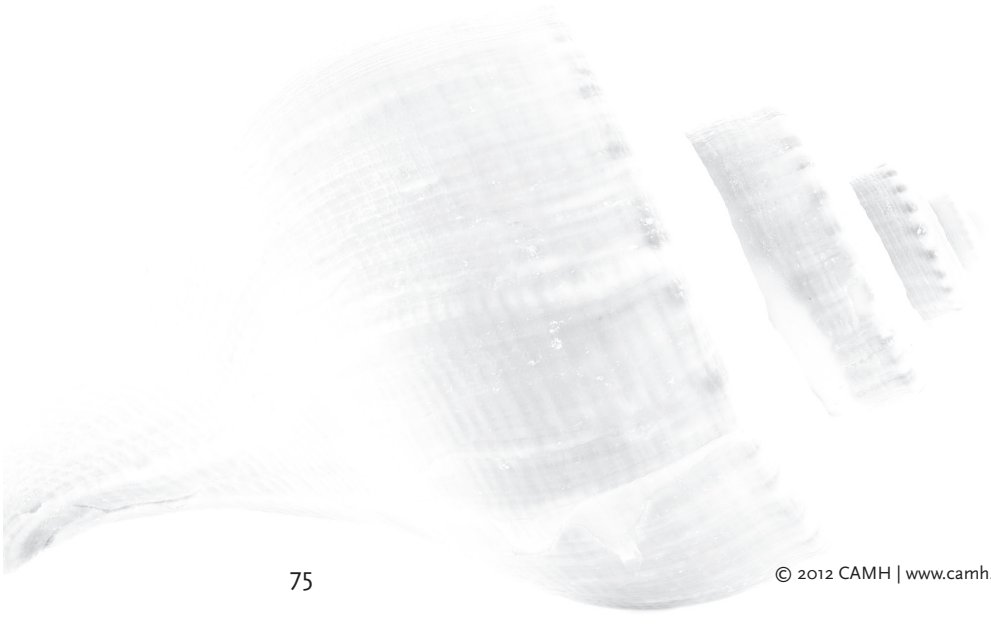
The second column provides more detailed components of each guideline question and offers suggestions of how you may go about implementing such practices within your initiative. It can also be used as a preliminary checklist to "tick off" the actions you already carry out. Please also refer back to the original set of guidelines for more information and examples on each action.

The third column allows you to identify what your initiative has achieved in relation to the best practice guidelines so far and how. Referring to your initiative's aims and objectives will be useful here. However, do not feel you have to fill in every row – only complete areas relevant to your initiative. Adding general notes here may also be useful as a future reference for the further development of your initiative.

The fourth column is intended for you to recognize what your initiative may be missing and how you could improve it. Be realistic and set goals for your initiative to apply over the next year. However, you may also find that you have achieved everything possible and may not need to provide any information in this column.

The fifth column allows you to document what specific actions you plan to take in order to achieve the goals over the next year. This could also be an opportunity to collaborate with people who use your services in order to receive their input on how you could improve your initiative and the services provided for refugees. Again, this column may not require completion if your initiative has already achieved its goals.

The final column helps you set a date for achieving these goals and to then later "tick off" what your initiative has achieved over a given period. The worksheet is intended to be a long-term tool that you could duplicate for the future development of your initiative aimed at promoting the mental health of the refugee population.



Worksheet for mental health promotion initiatives for refugees

Date: _____

Name of intervention: _____

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What else would you like your initiative to achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
1. Does your initiative identify the status and experience of the refugee population by...	...identifying the refugee's legal status?				
	...identifying the stage of the claimant process the refugee is currently in?				
	...identifying if the refugee has been exposed to trauma?				
	...classifying the refugee's needs (considering mental and physical health)?				
	...determining the family support networks available to the refugee?				
	...identifying how, when and where the population can be reached?				
	...other means?				
2. Does your initiative continually involve refugee community members through meaningful community involvement...	...working with communities to understand how they define mental health?				
	...identifying potential community partners?				
	...defining the goals of these partnership(s)?				
	...committing to achieving these goals?				
	...working to build credibility and trust to encourage community participation?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What else would you like your initiative to achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
3. Does your initiative address and modify protective factors (including determinants of health) for refugees' mental health concerns by...	...identifying relevant protective factors and social determinants of health that could reduce the risk of experiencing a mental health problem?				
	...assessing which protective factors and determinants can be modified and how?				
	...developing a plan to increase or enhance the effects of protective factors for refugees?				
	...other means?				
4. Does your initiative address and modify risk factors (including determinants of health) that could lead to mental health concerns for refugees by...	...identifying relevant risk factors and determinants of health that could negatively affect the refugee's mental health?				
	...assessing which risk factors and determinants can be modified and how?				
	...developing a plan to decrease the effects of risk factors for refugees?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What else would you like your initiative to achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
5. Does your initiative reduce negative attitudes about mental illness within the community by...	...educating organizations and professionals about cultural beliefs and taboos surrounding mental health?				
	...educating refugees about mental health?				
	...providing diversity and health equity training for professionals and non-professionals?				
	...working with communities to understand mental health?				
	...other means?				
6. Does your initiative intervene in multiple settings using multiple approaches that are culturally appropriate by...	...developing strategies to intervene in different environments?				
	...planning comprehensive approaches involving multiple methods?				
	...using strategies to reach refugees in formats appropriate to their needs and cultural preferences?				
	...identifying gaps caused by existing barriers and working to close them?				
	...encouraging professionals and non-professionals to work together to achieve goals?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What else would you like your initiative to achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
7. Does your initiative support professionals and non-professionals to establish caring and trusting relationships with refugees by...	...educating professionals around cultural taboos, cultural sensitivity and stigma within an anti-oppression framework?				
	...encouraging professionals to foster trusting relationships with clients?				
	...encouraging non-professionals to form relationships and get involved in initiatives?				
	...other means?				
8. Does your initiative provide a focus on individual resilience, skill building, self-efficacy and community capacity building for refugees by...	...providing an emphasis on skill building for the refugee community?				
	...providing further skill-building opportunities for caregivers, family members and associated peers?				
	...providing accessible educational opportunities for improving literacy, language and health care system navigation?				
	...providing educational information to promote factual understanding of mental and physical health?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What else would you like your initiative to achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
9. Does your initiative work to provide comprehensive support systems that are easily accessible and culturally competent for refugees by...	...forming ties between services, organizations and communities?				
	...facilitating the development of supports?				
	...providing access to support systems?				
	...understanding the impact of stigma and systemic oppression while working toward their elimination?				
	...providing cultural competence training for professionals and non-professionals?				
	...other means?				
10. Does your initiative ensure that information and services provided are culturally appropriate, holistic and accessible to refugee community members by...	...working with refugees to ensure that materials are correct and suitable?				
	...developing materials in native languages instead of translating existing texts or materials designed for people from other cultures?				
	...using examples that individuals can relate to?				
	...providing services that match with a culture's values and beliefs?				
	...other means?				

Questions based on the guidelines	Actions relating to the guidelines (Use as a checklist)	What has your initiative achieved so far?	What else would you like your initiative to achieve in the next year?	What specific action(s) do you plan to take to achieve this?	When do you hope to achieve this?
11. Does your initiative involve multiple stakeholders by...	...involving professionals and non-professionals?				
	...forming ties and partnerships with individuals, agencies and community organizations?				
	...engaging multiple sectors (i.e., public health, biomedicine, traditional medicine, policy-makers, education, immigration)?				
	...other means?				
12. Does your initiative address opportunities for structural and organizational change, policy development and advocacy by...	...engaging organizational, professional and community members?				
	...mobilizing ethnocultural communities?				
	...developing effective healthy public policies for refugees?				
	...other means?				
13. Does your initiative demonstrate a long-term commitment to the development and evaluation of culturally relevant programs by...	...continually involving community members?				
	...assessing the strengths and needs of the community?				
	...creating partnerships between the community and outside sources?				
	...setting a framework intended to support long-term initiatives?				
	...ensuring programs are continually evaluated?				
	...other means?				

Appendix 2:

Glossary

Accessibility: A measure of the proportion of a population that can access appropriate health services. For example, cultural accessibility considers whether access to health services is hindered by language, cultural taboos, beliefs or values.

Acculturation: A process in which members of one cultural group adopt or adapt to the beliefs and behaviours of another group. This may lead to changes in language preferences, attitudes and values, and loss of separate ethnic identification.

Best practices: "Best practices in health promotion are those sets of processes and activities that are consistent with health promotion values/goals/ethics, theories/beliefs, evidence, and understanding of the environment, and that are most likely to achieve health promotion goals in a given situation" (Kahan & Goodstadt, 2005, p. 8).

Capacity building: "Work that strengthens the capability of communities to develop their structures, systems, people and skills so that they are better able to define and achieve their objectives, engage in consultation and planning, manage community projects and take part in partnerships. It includes aspects of training, organizational and personal development and resource building organized in a planned and self-conscious manner reflecting the principles of empowerment and equality" (Skinner, 1997, quoted by Bush, 1999).

Community: "A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them." (WHO, 1998, p. 5)

Community action: The collective efforts of communities directed toward increasing community control over the determinants of heath and thereby improving the health status of the community as a whole.

Community capacity: The interaction of organizational resources, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of that community. Community capacity may operate through formal social processes and/or organized efforts by individuals, organizations and social networks that exist among them and between them and the larger systems of which the community is a part (Chaskin, 1996).

Community development: Any action that engages community members with the potential to transform local conditions in a positive way. Community development should emphasize the building of social relationships and communication networks, and contribute to the social well-being of community members.

Cultural competence: The capacity of an organization or individual to appreciate diversity, and to adapt to and work with people of different cultures, while ensuring everyone is treated equally.

Culture: The socially inherited body of learning that is characteristic of human societies, including knowledge, values, beliefs, customs, language, religion and art.

Determinants of health: These are based on the understanding that health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour. The term usually refers to non-lifestyle factors such as income, shelter, peace, food and employment.

Discrimination: Unfair treatment of individuals or groups because of, for example, their race, ethnicity, gender, religion, sexual orientation or disability.

Ethnocultural: Adjective referring to a group of people who share and identify with certain common traits, such as language, ancestry, homeland, history and cultural traditions. In Canada, this would refer to communities whose members have ethnic origins that are not French, British or Aboriginal.

Equity/inequities: Equity in health status is the presence of the same levels of health even between groups with different levels of socio-economic status (wealth, power or prestige). Inequities in health are differences in health status

between groups of people that correspond to their respective levels of social advantage or disadvantage.

Health: "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities" (World Health Organization, 1986).

Healthy public policy: Healthy public policy is characterized by explicit attention to health and equity in all areas of policy development, including non-health sector policies. Healthy public policy should be a collective effort across sectors, directed at creating healthy social and physical environments (World Health Organization, 1988).

Initiatives: Include a broad range of mental health activities, including services, information, campaigns, strategies, research and evaluation.

Literacy: "The ability to identify, understand, interpret, create, communicate, compute and use printed and written materials associated with varying contexts. Literacy involves a continuum of learning to enable an individual to achieve his or her goals, to develop his or her knowledge and potential, and to participate fully in the wider society" (UNESCO, 2004).

Mental health promotion: The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections and personal dignity.

Prejudice: "A state of mind; a set of attitudes held by one person or group about another, tending to cast the other in an inferior light, despite the absence of legitimate or sufficient evidence" (Canadian Race Relations Foundation, 2005–2012).

Programs: Include a broad range of mental health activities, including services, information, campaigns, strategies, research and evaluation.

Racism: Belief that one racial group has natural superiority over others; used, consciously and unconsciously, to justify, protect and maintain the position of one group.

Refugees: Migrants who flee their native country, for reasons related to racial, religious or political persecution, war, economic or environmental degradation, or other human rights abuses.

Risk factors or conditions: The social, political, environmental or biological conditions that are associated with, or cause, increased susceptibility to a specific disease, ill health or injury (Nutbeam, 1998). Risk conditions (e.g., substandard housing) are usually a result of unhealthy public policy and may be modified through collective action and social reform (Public Health Agency of Canada, 2002).

Self-efficacy: "People's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves, and behave (Bandura, 1994).

Social determinants of health "are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries" (WHO, 2012).

Social support networks: Help available to individuals from friends, family, co-workers and others within communities that can provide a buffer against adverse life events and living conditions, and can provide a positive resource for enhancing quality of life (Nutbeam, 1998).

Stigma: The negative attitudes that people can have toward individuals with mental health issues, or toward the general concept of mental illness. These negative attitudes can lead to prejudice, stereotyping and discrimination.

Taboo: The labelling of a subject by a culture or society as improper or unacceptable.

Appendix 3:

Resources

Mental Health Promotion and Counselling Services for Refugees in Toronto

The 519 Church St. Community Centre Among Friends – Peer Support Program for LGBTQ Refugees
519 Church St., Toronto, ON M4Y 2C9
Tel.: 416 392-6874
Website: http://the519.org/programsservices/queerimmigrantsandrefugees

Access Alliance Multicultural Health and Community Services – Newcomer Women's Health Programs
340 College St., Ste. 500, Toronto, ON M5T 3A9
Tel.: 416 324-8677
Website: www.accessalliance.ca

Canadian Mental Health Association – Newcomer Women's Wellness Program
1200 Markham Rd., Ste. 500, Scarborough, ON M1H 3C3
Tel.: 416 289-6285
Website: www.toronto.cmha.ca/

Canadian Centre for Victims of Torture – Support Groups and Counselling for Victims of Torture
194 Jarvis St., 2nd floor, Toronto, ON M5B 2B7
Tel.: 416 363-1066
Website: www.ccvt.org

CultureLink – Youth Settlement Support Groups, One-to-One Befriending Program
160 Springhurst Ave., Ste. 300, Toronto ON M6K 1C2
Tel.: 416 588-6288
Website: www.culturelink.net

Family Service Association of Toronto – Counselling for individuals who have witnessed trauma
335 Church St., Toronto ON M5B 1Z8
Tel.: 416 595-9618
Website: www.fsatoronto.com

FJC Refugee Centre – Support groups for refugee women
208 Oakwood Ave., Toronto, ON M6E 2V4
Tel.: 416 469-9754
Website: www.fcjsisters.ca/refugeecentre

Newcomer Women's Services Toronto – Newcomer Women's Community Support Network
745 Danforth Ave., Ste. 401, Toronto, ON M4J 1L4
Tel.: 416 469-0196
Website: www.newcomerwomen.org

Oasis Centre des Femmes – Social and Education Group for Newly Arrived Refugee and Immigrant Women and Children
College Park, Box 46085, Toronto, ON M5G 2P6
Tel.: 416 591-6565
Website: www.oasisfemmes.org

Suggested websites and online resources

Alone in Canada: www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/alone_in_canada.html

CAMH multilingual resources: www.camh.net/About_Addiction_Mental_Health/Multilingual_Resources/index.html

CAMH PTSD information leaflet: www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/ptsd_refugees_brochure.html

CAMH PTSD photonovella: www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/ptsd_photonov.pdf

CAMH settlement information: www.camh.net/Publications/Resources_for_Professionals/Guide_Addiction_Info_Referral/index.html

Citizenship and Immigration Canada: www.cic.gc.ca/english/index.asp

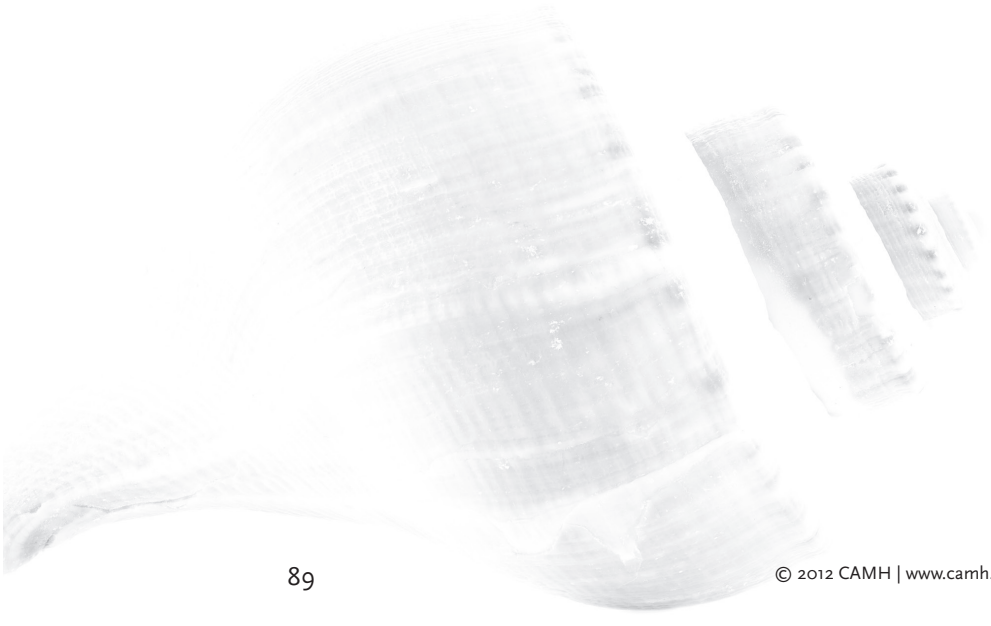
Cultural brokers: www.culturalbroker.info/

Diversity Rx: www.DiversityRxConference.org

Mental Health Commission of Canada: www.mentalhealthcommission.ca/Pages/index.html

Navigating mental health services in Toronto: www.crct.org/lanresources/PDFs/CRCT-NMHS-English.pdf

Public Health Agency of Canada: www.phac-aspc.gc.ca/index-eng.php



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