An Analysis of Crisis Services Accessibility of New Francophone Arrivals in the City of Winnipeg

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Submitted as Partial Requirement for

Master of Nursing:

Nurse Practitioner Major

Acknowledgments

Special thanks are due to my practicum committee for pushing me to a scholarly finish:

Chair, Dr. Diana Clarke Ph.D., for her gentle nudging, calm and pleasant demeanor, and firm guidance,
Internal member, Dr. Benita Cohen Ph.D., for her editorial skills, her expectation of excellence, and for her prediction of the work required in transcription, and
External member, Dr. Bruce Hutchison Ph.D., for his proof-reading skills, his unique perspective on the project and interesting recommendations.

Special thanks go out to my husband Léandre for being my sounding board and moral support throughout this endeavour. You are my rock.

Special thanks also to my daughter overseas, Chantale, for her forty hours of transcription and her computer skills. They proved invaluable to me many times over.

Thanks are in order for my family and friends who believed in me and encouraged me to the end.

A special recognition is extended to the aggregate population on which this practicum project was based; they bring a wonderful cultural richness to my practice.

In closing, I would like to dedicate this finished product to those who are no longer here to celebrate with me, but whom I know are very proud of me from where they are watching:

My parents, Fernand Lanthier and Tina Chateau-Tétreault, and my mother-in-law Elise Buissé.

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Abstract

The purpose of this practicum project was to facilitate access to mental health services and those health services that address issues causing emotional distress for new Francophone non English-speaking arrivals in the City of Winnipeg. The objectives were 1) to uncover Francophone mental health and specialized health resources in the city of Winnipeg, 2) to identify barriers, attitudes, and access issues pertaining to Francophone services, 3) to develop a directory of Francophone resources and links for health care professionals and other essential providers, and 4) to develop recommendations for future study and consideration. The project was implemented through telephone interviewing of 24 administrators and direct providers in 19 agencies that provided mental health and specialized health services, as well as refugee and immigration agencies. The study used qualitative methods and a semi-structured survey interview design.

Via analysis of the results, the project presents an argument that language barriers are indeed preventing access to care for Francophone immigrants, refugees and international students in the City of Winnipeg. This was widely stated by participants from key organizations that work with this aggregate population on an occasional to a frequent basis. It is also evident that, with use of Bachrach's Continuity of Care Dimensions/Principles, continuity of care for this population is equally compromised because of language barriers, lack of culturally sensitive providers, and lack of Francophone providers.

Chapter I- Problem Description

The following describes a practicum project implemented in the spring of 2005, for the Faculty of Graduate Studies, in partial fulfillment of requirements for the Master of Nursing degree, Nurse Practitioner major.

The Problem

There appears to be a lack of Francophone resources in the City of Winnipeg to address the particular mental health and psychological crisis issues that face many of the Francophone non English-speaking immigrants, refugees and international students. While these resources (specialized counselling, support groups, specialized medical services) are available in abundance in the English language, no such services are known to be available in the French language. And, while there are interpreters available in over thirty languages in the city of Winnipeg, none are presently available in French. This is rather surprising, given that French is considered to be Canada's second official language.

Definitions

- Francophones are those who comfortably understand and speak the French language. Bilingual depicts one who can comfortably speak and understand two languages.
- Immigrants are generally considered to be voluntary migrants seeking a better life; refugees are involuntary migrants who must leave their country of origin for fear of persecution due to race, religion, nationality, membership in a social group, or political opinion

(Citizenship and Immigration Canada, 2002). With immigrant women, this distinction is blurred. Immigrant women, for the most part, are considered dependants of men on immigration documents and the decision to immigrate is not necessarily theirs (Mulvihill et. al., 2001).

- For the purpose of this project, mental health issues are considered those that require a mental health provider (psychiatrist, psychologist, or mental health worker) and that are described in the DSM-IV-TR (American Psychiatric Association, 2000). Examples of these are anxiety disorders, mood disorders, psychotic disorders, substance-related disorders, adjustment disorders, personality disorders, and Post Traumatic Stress Disorder (PTSD).
- Psychological issues (leading to crisis), for the purpose of this project, are issues that are medically-related but of a sensitive enough nature to cause the client emotional distress. Examples of these are sexual assault, unwanted pregnancy, partner abuse, tuberculosis (TB), and Human Immune Virus infection (HIV).

The above issues are intertwined, in that unresolved psychological issues can lead to mental health disorders.

- Crisis, for the purpose of this project, is a situation where the individual's normal coping mechanisms are no longer adequate to maintain emotional equilibrium or mental health. Crisis requiring acute care (immediate intervention or hospitalization) is not addressed in this project.

Statistics and Demographics

In 2001, 249,920 immigrants settled in Canada; 4,560 (1.82%) of these settled in Manitoba. A total of 3,660 settled in Winnipeg. Refugees comprised 12% of these immigrants to Canada (27,831). Of these refugees, 34% originated from Africa and the Middle East. French was the only official Canadian language spoken by 12% of refugees (Citizenship & Immigration Canada, 2002). Refugees comprised 25% of immigrants to Manitoba (1,148 in Winnipeg in 2001).

Of the immigrants settling in Winnipeg from 1999 to 2001, 162 spoke French but no English (Manitoba Labour and Immigration, 2001). These numbers do not take into account the French-speaking Rwandan and Congolese refugees from the past 10 years, or the approximate 100 international students that are accepted at Collège Universitaire de St. Boniface (CUSB) yearly. Almost 100% of these international students apply to remain in Winnipeg after graduation (Therrien, 2002). They speak French as a primary or secondary language, and no English.

According to the Winnipeg Regional Health Authority (WRHA) Demographic Report (2000), Francophones make up 5% of the population of the WRHA whose 1998 census was 646,733. Thus the Francophone population (defined as those who identified French as their mother tongue) in 1998 was roughly 32, 335. Immigrants were not included in these numbers, given that most have an African dialect as their mother tongue.

The aggregate population of concern for this project is made up of three subgroups: 1) immigrant families from Morocco, Africa, 2) Black refugees from Africa (predominantly from central and western Africa), and 3) Black (African) and Caucasian (French) international students from the CUSB. Although all of the above make up the aggregate population of concern for this project, it should be stated that the Black African population will be mentioned predominantly as the Francophone refugee population is made up entirely of this subgroup, and will necessarily present with more acute problems on arrival (Vergara et al., 2003).

A small number of non English-speaking Quebec students (from the CUSB) also seek services from the WRHA. Several choose to stay in Manitoba to teach in Division Scolaire Franco-Manitobaine (DSFM) schools. Although these students do not share the emotional effects of resettlement that the African population does, they do still share the need for crisis intervention for things such as therapeutic abortion (TA), partner abuse, depression and anxiety related to schooling and being separated from family. However, for the purpose of this project, they were not included in the aggregate population as they are Canadian-born.

Immigrants from Morocco speak Arabic, with French as a second language. Most come with higher education which is not recognized in Canada, given that an equivalency has never been determined. Black African refugees and immigrants speak a variety of African languages, and those from central and western Africa speak French as a second language. Several

refugees have degrees or trades, but have no paperwork to substantiate these claims, having fled from life-threatening situations with no belongings. Many redo studies in their chosen fields, or study for new careers (Société Franco-Manitobaine, 2002).

The international student group has varied fluency in the English language (ranging from none to moderate), while their mastery of French is very good to excellent. Student counsellors had put in place a private agreement with one of the general practitioners (GPs) at the Centre de santé St. Boniface (CDS: a bilingual primary care health centre serving the Francophone population of Winnipeg and residents of St. Boniface, situated within walking distance of the CUSB) to address urgent health needs of this particular student population. This has been in place for the past two years. However, the status of this collaboration was on hold for two months this winter while the physician was on leave. He had also officially stated that he could no longer continue this collaboration on his return due to his heavy client workload. He has recently agreed to extend this service over the summer, having returned in the spring, but has officially given notice for the fall. The writer may be the one responsible for this collaboration once she officially becomes a Nurse Practitioner in the late fall of 2005.

With an increase in the immigration of French-speaking Moroccans and Black Africans to Winnipeg from 1999 to 2002 alone, the Société Franco-Manitobaine (SFM) has been sensitized to the fact that resources are lacking for this population. A forum to discuss the needs of the French-

speaking immigrant/refugee population was organized by the SFM in September 2002. Needs identified, in order of priority were: 1) employment, 2) housing, 3) integration, and 4) health care services. Barriers were noted to be language, lack of recognition of previous education, lack of affordable housing in St. Boniface, indifference by Winnipeg Francophones, lack of French services and resources, and lack of an organized system by the Francophone community to assist/welcome this population (SFM, 2002). Since then, an advocate has been hired to address some of the above needs. To date, employment and housing are in the process of being addressed, but not the latter two.

From personal observation as a primary care nurse at a St. Boniface community health centre, and in discussion with other professionals there, many issues arise in the population discussed. Providers have observed an over-utilization of TA as means of contraception, a resistance to use of other contraceptive methods, psychological/financial spousal and partner abuse, issues surrounding female genital mutilation (FMG), post-rape HIV, HIV of unknown etiology, TB, sexually transmitted infections (STIs), abuse by employers, post-war PTSD, substance abuse, undiagnosed schizophrenia, and sexual assault of a minor by a Canadian citizen. Lack of funds for the purchase of necessary medications and/or contraceptive methods, and for sponsoring immigration of spouses and /or children left behind, are common. Most women in these subgroups receive no help with childcare or domestic chores from spouses, have no other support systems, yet work full-time (or

more, as required by employers) in low-paying jobs and suffer from chronic fatigue to exhaustion. Several male and female Africans present with vague misplaced complaints of abdominal pain, which (according to Ivey & Faust, 2001) actually are symptoms of anxiety or depression. Traumatized refugees often somatize their symptoms (Gagnon, Tuck, & Barkun, 2004; Olness, 1998). Many require assistance in filling out forms, even when these forms are in French. Few of these families own or have access to a car. While most of the above-noted issues appear to pertain to the female gender only, at least 40% of the issues seen in the writer's practice affect the male clients as well. They will generally present with another symptom and not easily share the emotional problem, although it can be discovered within a few visits.

Significance of the Problem

The WRHA has recently put forth a guideline for evaluating the health care needs of refugees (Plourde, 2005). This guideline mainly focuses on physical pathology, and a mental health assessment is only briefly mentioned. The guideline does not shed any insight on how to approach potential crisis needs and mental health needs of this population. A recent article in the Winnipeg Free Press (April 24, 2005) exemplifies the problem with the story of a Francophone immigrant woman with mental health problems in the City of Winnipeg. Since her arrival one year ago, she has been unable to enter the mental health system and had, at the time of the article, become a homeless street person.

A few scattered resources are currently in place for the Francophone population and for refugee and immigrant populations, but none are based on an actual study of needs for this particular group, and minimal formal or informal partnerships exist (M. St. Hilaire, personal communication, 2002; A. Hrykaiko-Assié, personal communication, 2002; Jeannine Roy, personal communication, 2002; and Rebecca, Plurielle , personal communication, 2002). Several services exist for immigrant and refugee populations in the city of Winnipeg according to Manitoba Labour and Immigration (2001), The Volunteer Centre of Winnipeg (2002), and personal communication with workers at Sexuality Education Resource Center, (SERC), (2002). However, when one calls these services, there are no services available in French. This issue will increase in importance in the near future, given the active invitation to Francophone foreigners to immigrate to St. Boniface (SFM, 2001). The new Immigration and Refugee Protection Act, passed June 28th, 2002 (Citizenship and Immigration Canada, 2002), and the statement by Provincial Health Minister Becky Barrett that Manitoba wishes to double its intake of immigrants to meet its Canadian population percentage of 3.6%, seconded by Mayor Glenn Murray (Winnipeg Free Press, 2002) confirm the relevance of this issue.

Resources for meeting the medical (or physical) health care needs of Francophone immigrants, refugees, and international students in the WRHA appear adequate. There are presently three Francophone GPs at the CDS, and two Francophone nurses pursuing Nurse Practitioner (NP) education.

Youville Centre St. Vital has a Francophone NP. There are three Francophone GPs in St. Vital, and one in Transcona. At the time of writing of this paper however, none of the GPs are actually taking new clients. There are presently no resources in place for the international students at CUSB come the fall. St Boniface Hospital will usually find an interpreter for a Francophone client who cannot speak English, through volunteer services during business hours. The ability to find a French interpreter at any given time at other hospitals in the city is near impossible, as many service providers simply cannot wait for an interpreter to be called and arrive, or the interpreter is a lay person with minimal knowledge of anatomy and disease states (personal observation and second hand information from clients).

Mental health and psychological distress issues. Resources and programs appear to be lacking when the client's presenting problem is not purely a physical one. A client in emotional distress is even more challenging to understand, evaluate and diagnose, and a lay interpreter in this situation is not always effective, helpful, or appropriate. Hence, the real risk of misinterpretation, misdiagnosis, and erroneous treatment prevails. The negative consequences of such an encounter can be devastating. Examples of case in point from the writer's practice are post-TA clients who present pregnant again a month later, and a post-rape minor who did not complete her Morning After medications as prescribed. Both the educational sessions these clients received were in English with and without lay interpreters. Another example is that of an abused woman who went to a shelter, erroneously

informed that Immigration would not consider this a factor in the request for immigration papers for her son still in Africa. She later learned that she was also not entitled to Social Assistance, not yet being a Canadian herself. She was only able to rectify the situation by returning to her abusive spouse and working overtime for months to repay the Income Assistance that had been granted to her while in the shelter. This situation would have been prevented if she had been clearly informed by a knowledgeable provider in the French language, instead of an uninformed Francophone provider. The above example shows that limited Francophone services are not specialized in all areas.

Another example of these issues is that of a male refugee being followed as a contact by TB Control, but not aware that he was actually living with the contact (without translation of the letter he received, he thought the appointment was just “normal immigration follow-up”). His spouse is also HIV positive and he has received no counselling. Another case in point is that of a male refugee who has been unable, due to emotional distress related to post-war issues, to complete school or find a full-time job. He is being treated for depression but has turned to alcohol in his grief and guilt at not being able to provide for his family in Africa. He cannot be referred to Addictions Foundation of Manitoba as they have no French resources.

Clients with mental health or psycho-social issues are referred to specialists in those fields by their GPs, for the most part. Some clients will self-refer. At the CDS, clients have an advantage because there are several

professionals to address these needs: a Social Worker and a Mental Health Worker on a full time basis, and a psychologist and psychiatrist once weekly. However, none of the above are experienced in working with the African culture, nor with special circumstances such as PTSD, post-rape counselling, HIV counselling, pre and post abortion counselling, etc. These clients need specialized counselling by a professional knowledgeable in these unique situations. The above impression was confirmed through personal communication with L. Labossière (October 2004). She also was not aware of any Francophone professionals who could meet these particular needs that she could not.

The Project

Objectives. The overall goal of the project was to facilitate access to mental health services and those health services that address issues causing emotional distress for new Francophone non English-speaking arrivals in the City of Winnipeg. The objectives of the project were four-fold.

The first objective was to uncover any Francophone mental health and specialized health resources in the City of Winnipeg. Part of this objective was to discover what specializations these resources might have (i.e., cultural awareness training, experience with PTSD, couple counselling, etc.). This would also be achieved by probing into specialized non-Francophone health services to see if they had Francophone providers, interpreters, and/or reading material. The second objective was to identify barriers, attitudes, and access issues pertaining to Francophone services. The third objective was to develop

a directory of the above resources and links for health care professionals and other essential providers. The fourth objective consisted of the development of recommendations for future study and consideration.

Questions for Inquiry. A few questions, derived from the writer's clinical experience, were brought forward:

1. What formal resources (services, programs, interpreters, and reading material) are currently in place in the City of Winnipeg to address language barriers of Francophone clients who do not speak English?
2. Does a formal data bank of trained Francophone interpreters exist in the WRHA?
3. Are there any Francophone staff employed in the medical/social services or mental health fields that address sensitive issues (abortion counselling, post-rape counselling, addictions counselling, HIV and TB counselling and treatment, PTSD counselling)?
4. What are the beliefs of non-Francophone providers in the City of Winnipeg regarding the Francophone community's current availability and accessibility of resources?
5. Are existing Francophone mental health services trained in culturally-sensitive issues or specialized issues (such as PTSD)?

Summary

There appears to be a lack of specialized Francophone resources in the City of Winnipeg to address the particular mental health and psychological crisis issues that face many of the Francophone non English-speaking

immigrants, refugees and international students. Having said this, there are perhaps many appropriate services that the writer and her coworkers are not aware of. The goal of this project is to uncover them, should they exist, and to provide a directory of these services for the providers of the target population to refer to.

Chapter II- Literature Review

Health Needs of Immigrants

Literature on the health needs of immigrants, particularly female, is vast (Aroian, 2001; Davies & Bath, 2001; DeSantis, 1998; Ell & Castaneda, 1998; Ivey & Faust, 2001; Jackson, 1998; Lipson, McElmurry & LaRosa, 1997; Loue & Faust, 1998; Marshall et. al., 1998; Mayotte, 1995; Meleis et. al., 1998; Mulvihill, Mailloux, & Atkin, 2001; Olness, 1998; Reidel, 1998). The general consensus from all of the above-stated references is that needs specific to immigrant/refugee women of all ethnicities are isolation, financial difficulties, PTSD (Olness, 1998), and, frequently, family violence (Loue & Fast, 1998). The cited barriers to health care are language barriers (Bowen, 2001), lack of knowledge of the available resources, men's gate keeping, non-sensitive provider relationships, lack of female providers, time constraints (due to family obligations and immigration demands), and transportation issues (Riedel, 1998). Female immigrants/refugees are reported to utilize the health care system more than their male counterparts; yet they underutilize the system as compared to non-immigrant women of the same socio-economic class (Ten Have & Bijl, 1999). Both genders are more likely to present to an emergency room or walk-in clinic than to their own GP. They are also more likely to present to a medical provider for emotional distress than to a mental health provider, hence promoting under-diagnosis and under-treatment of mental health problems (Ell & Castaneda, 1998; Lipson, McElmurry, & LaRosa, 1997). Somatization of anxiety and depression is also

a very real problem and one that leads to increased use of the medical system (Gagnon, Tuck, & Barkun, 2004; Olness, 1998; Tilbury et al., 2001). Particular health needs cited for immigrant/refugee women are complications related to FMG, sexually-transmitted infections (STIs) through promiscuous spouses, contraception and breast-feeding issues, pregnancy and birthing outcomes (DeSantis, 1998), and an increased risk of TB, intestinal parasites, and depression (especially in refugee women pregnant in transit) (Aroian, 2001; Avery, 2001; Ivey & Faust, 2001).

Canadian Research on Immigration Health

The Kinnon Report (Health Canada, 1999), a literature review of research on Canadian immigration and health, reveals that most research has studied general immigrant populations, with a lack of concentration on sub-groups such as women immigrants to Canada, recent immigrants, refugees, and high-risk groups (i.e. from developing countries, new regions of origin from those previously studied). The Report recommends research on the immigration experience as a determinant of health and the need for more gender analysis in immigration research.

The September 2001 Working Paper on immigration and health (Health Canada, 2001) states that there is a lack of studies regarding Canadian immigrant/refugee subgroups, citing language barriers and limited sample size. Studies have suggested that immigrants to Canada are on average in better health than their Canadian-born counterparts. However, this changes after about ten years (etiology undetermined). The Working Paper addresses

three important studies on the health of Canadian immigrants/refugees. One is a study of the literature by Mulvihill & Mailloux (2000); the other two are studies of refugees of both genders. The first of these studied 1140 refugees to Calgary over 22 months (Dillman, as cited in Health Canada, 2001). The sampling was multi-ethnic with only 10% from the African continent. It concluded that refugees need special care and protection in a new country, particularly in the early stages of resettlement. It also concluded that 34% of refugees need immediate referral to a GP on arrival. The second study (Thonneau, as cited in Health Canada, 2001) categorized the health state of 2099 refugees to Quebec over a seven month span. The sample was again multi-ethnic and included no Africans. The conclusion was that refugee health was satisfactory, but the only responses requested were *good* and *poor.* The Working Paper recommends more research, and that perhaps the Canadian Population Health model should be modified to reflect challenges faced by immigrants. The Working Paper reiterates the statement made by the Final Report of the Metropolis Health Domain Seminar, relating to illness by immigrants, that : "…the increased risk probably results from an interaction between personal vulnerability and resettlement stress, as well as lack of services, rather than from diseases they bring with them to Canada" (Health Canada, 1998a, p. 14).

An unpublished thesis by a University of Manitoba Master of Social Work student (Nyman, 1992) describes a study very similar to the writer's. It explored the accessibility to mental health and social services by immigrants

and refugees via a telephone survey of 85 service providers in the City of Winnipeg. Interestingly, the majority of service providers, at that time, reported the availability of cross-cultural staff training and adequate networking with ethno-specific organizations. Specific cultures and languages were not addressed in this study however. The only exception to this was a question on interpreters, in which eight specific languages were asked about, but not the French language.

African Immigrants/Refugees

Studies of needs of Moroccan and Black African immigrants/refugees in North America are few (Avery, 2001; Faust, Spilsbury, & Loue, 1998; Lightfoot-Klein & Shaw, 1991), and those specific to Canada have been generated in Quebec where French services/resources are abundant (Vissandjee, Carigna, & Boudreau-Marchand, 1999). The study by Vissandjee et. al. actually studied only eight immigrant/refugee women, of which only three were African. Their results showed that these women saw disease prevention as ability to overcome financial problems and access to a healthy diet and medical care.

One study of particular interest is that of the process undertaken by a community mental health centre in Toronto, Ontario, where the cultural diversity is vast (Pyke, Morris, Rabin, & Sabriye, 2001). In 1996, this community became aware that the centre's antiracial policies were present as statements only, and not as realities. An effort was made to offer cross cultural training, antiracism seminars, and to hire visible minorities. This

resulted in 1) increased awareness by the particular targeted African community to mental health issues, 2) creation of links between the African community and the mental health centre, 3) new awareness by the African community of the different programs available at the mental health community centre, 4) the formation of an ongoing project between the community and the mental health community centre to continue to address specific issues, and 5) increased awareness of cultural issues in the mental health field by the community mental health centre staff.

Language Barriers

Language is cited as being a determinant in the quality of service and an important component of effective care. However, according to the Consultative Committee for French-Speaking Minority Communities (Health Canada, 2001), 50 to 55% of French-speaking minority communities do not have access to health services in French. The report also states that "…even in communities where Francophones are most heavily concentrated, resources aimed at Francophones are in short supply." (p.9). The report supports the contention that language barriers reduce use of preventive services, decrease compliance with treatment, reduce satisfaction with services, increase consultation time and number of diagnostic tests, and adversely affect quality of services where communication is crucial (i.e. social services, counselling, paraprofessional therapies). This is also supported by Bowen (2001) in her study of language barriers in access to health care in Canada. A study of Moroccan and Black African immigrant women in Amsterdam by Ten Have

& Bijl (1999) revealed decreased accessibility to mental health services due to inability of care providers to communicate effectively due to language and cultural barriers.

In 1988, the Immigrant/Refugee Health Outreach Worker Project: Planned Parenthood Manitoba was implemented (O'Neil, 1988). Four outreach workers (Cambodian, Vietnamese, Chinese and Spanish-speaking) were trained in areas of reproductive and maternal/child health, STIs, AIDS, family stress, crisis information and referral, consumer advocacy, community resources, English language training, and cross-cultural relations. Subsequent to this, other immigrant communities expressed interest, and in 1990 another needs assessment was done and the program was expanded to include workers offering services in sixteen languages (Bowen Stevens, 1993). From 1990 to 1993, the need for addressing AIDS in the immigrant/refugee population was also identified and three different projects emerged, offering services in seventeen different languages (Bowen Stevens, 1993). Although there is a gap in the literature as to what became of these projects, the end product of these early years is the Sexuality Education Resource Centre (SERC) which is funded in part by Planned Parenthood Canada and Manitoba Health. It currently has resources in thirty or so languages; of note, none in French (presentation by SERC to CDS, 2001). These resources are interpreters, counsellors, and written documents for issues related to reproductive health such as contraception, STIs, and issues related to FGM. A question could arise as to whether any of these interpreters in the 30 or so

languages could assist the aggregate population depicted in this paper. Due to civil wars in so many of the African countries, there is great mistrust between the different African groups (Olness, 1998). Anecdotally, personal communications with S. Buissé (president of the CUSB student union), 2004, A. Hrykaiko-Assié (co-worker married to an African international student), 2004, and with African clients from different countries over the past few years substantiate this hypothesis.

Language Interpretation

Language interpretation is a frequently used solution by service providers in order to assist in meeting the needs of clients. This section will review the literature on what is required of an interpreter, and how interpretation can complicate or hinder the actual process of meeting a need. Interpretation can be a useful tool, but only in the appropriate setting. It should be part of the solution, but not the only solution.

According to the Code of Ethics for Interpreters in Health Care (Roat, ed., 1995), the following is a list of rules to be followed:

Figure 1.

Code of ethics for interpreters in health care

1. *Confidentiality.*
2. *Accuracy: conveying the content and spirit of what is said.*
3. *Completeness: conveying everything that was said.*
4. *Conveying cultural frameworks.*
5. *Non-judgemental attitude.*
6. *Client self-determination.*
7. *Attitude toward clients.* An attitude of trust and respect should prevail.
8. *Acceptance of assignments.* The interpreter should disclose any perceived conflict of interest. He/she should withdraw from the assignment if his personal sentiments do not allow him to abide by the above rules.
9. *Compensation.* Only the fee/salary from the agency is to be accepted.

The above rules are not without problems. Confidentiality is very difficult in a small cultural community where the interpreter is likely to know the client or his family (Olness, 1998; Shin, 2002). The option of declining the assignment is not always a possibility if no other interpreter exists. Because of the attitude of trust and respect, the interpreter sometimes is sought, or steps forward, to be an advocate for the client when no one else will. Some agencies accept this, but others see it as a conflict and the interpreter is let go. An ethical dilemma arises when the interpreter has interpreted for the client in the past and knows information that the client does not disclose or denies. This can occur frequently in a small cultural community (Jackson, 1998). Another confounding factor is that women of many cultures must, for religious or cultural reasons, seek a care provider of their own gender only (Chun & Akutsu, 1999). Even if such a care provider is available, many immigrant or racially visible women mistrust Caucasians and

will be better served by a female care provider of a non-Caucasian ethnicity, preferably her own (Sharma, 2001).

Even in the same language and culture, clients and healthcare providers can fail to communicate. While culture and language are predominantly stated as barriers to communication, other factors such as class, power, disparate beliefs, lack of linguistic equivalence, and disparate use of language also come into play (Kaufert & Putsch, 1997). While use of an interpreter is often seen as a best solution, the care-giver, client, interpreter triad has certain dynamics that also need to be presented. This relationship is often influenced by institutional, professional, or structural forces. For example, one area may have put in place interpreters with poor mastery of the language they are to interpret, just to meet a workplace policy. To a *volunteer* interpreter in the workplace, interpretation may be perceived as an additional time-consuming task in one's already busy work schedule (Jackson, 1998). Also, importantly, in most instances, no formal training is offered in interpretation skills.

Kaufert & Putsch (1997) found, in their study of Canadian Aboriginal interpreters, that interpreters take on the role of mediator in many instances, rather than simply interpreter. Some transcripts actually demonstrated a variety of biases in the interpretation to client or care-giver. While clearly not the objective interpretation that is sought, it is a reality of interpretation. Having stated the above, interpreters often facilitate trust in these triads by explaining programs and cultural differences in care to the client and families. They may do this with culturally appropriate explanations, and by also

explaining clients' rights. Ultimately, culturally correct interpretation can lead to improved health education, client compliance, increased effectiveness and efficacy of the system.

Interpretation of the English language is a pervasive need of the non-English-speaking immigrant, refugee, and international student population and is critical in health care (Jackson, 1998). Jackson gives many examples of how inaccurate interpretation can be deleterious to the client, the care-giver and the system. Inaccurate interpretation can lead to inappropriate and expensive testing, wrong diagnosis and treatment, use of several different care-givers by clients in order to address the real problem, and frustration by client and care-giver. A recent study of 15 psycho-therapists and interpreters in 14 mental health centres in the United States (Miller et al., 2005) revealed that complex emotional reactions occur within the client-therapist-interpreter triad, that the interpretation can have an effect on the interpreter's own well-being, and that interpreters take on multiple roles in addition to interpreting language. According to Shin (2002), the best solution is that of bilingual and bicultural mental health providers, as they can be provide sensitivity to cultural issues and effective communication.

Conceptual Framework

Doyle & Visano (1986) made an important distinction between availability of and access to care. Availability was described as the existence or provision of a service to clients. Accessibility referred to whether a service was actually secured by the client. The intention of an organization to provide

access did not necessarily mean, according to these authors, that there existed reality of access to the available services.

Mainstream providers were described by Doyle & Visano (1986) as being organizations that offered services to members of the community at large; ethno-specific providers were said to be organizations that provided services based on a general criteria of culture, race, or language.

Bachrach's Continuity of Care. No theoretical models are available which specifically discuss language as a barrier to health care, however, *continuity of care* and *access to care* have been studied. Bachrach's model of Continuity of Care is particularly relevant to this project, and will be the conceptual framework on which this project is anchored. Bachrach (1981) described continuity of care as "a process involving the orderly, uninterrupted movement of patients among the diverse elements of the service delivery system." (p. 1449). Although prior debate in the literature had described or alluded to dimensions of continuity of care, Bachrach was able to conceptualize these into a model with seven dimensions (see Figure 2). She described discontinuity of care as being the absence of one or more of these dimensions.

Figure 2.

Bachrach's (1981) Dimensions of Continuity of Care

Longitudinal	• "Continuity of care starts when the need arises and ends when the need has been fulfilled."(p.193)
Individual	• Surmised that care would be planned with and for the client and his family. • Placed the client, and not the system, as reference point for the care.
Cross-sectional	• Understood that the client may have more than one need simultaneously, and may require different services for these various needs. • Each of these services may have a longitudinal dimension, but the totality of the services would lead to comprehensiveness. Continuity of care and comprehensiveness were said to be complementary, with each strengthening the other.
Flexibility	• The flow in services should correspond with any change in client circumstances, so that the client's regression or progression would be accommodated accordingly.
Relationship	• Could be interpreted in several ways. The relationship could be described by its closeness and warmth, by its same service provider, or by its team approach. • Clients having difficulties with interpersonal relationships would best benefit from a team approach.
Accessibility	• Described as an absence of psychological, physical, or economical barriers to service. • Alternately described as the ability of the client to access care when he needs it and in a manner that is acceptable to him both financially, ethically and morally. • Need for an "enabler" for clients who are not able to represent themselves. Continuity, in these circumstances, should ideally include the availability of such a person/professional who can assist the client in gaining access to the system.
Communication	• Implied a communication between the client and his service providers, but also among his service providers. • This linkage of services was said to only come

	about with continuity of information.

Bachrach (1993) further elaborated on this concept by redefining nine principles of continuity of care (see Figure 3).

Figure 3.

Bachrach's (1993) Principles of Continuity of Care

First principle: **Administrative climate** that "endorses, supports, and legitimizes" services for a clearly defined population. Should ensure that there are no barriers (financial, prejudicial, or administrative).	Second principle: **Access to care**, as described in the dimensions.	Third principle: **Full array of services**, described as essential. Examples are medical and psychiatric care, housing, rehabilitation services, crisis care, effective social supports, leisure activities, and asylum.
Fourth principle: **Individualization,** as described in the dimensions.	Fifth principle: **Flexibility**, as described in the dimensions.	Sixth principle: Importance of **linkage of essential services** and open lines of **communication** between these.
Seventh principle: Strongly advocates for a **continuity of care agent.** Could be called an enabler, an advocate, a case manager, or simply the care provider. Importance is that he/she provides a link which enables the client to access the service that is best suited to his particular need.	Eighth principle: **Client** should be treated **as a partner**, with consideration given to his person and his philosophies.	Ninth principle: System must include programs that relate to the **cultural reality** of the client. His cultural orientation must be understood and honoured.

The concept of continuity of care, which encompasses all of the afore-stated dimensions and principles, ensures for the client a service that is connected, follows a pattern, and persists over time, to completion. This concept stresses the assurance of ready access to service, even if it requires an enabler. It also stresses the need for quick and readily available access to client records for the purpose of continuity of treatment plans and communication between services.

The current project is an analysis of accessibility to care for the aggregate population. Bachrach's Continuity of Care model was chosen as most pertinent to the project even though it does not specify language barriers as a dimension or principle. This is because language barriers can be incorporated in all of the principles and dimensions, and analysed as a causative factor in not meeting the principles and dimensions of Continuity of Care.

Summary

Literature on the subject of immigrant health is vast. Many studies relate to both genders, many discuss the particular health issues facing women in the target population. According to Health Canada's 2001 Working Paper on immigration and health, many studies are still needed to address particular groups within this target population. Language barriers are cited as the most challenging barrier to access to health care, and the use of interpreters, although a bridge facilitating access, is not without its own challenges and complications.

Ultimately, continuity of care should mean a quicker resolution to the client's problem and a lesser degree of physical and emotional stress. It may also mean a decrease in the over-utilization of services such as care-givers and tests, and of the client's personal time and finances. This leads to the greater good of society at large. Access to care is a prime concern for the population discussed for this study. It presents with a rather unique package of issues, and requires specialized services that should also be available in the French language and be culturally sensitive. Some of Bachrach's principles (1993) and dimensions (1981) were used to guide the study of accessibility to services for this target population. Of note, the principle/dimension Flexibility was not used for this project, as it was considered to be too judgmental and difficult to deduce from a 30 minute interview. The key principles/dimensions used for the project are:

- Accessibility (described as absence of barriers),
- Communication between caregiver and client, and between caregivers of client,
- Full array of services,
- Longitudinal dimension,
- Individual dimension,
- Cross-sectional dimension,
- Supportive administrative climate,
- Cultural dimension, and
- Use of a continuity of care agent (enabler).

Chapter III- Methodology

The project was composed of two components. The primary component explored the current availability of Francophone specialized health and mental health services in the City of Winnipeg. This was accomplished via telephone interviewing of managers and/or those responsible for programs, as well as direct providers, in select mental health services and specific health issue-related agencies. The interviewer sought out any available or potentially available resources within both Francophone and non-Francophone organizations. Once these results were compiled, the second component consisted of the development of a directory of the available Francophone resources, for distribution to the organizations who deal with the target population on a frequent basis. Recommendations were also presented to address gaps and barriers identified through the findings.

Design

This study used qualitative methods, to allow for a comprehensive picture of the availability of services. A semi-structured survey interview design was utilized. Qualitative methods are descriptive rather than experimental. Text replaces numbers in the collection of data, and data is transcripted rather than tabulated. Theory is then used to explain the data, rather than to confirm a hypothesis (Locke, Spirduso, & Silverman, 1987). Descriptive designs study information that already exists. When they study current rather than past information, they are described as cross-sectional studies (Fink, 1995). The qualitative data obtained in this study allowed for

expanding on the *yes* and *no* answers given regarding the availability of Francophone services, and promoted discussion of any problems or planning in regards to this issue in the particular agencies interviewed.

Data Collection

Information was obtained via telephone interviewing with use of a survey. Questions were individualized according to specialized services. The interview survey was semi-structured, consisting of closed and open-ended questions. This allowed for a broader view of service availability in the French language. It also assisted in capturing that particular establishment's view of the need for Francophone services and interpreters. Interviews were audio-taped and then transcribed.

Use of the telephone interview was chosen for four reasons. Firstly, it is a method of gathering data of a semi-confidential nature in a private setting. While it cannot provide anonymity, it does not allow for visual recognition, thus allowing for more confidentiality than a person-to-person interview. Secondly, a large amount of information can be gathered in a relatively short period of time, having factored out transportation time and set-up time. Thirdly, it is deemed to be more effective than a mailed survey (which usually has a much lower response rate and often requires incentives) (Fink, 1995). Fourthly, the telephone interview is less likely to result in socially acceptable responses caused by the presence of the interviewer (Frey & Mertens Oishi, 1995). Socially acceptable responses refer to those that may not be the actual belief or attitude of the respondent, but those that he feels

are socially acceptable in the circumstance. For all of the above reasons, it was hoped that telephone interviewing would afford more sharing of information than an initial focus group would have, insofar as a lack of Francophone resources and personal and organizational beliefs and biases.

Limitations to telephone interviewing can be the lack of availability of non-verbal cues with answers, the need for a specific workstation for interviewing, and, to a lesser degree, the use of socially acceptable responses by participants.

Sample. Participants were chosen by purposive sampling. This is a strategy in which the investigator hand picks the cases to be included in the study (Mason, 2002). It was considered the most appropriate sampling for this study, given that the collection of data was in relation to a highly specific aggregate population and the total target population is an unknown to the investigator (LoBiondo-Wood & Haber, 2002). According to Wengraf (2001), random purposeful sampling (small sample size) "adds credibility to sample when potential purposeful sample is larger than one can manage" (p.103).

Administrators from all Francophone mental health and immigrant services agencies in the St. Boniface area were contacted. These are few; therefore, it was important that they all be contacted. Administrators of agencies and organizations in the City of Winnipeg, thought to be pertinent to mental health and medically-related crisis issues of this particular population, were contacted. These consisted of immigrant and refugee services in the city,

as well as specialized health services that this population was thought to have a need for. All of the above made up the inclusion criteria for the sampling (Fink, 1995). Many of these were already known to the investigator. Others were found via Contact (2003), the Mental Health Resource Guide for Winnipeg (2004), l'Annuaire des services en français au Manitoba (2005), and the Manitoba Interfaith Immigration Council's Orientation Guide for New Arrivals (undated).

Questions revolved around, and were limited to, the following issues: TB, HIV, partner abuse, sexual assault, abortion, and mental health issues (depression, anxiety, PTSD and substance abuse). By narrowing down the study to relate to these issues only, all of the specialized health services not addressing these particular issues were excluded in the list of agencies to call. The above describes the exclusion criteria for the sampling (Fink, 1995). This decreased the scope and numbers of participants. It also allowed for the ratio of immigration and refugee services, mental health and specialized health services, and Francophone combined services to be approximately 1:3. Administrators from the aforementioned agencies were free to designate an alternate if they were unavailable for interviewing, based on the assumption that the designate would give information representative of their agency. When possible, an attempt was made to interview both the administrator and a direct provider in each organization. The rationale for interviewing both was the investigator's suspicion that administrators' answers would reflect what they believed should be occurring while direct providers answers would

reflect actual practice. Conversely, administrators may be cognisant of the global picture while the direct provider may only be aware of that personally encountered in practice. If conflicting answers were discovered, they were both discussed in the results and discussion sections of this paper.

The administrators designated for telephone interviewing were initially approached for consent to interview. In most cases, only a voicemail was available, therefore a condensed message introducing the investigator and purpose of her call, with brief explanation of the study, was left (see Appendix A). Most required a second call a week later, and a second message. After verbal consent, a consent form and preview of the questionnaire was faxed with a request for response within one week (see Appendix B and C). A reminder telephone call was made once the week had elapsed. Participants were free to receive and respond by facsimile (fax), e-mail, or post; all chose to receive per fax, and all signed consents were received by fax except for two by post.

After the first two interviews (used as pilot test of the interview tool), it became evident that Francophone agencies would be better served and participation would be enhanced if the introductory phone call, consent form, and interview itself were all conducted in the French language. This proved to be correct, as not one Francophone agency declined interviewing. Approval for translation was received from the Ethics Research Board (Education/Nursing), and an *English to French* translator was hired to translate the tools in Appendices A, B, and C.

The sampling was carefully maintained at an equivalent number for the three subgroups interviewed:

- Francophone and bilingual services (7 organizations, total of 11 participants),
- immigrant/refugee services (6 organizations, total of 7 participants), and
- mental health/specialized health services (6 organizations, total of 6 participants).

A total of 24 organizations were initially called for interviews. Of these, four could not be contacted, and another was willing but timeframes available did not coincide. All Francophone services returned the call and agreed to be interviewed. One African association and one interpreter service did not return calls. Two specialized health services did not return calls. Two organizations had to reschedule the interview, one had to change the participant twice, and another had to cancel due to participant unavailability. Thus, in total, 19 organizations participated in the interviews.

Three of the organizations offered both administrator and direct service provider for the interview; six other participants were administrators who also provided direct services. Demographics of organizations and participants can be gleaned from Tables 1, 2, and 3.

Setting

The initial telephone contact and request were carried out at the writer's practicum clinical site, Family Medical Centre. This had been pre-approved by the practicum preceptor. Due to the lack of a private work station at the practicum site, the formal interview was carried out at the

investigator's own office workspace for the purpose of privacy and confidentiality. Permission had already been granted for this by the investigator's workplace director.

Timeframe

The above project was implemented within the 400 hour practicum, during the month of June, 2005. Two mornings per week were allocated to this project for the duration of the practicum period, as agreed upon with the preceptor.

The interview tool was piloted to ensure that it could be administered within the 20 to 30 minutes stipulated in the *Initial telephone contact and request for participation* letter. This was done by an initial interview of both administrator and provider at the writer's workplace, by telephone.

Tools

1. See appendix A for *Initial telephone contact and request for participation*.
2. See appendix B for consent forms faxed to participants.
3. See Appendix C for interview questions.

Data Analysis

The continuous comparing of data as it is acquired and transcribed is the process of the constant comparative method (LoBiondo-Wood & Harber, 2002). After transcription, data were printed and read while listening to taped interviews. This allowed for clarification and corrections in transcription. This important step also allowed for the prompting of theoretical memos, likened

by Wengraf (2001) to pushing a car to get the engine started, as thoughts are jotted down and themes emerge. Pertinent data was underlined during this initial analysis phase and thoughts noted. Data were then manually highlighted according to these codes:

- services available,
- Francophone resources available (including interpreter services),
- cultural awareness training, and
- beliefs and attitudes towards the crisis services needs of the population in question and the availability and accessibility of Francophone services.

This second phase of data analysis is called open coding. It allows for discreet parts of the data to be compared for similarities and differences (LoBiondo-Wood & Harber, 2002). Answers pertaining to the first three codes were tabulated into tables (yes as opposed to no for availability of interpreters, Francophone staff, or French reading material), for each subgroup of participant organizations (refugee and immigrant services, Francophone agencies, and specialized health and mental health services). This listing of coded categories, along with the cutting and pasting of pertinent transcription portions is called content analysis (Greenhalgh & Taylor, 1997).

From the last code highlighted, barriers, attitudes, and access issues were identified and analysed as different themes. The themes and highlighted data were then collated into tables according to the Continuity of Care

dimensions/principles. Although data were placed in tables according to participants and organizations, it was decided not to do so with the beliefs, attitudes and access section, as this was very personal to the individual participants and did not necessarily reflect the organization's views. Furthermore, the investigator could not ensure confidentiality if specifics were disclosed.

The tables facilitated the decision as to which organizations should appear in the directory of services for service providers of new Francophone arrivals in the City of Winnipeg. The other provision to being placed on this directory was the consent to appear on the list, as signed by the agency representative (the participant).

Reliability

Reliability is a measure of consistency (Fink, 1995). Reliability was not applicable to this project, as to most qualitative studies, as questions had to be individualized for different organizations.

Validity

Validity is a measure of the accuracy with which the interview data reflects what it is supposed to (Fink, 1995). Content validity was achieved through comparison of results to the Continuity of Care conceptual model.

Dependability

Dependability refers to the stability of the data. Given that this study was cross-sectional, at one point in time, it cannot be presumed that it could

be stable. Rather, data from this study would be somewhat fluid, as programs are adapted and new services are developed.

Credibility

Credibility relates to confidence of the truth of the data as presented by the participants. The constant comparison of data allowed for discrepancies in "the truth". However, it must also be said that a qualitative study examines the reality as seen by the participant. The use of telephone interviewing prevented a lot of the socially acceptable responses that would have prevailed with a focus group or in-person interviews.

Generalizability

This is not an expectation of a purposive sampling. What is applicable to the current study cannot be generalized to other aggregate populations, as none of the circumstances would be the same.

Ethical Considerations

As there was a possibility that client situations would be discussed during these telephone calls or cited in the survey answers, and colleague/participant opinions cited, formal ERB approval was sought and obtained. ERB also received disclosure of the translation of tools to the French language. This was also approved.

Consent from participants, citing confidentiality, was obtained in writing and dated. All participants signed the consent to interview, and all but two consented to having the name of their organization on the directory of services available for Francophones. The latter were those who had stated that

they had no Francophone staff or resources, or whose only Francophone staff had just left.

Confidentiality was maintained by the coding of individual interviews and organizations by numbers rather than names of participants or organizations. The investigator has a single copy list of participants and organizations linking names to numbers. This is kept apart from the interview results at the investigator's home. Once the practicum project paper has been defended, the single copy list will be stored in a locked area along with the tapes, printed copy of the interviews, and signed consent forms. The original transcripts will be copied onto a compact disk (CD) and then erased from the main computer. The CD will also be stored in the locked facility for the mandatory eight years recommended by the ERB.

The directory of organizations, with access information, will only contain information from organizations having granted permission. The participants' names will not appear on this directory.

Summary

The project consisted of 24 semi-structured telephone interviews with administrators and service providers in nineteen organizations providing refugee and immigration services, Francophone services, and specialized health and mental health services in the City of Winnipeg. Key questions revolved around Francophone providers, interpreters, audio or written resources, as well as any cross cultural training received. Beliefs and attitudes

about the availability and accessibility of Francophone resources were also sought.

Chapter IV- Results

Questions of Inquiry

The following five questions assisted in reaching objective #1. Although cultural awareness and comfort appears in Tables 1, 2, and 3, it will not be addressed until question 5.

1. *What formal resources (services, programs, and reading material) are currently in place in the City of Winnipeg to address language barriers of Francophone clients who do not speak English?*

Francophone and bilingual services. (Table 1). Seven Francophone and Bilingual service organizations were contacted and interviewed. Two of these were health services, three were counselling services, one was specific to Francophone immigrants, and one was program-related and did not have a mandate for direct care (although the participant interviewed was providing direct care).

Several organizations with a bilingual mandate do not in fact have all bilingual staff. Some have bilingual receptionists and support staff, but very few bilingual service providers. One organization, deemed Francophone, has only one counselling service in French, but the complementary necessary counselling is only available in English. One organization has three GPs, necessary for referrals, but they all have a full complement of clients. However, there are more counselling services available in French than the investigator was originally aware of, and another agency was also discovered via the study (not contacted by the investigator). Most of these have waiting

lists of three to six months. Two Francophone programs are working primarily with the aggregate population, but both interviewees are sole providers (the only employees) in their individual programs. One is overwhelmed by the demand; the other sees a great need to expand what her program offers, but this would require more resources.

Table 1.

Francophone and bilingual services

Organization service	Franco-phone staff members	Participant category	Franco-phone material (pamphlets, forms, videos)	Awareness of and comfort with African culture
Health				
• Bilingual (#1,2)	All	-Director -Service provider	Yes Yes	Minimal Minimal
• Bilingual (#20)	Reception, 1 part-time NP, 5 nurses	-Service provider	Some	Minimal
Programs				
• Francophone (#7)	One (alone in program)	Director (and service provider)	Yes	Moderate
Counselling				
• Bilingual (#14)	2 of 6 counsellors	Administrator	No	Minimal
• Francophone (#15,16,17, 18)	All	-Service provider -Service provider -Service provider -Director	Yes	Extensive Extensive Moderate Minimal
• Francophone (#23)	One Counsellor and support staff.	Director and service provider	Yes, most.	Minimal
Immigrant				
• Francophone (#24)	One (only service provider in program)	Director and service provider	Yes	Extensive

Please note: (#) indicates participant interview for investigator use. Re: Awareness and comfort with African culture, Minimal represents still uncomfortable, Moderate represents fairly comfortable and knowledgeable, and Extensive indicates vast knowledge and experience.

Immigrant and refugee services. (Table 2). Eight organizations working with refugees and immigrants were contacted, and six responded. Two offered specialized counselling, one offered mental health counselling, another offered health counselling, and two offered social services. An African organization and an interpreter service did not respond to the request.

Social services agencies in place for refugees and immigrants are both scarce in Francophone capabilities. The refugee agency has one full-time Francophone worker who also accompanies clients to appointments as requested. This leaves her unavailable for others who present or call. She is sometimes assisted in these instances by two Francophone coworkers from other departments. She also attempts to meet the demands from outside her agency (for interpretation). The demand is greater than the time in her day. The immigration agency only has an employee “in another department” who continues to “take French lessons”. Luckily their demand for French is limited, and they usually refer to the Francophone resource discussed in the previous section.

All four counselling agencies, specialized in different areas, have no Francophone capabilities. One specialized counselling service has a Francophone counsellor only four hours weekly, and he is male, which is an

issue with female Africans. Most will not see a male counsellor. The one agency that sees only females has no Francophone counsellor.

Table 2.

Immigrant/refugee services

Organization service	Participant category	Francophone providers or interpreters	Franco-phone material	Awareness of and comfort with African culture
Health counselling • Refugee and immigrant (#4)	Manager and service provider	None of either	No	Moderate
Social services • Refugee (#5,9)	-Director (and service provider) -Service provider	One provider -the provider; 2 providers in an adjacent department help	Yes Yes	Extensive Extensive
• Immigrant (#19)	Director (and service provider)	One in Employment counselling only, no interpreters.	Some	Moderate
Counselling • Refugee and immigrant (#10)	Manager (and service provider)	Provider 4 hours /week only. No in-house interpreters.	No	Moderate
Specialized counselling • Refugee (#8) • Refugee and	Manager (and service provider) Service	None of either.	No	Extensive Extensive

immigrant (#21)	provider	None of either	No	

Please note: (#) indicates participant interview for investigator use. Re: Awareness and comfort with African culture, Minimal represents still uncomfortable, Moderate represents fairly comfortable and knowledgeable, and Extensive indicates vast knowledge and experience.

Mental health and specialized health services (Table 3). Two organizations providing services (intervention and counselling) for each of sexual assault, therapeutic abortion, HIV and TB, spousal abuse and addictions were contacted. Of these, one sexual assault intervention agency referred the writer to the other agency (who did not respond), one TB agency did not respond, both HIV and TA agencies did respond, one addictions agency did not respond, and one spousal abuse agency could not coincide times with the interview scheduling. Thus, six of the ten contacted agreed to participate.

These services have very few Francophone capabilities. There are two designated bilingual (French) positions in the large specialized mental health agency. Specialized health services (TA, HIV, and TB) have either one part-time Francophone provider on staff, Francophone clerical staff, or none at all. One service mentioned that a certain medical specialist on staff spoke French. This physician is only at that site a few half-days per week however.

All specialized health services will make use of an interpreter if the client brings family or friend (as interpreter), or if it was pre-booked. Otherwise, the appointment is assisted by written French material or any

Francophone clerical staff that is working on that given day. Appointments sometimes need to be rebooked if communication is impossible.

Table 3.

Mental health/specialized health services

Organization service	Participant category	Francophone providers or interpreters	Francophone materials	Awareness of and comfort with African culture
Mental health • Specialized (#6)	Direct provider	2 designated bilingual positions (in 2 of 3 departments); no interpreters.	No	Minimal
Health • specialized (#3)	Direct provider	No; Pre-booked interpreters only	No	Moderate
• specialized (#11)	Direct provider	No Francophone providers; Use clerical staff or hospital language bank	Yes	Minimal
• specialized (#12)	Direct provider	One casual Francophone provider only; no interpreters.	Yes	Minimal
• specialized (#13)	Direct provider	One part-time Francophone medical specialist (of 4); no Francophone	Yes	Minimal

• specialized (#22)	Direct provider	interpreters One Francophone part-time nurse ; Pre-booked interpreter only	Yes	Minimal

Please note: (#) indicates interview for investigator use. Re: Awareness and comfort with African culture, Minimal represents still uncomfortable, Moderate represents fairly comfortable and knowledgeable, and Extensive indicates vast knowledge and experience.

2. *Does a formal data bank of trained Francophone interpreters exist in the WRHA?*

No formal Francophone data bank exists. One immigration specialized counselling agency has a language bank of 26 languages at this time, but none in French. A fee-for-service interpreter bank in the city could not be contacted; however, it was not mentioned by any of the participants as a possible resource. There is no interpreter service at the city's largest hospital; interpreters are sought by a request over the Public Announcement system. Alternately, if a service provider is aware of an interpreter they've used in the past, they will try booking them ahead of time if they anticipate the need. Winnipeg's second largest hospital does state that it has an interpreter bank. Once a request is sent to the Volunteer Office, the volunteer looks in a directory for a Francophone staff member (usually), and calls to see if that person is working and available on that given day. It seemed to be the

consensus that busy service providers cannot afford to wait the time required for an interpreter to "possibly" appear.

This system only works well with pre-booked interpreters. However, few specialized providers use this service as they only realize they need an interpreter once the client presents. Providers usually deal with this by using Francophone support staff as available. This is "hit and miss", and these people are not trained for medical interpretation. Furthermore, they must be displaced from their actual work to interpret. They are therefore usually only used for writing down appointment times and medication schedules.

Interpreters were not deemed as being appropriate in mental health services by mental health and psycho-social counsellors:

> "…difficult to know how precise the interpretation is …when interpreted to the client and for the client…" (translated, participant #2).

> "If you don't have a trained interpreter, you are fighting…to make sure the information is accurate…and scared that the interpreter is trying to spread their own feelings on the issue…" (participant #10).

Interestingly, many of the participants from refugee and immigrant services seem to think that St. Boniface as a community would easily provide either French services or interpreters. Many of these participants stated that their providers would not seek a Francophone interpreter (because they have none) but would seek one speaking the same African dialect as the client. However, all but one African participant emphasized that clients would refuse such an interpreter if given a choice, for purposes of confidentiality in their own community. One African participant stated that often a Francophone

provider from outside the community is even not acceptable, as many of these do present with personal biases (re: therapeutic abortion, promiscuity, etc.). It was also disclosed that the WRHA French Language Services (one provider only) was relocated in the fall of 2004 from Health Sciences Centre (HSC) to St. Boniface General Hospital (SBGH). Although it is not part of her role, she has done some medical interpretation at HSC in the past, and has recently done some at SBGH. Again, this is beyond her mandate, as she is alone in the role. A former co-worker of hers has continued to ensure some pre-booked interpretation at HSC, but again it is outside the mandate of her role. Word of mouth is increasing the demand for their services, despite it being outside their job descriptions.

3. *Are there any Francophone providers in the medical/social services or mental health fields that address sensitive issues (abortion counselling, post-rape counselling, addictions counselling, HIV and TB counselling and treatment, PTSD, and partner abuse)?*

Information can be seen in Tables 2 and 3. Participants in all areas providing services in the above specialties were contacted. The investigator was unable to speak with someone from the Sexual Assault Crisis Unit and was referred to another service where she was again unable to speak with someone within the practicum timeframe.

Generally, Francophone staff is minimal to non-existent in all of these specialty areas, except in the area specialized for addictions. There, two designated bilingual positions exist. However, because these specialized

providers are designated bilingual, they might have to see a Francophone client for a specialization other than their own. Specialized services generally have very limited access to almost non-existent Francophone interpreters and make do with available support staff or by rescheduling appointments.

One organization categorized under refugee services specializes in PTSD. There is no Francophone counsellor, support staff, or interpreter. However, the investigator was told a request for French services has never been received. It is unknown if this is because referring agencies know there is no availability of Francophone providers, or that needs have been met through the other African dialects that are available there. It was also said that Swahili is the universal African language, but yet this organization did not have a Swahili-speaking counsellor.

It was learned via a participant from another service that the physician at the Respiratory Clinic speaks very good conversational French, though not her mother tongue. The participant interviewed in another department of the same specialty did not know this.

Both specialty organizations that provide therapeutic abortions now have reading material in French regarding the procedure. However, both offer contraceptive counselling verbally and have no Francophone counsellors. Clients are referred back to their own health care providers for follow-up.

HIV nurse specialists obtain materials from, or refer clients to, HIV websites in the French language. These are apparently plentiful. Specialties that deal with spousal abuse generally did not give out written material. One

such organization, designated Francophone, had a non-Francophone counsellor for work skills and up-grading. It was stated that interpreters were not sought for sessions, as they were considered to be a good exercise in learning the English language, which was deemed necessary for employment in Manitoba.

4. *What are the beliefs of non-Francophone caregivers in the City of Winnipeg regarding the Francophone community's current availability and accessibility of resources?*

The following section addresses objective #2. It is a presentation of the different themes disclosed in the interviews, regarding attitudes towards the actual need for Francophone providers or interpreters for Francophone immigrants and refugees in the City of Winnipeg.

Theme #1: *Things are fine.* The information, or views, disclosed in this portion of the interview proved to be very interesting. Some participants working directly with refugees and immigrants appeared to believe that all is well, and that, should the need arise, St. Boniface as a community will have all the services required. When asked where they would direct a Francophone client for care, they often cited Centre de santé. However, according to the Centre de santé, its GPs already have a full complement of clients and cannot handle more. When this access problem was disclosed to the participants, several then recommended other refugee or immigrant services as being equipped with Francophone interpreters. Again, this was not congruent with the reality as presented by interviewees from those organizations.

This attitude was, interestingly enough, displayed by participants of the male gender and African origin. They appeared to believe that their organization could deal with most problems and, if not, would refer to other organizations (which, on speaking with participants of those organizations, would not be accessible to those clients). Also, a small minority of these participants felt that using an interpreter or volunteer from the community, or a family member, was perfectly acceptable for medical interpretation.

Theme #2: *Interpreters are sadly lacking.* This belief was prevalent in the specialized health services. They seemed aware of the importance of relaying medical information correctly, and having it well understood. Most specialized services were fully aware of the lack of Francophone interpreters, and especially the lack of a formal interpreter system. Most had run into the problem of needing a non-existent Francophone interpreter, and had tried various methods of dealing with the problem (non-verbal communication, use of Francophone staff when available, use of informal resources used in the past, use of the internet or French literature, rescheduling of appointments).

Theme #3: *Access to Francophone care is almost non-existent.* Providers who had had the experience of having to refer a Francophone client to Francophone mental health services, or even to a Francophone GP, found that the availability of these was almost non-existent. Francophone GPs are very few in the city, Francophone mental health providers even more scarce. The other reality disclosed was that many of these clients did not yet have GP, and one is required in order to refer to specialized services such as

Psychiatry. One participant gave an example of a Francophone psychiatrist who agreed to see a client, but referral was delayed as the client could not find a GP that she could go back to after consultation.

Theme #4: *The situation is near-critical.* Francophone providers, and especially the African female ones, described the situation as being near-critical. The situation as described in Theme #3 was again mentioned; this situation is also disclosed in the April 24, 2005 article in the Winnipeg Free Press. It describes a situation where a Francophone immigrant woman, who developed mental health problems after arrival to Canada, ended up living as a street person because she *fell through the system,* not being able to find a GP who could understand her problem and refer her for specialized care. She lost her housing and ended up on the street for six months, despite the Francophone community's attempts at finding solutions for her. Another problem shared in the interview was an increasing incidence of spousal abuse occurring within months of arrival. The police become involved and a warning is given to get counselling, but Francophone counselling is not easily obtained. One participant disclosed that she had to plead her case to four different Francophone organizations who offered this service before her clients could be offered counselling to prevent a charge and a court case. The issue was not the availability of the services, but rather the accessibility. Each place had a six month waiting list.

5. *Are existing Francophone mental health services trained in culturally-sensitive issues or specialized issues (such as PTSD)?*

It became evident that cultural awareness training was being offered in various organizations, but each organization had had variations in training, from half-day multi-cultural presentations to two day workshops. Participants from specialized services (outpatients) at HSC stated that they received a mandatory workshop on cultural awareness, but that it was very specific to the Aboriginal culture. None of the participants had received training in the African culture, and those who worked with this population were not aware of a service that could provide same. Cultural awareness of and comfort with the African culture in particular Francophone mental health services can be gleaned from Table 1. Individual counselling specializations for each organization can be gleaned from Table 4.

A provider approached prior to the study had stated that she had minimal training, was not comfortable with the African culture, and was not specialized. Her co-provider, a non-African study participant, responded that she had moderate training, was very comfortable in working with this culture, and was trained in addictions and PTSD counselling as well as individual, couples and family counselling. She had even done counselling with HIV clients. This difference in responses from one organization demonstrates that the results of this study are very subjective, and also emphasize that, in any given workplace, most individual providers are not aware of the entire scope of training, experience and comfort zones of co-providers, as well as their

other skills such as language. However, these were indeed two separate individual responses from different time periods, and the former was not part of the current study.

Table 4.

Counselling specialties

Organization	PTSD	Individual	Couple	Family	Addictions	Francophone counsellor
Francophone shelter	No	Yes	No	No	No	Yes (limited access)
*Bilingua*l health	Yes	Yes	Yes	Yes	Yes	Yes
*Francophon*e counselling	No	Yes	Yes	Yes	No	Yes
Bilingual counselling	No	Yes	Yes	Yes	No	2 of 6 (waiting list)
Bilingual health	No	Yes	No	No	No	No
*Francophon*e settlement	No	No	No	No	No	Yes
*Francophon*e WRHA	No	No	No	No	No	Yes
Immigrant and refugee health	No	Yes	No	No	No	No
Immigrant counselling	No	Yes	No	No	No	No
Refugee settlement	No	No	No	No	No	Yes
Immigrant settlement	No	No	No	No	No	No
Immigrant and refugee counselling	Yes (not war)	Yes	Yes	Yes	No	Casual (4 hrs/wk); male
Refugee counselling	Yes	Yes	No	Yes	No	No
Specialized TB	No	Yes	No	No	No	No ? physician
Specialized HIV	No	Yes	No	No	No	No
Specialized HIV	No	Yes	No	No	No	No
Specialized TA	No	Yes	No	No	No	part-time nurse
Specialized TA	No	Yes	No	No	No	Casual (poor availability)

mental health	No	Yes	No	Yes	Yes	Yes (2 designated bilingual positions)

It should also be noted that three of the participants from Francophone or designated bilingual organizations were African born. These providers were all very comfortable with the African culture, and the black Africans stated that, despite the country of origin, the African cultures are all derived from a same base, and cultural norms are the same. The cultural nuances (an example being that a man, especially a father, requires greater respect) are known to all Africans. These are not common knowledge to North Americans. Having said this, these three participants had no medical knowledge. Two Africans did not feel it their place to be doing medical interpretation, although they do accompany clients to non-medical appointments. The third African participant thought it acceptable for volunteers to do medical interpretation, but her director, present for the interview, was quick to interject and say it was not. This again demonstrates that qualitative inquiry studies how reality is perceived, not necessarily the factual reality.

Directory of Francophone Mental Health and Specialized Providers in the City of Winnipeg (Appendix D).

This section meets objective #3 of the practicum project. While three specialized health services actually had some providers that were Francophone, their accessibility was so minimal that it was decided not to mention them at all (e.g., 1 out of 30 nurses, not in the same department, only

working on a casual basis, use of infrequently available interpreters). Also, the interviewees had not requested permission from these providers to represent them as Francophone providers. Thus, listing their workplace as having available Francophone providers (even without giving their names) could have potentially increased their workload without their consent. Consequently, of a total of 24 interviews conducted, from 19 different sample sites, only 12 organizations are listed as having formal Francophone capacities. It must be noted that these organizations have available Francophone providers, but not necessarily accessible Francophone providers. Their limitations to access are highlighted in the *Limitations* section for each individual organization. One organization without Francophone provider (NEEDS) is also listed as it may be an alternate counselling site for Francophone African refugees in an African dialect.

Chapter V- Discussion and Recommendations

Comparison of the Results with the Literature

Issues pertaining to access to mental health and specialized health care for Francophone immigrants, refugees, and international students in the City of Winnipeg appear to coincide with those raised in the literature. Barriers are again cited as being language barriers, financial barriers (need for employment), and meeting basic needs first (housing). This reflects Bowen's findings on language barriers (2001), and the SFM's 2002 focus group results regarding language, employment and housing as key barriers to health. However, new issues raised were the lack of available and accessible GPs for these new arrivals, especially those requiring referral to a mental health or specialized health provider.

Interpretation issues appear to coincide with the literature to varying degrees among interviewees. Providers who are African immigrant women are acutely aware of the issue of gender and community affiliation as being barriers to accepting use of an interpreter, as described by Chun & Akutsu (1999) and Shin (2002). Male Africans do not see this as an issue. Non-immigrant participants from specialized health organizations admit that language barriers make history-taking and education very difficult, and sometimes even impossible. This emulates the literature on language barriers (Bowen, 2001; Health Canada, 2001) and on language interpretation (Jackson, 1998). Some mental health services providers shared their concern

regarding the appropriateness of interpretation; this reflects the findings of Kaufert & Putsch (1997).

A comparison of the findings to Bachrach's dimensions/principles of continuity of care is presented below in Table 5. It is evident that the present health care system in the City of Winnipeg does not have the resources to offer continuity of care for new Francophone arrivals, especially if African and refugee. It is also evident that, while some services that could offer continuity of care for this population do exist, they are often not accessible due to a small number of providers or their demand overload. Some mental health services that do exist and could be available are not accessible due to the unavailability of a primary care provider for referral.

Table 5.

Results as compared to Bachrach's Dimensions/Principles of Continuity of Care

Dimension/ Principle	Meets criteria	Rationale
Accessibility (absence of barriers)	No	• Lack of GPs for initial referral • Lack of trained unbiased Francophone interpreters • Lack of Francophone providers in specialized and mental health services • Limited numbers of Francophone settlement workers
Communication between client and provider, between providers; Linkage of services	No	• Lack of trained medical interpreters • Lack of Francophone providers (specialized or otherwise) • Lack of awareness among providers as to what is actually available and accessible
Full array of services	Yes	• A good array of services are available (not to be confused with accessible)
Longitudinal dimension	No	• Referrals blunted by either lack of Francophone providers, interpreters, or lack of an enabler
Individual dimension	No	• Can't plan care with client if can't communicate
Cross-sectional dimension	No	• Organizations provide a good service as long as service requirements stay within an acceptable limit • When other issues present, many providers are no longer able to assure a smooth transition to another provider, either from lack of

		accessibility or breakdown in communication
Supportive administrative climate	No	• Few designated bilingual positions • Few with cross-cultural training (Aboriginal cultural awareness is a very good start, but does not address the African culture) • Those with trained interpreters have none who speak French • Providers in designated bilingual positions are forced to do counselling outside of their specialization for lack of a designated bilingual position in each available specialty
Cultural dimension	No	• None of the agencies had specific cultural awareness training for the African culture • Many saw themselves as knowledgeable and comfortable in working with this population
Use of a Continuity of Care agent (enabler)	No	• Only in select agencies (surprisingly those with the fewest providers) • "unfortunately, it's up to the client to find his own interpreter" • "the client has to do his own research for" …a provider for a specialized service • "that's not my job (role, mandate)"

Summary of the Unexpected Results

The results of the interviews, as disclosed in Chapter Four, were not other than expected by the investigator. However, there were a few surprises.

These are summarized below:

1. There were more Francophone mental health resources than expected. However, these could not be accessed by those who needed them for lack of a GP for referral or due to long waiting lists.
2. Immigration and refugee providers (non-Africans and non-Francophones) believed Francophone services to be adequate to meet the needs of new Francophone arrivals.
3. More providers than expected (at least one third) did not see a problem with having a member of the small African communities interpret personal and medical information.
4. While many Francophone immigrants and refugees were said to refuse interpreters from their own communities, they also were said not to be comfortable with many Caucasian interpreters as they presented with their own personal values (ex: regarding therapeutic abortion, contraception, spousal abuse, promiscuity).
5. Several Francophone mental health providers (non-Africans) had received no cultural awareness training, and did not seem to express a need for same.
6. There appears to be a wide variation between what participants perceived to be available services, as well as perceived interpretation needs of these clients.
7. Those who worked closely with these clients in the health fields appeared to be most aware of increasing needs.

8. Those who worked in complementary services appeared to think that Francophone mental health and specialized services were easily accessed; however, it became apparent that they had not had to directly attempt to access these services.

Limitations

Limitations of this project had been predicted as being the small sample size and the potential refusal of key informants to participate in the interview process. This refusal was hypothesized as being due to key informants not being available within the timeframe of the study or not placing this study as a priority in their busy work schedule. It was expected that one quarter to one third of persons approached would decline. In reality, none of those approached actually declined: rather, timeframes did not coincide for two of the potential participants. Although administrators were the ones originally contacted, only three organization administrators agreed to being interviewed, the others were very willing to participate, but through the interviewing of a direct service provider. This decreased the extent to which the administrative climate was studied, and limited the comparing of responses between administrators and direct providers. Two of the three organizations where both administrator and care provider were interviewed provided very similar responses to all questions. However, this is not a sufficient number on which to make deductions.

The sample size was kept to a limit due to the timeframe available.

Given the practicum timeframe of 400 hours, it is evident that the project could not and did not have the breadth required to have interviewed all possible community mental health and specialized services in the City of Winnipeg. Also, although an attempt was made, the investigator was unable to interview a key interpreter service in the city, the Respiratory Clinic, or any provider from the Sexual Assault Crisis Intervention network. No attempt was made to interview psychiatrists or medical specialists, presuming no availability for interviews at short notice.

The study was also made very difficult in that the investigator spent her days at a practicum site where she did not have her own voicemail. This meant she had to ask potential participants to leave her a message at her home voicemail. This was somewhat awkward for all involved. Another encumbrance was that some participants phoned the investigator after hours and offered to do the interview at those times. This was unfortunately impossible as the attachment for the recording Dictaphone did not comply with any of the home telephones, but only with the Manitoba Telephone System (MTS) telephones in the workplaces. Therefore, two would-be participants did answer key questions but were not made part of the official study due to lack of written consent and recording.

Other limitations predicted were the lack of awareness of important resources by the investigator, and personal bias/attitude toward the target population by individual participants. According to Greenhalgh & Taylor (1997), there is no way of controlling against investigator bias in a qualitative

study, as all investigators have views, and ideological and cultural perspectives. The investigator did attempt, however, to keep personal bias at a minimum, by avoiding leading questions or providing personal opinion during the interviews.

Another limitation was thought to be the time constraint of the actual interview, in not allowing for further discussion. However, the interviewer was very conscious of the time, and on only five occasions did the interview last longer than 30 minutes, at the insistence of the interviewee.

Interviewer-related error is another possible limitation, as the interview was semi-structured. The interviewer may have missed important cues by the participant, or neglected elaborating on a theme that would have brought in pertinent information (Fowler & Mangione, 1990).

Recommendations

This last section addresses the fourth objective of the project. Many of the participants, especially those who had had personal experiences in attempting to access Francophone services, were eager to know what the investigator would be doing with the results of the study. An explanation was given to each one that this was a practicum project, and that the study could not be as extensive as if the investigator had had the time to work on the study full-time. It was explained that a directory of available Francophone services disclosed by the study would be made available to them. A set of recommendations would also be put forth, and the investigator would be very

glad to share this with the Société Franco-Manitobaine and the WRHA Language Barriers Working Group.

The recommendations are:

1. the development of a complete and extensive directory of all Francophone mental health and health-related resources in the City of Winnipeg,
2. the scheduling of focus groups for Francophone services with : a) refugee/immigrant services, b) mental health related services, c) specialized health services, and d) Mount Carmel's Cross Cultural Counselling Program,
3. cultural awareness workshops specific to the African culture, to be made available to Francophone and specialized service providers,
4. the development of a formal French language interpreter bank,
5. remuneration for trained interpreters,
6. remunerated training in medical interpretation for support staff (on a volunteer basis) and volunteers,
7. increase funding to allow for another provider or assistant in the WRHA French Language Service,
8. increase funding to allow for one or two administrative assistants for the Acceuil Francophone,
9. increase funding to allow for another Francophone settlement worker at Welcome Place and one at International Centre, to assist in meeting external demands from other service providers,

10. make results and recommendations of the Language Barriers Working Group, funded by the WRHA, available to all providers interested,
11. encourage the use of case managers for any Francophone new arrival requiring mental health or specialized services,
12. lobby the Centre de santé to allow some accessibility to Francophone immigrant/refugee families. This could be largely managed by the NP, with GP support. An exception is being made at Mount Carmel Clinic already for all immigrants/refugees (outside of the designated postal code requirement), but they have no Francophone staff. Youville Centre St. Vital is also making an exception for their Teen Clinic (accepting teen clients out of their designated postal codes, to ensure access to care).
13. lobby the College of Physicians and Surgeons to keep a list of GPs and specialists according to language fluencies.
14. an assessment of the health and mental health needs of this aggregate population should be undertaken, as well as a study of how this population views our medical system, in order to make recommendations for improved care of new Francophone arrivals.

Future Directions

A few exciting projects being implemented in the City of Winnipeg were disclosed through these interviews. The first is the recent hiring of a Francophone settlement worker in St. Boniface by the Société Franco-Manitobaine. This African woman is familiar with the African culture, is herself an immigrant, and has worked in the past as a recruitment officer with

the CUSB for international students. She appears to be a woman with a vision, has a caring, comprehensive attitude towards members of her culture, while wanting to integrate them into the Francophone community. She states that the new Francophone arrivals do want this integration, but for this to occur, employment and housing are priorities that must be met. These people cannot integrate themselves in the Francophone community "if they live in the North End, and have no money for transportation". Her intention is also to do some lobbying for Francophone healthcare access for these people. She feels that, with all the other barriers that they face, exceptions should be made to meet health care needs on arrival here. Some flexibility should prevail.

The second exciting disclosure was that of the WRHA Language Barriers Working Group. A consultant was hired six months ago to do a study on the actual language barriers situation in healthcare in Winnipeg (phase one); this was presented to the WRHA in the fall of 2004. She has presented her recommendations (phase two) to the WRHA in June, 2005. Although this study is internal at the moment, it is certainly hoped that key players will be informed of the results. Apparently, five different groups were approached for feedback; Francophones were one of the groups (S. Bowen, personal communication, June 29, 2005).

Conclusion

The current project presents an argument that language barriers are indeed preventing access to care for Francophone immigrants, refugees and international students in the City of Winnipeg. This has been widely stated by

participants from key organizations that work with this aggregate population on an occasional to a frequent basis. Although the aggregate population includes Caucasians, the accessibility problem appears to be most acute for the black African Francophone population, as the cultural dimension is added. The latter subgroup also makes up the Francophone refugee population, which, in itself, generally presents with more acute needs. It is thus evident that, with use of Bachrach's Continuity of Care Dimensions/Principles, continuity of care for this population is compromised because of language barriers, lack of culturally sensitive providers, and lack of Francophone providers. This can potentially lead to a greater financial burden for the WRHA and the City of Winnipeg as unmet needs lead to crises, hospitalizations, not to mention overuse of diagnostics and care provider resources.

Steps are presently being taken to sensitize the WRHA to this problem. Funding will likely be the prevailing factor in the implementation of recommendations put forth to them. On a smaller scale, the SFM's new coordinator has many plans and projects she hopes to implement. On an even smaller scale, although the investigator is not funded to pursue the recommendations she has put forth, she is impassioned by the issue and intends on lobbying in her own workplace to be able to take her own clientele once she is registered as a Nurse Practitioner, so that she can increase access to Francophone care and even become a case manager for specific clients of the aggregate population. In the interim, it is hoped that the directory of

Francophone providers in Appendix D will assist in facilitating access to care, and thus continuity of care, for even a few of the aggregate population.

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APPENDIX A

Initial Telephone Contact and Request for Participation

Hello. Good morning/afternoon. My name is Diane Buissé. I am a Master of Nursing student in the Nurse Practitioner stream at U of M. Instead of a thesis, I am required to do a 400 hour clinical practicum in a family practice setting. Within this practicum, I am required to do a project, similar to a thesis, but not as extensive. The objective is that the project will contribute to clinical practice.

I am also employed as a primary care nurse in the St Boniface area where I see the international student population of the St Boniface College, as part of my clientele. These, along with most of the African immigrant and refugee client population that I see, speak no English. Their accessibility to services will be the basis of my practicum project.

What I am requesting of you, or a designate of your facility, is your consent to participate in a 20 to 30 minute telephone interview at a time and date of your choosing. The content of the interview will relate to services available in the mental health fields and services that address unique needs that cause emotional distress for this population, as well as the accessibility of these services.

The proposed participant will then be allowed to answer yes or no, and ask questions as desired.

If answer is no, writer will thank them for their time.

If the answer is yes:

Thank you so much. I will be mailing you a “consent to interview” form and an outline of the interview questions. Could you be so kind as to respond within a week of receiving it so I can plan ahead? Would you like to book the interview time in your schedule now? I plan to start in two weeks from now and am booking Wednesday and Thursday mornings, to not interfere too much with practicum clinical time. Would this be convenient for you?

Thank you and I look forward to speaking with you on the *date determined by the participant.*

Demande initiale pour interview et requète de participation

Salut. Je m'appelle Diane Buissé. Je suis étudiante en maitrise de soins infirmières à l'université du Manitoba, dans la voie infirmière pratitienne. Aulieu d'une thèse, je dois completer 400 heures de stage clinique et, dans ce stage, je dois faire un projet spécial qui contribut au domaine clinique.

Je suis aussi infirmière de santé primaire à St Boniface. Parmi mes clients, je vois des étudiants internationaux, ainsi que des nouveaux arrivants qui ne parlent pas l'anglais. Leur accès aux services sera la base de mon projet de stage.

Ce que je vous demande aujourdhui, c'est si vous, ou un désigné de votre organisme, seriez pret à participer à un interview téléphonique de 20 à 30 minutes à ce sujet. J'ai les mercredi et jeudi matins du mois de juin libres pour ce but. Est-ce que vous seriez intéressé? Pourrait-on fixer une date?

Je vous enverrez par télécopieur le consentement à signer, ainsi qu'un aperçu de l'interview. Je vous remerci beaucoups de votre intérêt, et on se reparle le *date choisie par le participant*.

APPENDIX B

AN ANALYSIS OF CRISIS SERVICES NEEDS FOR NEW FRANCOPHONE ARRIVALS IN THE CITY OF WINNIPEG

Consent Form

Research project title: An analysis of crisis services needs for new Francophone arrivals in the city of Winnipeg**.**

Researcher: Diane M.N. Buissé RN BN, student, faculty of Graduate Studies-Nursing, University of Manitoba.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the project

The goal of this project is to increase access to care for Francophone non English-speaking immigrant, refugee, and international students in the city of Winnipeg. This will be achieved via two objectives:

- to discover the actual Francophone services available in the city of Winnipeg, as well as the specialized mental health and psychosocial resources that they need to be tapped into.
- to compile and distribute a list of these services to increase communication and linkages.

Project procedures

To meet the above objectives, you are being asked to:

- consent to a 20 to 30 minute telephone interview,
- consent to having your workplace placed on a list of resources if applicable

Interviews will be tape-recorded and results transcripted.

Confidentiality

Institution/organization names will be disclosed for the list only. Original tapes and questionnaire with names of participants will be destroyed after transcription. Names of interviewees will not be included in the transcripts.

Risk and discomfort

This project is not meant to be an evaluation of your resources or accessibility, or that of your organization. This project aims to uncover what is available, not to seek out what is not. Your participation is completely voluntary, and you may choose to terminate the interview at any time.

Feedback

Feedback to telephone interview participants will be mailed or e-mailed at a later date. Resource lists will be mailed to all participants unless they expressed a wish to not receive or participate.

Remuneration

This project is not funded by any organization; no remuneration will be received.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any answers you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

Diane Buissé xxx-xxxx (res.)

Dr Diana Clarke (supervisor) xxx-xxxx (bus)

This research has been approved by the Education/Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

I consent to being interviewed:

Participant's signature Date

Researcher's signature Date

I consent to having my organization's name included in the list of resources:

Participant's signature Date

Researcher's signature Date

ANALYSE DES BESOINS EN MATIÈRE DE SERVICES D'URGENCE DES NOUVEAUX ARRIVANTS FRANCOPHONES À WINNIPEG

Formulaire de consentement

Titre du projet de recherche :	Analyse des besoins en matière de services d'urgence des nouveaux arrivants francophones à Winnipeg
Chercheuse :	Diane M. N. Buissé, inf. aut., B. Sc. inf., étudiante, Faculté des études supérieures en sciences infirmières, Université du Manitoba

Le présent formulaire de consentement, dont je vous remettrai une copie pour vos dossiers et à titre documentaire, s'inscrit dans la philosophie du consentement éclairé. Il devrait vous donner une idée générale de l'objet de la recherche et de la nature de votre participation. Si vous désirez plus de renseignements sur l'un des points mentionnés dans les présentes ou d'autres renseignements, n'hésitez pas à demander. Veuillez prendre le temps de lire attentivement le présent document et de vous assurer de bien comprendre les renseignements qu'il contient.

But du projet

Le présent projet a pour but d'accroître l'accès des immigrants, des réfugiés et des étudiants étrangers francophones ne parlant pas anglais aux soins de santé à Winnipeg. Je me propose d'atteindre ce but par voie de deux objectifs :

- déterminer les services en français offerts actuellement à Winnipeg ainsi que les ressources spécialisées dans les domaines de la santé mentale et de la médecine auxquelles ils doivent avoir accès;
- inventorier et dresser la liste de ces services afin d'améliorer les communications et la création de liens.

Méthode

Afin de me permettre de réaliser les objectifs indiqués ci-dessus, je vous demande :

- de m'accorder une interview téléphonique de 20 à 30 minutes;
- de consentir à ce que je place votre lieu de travail sur une liste de ressources, s'il y a lieu.

Les interviews seront enregistrées et les résultats transcrits.

Confidentialité

Je divulguerai les noms des établissements et des organismes uniquement pour la liste. Après leur transcription, je vais conserver les bandes originales et les questionnaires comportant les noms des participants dans un endroit fermé à clef pendant les huit années obligatoires, après quoi je les détruirai. Je n'indiquerai pas le nom des intervieweurs dans les transcriptions.

Risque et gêne

Le présent projet ne vise nullement à évaluer vos ressources ou votre accessibilité ni celles de votre organisme. Il a pour but de mettre au jour ce qui est accessible et non ce qui ne l'est pas. Votre participation est tout à fait facultative et vous pouvez choisir de mettre fin à l'interview quand bon vous semble.

Résultats

Je communiquerai les résultats du sondage aux participants et leur ferai parvenir la liste des ressources par la poste ou par courrier électronique, à une date ultérieure, à moins qu'ils aient exprimé le désir de ne pas les recevoir ou de ne pas participer.

Rémunération

Comme ce projet ne reçoit l'aide financière d'aucun organisme, aucune rémunération n'est versée.

L'apposition de votre signature sur le présent formulaire signifie que vous avez compris de façon satisfaisante les renseignements sur la participation au projet de recherche et que vous acceptez d'y participer à titre de personne interrogée. Elle ne constitue en aucun cas une renonciation à vos droits juridiques et ne dégage nullement les chercheurs, les organisateurs et les établissements participants de leurs responsabilités et obligations légales et professionnelles. Vous êtes libre de vous retirer du projet quand bon vous semble ou de refuser de répondre à des questions qui ne vous plaisent pas, et ce, sans crainte de préjudice ou de représailles. N'hésitez pas à demander des éclaircissements ou à poser des questions au fur et à mesure que nous avançons car il est important que votre participation soit tout aussi éclairée que l'était votre consentement initial.

Diane Buissé : (domicile) xxx-xxxx
D[r] Diana Clarke (superviseure) : (bureau) xxx-xxxx

Le présent projet de recherche a reçu l'approbation du Education/Nursing Research Ethics Board. Si vous avez des questions ou des préoccupations à son sujet, vous pouvez communiquer avec l'une ou l'autre des personnes susnommées ou avec le Human Ethics Secretariat au 474-7122. Je vous ai remis une copie du présent formulaire de consentement pour vos dossiers et à titre documentaire.

Je consens à me faire interviewer :

Signature du participant	Date
Signature de la chercheuse	Date

Je consens à ce que le nom de mon organisme soit ajouté à la liste des ressources :

Signature du participant	Date
Signature de la chercheuse	Date

APPENDIX C

Telephone Interview

Demographics

- What is the name of your establishment/organization?
- Is it part of the WRHA, publicly or privately funded?
- What is the mandate of your establishment/organization?
- What is your designation/role in the workplace?
- Do you work with clients/patients directly**?**
- How long have you worked in this position/workplace?

Client/patient services

- What services are offered at your place of work?
- How sensitive are these services for communication? In other words, what repercussions would there be if a client did not completely understand the pre or post service instructions?
- Does your workplace provide written instructions prior to or after providing services?
- Does your establishment/organization provide follow-up for clients who may have language barriers/communication problems? If so, how is this done?

French language

- Do you speak French?
- Do any of your co-workers speak French? If so, how many, and are they in direct patient/client care?

- Is there an interpreter service for clients who speak only French in your workplace? If so, how is it accessed, and is it available at all times that your workplace is open for business? Are your interpreters volunteers, or are they remunerated? Have they been counselled or educated in interpretation skills?
- Have any of your staff been to any cultural awareness workshops? Are any of them comfortable or familiar in working with the African population?
- Are written materials that you hand out to patients/clients available in French?
- What would you or your staff/coworkers do to address the needs of French African clients who do not speak English fluently?

Availability of French mental health services and psycho-social resources in the city of Winnipeg

- Have you or your co-workers ever needed French mental health or psycho-social services to refer clients/patients to?
- Do you know of any that you can or have referred to? How accessible were they to the client/patient requiring the service?
- Have you or a co-worker required a French interpreter? Were you able to obtain one? If so, from where?
- Do you feel that the services available in French for non-English speaking Francophone immigrants, refugees, and international students are adequate?

- Does this problem affect you? Have you run into this situation in the past?
- Is there anything else you would like to add?
- Would you be interested in learning the results of this telephone survey?
- May I add the name of your organization to a list of services that are available for Francophone non English-speaking clients?

Thank you so much for your time and your contribution to this project. The Francophone non English-speaking immigrant/refugee/international student population are a lovely people that I have been privileged to have worked with, and I hope to enhance their accessibility to needed services through linkages established through this project.

Interview téléphonique

Données démographiques

- Quel est le nom de votre établissement ou organisme?
- Fait-il partie de l'ORSW (Office régional de la santé de Winnipeg) et est-il financé par des fonds publics ou privés?
- Quel est le mandat de votre établissement ou organisme?
- Quel est votre poste, titre ou rôle dans le lieu de travail?
- Travaillez-vous directement auprès des clients?
- Depuis combien de temps occupez-vous ce poste ou travaillez-vous dans ce lieu?

Services à la clientèle

- Quels sont les services offerts à votre lieu de travail?
- Quelle est l'importance des communications relativement à ces services? Autrement dit, quelles seraient les répercussions si un client ne comprenait pas entièrement les marches à suivre avant et après les services?
- Votre lieu de travail donne-t-il des directives écrites à suivre avant ou après la prestation des services?
- Votre établissement ou organisme assure-t-il un suivi auprès des clients qui ont des obstacles linguistiques ou des problèmes de communication? Si oui, comment procède-t-il?

Français

- Est-ce que certains de vos collègues parlent français? Si oui, combien parlent français et travaillent-ils directement auprès des clients?

- Y a-t-il des interprètes à la disposition des clients qui parlent uniquement français dans votre lieu de travail? Si oui, comment y a-t-on accès et sont-ils disponibles durant toutes les heures d'ouverture? Vos interprètes sont-ils bénévoles ou rémunérés? Ont-ils reçu une formation ou des conseils dans l'art de l'interprétation?
- Y a-t-il des membres de votre personnel qui ont suivi des ateliers de sensibilisation culturelle? Y en a-t-il qui sont à l'aise de travailler avec la population africaine ou qui la connaissent bien?
- La documentation que vous remettez à vos clients est-elle disponible en français?
- Qu'entendez-vous faire ou qu'entendent faire votre personnel ou vos collègues pour répondre aux besoins des clients africains francophones qui ne parlent pas couramment anglais?

Accessibilité des services de santé mentale et des ressources psychosociales à Winnipeg

- Vous est-il déjà arrivé ou est-il déjà arrivé à vos collègues d'avoir à diriger des clients vers des services de santé mentale ou psychosociaux en français?
- Connaissez-vous de tels services vers lesquels vous pourriez diriger ou vers lesquels vous avez déjà dirigé des clients? Comment accessibles étaient-ils envers les clients qui en avaient besoin?

- Vous est-il déjà arrivé ou est-il déjà arrivé à vos collègues d'avoir besoin d'un interprète vers le français? Vous a-t-il été possible d'en obtenir un? Si oui, d'où venait-il?
- Estimez-vous que les services offerts en français aux immigrants, aux réfugiés et aux étudiants étrangers francophones ne parlant pas anglais sont suffisants?
- Ce problème vous touche-t-il? Vous êtes vous déjà trouvé dans cette situation?
- Y a-t-il autre chose que vous aimeriez ajouter?
- Désirez-vous recevoir les résultats du présent sondage téléphonique?
- Pouvons-nous ajouter le nom de votre organisme à la liste des services offerts aux francophones qui ne parlent pas anglais?

Je vous suis extrêmement reconnaissante de votre temps et de votre collaboration. Les immigrants, réfugiés et étudiants étrangers francophones qui ne parlent pas anglais sont des gens formidables avec lesquels j'ai eu le privilège de travailler. J'espère pouvoir accroître leur accès aux services dont ils ont besoin grâce aux liens qu'établira le présent projet.

APPENDIX D

Directory of Available Francophone Resources in select Mental Health and Specialized Health Services in the City of Winnipeg

Please note that this resource list is not extensive or complete, but rather that which the interviewer was able to uncover for providers' benefit during her practicum experience in June 2005. Organizations listed below granted permission to appear on the list through consent obtained by study participants.

Organization	**Acceuil Francophone (Bilingual Services)**
Contact #	984-5628
Francophone resource	One only Monday to Friday
Specialization	Settlement services for Francophone arrivals
Mental health specialization	None
Limitations	Only one provider

Organization	**AFM (Addictions Foundation of Manitoba)**
Contact #	944-6226
Francophone resource	Two designated bilingual positions
Specialization	Addictions counselling
Mental health specialization	Alcohol, drugs, and gambling addictions counselling programs. Some in-patient treatment for same.
Limitations	Francophone providers not specialized in all areas of the program, but will continue to work with the client if client so chooses.

Organization	**Centre de santé (St. Boniface Health Centre)**
Contact #	235-3910
Francophone resource	All staff
Specialization	General Practitioners, Nurse Practitioner (pending), nurses, Dietitian
Mental health specialization	Social Worker, Mental Health Worker Individual, couples counselling and group sessions. Some experience with PTSD and addictions. Consultant psychiatrist ½ day per week, consultant psychologist up to ½ day per week on demand.
Limitations	Physicians not currently taking new clients (this is revisited every 3 months). Must have a physician for referral to psychiatrist.

Organization	**Centre Renouveau (Aulneau Renewal Centre)**
Contact #	987-7090
Francophone resource	2 of 6 counsellors
Specialization	Counselling Group sessions on request
Mental health specialization	Individual and couples counselling. Play and drama therapy.
Limitations	Waiting list. Fee according to income.

Organization	**Centre Youville Centre St. Vital**
Contact #	255-4840
Francophone resource	Nurse Practitioner Monday-Wednesday; 5 nurses, receptionists
Specialization	Teen Clinic on Tuesday evening Primary care
Mental health specialization	none in French
Limitations	Accept clients by postal codes, but do not turn away teens that present

Organization	**International Centre**
Contact #	943-9158
Francophone resource	One only, in Employment Services
Specialization	Settlement Services, Employment Services, Interpreter Bank for **immigrants**
Mental health specialization	none
Limitations	No French interpreters

Organization	**L'Entretemps des Franco-Manitobaines**
Contact #	925-2550
Francophone resource	One counsellor and all support staff
Specialization	Second-stage housing (non-crisis womens' shelter). Capacity for 5 families
Mental health specialization	Play therapy for children Individual counselling
Limitations	Non-crisis. Waiting list. Employment counsellor non French-speaking

Organization	**Mount Carmel Clinic**
Contact #	589-9420
Francophone resource	One casual (4 hours weekly only) counsellor
Specialization	Primary Care, including physicians, nurses, Outreach Program, Social Workers, Psychologist, Dental Program, and daycare
Mental health specialization	**Cross Cultural Counselling Program** (Psycho-social intervention)
Limitations	Accept clients by postal code BUT will not turn away refugees and immigrants

Organization	**NEEDS Centre for War-Affected Families**
Contact #	940-1260
Francophone resource	none, but many African dialects available
Specialization	Counselling with **war-affected refugees** and **children of both refugees and immigrants** up to age 15
Mental health specialization	PTSD
Limitations	Only war-affected refugees No Francophone providers

Organization	**Plurielle**
Contact #	233-1735
Francophone resource	All staff
Specialization	Employment counsellor Education and Up-grading counsellor Counselling therapies
Mental health specialization	Individual counselling and Thera-play
Limitations	None

Organization	**SERC (Sexuality Education Resource Centre)**
Contact #	982-7811
Francophone resource	None at this time, but **working on same**
Specialization	Counselling re: all aspects of reproductive health. Interpreters in 26 languages
Mental health specialization	none
Limitations	No French interpreter at this time

Organization	**Welcome Place**
Contact #	977-1000
Francophone resource	One settlement counsellor Two Inland Protection counsellors
Specialization	Settlement counselling for **refugees** Inland Protection counselling for new arrivals requesting asylum Often accompanies clients to appointments and interprets
Mental health specialization	none
Limitations	Many external requests (from other agencies) over and above internal needs

Organization	**WRHA Francophone Services**
Contact #	258-1081
Francophone resource	One only
Specialization	Coordinates Francophone services WRHA
Mental health specialization	none
Limitations	Interpretation not in her mandate, although she has done some in the past. No interpreter bank