DEVELOPMENT OF A MODEL OF CULTURALLY ACCESSIBLE MENTAL HEALTH AND SOCIAL SERVICES

A Practicum
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

by

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ABSTRACT

Mental health and social services in Canada are frequently inaccessible for immigrants and refugees. The objectives of this practicum were to identify the barriers experienced by immigrants and refugees in accessing mental health and social services, develop indices of culturally accessible services, and catalyze efforts to reduce the identified barriers. The practicum entailed the completion of an applied research project with the Canadian Mental Health Association, Manitoba Division Inc. The project had been funded through a grant awarded by Manitoba Culture, Heritage and Citizenship.

In order to identify barriers and potential remedies, a review of the literature was completed and two programs in Winnipeg that are reputed to be exemplary in their provision of culturally accessible services were studied. Based upon the literature review and the program descriptions, a draft was developed of a document intended for the use of planners, managers, and evaluators in making services culturally accessible. Feedback was obtained from 30 key informants regarding the draft in three focus groups and in some additional written comments. The initial draft of the document was well-received.

The draft was revised based upon the feedback, and the final printed version entitled "Increasing Access" was subsequently distributed to a mailing list of 125 organizations and individuals across Manitoba. A telephone survey was conducted of a sample of the

final document's recipients approximately eight weeks after it had been distributed. The telephone survey indicated that the document has not yet been used to a great extent for planning and evaluation, but the majority had used it for educational purposes. Some suggestions were made for its improvement, and a question was raised about its generalizability to other target groups. However, the document has received generally favourable responses from those who have become familiar with it. Respondents commented positively about its readability and content, and initially have found it to be useful as an aid in education and training.

A mail survey instrument has been designed to assess the utility of the document and confirm responses from the telephone survey. It is planned to distribute the mail survey six months after circulation of the document.

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I am indebted to my practicum advisor and committee chairperson, Dr. Sid Frankel, for his astute guidance and never-failing support throughout the completion of this practicum. I also am grateful for the direction and assistance willingly provided by committee members, Professor Paul McGeachie and Dr. John O'Neil.

Although there are many individuals who contributed to the completion of the work within the practicum, I would especially like to express my appreciation to the staff of the Canadian Mental Health Association, Manitoba Division Inc.

Most of all, I wish to thank my husband, George, for his ongoing encouragement and understanding during the many months of the practicum.

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I. INTRODUCTION

Aim of the Practicum

The primary objectives of this practicum were: to develop indices of culturally accessible mental health and social services; identify cultural and linguistic barriers experienced by refugees and immigrants in accessing mental health and social services; and catalyze efforts to reduce the identified barriers.

Mental health and social services in this practicum refer to institutional and community-based programs that provide counselling and related services for individuals who have mental health or social problems. These programs include inpatient, outpatient, emergency, transitional, and/or community-based services, which typically draw upon one or more professional disciplines including psychiatry, social work, psychology, and psychiatric nursing (Barker, 1987; Health and Welfare Canada, 1988).

In completing the practicum, the focus was on urban mental health and social services, and immigrants and refugees in Winnipeg, although immigrants/refugees and services elsewhere in Manitoba were also addressed. The intent was to identify the barriers experienced in accessing services regardless of where an immigrant or refugee may live. Data gathering about the issues was not restricted to Winnipeg. The literature review included studies completed in a variety of cities and towns in Canada and elsewhere, although caution was used in interpreting

the literature from other countries where financial barriers may be more significant. In attempting to reduce barriers, both Winnipeg and non-Winnipeg services were included.

The Canadian Mental Health Association, Manitoba Division Inc. had recently received approval to undertake a project entitled "Serving Immigrant and Refugee Mental Health Needs: Discovering Current Patterns and Encouraging Innovation". The project was funded through a Newcomer Services Support Program (NSSP) grant awarded by the Immigration and Settlement Services Branch of Manitoba Culture, Heritage and Citizenship. The practicum entailed the design and completion of this project with the Canadian Mental Health Association (CMHA).

The original proposal which was submitted to obtain funding for the project is included in Appendix A of this report. As will become apparent, there was considerable overlap between the practicum and the project as it was originally proposed. The variances between the two relate primarily to the expected dates for the completion of activities outlined in the project proposal, and the design and implementation of a telephone survey in the practicum that had not been proposed for the project.

Educational Benefits to the Student

There were a number of learning objectives for the student within this practicum. First of all, the comprehensive review of the literature that was undertaken enlarged the student's knowledge base pertaining to multiculturalism and issues affecting mental health and social services to immigrants and refugees. This was of importance as one of the student's prime areas of interest prior to enrollment in the

MSW program was to obtain an increased understanding of the impact of changing immigration patterns on the delivery of social services and education in Canada. A specific expertise was gained in the delivery of services to immigrants and refugees. The practicum also led to increased skills in reviewing and critically evaluating the literature outside of the professional journals which are more typically utilized in the completion of graduate coursework. In addition, some practice in using secondary data sources was gained.

A second major objective was achieved through the development of a model that is supported theoretically and empirically. The development of a document pertaining to culturally accessible services provided opportunities to practice skills in the analysis of service systems, identification of barriers in service delivery, and in qualitative descriptive case study methodology. The completion of this document also refined skills in writing reports related to organization, clarity, conciseness, and the presentation of supporting documentation.

Thirdly, the completion of this practicum developed skills in utilization and awareness of community resources and services, as well as needs identification. The ability to gather data from key informants and distill relevant information from sometimes conflicting data also resulted. All of these tasks were seen as enhancing skills in communication, collaborative research and program planning. The ability to speak to groups and deliver critical information effectively was practiced as a result of the need to obtain feedback from key informants regarding a draft document.

Finally, the student acquired additional skills in the analysis of

qualitative data in both the initial development of the document and the subsequent revision, based upon feedback from key informants and service providers. Following the development of the draft document, learning objectives pertained to the data obtained from key informants and the development of follow-up surveys to study the impact of the final document.

Overall, the learning objectives of this practicum enabled the student to develop an ability to adopt an organizational focus rather than a client focus when examining services. Although the student had previously accrued considerable clinical experience in mental health, this practicum provided the opportunity to acquire the additional skills needed for planning and evaluating services in a wider context than is typical in clinical practice. Furthermore, most of the interagency communication and coordination skills which were possessed by the student related to specific clients, rather than broad service delivery or organizational issues.

As planning, organization, and coordination are essential functions of all levels of social work administration, the aforementioned learning objectives will be highly useful in post-graduate administrative positions. The "learning by doing" emphasis of the practicum allowed for the practical application of the concepts which had been learned in the MSW coursework.

II. LITERATURE REVIEW

Multiculturalism

Canada has been described as a land of immigrants throughout its history (Dickenson, 1975). Although Canada's people have always represented many cultures, in the first fifty years of Confederation all individuals were basically expected to assimilate into the Anglo-Canadian culture (Task Force on Multiculturalism, 1988). The first appearance of a cultural mosaic became evident in the 1920s and 1930s, but official support for cultural diversity remained minimal until the 1960s. In 1971, multiculturalism was officially sanctioned with the introduction of a federal policy of multiculturalism and has become increasingly a part of Canadian society in a number of pieces of legislation including the Canadian Multiculturalism Act which was passed in 1988 (Sheridan, 1989).

Across Canada, however, multiculturalism policies have had a limited effect on educational and service-oriented institutions. In addition, the official multiculturalism policies have been criticized for placing too much emphasis on being "different", and not enough on being Canadian. Multiculturalism has struggled for a long time to achieve policy status within a general public opinion that residents of Canada should be Canadians first. Specific concerns voiced by participants in a recent public forum which travelled across Canada include the funding of multiculturalism programs, the celebration of

heritage cultures rather than embracing and celebrating a Canadian national character, and the common tendency to be hyphenated Canadians (e.g. Italian-Canadians, Irish-Canadians) rather than Canadians first (Spicer, 1991).

Efforts by individual provinces to develop specific provincial policies and legislation with respect to multiculturalism have varied considerably. Officially, multiculturalism was recognized in Manitoba as early as 1970 when the provincial government clearly indicated its support for the Manitoba cultural mosaic (Task Force on Multiculturalism, 1988). Following a series of initiatives related to multiculturalism in the 1970s and 1980s, the Manitoba government published Manitoba's Policy for a Multicultural Society in 1990.

Immigration Trends

At the present time, the federal government is consciously moving to restore immigration to post-war levels as increased migration is needed for Canada's economic growth and social development (Manitoba Culture, Heritage and Citizenship, 1991). In 1989, approximately 190,000 immigrants and refugees landed in Canada, and, according to the federal government's recently introduced five year plan for immigration, by 1992 immigration levels will reach 250,000 (Employment and Immigration Canada, 1990).

It should be noted that there has been a shift over time in the source countries from European to Asian and Central/South American countries. Between 1945 and 1970, most immigrants were from Europe, but in the last ten years, Asia was the largest single source of new immigrants (Ledoux & Pendakur, 1990).

On an annual basis, Manitoba receives approximately 3% to 5% of the national number of immigrants, which is similar to the province's population as a percentage of the total Canadian population. The shift in the source countries at the provincial level has been similar to the national pattern, with the dominant sources since 1986 being the Philippines, Poland, Hong Kong and Vietnam (Manitoba Culture, Heritage and Citizenship, 1991).

With respect to categories of immigration, the number of immigrants in the family and independent classes in 1989 totalled just over 4,100. The number of refugees (including Convention refugees and members of designated classes) has increased steadily in the last few years with almost 1,900 refugees arriving in 1989. The vast majority of immigrants coming to Manitoba are destined for Winnipeg. The provincial government supports the federal policy of a moderate, controlled growth in immigration. The changing source countries and general growth in immigration means that the province will continue to increase its cultural diversity.

Cross-cultural Counselling

Along with the increasing emphasis towards multiculturalism in Canadian society in general, there has been a growing trend to attempt to provide a wide range of services in a manner that is consistent with the consumer's or client's cultural background. Researchers and practitioners in a number of fields including health, education, and social services have increasingly recognized the need to address cultural factors in service delivery in the last twenty years. Although "multiculturalism" has been coined as a result of Canadian usage

(Department of Secretary of State, 1987), other countries, particularly the United States, have also experienced a surge of interest in developing "cross-cultural" counseling and therapy since the mid-1960s (Lonner, 1985).

The professional literature in the areas of multicultural and cross-cultural services has also grown with many new journals specializing in the field. However, there are still many ambiguities and little consensus about basic concepts such as "culture" and "multicultural" (Young, 1979). Young (1979) also argued that "multicultural" and "multi-ethnic" have often been used interchangeably in the literature when in fact "multi-ethnic" was the more appropriate term. Newer terms such as "culturally sensitive", "culturally accessible", and "culturally appropriate" are now often used without definition in both academic journals and government documents. Although it may not be possible to arrive at universally-accepted definitions of the myriad of terms in the field, it is important to begin to operationally define and establish criteria for these concepts in order to assist in service planning and evaluation.

Access and Barriers to Mental Health Services

Considerable research has been devoted to estimating mental health needs in the general population as well as to the study of mental health service utilization. The Canadian Mental Health Association has estimated that one-third of Canadians suffer from emotional problems at some point in their lives, and that for one in six Canadians (17%), these problems will be severe enough to require professional assistance (Manitoba Health Organizations Inc., 1990). In the United States,

estimates have been comparable, with the federal government reporting that 15% of the U.S. population requires mental health care at any given time (Stefl & Prosperi, 1985).

In many social service and mental health systems, there is a large gap between the estimate of the need for services and the actual rate of service utilization. Researchers in Canada and the United States have reported that approximately one out of five individuals who need mental health care receive formal, specialized mental health services (Canadian Task Force, 1988a; Stefl & Prosperi, 1985). Studies pertaining to specific populations such as immigrants and refugees have indicated that they use formal mental health care to even a lesser extent (Canadian Task Force, 1988b; Munroe-Blum, Boyle, Offord, & Kates, 1989).

The gap between need and service utilization is often assumed to be related to difficulties with access to services, and attention then turns to the types and extent of barriers which may influence access (Stefl & Prosperi, 1985). The importance of focusing on access and identification of barriers has been stressed by researchers as central to meeting clients' needs (Doyle & Visano, 1987).

Although the concept of access has frequently been discussed with respect to service utilization, the term is ambiguous and has been used in various ways by researchers and policy makers. Standard definitions of access in the program evaluation literature have included both the entry and continuation of clients in programs. Rossi and Freeman (1989), for example, described access as referring to "the structural and organizational arrangements that facilitate participation in the program" (p. 197). In contrast, other researchers and planners have

argued that access and utilization are two different components of service use, and that access refers to functions occurring prior to the actual delivery of services (Doyle & Visano, 1987b).

In a study devoted to the definition of access in health policy and services, Penchansky and Thomas (1981) found from their review of the literature that access was most frequently described as relating to an individual's ability to enter into or make use of a service system. Similarly, Donabedian (1973) had previously described accessibility as not only concerned "with the propensity to seek care but with a 'lack of fit' even when the source of care and the client are brought together" (p. 424).

Penchansky and Thomas proposed that access is in fact a general concept composed of the five dimensions of availability, accessibility, accommodation, affordability, and acceptability. Although they acknowledged that these dimensions are difficult to separate, the following descriptions were given:

Availability - pertains to the adequacy of the supply of services.

Accessibility - refers to the relationship between the location of services and the client's location.

Accommodation - the way in which service systems are organized to accept clients, (e.g. includes hours of operation, arrangement of appointments) and the clients' perceptions of their appropriateness and willingness to adapt.

Affordability - the relationship between the cost of services to

the client and the client's ability to pay.

Acceptability - refers to clients' attitudes towards characteristics of service providers as well as to the providers' attitudes toward client characteristics.

Although there is still no universally accepted definition of access, within the mental health and social services fields its usage has generally been as a comprehensive, multi-dimensional term. Similarly, Stefl and Prosperi (1985) list common attributes of barriers to access as being availability, accessibility, acceptability (includes the issue of stigma), and affordability. In comparison to the Penchansky and Thomas taxonomy, the primary omission in this list is the accommodation attribute.

In this practicum, access has also been viewed broadly as referring to a client's ease of entry to and use of a service. The focus has been on identifying barriers to entry, or initiation of service, but barriers to continuation of service were also addressed as clients will terminate involvement if services are not culturally sensitive.

Developmental Planning Model

One of the major components of the proposed practicum was the development of a protocol document which was to attempt to address the need to specify characteristics and models of culturally accessible services for service planning and evaluation. The methodology for the development of this document was in keeping with the integrative planning approach proposed by Mayer (1985). This approach draws heavily

upon the developmental planning model which stresses that specific ends and means are developed through the planning process to meet general ends or goals. The general ends or goals have widespread support, and developmental planning is typically associated with a comprehensive view of planning rather than one that conforms to a narrower, technological approach. Mayer argued that developmental planning can be practiced in a number of contexts, including the participatory style which was utilized in this practicum.

The protocol document that resulted from the practicum was intended to have utility for both planning and evaluation activities. With respect to planning, it was designed to be helpful to those who undertake strategic planning, issue-oriented planning related to multiculturalism, and needs assessments. The document is intended to assist with key components of the planning process including assessment of the external environment, trends, and barriers (Mayer, 1985). It is meant to function as a guide for ensuring that implementation planning considers means to enhance accessibility for immigrants and refugees. Bryson (1988) stressed the importance of group discussion as a key component of strategic planning, and this method was also incorporated into the practicum's planning process.

Evaluation

The document that was developed in the practicum falls within the scope of formative, rather than summative, evaluation (Smith, 1990). The aim was to assist in determining what efforts should be made to improve the functioning of a program with respect to cultural accessibility, not to establish the effectiveness of a total program at

its conclusion.

Rossi and Freeman (1989) characterized the three major types of evaluation activity as evaluation of innovative (new) programs, full-scale evaluation of established programs, and the fine-tuning of established programs. According to Rossi and Freeman, most resources in evaluation are devoted to the assessment of established programs particularly in relation to fine-tuning efforts. Although the protocol document was designed to provide useful information for all types of evaluation, it is anticipated that initially it will be most frequently used in the fine-tuning of programs.

The development of a document that specifies criteria for culturally accessible services not only falls within the scope of evaluation activity, but also relates to the field of quality assurance (Clemenhagen, Champagne, Contandriopoulos, & Pineault, 1985). Quality assurance and assessment involve the use of criteria and standards as indicators or measures of care. Criteria and standards can be either explicit (formal, written characteristics) or implicit (less specific and more subjective). Explicit criteria tend to be more reliable than those that are implicit, and the two main sources for establishing explicit criteria are scientific literature and selected experts (Clemenhagen et al., 1985). It should be noted that explicit criteria are most likely to be accepted and implemented by those who assist in their formulation.

In the practicum, data from primary sources were primarily qualitative in nature, although some data were quantitative. The main techniques used to gather the data were interviews and a structured

group process. A telephone survey was also conducted of a sample of the document recipients. The combination of these techniques, rather than the reliance on just one, will contribute to a "full picture" (Mayer, 1985). Use of qualitative, rather than quantitative analysis alone, allowed for the emersion of the rich, descriptive data that is especially useful in exploratory research.

Qualitative procedures have proven to be especially useful in determining the nature of a problem and raising the consciousness of those involved (Rossi & Freeman, 1989). McKillip (1987) noted that use of community forums and public hearings are the data collection methods of choice when political factors must be taken into account. Forums have an advantage of building support which is key during the planning process (League of California Cities, 1975).

Although human service organizations have frequently been criticized for their seeming inability to change, research evidence suggests that they are capable of change and innovation (Hasenfeld, 1983). Some of the forces that contribute to an organization's stability and/or willingness to change include its niche in the environment, funding patterns and resources to make changes, internal power balances, shifts in political sentiments, legislative, and governmental policies, changes in client characteristics and needs, and development in service technologies. Several of these forces, particularly those related to political sentiments and changing client characteristics, have certainly been (and will continue to be) influential in education and social services' attentiveness to cultural factors in service delivery. Hasenfeld also noted that organizational

change, particularly of an incremental rather than radical nature, is also facilitated by clear and specific information related to the area of change, and thus it will be important for the document to be educative as well as evaluative.

Finally, it should be noted that there are some issues related to cross-cultural research and evaluation that were anticipated at the outset of this practicum. Patton (1985) argued that all evaluations can be successful regardless of geographical location if they are sensitive to cultural differences. Evaluations must address culturally different perspectives such as those of the evaluator and the participants with regard to customs, resources, and communication patterns. The most obvious issue in cross-cultural evaluation relates to language barriers encountered both in communicating with participants/informants and in the development of evaluation instruments (Ginsberg, 1988). Ginsberg advocated the use of translators to both translate the language and serve as interpreters of customs, and suggests that multiple informants should be used to avoid the biases of a single individual.

III. INTERVENTION

Setting and Personnel

As described earlier, the proposed setting for the practicum was the Canadian Mental Health Association (CMHA), Manitoba Division Inc. CMHA is a non-profit organization with major objectives of the promotion of good mental health and the improvement of care provided to individuals who experience mental health problems. The organization's Board of Directors includes representatives from all regions of the province, and there are six additional committees which provide guidance for specific tasks in the organization (Professional Advisory Committee, Legal Issues Committee, People Helping People, Women and Mental Health Committee, Fundraising Committee, and Consumer Advisory Committee). The direction for the project was provided by the Immigrant and Refugee Mental Health Subcommittee of the CMHA Professional Advisory Committee. Administrative and clerical support were provided by CMHA.

The setting for this project turned out to be very appropriate for a number of reasons. CMHA's provincial mandate enabled the project to consider services beyond those in Winnipeg, and the document which resulted is therefore broader in scope and likely more widely applicable to services in other geographic areas. The fact that CMHA has a national office, as well as other provincial divisions, meant that it is relatively widely known. This was useful, for example, during the completion of the literature review when individuals from across Canada and the United States were contacted by telephone. Another helpful

aspect of the choice of setting was the overlap of the organization's objectives and the goals of the project. In its mental health promotion activities, CMHA is particulary concerned with high risk groups experiencing stress (including immigrants and refugees), and is also interested in improving accessibility and quality of care for underserved groups. Finally, the range of professional qualifications held by members of the subcommittee which provided direction for the project helped to ensure that the project's document did not put forward the views of only one particular professional discipline.

At the beginning of the practicum, a small group of seven stakeholders was identified in conjunction with the practicum committee to serve in an advisory capacity for the project. Names of individuals who might be willing to serve as advisors were provided by the practicum committee and contacted by the student by telephone. Two of the four individuals initially suggested declined, but each identified another person within his/her organization who accepted. A letter outlining the project and the expected role of the advisory group was subsequently sent to four individuals who agreed to participate (See Appendix J).

The members of the resulting advisory group were the three members of the Immigrant and Refugee Mental Health Subcommittee, an ethnocultural community organization representative, a service provider, a manager from an immigrant serving agency, and a representative from a provincial government department concerned with immigrants and refugees. Although it was important to ensure input from a variety of sources, the number of stakeholders was kept reasonably small so that the management of the project did not become unwieldy. In selecting the advisory

group, consideration was given to the accessibility of the individuals during the project. Although it was not felt to be necessary to meet as a group on a regular basis, contact was maintained at least on an individual basis to solicit input at various stages.

The relatively loose structure of the advisory group had both benefits and disadvantages. Agreement to participate in the group was gained from a few members on the basis that there would not be many meetings to attend. More structure and meetings would have likely resulted in more refusals to participate. A subsequent drawback, however, was that attendance at the two meetings which were held was poor, and at times it was difficult to get feedback even informally from some members. In retrospect, it may have been helpful to have mapped out in more detail the tasks and amount of time anticipated of an advisory group member, and more closely matched the participants with the demands.

Another strength of the advisory group was the wide range of expertise and perspectives of the members. This diversity made it possible to gain a variety of viewpoints at any particular point in the project. In addition, because of the loose structure, it was also possible to select only one or two members to approach for consultation on a particular issue. The time of the other advisory group members was therefore not wasted and, in general, it was possible to get advice without having to wait for, or arrange, large group meetings.

Clients

The ultimate beneficiaries of the project were identified in the original project proposal to be immigrants and refugees who experience

mental health problems. In the practicum, however, the targeted group of the intervention was primarily the intended readership of the document: mental health and social service planners, managers, and evaluators. Representatives of ethnocultural community organizations and other professionals in the community (e.g. physicians, nurses) were also invited to comment on the draft of the document, and thus were also, to an extent, a part of the intervention process.

Duration

A time table of the project activities was outlined in the original project proposal and extended over a six-month time period. The actual practicum took somewhat longer to complete. It began in February, 1991, and by November, 1991, the final document was disseminated to a wide range of mental health and social services.

The stages of the project involving the review of the literature and the case studies were primarily responsible for the extra time involved in its completion. The review of the literature had been forecast to take six weeks, but actually took approximately ten. This was partially due to the volume of material that was reviewed, as well as to delays in receiving reports not readily available locally (e.g. unpublished reports, documents with a limited circulation). The two weeks anticipated for the completion of the case studies was also insufficient, and they actually took seven weeks to complete. The additional length of time needed was primarily due to the steps involved in identifying the programs to be studied and securing their cooperation, and to the gaps in time between interviews that were completed as a part of the case studies.

Finally, the meetings held to receive feedback on the draft of the project's document were delayed several weeks to avoid the peak holiday time of the month of July and early August so that attendance would not be highly affected by summer vacations.

The telephone survey of a sample of the document's recipients was conducted in January, 1992. Time frames for completion of the telephone survey and the design of the mail survey were not provided in the project's original proposal, and also lengthened the completion of the practicum.

Activities

The activities of the practicum consisted of the following major tasks:

1. A comprehensive review of the literature. The review was completed through computer searches of publications in professional journals and relevant articles were obtained from university libraries or directly from the authors. In addition to obtaining periodical literature, relevant books and recent dissertations were reviewed. Pertinent reports were obtained from provincial government offices who deal with immigrants, multiculturalism, mental health and social services. Contact was also made by telephone with the CMHA national office and most of its provincial association offices. Key informants in universities, government offices, and community organizations were also contacted in urban centres such as Toronto, Montreal, Ottawa, Vancouver, Minneapolis, and Denver, to discuss other relevant projects. Information was also sought from several key individuals locally.

In total, approximately 140 documents were reviewed. Close to

one-half of the documents consisted of articles from professional journals, most of which were obtained from university libraries. (A few were obtained directly from the authors or from other individuals.) Approximately 25 books were reviewed and most of these were obtained from university libraries, although provincial government libraries (e.g. Education, Health) and contacts with individual professionals were also used. Over 25 reports produced by various levels of government were obtained from a number of sources including relevant government offices, university libraries, and contacts with the authors. Unpublished reports and mass communications such as newsletters constituted a further 20 of the documents, and were obtained primarily from agency or individual professional libraries (e.g. CMHA, Centre for Intercultural Development, advisory group members).

2. Two case studies. A description of two specific programs which are considered to be exemplary in their provision of culturally and linguistically accessible services was completed. These program descriptions were essentially brief case studies which were intended to provide additional information from the "real life context" about the way mental health and social services are, and might be, delivered to immigrants and refugees.

The case study as a research design is an appropriate choice when, as in this case, research questions take the form of "How" and "Why" (Yin, 1984). Other research strategies which answer "How" and "Why" questions are histories and experiments. However, case studies are the preferred design when examining contemporary events in which the researcher cannot manipulate the relevant behaviours. In addition, as

Yin has indicated, case studies have a distinctive place in evaluation research. One specific application involves the description of real-life situations in which an intervention has occurred (i.e. the description of programs reputed to be exemplary in their culturally accessible services).

Three common concerns cited in reference to case study research are its potential lack of rigor (with the findings influenced by biased views), minimal basis for generalization, and tendency to take too long with subsequently unwieldy reports (Yin, 1984). In this practicum, the use of several interviewees, guidelines for semi-structured interviews, and multiple sources of data reduced the concern over "lack of rigor" in case study research. The use of such data triangulation has been highly recommended to avoid bias (Patton, 1980). The concern about generalizability was also addressed to an extent by ensuring that two diverse programs were studied. Finally, the brevity of the practicum's case studies, and the purpose of the research, addressed the concern about potentially excessive time for completion and lengthy reports.

The two programs studied were identified by reviewing community resource inventories and discussing suggestions with the practicum committee and stakeholder-advisors. (See Appendix K for a copy of the initial letter to the programs.) In selecting these exemplary programs, consideration was given to the characteristics of the clients, the size of the organization, location, catchment area served, length of time in operation, and willingness to participate in the project. As noted previously, the two programs were to differ somewhat in these factors.

The description of the programs was based on available written

material, interviews of a management staff member, a direct service worker, and a client, and tours of the program's facilities. It should be noted that the use of multiple sources of evidence is a defining characteristic of case study research (Yin, 1984). Data gathered from the interviews were intended to be qualitative in nature. See Appendix B for an outline of the procedures used to complete the interviews. The program descriptions are presented in Appendix C.

The results of the program descriptions indicated that each of the programs studied had adopted a different approach for providing culturally accessible services. Each of the approaches in fact validated an option which had appeared to be viable in theory: multiculturalized mainstream organizations and specialized units within mainstream organizations.

In each case, specific approaches undertaken by the program to provide culturally accessible service addressed barriers from all eight of the major categories of barriers which were found in the literature review. Many of the approaches utilized were directed at similar barriers within each of the categories. Both programs identified barriers in the cultural and language categories as being of primary concern in providing services to immigrants and refugees.

The studies of these programs lent support to previous researchers' claims that none of the three options for providing culturally accessible services is superior overall (i.e. multiculturalized mainstream organizations, specialized units within mainstream organizations, and "linkages" of mainstream organizations to ethnocultural and immigrant serving agencies). Instead, the choice of

an option depends on the situation and organization. The program descriptions also suggested that implementing any of the options requires political will and a genuine commitment to making services culturally accessible, and provided real-life examples of programs that have reduced barriers for immigrants and refugees.

3. Preparation of a draft document. Based upon the literature review, program descriptions, and other information gathered from key informants, a draft of a document was developed which outlined criteria for the provision of culturally and linguistically accessible services. The document was primarily intended for the use of service planners, managers, and evaluators. It was felt that the document needed to be readable, with information presented concisely. The document was to have both an educative function and an evaluative function.

In the resulting draft, research and general trends were summarized in narrative form in the first part of the document. Barriers and the suggestions for reducing the barriers were presented in the second part, with general introductory comments made about each category of barrier. A checklist which summarized all the barriers was included at the end as an aid for quick reference.

4. Focus groups. A list of key informants who were to be asked to give feedback on the draft document in three focus groups was developed in conjunction with the project's advisory group. Sixty-five individuals were selected representing ethnocultural community organizations, mental health and social services, immigrant serving agencies, and other professionals in the community. Three dates were established for the focus group meetings and each individual was invited

to one of the meetings as well as to one on an alternate date. The letter of invitation (see Appendix L) and enclosed copy of the draft document were sent out approximately five weeks in advance of the meetings.

Focus groups are group interviews that focus on a particular topic typically supplied by a researcher (Morgan, 1988). Emphasis is placed on observing the interaction within the group and discussion is directed by a moderator (frequently the researcher). Focus groups generally consist of 8 to 12 individuals and typical sessions last from one and a half to two hours (Stewart & Shamdasani, 1990). In exploratory research aimed at obtaining perspectives about a topic, only a few focus groups are usually required, with a relatively high degree of structure provided by the moderator (Morgan, 1988). As a method of collecting qualitative data, focus groups are useful either on their own, or, as in the case of this practicum, as a supplement to other qualitative and quantitative methods.

Focus groups permit the opportunity to observe a large amount of interaction about a topic in a small amount of time, and group discussion about a single topic often brings forth rich data that would not have been obtained on an individual basis (Morgan, 1988). These advantages of focus groups were both of importance in choosing a method to obtain feedback about the draft document. In addition, the group interaction allowed the student to ascertain the extent to which comments drew agreement among the group. The largest disadvantage of focus groups relates to the fact that the discussion is controlled by the moderator and that the interaction is not observed in a naturalistic

setting (Morgan, 1988). However, as the purpose of the practicum's focus groups was to obtain opinions about a planning and evaluation document, the "naturalness" of the interaction was not essential.

A "feedback sheet" (in Appendix L) was also provided with the invitation letter to provide the respondent with some guidance in reviewing the draft. Informants were encouraged to submit written comments on the draft as well as, or instead of, attending a group meeting. Of the 65 individuals invited, 26 attended the focus groups and an additional 4 submitted written comments. See Appendix D for more detailed statistics regarding the respondents.

The first focus group was scheduled in the evening and most ethnocultural community organization representatives and other professionals such as physicians were invited to this meeting. Although an evening meeting had been felt to be most suitable for these informants, it was actually quite poorly attended and the smallest of the sessions (three key informants in attendance). The second focus group, held in an afternoon, was the one primarily arranged for service providers and was attended by 11 people. The final focus group, also in an afternoon, was the alternate session for all those who could not attend the meeting for which they were originally scheduled. It was, in fact, the largest group with 12 key informants in attendance.

Attendance at the meetings had been encouraged by having potential respondents return a form (in Appendix L) indicating which meeting they would attend. Those who did not respond received a follow-up phone reminder. In view of the low attendance in the evening meeting, it may have been more useful to hold the third meeting during a morning, and

invite all respondents to attend any one of the three meetings. In addition, despite delaying the meetings until late in August, a number of people indicated that they could not attend as a result of their summer vacations.

The numbers of people at each meeting were all small enough to facilitate group discussion. Although it was originally thought that interpreters might be needed, all invitees selected had a working knowledge of English. Each of the meetings was approximately two hours in length and involved a structured review of the document based upon the outline that was also used in the feedback response sheets. In order to accurately record the comments made in the focus groups, the meetings were videotaped. Participants had been informed of the videotaping in the initial invitation letter and were asked again for their consent at the beginning of the meetings.

For the most part, people adjusted easily to the videocamera with a few jokes made by the respondents about what comments might be recorded. The camera was equipped with a wide-angle lens and a remote control, and thus did not require an extra individual for its operation. This means of operating the camera meant that not everyone's faces could be seen as they were talking, but in reviewing the tapes, it was generally easy to discern who had been speaking. It may also have been easier for the participants to adjust to the camera because there was no extra person there for its operation.

In general, the sessions appeared to run smoothly. The size of the groups facilitated discussion and most participants contributed actively throughout each session. The length of the sessions was just

adequate to permit review of the document, but a formal coffee break was sacrificed to keep to the two-hour limit. As many of the participants seemed to know each other, a break may have been viewed positively by the participants. Another minor disadvantage for those attending the afternoon sessions was the tow-away zone that existed for parking spots near the meeting room, although only a few people were affected.

5. Analysis of the feedback and preparation of the final document. When all the focus groups were completed and written comments on the draft had been received, an analysis of the feedback was completed. The videotapes of the focus groups were reviewed several times each and a report was prepared which summarized the meetings. This summary report was subsequently distributed to all individuals who had commented on the draft and a copy of it can be found in Appendix E. The written comments were also summarized and a copy of this summary is Appendix F.

All of the comments on the draft were analyzed with respect to their content, the frequency with which they were made, the level of agreement about the comment, and the source of the comment. Following the analysis of the comments, a meeting was held with the Immigrant and Refugee Mental Health Subcommittee to discuss the feedback and the proposed changes to the draft based upon the analysis of the comments. It was proposed that most of the comments made on the draft be addressed in the revision, with many in fact entailing only minor changes (e.g. clarification of wording, the use of concrete examples, additional ideas about the barriers or their reduction). The few comments that were not incorporated either involved lack of agreement between the respondents

(e.g. whether the document was too academic in nature) or additions to the document that were outside its intended purpose.

One major change was proposed with regard to the organization of the document, with the review of the literature to be placed in the second part, rather than the beginning, of the document. In the focus groups, many potential recipients of the document had indicated that the usage of the document might be facilitated by having the identification of the barriers and recommendations for addressing the barriers be the first part of the document.

The subcommittee members supported the changes that were proposed and the document was revised accordingly. Once the final version of the document was completed, arrangements were made to have the document printed and bound by a local firm that was recommended by CMHA. A copy of the final version of the document sent to the printers is included in Appendix G.

A draft of a mailing list of potential recipients was developed and distributed to the advisory group for their suggestions. The list included all those individuals who had received a draft document and expressed an interest in having a final version, mental health and social services as well as related organizations in Winnipeg, similar major organizations in rural centres across Manitoba, and provincial government departments concerned with immigrants and refugees. See Appendix M for a copy of the cover letter that was sent with the final document. The number of copies of the document required as a result of the mailing list, exceeded the number that could initially be printed within the project's budget. Consequently, the mailing list was reduced

and additional funding has been sought to allow for the printing and distribution of an additional 200 copies.

Recording

The major recording completed during the practicum consisted of the videotaping of the focus groups. The videotapes of the three meetings recorded just over five hours of discussion in total. As noted previously, four other individuals responded to the draft by submitting written comments, and these comments are also part of the recording which was completed.

Other recordings which occurred during the practicum related to the data gathering activities of the exemplary program descriptions (see Appendix C for the program descriptions) and arrangements of the key informant sessions (e.g. responses pertaining to attendance at the meetings).

IV. EVALUATION

Procedures

Overview. To a large extent the evaluation of the practicum was composed of the evaluative aspects of the project itself. The project's evaluation included:

a) feedback from the key informants regarding the document,

b) a telephone survey of a random sample of the recipients of the document, and

c) a mail survey of all the recipients of the document (following the completion of the practicum).

Members of the student's practicum committee also provided evaluative feedback on an ongoing basis, and at the end of the practicum comments were also sought from the Executive Director of CMHA. At the conclusion of the practicum, the student completed a self-evaluation regarding the extent to which the learning objectives were achieved.

Feedback from key informants. Mention has already been made of the summary report which was prepared regarding the feedback received on the draft document during the focus groups (see Appendix D). A few key informants also provided written comments which are summarized in Appendix F. At the end of each focus group, the student ensured that an opportunity was also given to the key informants to discuss the document or project more informally. Several individuals approached the student at these times and made complimentary remarks of a general nature about

the document. In addition, one individual indicated appreciation of the opportunity to provide feedback and two others remarked that the focus groups had been conducted well.

Telephone survey. Approximately eight weeks after the final document was distributed, a telephone survey was conducted by the student with a purposive sample of the document's recipients. The telephone survey was exploratory in nature, with the intention of obtaining some initial feedback on the document's usage with several recipients who had no prior involvement in the project, as well as from some individuals who had reviewed the draft.

The telephone survey was essentially intended to be a semi-structured interview, with the questions asked in a reasonably standard way across the respondents. The construction of the survey and the procedures for its completion were based on the survey methodology proposed by Dillman (1978). Dillman developed the "total design method" (TDM) approach for conducting mail and telephone surveys to maximize response quality and quantity. Response rates for Dillman's TDM telephone surveys were reported to be 85% with the general public, and over 90% with homogenous samples (e.g. students, professional groups).

The TDM describes the step-by-step details of conducting surveys including sampling, length of the survey, general principles for writing questions, and administration of the survey. With regard to telephone surveys, Dillman stressed the importance of simplicity in the questions in order to ensure comprehension. Open-ended questions were noted to be useful in telephone surveys, but optimal responses generally require skillful probes.

The resulting telephone survey for this project can be found in Appendix H. It consisted of a brief introduction, ensuring that the respondent was aware of the project, had read the document, and was willing to participate, as well as the nine survey questions. Most of the questions were open-ended, and additional probing was anticipated to further draw out the respondents as needed. The survey could be completed in less than 5 minutes, but additional time was allotted as required if the respondent wished to answer the questions at length. Dillman (1978) indicated that research has suggested that the length of the interview does not seem to create difficulties, and the surveys in the several studies cited took considerably longer to complete than the present survey.

The sample was selected by dividing the mailing list into the nine major categories on which it originally had been developed. Three groups of individuals had been sent the document based upon their involvement in the project: individuals in the exemplary programs, service providers who were identified as key informants, and all other key informants invited to the focus groups who requested a copy of the final document. An additional six categories of organizations had been established as follows: CMHA offices throughout Manitoba, hospitals in Winnipeg, major mental health and social services in Winnipeg and selected agencies in other parts of Manitoba, school divisions in Winnipeg with a clinical support service, selected planning bodies in Winnipeg, and relevant federal and provincial government offices.

One organization from each of these categories was then randomly selected by assigning each organization in the category a number and

subsequently using a random number table (Babbie, 1973) to pick the organization. The procedure was repeated to pick a second organization in each category which would be contacted if the first one could not be interviewed. A list of nine names (with nine alternates) thus became the sample. All nine organizations were contacted within a 10-day period, and subsequently four alternates were also contacted. The results of the telephone survey are presented later in this chapter.

Mail survey. A mail survey was also developed as a part of the practicum, which is planned to be used in June, 1992. The purpose of the mail survey is to obtain feedback from all individuals who were on the original mailing list for the document in November, 1991.

As with the telephone survey, the mail survey was developed utilizing Dillman's (1978) TDM approach to survey construction. Although the response rates for mail surveys are usually lower than with other methods such as face-to-face interviews or telephone surveys, the TDM has yielded response rates of 60% to 75% even with lengthy surveys of the general public. Dillman indicated that response rates with homogenous samples (as in the current project) approach those obtained with other methods. It should also be noted that response rates do not seem to be adversely affected by increasing length of questionnaires when they remain less than 12 pages.

In contrast to the telephone survey, open-ended questions pose difficulties in mail surveys due to the absence of the interviewer for probing and the problems which some respondents have in expressing themselves in writing. Thus, in developing mail surveys one must also consider using one of three other basic question structures: close-

ended with ordered choices, close-ended with unordered response choices, and partially close-ended. In weighing the advantages and disadvantages of all four question structures, Dillman concluded that any of the four may be the most appropriate choice depending upon the question and the information sought.

Following many of the specific guidelines of the TDM regarding wording of questions and format of the pages, the mail survey for this project was developed. A copy of the mail survey is presented in Appendix I. It should be noted that the cover letter sent with the document briefly gave advance notice of the survey and made an initial appeal for cooperation.

Results

Feedback from key informants. The formal feedback received on the draft document from key informants is summarized in Appendices E and F. Informally, the student received positive comments on the draft of a general nature after each of the focus groups. In addition, several individuals have made complimentary general remarks about the overall content and format of the final document since its distribution in December, 1991. These individuals have included key informants, as well as others from mental health and social service organizations who had not previously commented on the draft document.

Telephone survey. A total of 13 organizations were contacted in order to obtain the participation of one organization in each of the nine categories established for the survey's sample. With one organization from each of the nine categories completing the survey, the response rate for the telephone survey was 100%.

Five of the organizations that completed the survey were those that had been selected first in their category using the random number procedure. Four organizations that had been selected first in their category did not participate. The reasons for their non-participation are:

- the resignation of the recipient of the document with no one else available to comment,
- the vacation of the individual in the organization designated as most appropriate to respond,
- the recipient had not read or passed on the document, and
- the recipient could not find the document.

As a result, an additional four organizations that had been the randomly-selected alternate choices were contacted and subsequently completed the survey.

All interviews were completed in the one-month period extending from January 20, 1992 to February 20, 1992. A few organizations were contacted several times to establish and then reach the appropriate individual to be interviewed. In five cases, interviews were completed with the individual to whom the document had originally been mailed. In the other four cases, another individual within the organization was designated to be more appropriate for the survey. The actual interviews took an average of 11 minutes to complete, with the majority ranging from 5 to 12 minutes. One individual spent a total of 35 minutes responding to the survey in two phone calls.

As described earlier, the telephone survey consisted of nine questions, most of which were open-ended in format. The results of the

survey will be presented by discussing the responses to each question in the order given in the survey (see Appendix H for a copy of the survey instrument).

In response to the first question, all nine organizations indicated that they had kept the document. In eight cases, the document was being stored with the person who was being interviewed. In the one other case, the document was being circulated within the organization.

The second question asked how the document had been used and the majority of respondents (five) indicated that it had been used for educational purposes, either for staff training within the organization (three) or for presentations outside the organization (two). This is of importance as the document was originally envisioned as primarily for planning and evaluation. Other uses identified by respondents did relate to program planning (one), and the review and evaluation of existing programs (two). The individual interviewed from the organizational category of "planning bodies" indicated that the document would most likely be used as a part of the organization's data base for future research projects.

Question 3 asked respondents to identify what they found useful about the document. One theme in the responses reiterated the document's usefulness for presentations and staff training, as well as the format. A respondent who had previously commented on the draft document indicated that the organization of material in the final version had been improved. Another theme was the applicability of the document to many groups, not just immigrants and refugees, as well as the general population. One respondent indicated that the document

would be applicable to any group marginalized by society. This respondent also described the document as sensitive to cross-cultural differences, yet with remedies that apply to all individuals in Canadian society. Another respondent expressed a similar viewpoint, stating that the document's suggestions would enhance mental health services for everyone, not just immigrants and refugees. However, one respondent from a rural area in northern Manitoba, did not agree as she had found that the document was not relevant to her work with Natives except for the sections that addressed language barriers. Other useful aspects of the document mentioned by other respondents were the "how-to's" for organizations and the checklist.

In response to question 4 which asked what was not useful about the document, the majority of respondents (five) had no comments to offer. Two respondents (both from mental health services) indicated that the document may not be used much within their organizations as they did not serve many immigrants and refugees. Two respondents (one from a mental health service and one from a hospital) had found the document to be too idealistic, citing budget constraints and general lacks in psychiatric services which make a focus on immigrant and refugee needs seem "out of the question". One respondent from an immigrant serving agency had found the document to be too general. This is not surprising as the document had been intended for mainstream service providers, not those individuals in specialized immigrant serving agencies.

Questions 5 and 6 asked respondents to specify any changes which are needed in the document's content and layout. Very few respondents

(three) identified the need for any changes.

With respect to changes in the content, one respondent indicated that he had found the document to have an American slant, indicating as an example the references to fees being charged for services. The respondent did not seem to be familiar with the fact that fees are charged for some services (e.g. counselling) across Canada as well. This respondent also made two specific suggestions for additions to the remedies in the document. The first was that the remedy that relates to immigrants and refugees being given more information about cultural norms related to mental health in Canada should appear under Barrier 1.3 of the Information/Outreach category. The remedy is already present in the Acceptability category under Barrier 2.1, but previous feedback provided on the document has been that some repetition of remedies as relevant is useful. The second suggestion was that clergy should be included as potential interpreters because some immigrants and refugees have developed a trusting relationship with clergy leaders, and trust was felt to be vital in using an interpreter. Further to the theme noted previously that the document was applicable beyond immigrants and refugees, another respondent suggested that the document may be more widely used if it were reframed as one aimed at increasing cultural accessibility of services for everyone, not just immigrants and refugees.

No suggestions at all were made with respect to changes in the layout. This question instead elicited positive remarks indicating that the document was easily read, clear, and had an excellent format.

Eight of the nine respondents stated that additional consultation

or training would not have made the document more useful (question 7), some of whom noted that it was clear and self-explanatory. However, one respondent indicated that additional training would draw more attention to the document and "make sure it doesn't get lost". Another respondent felt that the document's usage would relate more to an organization's motivation to change, and that any training offered would need to be individually tailored to the specific organization's needs. The only respondent who indicated that additional training would be helpful was from a rural area and reported that "documents like this generally come out of the blue". Therefore, additional consultation would have helped to clarify the potential use of the document. This comment suggests that it may have been useful to send an additional announcement to rural organizations explaining the document and its potential uses prior to its distribution.

Question 8 asked respondents to identify which remedies they had been able to implement or explain the reasons why they had not been implemented. Eight of the nine respondents reported that they had not implemented any of the remedies, but several of these responses were qualified with "not yet". This generally seemed to be related to the relatively short amount of time between the distribution of the document and the completion of the telephone survey. One respondent (from a government office) indicated that the organization did not provide direct services and therefore could not use any of the remedies. Another respondent stated that her organization did not need to make any changes. The one respondent who had indicated that some remedies had been implemented identified them as being related to networking with

other agencies and community outreach.

Finally, question 9 asked for additional suggestions regarding future versions of the document. Three respondents had no suggestions. The most frequent response given was that additional copies of the document were needed, both within organizations and by widening the distribution to include other organizations. Further to comments made earlier in the survey, additional suggestions included reducing the focus on immigrants and refugees in the document and modifying it to be one intended to make services more culturally accessible for everyone. The respondent from the immigrant serving agency suggested that the document be made less general or introductory. This comment indicates that the document may not be appropriate for individuals who already have expertise in serving immigrants and refugees. Additional feedback about the document's level of sophistication will be sought on the mail survey. One respondent who primarily serves children and families suggested that additional emphasis be placed on children's needs. A question will be incorporated on the mail survey to assess the level of agreement about this suggestion.

Overall, the telephone survey was very helpful in providing some initial data about organizational responses to the final document. The data generally seem to indicate that the document is being kept by the organizations, but has received only limited circulation to date. One respondent had reported that his organization had made seven xerox copies to allow for distribution to its management team.

These exploratory survey data indicate, however, that the document has had an overall favourable response, particularly with respect to its

use at a tool in education and training. However, to date it has had limited use in planning and evaluation activities. The format has been well-received, the document generally appears to be readily understood, few criticisms have been made, and the need for additional training seems to be minimal.

The tone of the responses to some questions suggested that it may take some time for organizations to actually begin to use the document. The mail survey which will be sent out in June, 1992 will therefore allow more time to elapse before requesting additional feedback about the document. This will be especially important in determining the extent to which and the ways it has been used. The inclusion of some questions in the mail survey which rate the document will also be helpful in obtaining additional data. In addition, the mail survey will be useful in confirming findings from the telephone survey. The results of the telephone survey have led to the incorporation of additional questions on the mail survey to assess:

(a) the level of support for the suggestion of utilizing clergy as interpreters,

(b) whether the document is generally perceived to have an American, rather than a Canadian, slant,

(c) the document's applicability to Aboriginals, non-immigrant culturally different persons, and the general public, and

(d) whether the document deals sufficiently with the barriers experienced by immigrant and refugee children.

Feedback from practicum committee and CMHA. At the conclusion of the practicum, the student requested evaluative comments from two

members of the practicum committee and from the Executive Director of CMHA. Open-ended questions were asked related to learning goals in the practicum and the overall performance of the duties in the practicum, as well as inviting any additional comments.

The feedback received from all three individuals interviewed was very positive. Specific strengths identified in relation to the practicum's tasks were the comprehensiveness and conciseness of the literature review, the facilitation of the focus groups, and the analysis of the feedback received from the focus groups. In addition, positive remarks were made about organizational skills, writing abilities, commitment to scholarship in applied research, and attention to details that facilitated the operationalization of the project. There was unanimous agreement that the learning goals had been achieved.

No weaknesses were identified in the student's performance. However, one comment was made that conceptual frameworks could have been discussed to a greater extent in the literature review if it was aimed at a different audience (e.g. in a professional journal). Another comment suggested that the student's strengths in analysis and objectivity may lead to some difficulty in roles requiring a warm, empathetic response, and the student was alerted to this as a cautionary note. For example, the focus groups which occurred in the practicum worked well with a business-like, task-at-hand approach. However, other meetings or presentations which the student may be responsible for in the future may require a quite different approach.

Self-evaluation. In order to complete a self-evaluation, the student also reviewed the four sets of learning objectives of the

practicum, as well as reflecting on the performance of the practicum's specific tasks. The first learning objective related to an increased knowledge base pertaining to mental health and social services for immigrants and refugees. This was achieved, particularly during the course of the literature review, and the student is now also much more aware of how to obtain information about an issue outside of the formal academic literature.

The second set of learning objectives related to the development of a protocol document was achieved with the printing of Increasing Access. The several drafts involved in developing the document certainly increased the student's ability to consider alternate possibilities for the organization of written material, as well as verifying the importance of writing for a targeted audience. An unanticipated benefit related to these learning objectives was the facility that the student developed with computer word-processing and methods for producing visually-appealing printed material.

The use of the advisory group, completion of two case studies, and facilitation of three focus groups, ensured the successful achievement of the third set of objectives regarding the identification of community resources and interaction with key informants. As a result of these various interactions, the student was able to enhance skills in individual face-to-face and telephone interviews, chairing small group meetings (up to eight individuals) and facilitating larger group discussions (up to 15 individuals).

The final set of learning objectives pertained to the refinement of analytical skills. The completion of the practicum necessitated

various types of analysis, including the initial review and critique of the literature, the summarization and incorporation of the feedback on the draft document, and the analysis of the telephone survey data.

In summary, the student achieved all of the learning objectives which were established prior to undertaking the practicum, and in fact developed some skills that had not been anticipated (e.g. computer usage, organization of meetings, use of videorecording equipment). In addition, skills were acquired in planning and evaluating services in a wider context than had previously been experienced in the student's primarily clinical practice. The primary self-criticism relates to the overall underestimation of time needed to complete the practicum, which primarily resulted from steps involved in completing the case studies and facilitation of optimal attendance at the focus groups. In future projects that involve a number of individuals and/or organizations, the student will no doubt will be more prepared to allow more time for task completion, as well as being flexible in time lines.

As a final comment, it should be noted that the student remained challenged by (and enthusiastic about) the practicum throughout its duration. This is partially as a result of the practicum's many varied tasks and the skills subsequently obtained, and also because of the student's continued interest in increasing cultural accessibility of mental health and social services.

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Manitoba Family Services Immigration and Settlement Services

APPENDIX A

PROJECT PROPOSAL

NEWCOMER SERVICES SUPPORT PROGRAM (NSSP)

GRANT APPLICATION

A: General Information

1. **Name of Organization:**

   Canadian Mental Health Association Manitoba Division

   Address: 2 - 836 Ellice Avenue, Winnipeg, Manitoba

   Postal Code: R3G OC2

   Phone No.: 775-8888 Contact Person: Mr. Bill Martin

2. **Are you a Non-Profit Incorporated organization?**

   __x__ Yes _____ No

3. **For how long has your organization been in operation?**

   __47__ year(s).

4. **What are the objectives of your organization?**

   The Canadian Mental Health Association, Manitoba Division is guided by two objectives: (1) The promotion of good mental health and (2) the improvement of the care provided to those who are experiencing mental health problems.

5. **What target group(s) does you organization serve?**

   With regard to mental health promotion activities, the relevant target group is the public at large. However, the organization is especially concerned with high risk groups experiencing stressful situations, including immigrants and refugees. With regard to the improvement of mental health care, the relevant target group is those who are currently experiencing, or will in the future experience, mental health problems. We are also especially concerned with improving access and quality of care for under-served groups such as immigrants and refugees.

6. Please indicate sources of funding support your organization will receive this fiscal year?

Sources(s)	Amount
Province of Manitoba - Department of Health	$110,000
Province of Manitoba - Department of Labour	$ 20,955
Fundraising	$210,000
Pine Falls United Way	$ 2,600

7. Please provide the following information regarding the principal officers of your organization:

President: Ms Sharron Gould

Address: 2 - 836 Ellice Avenue
Winnipeg, Manitoba

Postal Code: R3G OC2 Phone: 775-8888

Vice-President: Dr. Ron Richert

Address: 2 - 836 Ellice Avenue
Winnipeg, Manitoba

Postal Code: R3G OC2 Phone: 775-8888

Secretary: Catherine Medernach

Address: 2 - 836 Ellice Avenue
Winnipeg, Manitoba

Postal Code: R3G OC2 Phone: 775-8888

Treasurer: Mr. Rick Chale

Address: 2 - 836 Ellice Avenue
Winnipeg, Manitoba

Postal Code: R3G OC2 Phone: 775-8888

8. Have you previously received funding under this program?

__x__ Yes _____ No Please indicate year(s) received 1986/87

PART B: PROJECT FUNDING REQUEST

1. **Under which Newcomer Services Support Program category is your organization applying for? (Please check one)**

   _____ Settlement Materials and Project Development

   _____ Community Development Project

   __x__ Settlement and Adaptation Research

2. **Working Title of Project:**

   Serving Immigrant and Refugee Mental Health Needs: Discovering Current Patterns and Encouraging Innovation.

3. a) **Is this a new project?** __x__ Yes _____ No

   b) **Is this an ongoing project?** __x__ Yes _____ No

   If yes, please explain the ongoing nature of the project.

   Although the project will in and of itself produce useful outcomes, the information gathered will be utilized to develop further action research proposals focused upon rendering the various mental health service delivery systems more culturally accessible.

4. **What are the objectives of the project?**

   The objectives of the proposed project are: (1) to develop indices of the cultural accessibility of human service programs which can be used in planning and evaluation activities, (2) to describe the range of cultural and linguistic barriers to mental health care currently experienced by immigrants and refugees in Manitoba, and (3) to catalyze the development of efforts to reduce cultural and linguistic barriers to mental health service consumption.

5. **Who are the target groups served by the project?**

   The ultimate beneficiaries of the project will be immigrants and refugees in Manitoba requiring some form of mental health care. These benefits will be realized through targetting information to mental health service providers, immigrant serving agencies, and relevant ethno-cultural community organizations.

6. Project Proposal: Please attach a project proposal which includes how you plan to carry out objectives, activities planned, resources to be used, time-table for implementing project, and method to be used for evaluating project.

7. Expected results of the project.

The proposed project should result in : (1) a pragmatic statement of the characteristics of culturally accessible programs for use by service providers in planning and evaluating their programs, (2) a testable model of the cultural and linguistic accessibility of mental health care to immigrants and refugees in Manitoba which can be verified through further research, and (3) the development of efforts on the part of mental health service providers and ethno-cultural community organizations to render mental health services more accessible to immigrants and refugees in Manitoba.

8. Duration of project for which funding is requested.

Start Date: June 1, 1990 Completion Date: December 20, 1990

9. Who is responsible for the management of this project?

Name: Mr. Bill Martin, CAE

Position: Executive Director

Address: 2 - 836 Ellice Avenue, Winnipeg, Manitoba

Postal Code: R3G OC2

Phone: 775-8888

10. Project Expenses:

	Total Project Budget	MSSP Portion Requested
Salaries/Honorarium: (Including Benefits)	$ 5,878.13	$ 5,878.13
Advertising and Promotion:	$	$
Office Supplies:	$	$
Travel:	$	$
Materials:	$ 636.00	$ 636.00
Report and Evaluation:	$	$

Other: (please specify)		
Computer literature search and long distance telephone costs to obtain literature.	**$ 300.00**	**$ 300.00**
Rental of recording equipment and purchase of tapes to record key informant forums.	**$ 150.00**	**$ 150.00**
Total Expenses:	**$ 6,964.13**	**$ 6,964.13**

11. Please specify sources if total project requirements exceeds amount requested under Newcomer Services Support Program:

Sources(s)	Requested	Approved
At least $10,000 worth of	$	$
volunteer professional and	$	$
administrative time will be	$	$
provided by the Canadian Mental	$	$
Health Association, Manitoba	$	$
Division. Volunteers will be		
involved in orienting the		
research assistant to mental		
health care and services to		
immigrants and refugees in		
Manitoba, directing and		
supervising the preparation of		
the protocol document and		
guiding and participating in the		
key informant forums. Staff		
will provide administrative and		

clerical services, including preparation of reports, letters, and the protocol document.

I certify that to the best of my knowledge the information provided by me in this grant application is accurate and complete and that the project is endorsed by the organization or group I represent.

Signing Officer of Organization: _____
Signature

May 22/90
Date

Name (please print): Sharron Gould

Position: President, Board of Directors, CMHA Manitoba Division

Address: 2 - 836 Ellice Avenue, Winnipeg, Manitoba

Postal Code: R3G 0C2

Phone: 775-8888

PROJECT PROPOSAL

NAME: Serving Immigrant and Refugee Mental Health Needs: Discovering Current Patterns and Encouraging Innovation.

PLAN TO MEET OBJECTIVES:

OBJECTIVE: Development of Indices of Cultural Accessibility for Service Planning and Evaluation

Progress toward meeting this objective will be made through five components of project activity:

1. A comprehensive review of the literature related to the provision of mental health care to immigrants and refugees, cultural barriers to service experienced by immigrants and refugees and other members of minority ethnic groups, and attempts to provide services in a culturally accessible fashion. The review will include government reports and agency-based evaluation studies, as well as literature published in professional journals and books.

2. Description of Manitoba human service programs which are reputed to provide culturally and linguistically accessible services.

3. Development of a draft document containing planning and evaluation criteria to ensure that services are provided in a culturally and linguistically accessible fashion. These criteria will be derived from the literature review and descriptions of exemplary programs. The purpose of the draft document would be to assist agencies in designing appropriate service delivery systems and monitoring and evaluation mechanisms which focus upon questions of cultural accessibility.

4. Refinement of the draft document through discussion of it in key informant forums described below, and feedback from a small sample of service providers and ethno-cultural organizations.

5. Broad dissemination of the draft document to service providers.

OBJECTIVE: Development of a Testable Model of Cultural and Linguistic Barriers Experienced by Immigrants and Refugees in Manitoba.

This description will be assembled through key informant forums including representatives of ethno-cultural community organizations, immigrant consumers of mental health services, immigrant serving agencies, and mental health service providers.

OBJECTIVE: Catalization of Efforts to Reduce Cultural and Linguistic Barriers to Consumption of Mental Health Care by Immigrants and Refugees.

Progress toward meeting this objective will involve two types of activity:

1. **Dissemination of the draft planning and evaluation criteria document described above.**

2. **Exchange of information in key informant forums described above.**

Activities Planned:

As described above, the proposed project will include the following activities:

1. **Literature review.**

2. **Systematic observation and interviews to describe exemplary programs.**

3. **Preparation of a draft planning and evaluation criteria document.**

4. **Dissemination of the draft document to mental health service providers.**

5. **Arrangement of key informant forums to develop an understanding of cultural and linguistic barriers to mental health service for immigrants in Manitoba.**

Resources:

Human resource requirements will include the efforts of suitably qualified individuals to:

1. **Locate and review the relevant literature.**

2. **Prepare and revise a draft planning and evaluation protocol document for culturally accessible human services.**

3. **Organize, facilitate and record the proceedings of key informant forums.**

Most of this manpower will be provided by volunteer members of the Professional Advisory Committee, Canadian Mental Health Association, Manitoba Division and its Immigrant Mental Health Subcommittee. This includes individuals with professional qualifications in clincial psychology, education, human ecology, medical anthropology, nursing, political science, psychiatry, and social work. In addition, representatives of key stakeholders (ethno-cultural community organizations, immigrant service agencies, mental health service providers) will be added to the subcommittee.

The staff of the Canadian Mental Health Association, Manitoba Division will provide the administrative direction and support for the project.

Beyond this, 375 hours of research assistant time will be required at a cost of $14.25 per hour with an additional 10%, $534.48, required for benefits. Thus, the total human resources costs will be $5,878.13.

Costs for materials and equipment will include:

1. $336.00 for printing and duplication of the draft protocol document (300 copies of 20 pages at a cost of 5.6 ¢ per page).

2. $300.00 for envelopes and postage costs to contact recipients, organize meetings, and disseminate the draft protocol document.

3. $300.00 for computer literature search costs and long distance telephone costs to obtain agency based evaluations and government reports.

4. $150.00 for rental of recording equipment and purchase of tapes to record key informant sessions.

Therefore, the total material and equipment costs will be $6,964.13.

Implementation Time Table:

The following outlines the planned schedule for implementation of project activities in 1990:

	Begins	Ends	Duration
1. Review of Literature	June 1, 1990	July 13, 1990	6 weeks
2. Description of Exemplary Programs	July 16, 1990	July 30, 1990	2 weeks

	Begins	Ends	Duration
3. Preparation of Draft Protocol Document	July 31, 1990	August 20, 1990	3 weeks
4. Obtaining Feedback on the Draft Protocol Document	August 21, 1990	Sept. 14, 1990	3 weeks
5. Arrangement & Preparation for Key Informant Forums	Sept. 4 , 1990	Sept. 24, 1990	3 weeks
6. Occurrence of Key Informant Forums	Sept. 25, 1990	Oct. 9, 1990	Not Applicable
7. Revision of Draft Protocol Document	Oct. 10, 1990	Oct. 24, 1990	2 weeks
8. Dissemination of Protocol Document After Printing	By November 30, 1990		Not Applicable
9. Preparation of Report of Key Informant Sessions	Oct. 25, 1990	Nov. 15, 1990	3 weeks
10. Revision and Circulation of Report of Key Informant Forums	Nov. 16, 1990	Nov. 30, 1990	3 weeks
11. Preparation of Final Report	By December 20, 1990		Not Applicable

EVALUATION:

A report will be prepared describing the implementation of the project, and containing the protocol document and a summary of the key informant forums. Data regarding the quality of the protocol document will be presented, including feedback from the key informant forums and responses from a small purposive sample of service providers and ethno-cultural community organizations. The key informant forums will be evaluated through data from questionnaires to be completed by participants and reports of participant observers.

In addition, the utilization and impact of the protocol document and the effect of information exchanged in the key informant forums will be evaluated through a self administered mail survey to be disseminated in early August, 1991.

The survey will be sent to all human service organizations receiving the protocol document (approximately 250) which will likely also include most service providers involved in the key informant forums. In addition, a similar survey will be sent to the approximatley 50 ethno-cultural community organizations to be involved in the key informant forums.

Alterations will then be made to the draft protocol document on the basis of survey results, and it will be more widely distributed to program providers.

If a Newcomer Support Services Support Program grant is obtained for this project, the Canadian Mental Health Association will seek funding for the impact survey from another source, possibly the Manitoba Mental Health Research Foundation.

Additional Benefits:

An additional benefit of this project is that it will provide a firm empirical basis upon which to plan further applied research aimed at enhancing the cultural and linguistic accessibility of services. Specifically, the project will result in:

1. A model of culturally accessible serviuces which can be verified through further research.

2. An assessment of the accessibility of some services to immigrants which can be generalized throughout the service system.

3. A methodology for catalyzing organizational change which can be more widely tested.

The Canadian Mental Health Association, Manitoba Division plans to apply for funding from other sources to further these goals.

Future efforts could involve:

1. A sample survey of the caseloads of the various services to determine to what extent immigrants from various regions of origin are actually served, i.e. are they appropriately represented given their numbers in the general population?

2. A survey of agencies providing mental health services to determine the extent to which they conform to the model of a culturally accessible service. Furthermore, the relationship of the various components of this model to actual rates of immigrants receiving service will be evaluated.

3. A survey of immigrant serving and ethno-cultural community organizations to obtain information from their perspectives as to which mental health service providers conform to the model of a culturally accessible service, and about the kinds of obstacles experienced by immigrants seeking mental health services.

4. A broader test of the effects of planning information and problem solving sessions with ethno-cultural community organizations upon organizational efforts to improve service accessibility.

APPENDIX B

Procedures for Obtaining Exemplary Program Descriptions

Commentary for Reader:

These procedures, including both the steps for completing the program descriptions and the interview guidelines, were established by the student as an aid to completing the case studies. The intention was to collect as much data as possible within the time parameters, and to study the two programs in similar ways. It should be noted that the interview guidelines served the purpose of ensuring that specific areas were addressed, but the exact wording of the questions was not formulated. This facilitated the desired informality and flexibility during the actual interviews.

Steps in Completing Descriptions

1. Identify program. Each of the two programs was identified by reviewing resource inventories and discussing suggestions with the practicum committee and stakeholder-advisors. In selecting the exemplary programs, consideration was given to the characteristics of the clients, the size of the organization, location, catchment area served, length of time in operation, and willingness to participate in the project.

2. Contact director:
   - Explain project
   - Explain selection of this program
   - Secure willingness to participate
   - Set up interview, and indicate desire to interview a direct service staff and if possible, a client as well.
   - Negotiate any areas of concern

3. Send letter of thanks for anticipated participation, with outline of project, assurances of confidentiality, and confirm interview time.

4. Conduct interviews (see guidelines), review documentation (e.g. agency brochures, blank forms completed by clients, policy manuals), obtain tour of physical facility.

   Have interviewees jointly identify a client who may be willing to be interviewed, and contact client for appointment. The individual selected should ideally represent a "typical" client, verbally expressive, and may be someone who is no longer receiving services. Confidentiality will be discussed with client prior to conducting interview, and signed consent obtained.

5. Send letter of thanks for participation and indicate intent to

forward draft document and invitation to focus groups.

6. Interview client, and send letter thanking for participation.

Guidelines for Interviewing Staff

Interviews of the management (M) and direct service (DS) staff will be conducted individually, will be approximately one hour in duration, and are aimed at collecting information to address the following areas. Indications of M and DS in the list below symbolize the areas that will be emphasized with each individual.

Areas to be covered:

A. History (M) - when and how did the program begin.

B. Mandate/mission/catchment area (M)

C. Objectives (M & DS)

D. Funding (M)

E. Administration (M) - how is the program administered and by whom.

F. Staffing (M)

G. Program activities (M & DS)

H. Clients - numbers, demographic characteristics (M & DS)

I. Problems/constraints (M & DS) - particularly in the area of service delivery.

Questions will also be asked of both staff interviewees as follows:

1. What are the multicultural components of your program, particularly those that relate to immigrants and refugees?

2. Cite examples of what your organization does to decrease potential barriers in these areas.

3. Information awareness - How do clients generally find out about the program?

4. Physical/geographical - How close is the program to public transportation and clients' homes?

5. Cultural factors - What languages are spoken by staff? What, if any, interpreters are used? Is the board representative of the client population? Do hiring practices encourage multicultural staffing?

6. Administrative factors - What are the hours of service? Are written materials in English only? Does the length of application and other forms appear prohibitive to clients? What is the waiting time for appointments?

7. Costs - What is the fee for service? Is day care available? What assistance is available regarding transportation costs?

8. Are there specific approaches that your program has taken to reduce barriers which you think would be helpful to other programs?

9. Are there any approaches which you have tried, but felt were unsuccessful and/or should be avoided?

Guidelines for Interviewing Clients

* Must establish need for interpreter prior to the interview and will utilize program resources to obtain an interpreter.
The language used in the interview should be noted.

Obtain information regarding client's:

Sex

Place of birth

Age - under 25
25 - 34
35 - 49
50 - 64
over 65

Date of arrival in Canada

Length of time lived in Winnipeg

English speaking? For how long?

Language first learned

Language usually spoken

Questions

1. When did you came to Program A?

2. Why did you seek service from Program A?

3. How did you find out about the program? (e.g. family, friends, written material, other agency).

4. What happened when you first went there?

5. How far did you have to come? What difficulties did you have in getting there?

6. Were you able to understand the staff? Did they seem to understand what you wanted? What language did you communicate in? Would you have had a preference for a different language? Was an interpreter used? Provided by whom?

7. When did you usually use the program (e.g. a.m., p.m.) Was this convenient?

8. What would you like to see changed about the program so that it would be easier for others to use?

APPENDIX C

Descriptions of Two Exemplary Programs

Introduction

These two programs were identified by reviewing resource inventories and discussing suggestions with the practicum committee and stakeholder-advisors. In selecting the exemplary programs, consideration was given to the characteristics of the clients, the size of the organization, location, catchment area served, length of time in operation, and willingness to participate in the project.

The descriptions which follow are brief summaries of the data obtained through interviews of a management staff member, a direct service worker, and a client from each program, reviews of written material, and observational visits to the programs' facilities. The written material reviewed included program brochures and descriptions, staff lists, job descriptions and statistics related to service delivery.

The purpose of the program descriptions is primarily to give an overview and highlight the major aspects of the program which influenced the student in the preparation of Increasing Access.

Each of the program descriptions has been organized according to the following outline:

A. Description

- History

- Scope
- Funding
- Administration and staffing
- Program activities

B. Applicability

- Multicultural components
- Barriers to services for immigrants and refugees
- Approaches to reduce barriers
- Relationship to model of culturally accessible services

1. Mount Carmel Clinic: Cross Cultural Counselling Unit

A. Description

History. The Cross Cultural Counselling Unit (CCCU) began as a program operated solely by volunteers in October, 1985. Originally the main goal was to provide emotional support to immigrants and refugees from Latin America. Services were initially provided at the Immigrant Access Service. Gradually immigrants and refugees from many other countries began to be seen, and in May, 1989, the program moved to the Mount Carmel Clinic. In February, 1991, the program was given funding to continue as a demonstration project for one year.

Scope. The unit provides community-based social and emotional support to those immigrants and refugees who are experiencing, or are at risk of developing, difficulties in their adaptation. Referrals are accepted from a wide variety of sources including settlement agencies, Employment and Immigration, health services, lawyers, schools,

professionals within the Mount Carmel Clinic, and individuals.

Funding. Until February, 1991, the work of the CCCU had been done on a voluntary basis, with "in kind" support and assistance provided by the Mount Carmel Clinic since May, 1989. One year of funding was obtained through the Newcomer Services Support Program beginning in February, 1991, and permitted the continuation, as well as some expansion and evaluation, of services. Funding is also currently provided by the Core Area Initiative (provides the majority of funding) and the Winnipeg Foundation.

Administration and staffing. The CCCU is a program of the Clinic and consists of a full-time Program Coordinator, a Volunteer Coordinator, eight part-time Cross Cultural Counsellors, and a full-time secretary. During the demonstration project, there is sufficient funding for three full-time paid positions, but several of the counsellors still provide services solely on a voluntary basis.

The Program Coordinator is responsible for the planning, coordination, and evaluation of the unit's procedures and program activities, and reports to the Executive Director of the Mount Carmel Clinic. The Cross Cultural Counsellors are from different ethnic groups and have experience and qualifications in the areas of psychiatry, psychology, and social work, and are from a range of ethnic backgrounds. Those counsellors whose professional qualifications are not recognized in Manitoba are required to identify themselves as lay counsellors. The counsellors are responsible for the delivery of counselling services and report to the Program Coordinator.

Program activities. All clients referred to the CCCU are

initially assessed through indepth client interview(s) involving thorough history-taking, clinical judgement of the counsellor, collection of collateral information, and case consultation. Outcomes of the assessment can be to initiate counselling (if the client's needs can be met and fall within the expertise of the counsellor), a referral to another counsellor in the CCCU or elsewhere within the Mount Carmel Clinic, or a referral to other services in the mental health system.

If counselling is initiated by the CCCU, a formal counselling plan is developed and a time-frame is established for the anticipated duration of the intervention. Treatment is generally brief (approximately five to six sessions) and counsellors use a variety of therapeutic approaches. Goals include educating clients about mental health and social services, and helping them to cope with psychosomatic complaints. There is a special focus on victims of torture, with an assumption made that all clients are victims of torture or have experienced some degree of oppression or trauma. Past experiences are stressed.

In addition to individual and family counselling, the CCCU also offers self-help support groups, cross cultural consultation to professionals, and educational presentations, as well as undertaking research activities.

B. Applicability

Multicultural components. CCCU is essentially a specialized unit that provides culturally sensitive services within a mainstream service. The staff have specialized training and experience in working with immigrants and refugees, and several of the counsellors are themselves

immigrants or refugees. An attempt is made to match the client's and counsellor's cultural background, and services are presently offered in more than ten languages. Translators would be used if necessary, although the need for translation has been very minimal.

Barriers to services for immigrants and refugees. The barriers which are considered by CCCU to be generally of greatest significance in providing services to immigrants and refugees are those that relate to language and culture. With respect to language, the prime barrier is the immigrant or refugee's inability to speak English or the language used by the service provider. Cultural barriers include the client's potential lack of understanding of the mental health and social service system, differences in cultural background between service provider and client as well as ignorance of immigrants' cultures, providers' lack of familiarity with culture shock and the adaptation process, and providers' lack of understanding of clients' symptoms. A practitioner's lack of understanding of an immigrant's or refugee's symptoms and experiences related to torture and oppression is also of concern as it leads to insensitivity in services.

Approaches to reduce barriers. The following approaches have been implemented by CCCU to reduce barriers identified either directly by the program or by others working in the area of immigrant and refugee mental health. This is not necessarily a complete list of all attempts made by CCCU to provide culturally sensitive services, but are those that were readily apparent in the brief study of the program. The type of barrier(s) being addressed is noted in parentheses at the end of each strategy.

- Provision of services is by staff who have an understanding of the client's cultural background and language. (Cultural, language, administrative)

- Services are provided by individuals who understand the difficulties of the adaptation process related to culture shock and previous experiences related to torture and oppression. (Cultural, acceptability, operational)

- Information about the program is provided through the ethnocultural communities, as well as through agencies and professionals working with immigrants and refugees. (Information/outreach)

- The program is easily accessible by public transportation. (Physical/geographic)

- The waiting time to obtain services is relatively short (approximately two weeks as of mid-1991). (Operational)

- There is no charge for the services provided by CCCU. (Financial)

- Referrals are made to other services to meet specialized needs and assistance is provided to clients by CCCU to follow up the referrals (e.g. clients may be escorted for initial appointments). (Physical/geographic, information/outreach)

- An emphasis is placed on educating other professionals about the effects of torture and oppression on adaptation, as well as developing their understanding of cultural variables on mental health. (Cultural, information/outreach)

Relationship to model of culturally accessible services. The review of the literature has indicated that three options are viable for

organizations to provide culturally accessible services: integrated or "multiculturalized" organizations, specialized units within an organization, and the bridging of mainstream organizations to ethnocultural and immigrant serving organizations. The CCCU provides a good example of the specialized unit option, and demonstrates particularly clearly how an organization can provide culturally accessible services to clients even from a range of ethnic backgrounds. The CCCU has been staffed so that the provider shares an understanding of the same language and culture, as well as having experienced migration and adaptation. As was suggested in the discussion of this option in theory, the specialized training and experience of the members of the unit has also enabled easy access to various ethnocultural communities which facilitates the sharing of information and outreach activities. In addition, emphasis has been placed on educating other professionals thus increasing cultural sensitivity throughout the organization and in other services.

2. Cross Cultural Mental Health Specialist

Manitoba Health: Winnipeg Region

A. Description

History. The development of the position of Cross Cultural Mental Health Specialist within the Winnipeg Region of Manitoba Health came about as a result of pressure to increase the accessibility of mental health services by immigrants and refugees. The position began to evolve in 1989, and was officially established in October, 1990. In order to establish the position, an existing mental health position in the region was redeveloped into this more specialized role.

Scope. The purpose of the position is to increase accessibility of mainstream mental health services for immigrants and refugees. The Cross Cultural Mental Health Specialist provides a specialized resource to departmental staff and to other agencies with respect to clients who have difficulty accessing services as a result of cultural and linguistic barriers. Referrals are received from intake staff, community mental health workers, other Regional program staff, and from external agencies. Services are provided to individuals over age 16 and their families directly by the specialist and/or by facilitating service from other staff.

Funding. No additional money was available for the creation of a new position which meant that an existing position had to be used to develop the Cross Cultural Mental Health Specialist. This approach fits with the philosophy that culturally accessible services can be provided within existing resources and therefore at a minimum cost to government.

Administration and staffing. There is presently only one Cross Cultural Mental Health Specialist within the department. Administration and supervision are provided by a Mental Health Supervisor in the Winnipeg Region office.

Program activities. Duties of the position include consultation, and liaison with departmental staff and external agencies, as well as assessment, treatment, and crisis intervention directly with clients. The majority of the specialist's services are indirect (consultation or liaison). Services are provided in the office, home, hospital, or at other agencies.

Attempts are made to ensure that the Cross Cultural Mental Health

Specialist is not flooded by too many direct service demands. The Mental Health Specialist carries a small caseload, (at the beginning of 1991, 28 cases) primarily undertaking assessments and identifying other resources to be used in intervention. In these cases, the specialist is responsible for documentation of the activities undertaken. Direct contact also occurs with clients of community mental health workers and interviews are generally conducted jointly with the community mental health workers. The community mental health workers are responsible for recording activities related to jointly shared cases.

B. Applicability

Multicultural components. The position of Cross Cultural Mental Health Specialist was developed with a view to supporting mainstream organizations in their development of more culturally accessible services. The multicultural components of this program therefore relate to liaison with and education of mainstream organizations in order to facilitate their becoming "multiculturalized".

Efforts are directed at increasing cultural sensitivity of staff, bridging any language gaps between service provider and client, and emphasizing trust and patience in client relationships. Case consultation and educational presentations are provided by the specialist aimed at increasing cultural sensitivity. Interpretation services are obtained as needed from Immigrant Access Service counsellors (used frequently) and the Language Bank at the International Centre. Members of the immediate family and close friends have also been used. However, there is a recognition that it is important to use interpreters who have some knowledge of mental health.

Barriers to services for immigrants and refugees. Interview data suggest that prime barriers of concern to the Winnipeg Region staff relate to culture and language. Language barriers include the client's inability to speak English or the language used by the provider, as well as specific difficulties in conveying feelings when the knowledge of a language is limited. Lack of sensitivity to other people's culture and negative attitudes of the public towards immigrants and refugees were seen as being key cultural barriers. Cultural and language barriers are seen as more relevant in determining accessibility of services than the length of time the client has spent in Canada (eg. one cannot assume that an individual who immigrated 50 years ago will not have any difficulty accessing services).

Approaches to reduce barriers. The following approaches have been implemented by the Winnipeg Region to reduce barriers perceived to be affecting immigrants' and refugees' accessibility of services. As with the Mount Carmel Clinic CCCU, this is not necessarily a complete list of all of the program's attempts to increase cultural accessibility of mental health services. The type of barrier(s) addressed are again noted at the end of each strategy.

- Development of a specialist position aimed at increasing sensitivity of all mental health service providers. (Cultural, administrative)
- The qualifications needed for the position include demonstrated ability to work with a culturally diverse group and thorough knowledge of cross cultural issues in mental health. (Administrative)
- The provision of educational programs such as workshops,

inservice training, and informal information-sharing have been undertaken internally and with external agencies. (Administrative, information/outreach)

- Intervention and consultation are provided as necessary for clients that cannot access mainstream services due to cultural and/or language barriers. (Cultural, language)
- The need for interpreters to have some basic training in mental health is stressed. (Language, cultural)
- Services are offered in various locations including a client's home and thus barriers relating to transportation and potential deterring physical characteristics of an office are reduced. (Physical/geographic)
- Telephone reception services are provided 24 hours a day. (Operational)
- New referrals to the specialist are responded to within a few days. (Operational)
- There is no charge for the services provided. (Financial)
- Ongoing liaison with ethnocultural communities is emphasized. (Cultural, informational/outreach)

Relationship to model of culturally accessible services. The Cross Cultural Mental Health Specialist demonstrates well the option of a "multiculturalized" mainstream organization in providing culturally accessible services. (As noted previously, the literature review has suggested that an integrated or "multiculturalized" organization is one of three viable options.) Through this position, a mainstream agency has been able to provide culturally sensitive services throughout the

organization, thus avoiding the potential pitfall of isolation in service delivery. The importance of sensitizing all service providers is substantiated by this program.

Conclusion

As is apparent from the program descriptions, each of the programs has adopted a different approach for providing culturally accessible services. Each of the approaches in fact validates an option which appears to be viable in theory: multiculturalized mainstream organizations (Winnipeg Region, Manitoba Health) and specialized units within a mainstream organization (CCCU).

In each case, specific approaches undertaken by the program to provide culturally accessible service have addressed barriers from all eight of the major categories of barriers found in the literature review. Many of the approaches utilized have been directed at similar barriers within each of the categories. Both programs have identified barriers in the cultural and language categories as being of primary concern in providing services to immigrants and refugees.

The difference in overall approaches to providing culturally accessible services in the two programs has, however, led to the use of different methods for reducing barriers. With respect to language barriers, for example, the Winnipeg Region draws upon interpreters and emphasizes that they be trained in mental health at least to some extent. In contrast, the CCCU has staffed its program in such a way that a client and a provider can share a common language.

Although the overall approaches in the two programs are different, as are many of the specific strategies for the reduction of barriers,

each of the programs validates an option that was thought to be viable in theory. The studies of these programs also lend support to previous researchers' claims that none of the three options is superior overall, and depends on the situation and organization. However, the choice of an option may facilitate the reduction of some barriers with little effort, while still requiring that others be consciously addressed. For example, an organization that opts to establish a specialized unit with multilingual staff may have greatly reduced some language barriers, but still need to ensure that staff be aware of interpreters' services for clients who need to obtain other services. It is also clear that implementing any of the options requires political will and a genuine commitment to making services culturally accessible, and these case studies provide real-life examples of programs that have reduced barriers for immigrants and refugees.

APPENDIX D

"Increasing Access" Draft: Respondent Statistics

Total invited to comment: 65
who came to focus groups: 26
who responded in writing: 4
Total number of responses: 30

Respondents by Category

Exemplary Program Representatives: 6 individuals were invited
5 came to focus groups

Canadian Mental Health Association: 2 were invited
1 came to a focus group

Mainstream Agency Service Providers: 14 were invited
5 came to focus groups; 1 responded in writing
(6 could not come due to vacation)
* Total number of service provider responses: 12 (55%)

Immigrant Serving Agency Representatives: 12 were invited
4 came to focus groups; 1 responded in writing
* Total number of immigrant serving agency responses: 5 (42%)

Other Organization Representatives: 9 were invited
4 came to focus groups
* Total number of other organization responses: 4 (45%)

Physicians: 4 were invited
1 came to a focus group
* Total number of physician responses: 1 (25%)

Ethnocultural groups: 8 were invited
3 came to focus groups; 1 responded in writing
* Total number of ethnocultural group responses: 4 (50%)

Other individuals: 1 psychiatric nurse came to a focus group
2 academics came to focus groups
1 registered nurse responded in writing
* Total number of other individual responses: 4

Note: At least 12 (40%) of the respondents are themselves immigrants or refugees.

APPENDIX E

Report on Key Informant Sessions

"INCREASING ACCESS" DRAFT:
SUMMARY OF COMMENTS
FROM MEETINGS OF AUG. 19, 20, & 21, 1991

GENERAL COMMENTS ON BARRIERS AND REMEDIES

Several participants indicated that the barriers and remedies were thoroughly covered, clearly presented, and that the systematic layout was helpful in understanding the material. A comment made about the style indicated that the barriers and remedies may be too "neatly packaged" to reflect the complexity of the issues involved.

No concerns were raised with respect to the categorization per se, but the source of the categories needs clarification. For some participants the barriers seemed to flow from the fourth "linkage" option discussed in the review of the literature, although this was not the intent. Barriers identified are consistent with those identified in other service areas (e.g. education of youth).

Comments were made regarding the order in which the barriers are presented. A suggestion was made that they be organized in order of priority (e.g. language first, cultural second, etc.). The present order tends to reflect the process that clients experience.

The concept of accommodation needs elaboration in the review of the literature (pages 11 and 12), particularly since it influences 5 out of 8 barrier categories.

Consideration should be given to moving the references for each barrier section to the end of each section. A suggestion was made that listing references for each remedy would be helpful.

Generally lacking in the remedies were references to the use of group approaches which are helpful in increasing service efficiency and work well in strategies for prevention.

Some of the remedies are quite general and it would be helpful if they were specified in measurable terms and made easier to operationalize and evaluate. Generally, repetition of remedies where appropriate would be of assistance.

INDIVIDUAL BARRIER SECTIONS

1. INFORMATION

An addition should be made to this section to reflect the fact that not all service providers are aware enough of the prevalence and impact of traumatic events that are experienced by some of their clients prior to immigration.

The section on the use of networks (remedy for Barrier 1.4) should be expanded as it is not clear enough.

Consider appending a list of resources at the federal and provincial levels that could be used as contacts by the reader. Try to avoid resources which will become out of date quickly.

The Barrier 1.3 "Immigrants and refugees may not understand mental health service systems" needs to be rephrased to indicate that some (as opposed to all) immigrants and refugees may not understand the service systems. With respect to remedies for this barrier, a mental health service should also attempt to present itself as more acceptable to immigrants and refugees by modifying the way it portrays itself and disseminates information.

2. ACCEPTABILITY

There was agreement that lack of acceptability of mental health services is an issue with the population at large, not just for immigrants and refugees. In the general statement, the sentence "For many immigrants and refugees, stigma is attached to mental illness because it is often associated with immoral thoughts or behaviours and may be viewed as familial in nature." raised some concerns. The use of "immoral thoughts" was unclear for many participants, and the sentence is poorly structured. An addition should be made to the general statement regarding the lack of trust in authority figures, especially for victims of torture.

With respect to Barrier 2.1 "The stigma attached to receiving mental health services is felt acutely by immigrants and refugees", the group approach should be noted, particularly self-help groups, in order to address needs other than mental health. Close contact with immigrant and refugee communities is needed to ensure adequate understanding of mental health. The remedy of "taking steps against racism" should be strengthened if possible, especially with respect to affirmative action.

3. CULTURAL

Some concern was expressed that the general statement is too narrow given the barriers that are addressed. A question was raised as to why only religious beliefs were identified in the statement.

With respect to Barrier 3.1 which addresses cultural conceptions of mental health and mental illness, the remedy of educating immigrants and refugees drew several comments: the focus on a formal process may not be suitable for all; Western conceptions should be replaced by North American conceptions; the remedy should be qualified to indicate that only some immigrants and refugees need or want increased awareness. Also with respect to 3.1, it is not always feasible to use religious leaders as a remedy. Regarding the remedy of educating service providers, it would be helpful to distinguish between inservice and preservice training. Both types of training are needed. Agencies could lobby regarding preservice training, and additionally set up criteria for entering field placements such as prerequisites of training in cross-cultural issues.

A question was raised as to whether Barrier 3.2 "Potential immigrant and refugee clients may have difficulty travelling, or do not want to travel, to services alone" belongs in the Cultural category, or whether it should be in the Physical/Geographic section. The potential remedy of encouraging involvement of family members was felt to not always be appropriate (e.g. when children are used as translators by the family).

Under Barrier 3.4 "Cultural traits in many areas affect the way services must be delivered to be culturally sensitive", the term traits was felt to have a different connotation than is acceptable with respect to culture (e.g. as inappropriate as "gender traits"). Also with respect to 3.4, brief therapy should not be the only approach advocated with immigrants and refugees.

4. LANGUAGE

In the general statement, national statistics may need to be introduced rather than those that are related only to Manitoba, if the document is to be used across Canada. A clear definition of "not having English language ability" is needed.

With respect to the use of interpreters, it was suggested that some research has indicated that when a client has any English ability, it is better to go without an interpreter. (Recent research from Denmark regarding interpreters could be consulted.) Another obstacle to the use of interpreters is that sometimes the service provider rejects the interpreter. Several participants stressed that interpreters must be highly trained and should not be volunteers when used in a professional capacity. In addition, it was noted that clients need to understand that interpreters are acting in a specialized role and are bound by confidentiality. The difference between translation and interpretation needs to be emphasized.

With regard to the employment of bilingual staff, a suggestion was made that professionals who have a second language other than English or French should also be recognized as having a language asset.

5. PHYSICAL/GEOGRAPHIC

Access to English rather than French services is generally assumed to be required, but it is important to remember that some non-English speaking immigrants and refugees already have attained fluency in French as a second language.

With respect to Barrier 5.1 "Clients are unable to obtain transportation to reach service settings", the remedy of offering home visits to clients was of concern to some participants. Allowing the service provider more flexibility to use or dismiss home visits may be more appropriate. In addition, it was not clear that the volunteer program mentioned as a remedy referred to a volunteer transportation program.

Regarding the remedy of posting symbols and other pictorial signs, resources for agencies interested in producing signs and symbols would be helpful.

6. OPERATIONAL

The general statement and barriers were felt to be from the client's, as opposed to the provider's, point of view. Some attention should also be given to the provider who is overwhelmed by large caseloads; the use of group approaches might be incorporated here. A question was raised as to how the last sentence of the general statement is related to culture (e.g. a lot of clients may not be able to take time off work).

Repetition of the remedies provided in 6.1 (related to telephone reception) was suggested for 6.2 (waiting for appointments).

The need for agencies to be able to respond on a 24 hour basis was raised. Agencies may have organizational options to in fact provide more coverage rather than utilizing other agencies.

With respect to translation of forms, a comment was made that translations must be relevant to the culture. (e.g. "Do you feel blue?" may lose meaning in translation.) In addition, arrangements must be made to translate information provided by a client on a form in another language into English or French.

The last barrier in this section relates to delivery of service. Some participants indicated discomfort with remedies which are essentially approaches to therapy falling under the Operational category as there seems to be a change in focus from earlier barriers in this section. A new category may be in order, or perhaps a name change from Operational to one such as Service Provision, Service Delivery, or Programming.

It was also suggested that the extra time it takes to provide

service when the provider and client do not speak the same language, and the extra costs involved, be noted in the document.

7. ADMINISTRATION

Several comments were made regarding Barrier 7.1 which indicates that services lack multicultural staff. One participant indicated that the barrier is too narrowly defined, that the remedies suggested are broad and sweeping, and the barrier should be broadened. Another individual disagreed with the barrier completely, saying that hiring multicultural staff may worsen a situation if ethnic staff are "dumped on" and not all staff are made responsible to see a wide range of client groups. It was also suggested that 7.1 be the second barrier presented in this category, as 7.2's remedies (pertaining to culturally sensitive service providers) may be easier to undertake immediately.

The issue of difficulty obtaining credentials was viewed as very important and needing to be underscored in the document. The number of immigrants and refugees involved may be quite small. The inability of professionals to meet requirements should be reworded to place the onus on the system, not the immigrant. Additional remedies were offered: orientation of professionals prior to immigration, service providers can hire uncredentialled professionals in some capacities.

Under Barrier 7.5 (service providers lack information), it was suggested that use should be made of existing data such as information from immigration and settlement services, the Winnipeg area survey, the Census, and other Statistics Canada surveys.

8. FINANCIAL

Although not specific to immigrants and refugees, it was noted that the fact that funding does not follow the client leads to difficulty in accessing services.

QUICK CHECKLIST

The position of the Quick Checklist in the document was described as potentially too far back. The checklist also tends to place emphasis on barriers rather than remedies. An extended Table of Contents which includes the remedies was suggested as an option.

In addition, the title indicates the barriers are faced by immigrants and refugees when in fact they are "across the board". An improved title suggested was Quick Checklist of Barriers to Mental Health Care.

GENERAL COMMENTS ABOUT THE DOCUMENT

Many positive comments were made about the document throughout

including: well-written, clear, pulls together a lot of information and serves as a framework, and well-referenced.

Some discussion occurred about the order of material in the document with concerns voiced that Part I (the literature review) takes time to go through, and may discourage readers who may make more use of Part II. Suggestions made included switching Parts I and II, placing Part I in an appendix, or physically separating the two parts and giving smaller circulation to Part I. The Quick Checklist may be more useful prior to Part II. Little negative feedback was obtained about the location of the Glossary.

Two additional sections mentioned were a revised User's Guide which would reflect the new organization of the document and a conclusion which would discuss any future directions of the project. The future directions might be described in the covering letter sent when distributing the document. The "After the Door is Opened" report would make a good companion document in distribution.

The document's audience was not clear to all participants and needs to be specified at the beginning. Some found the style too academic in nature, particularly in Part I.

Other general comments made:

- The fact that the manifestations of mental health problems of immigrants and refugees are the same as the rest of the population should be stressed (perhaps as a part of the introduction to Part II).

- Pictures and other illustrations will may be distracting if added to the report, and the intended readership is used to receiving information from words alone.

- Immigrants and refugees have been grouped together as one as though they have the same problems, yet this is not the case. Also, not all immigrants or refugees have the same problems (treated with a more monolithic approach than should be).

- The document does not specify the length of settlement addressed, which has an impact on the barriers which are faced.

- Issues related to gender and age were not addressed.

- This document does not address the need for a more holistic approach in services generally.

APPENDIX F

Summary of Written Comments on the Draft Document

A total of 4 individuals responded in writing. With respect to the specific comments made regarding barriers and remedies, there was little overlap between the written comments and those made at the focus groups.

General comments about the document

Comments indicated that the document is well-researched, easily read, and clear.

Two individuals made mention that they would like more focus on the "how to" of the remedies.

One individual stressed the costs involved throughout in implementation of the remedies.

General comments about the barriers

- reasonable and practical
- introduction to the barriers section should indicate that the intensity of barriers will be greater for immigrants and refugees who have cultural backgrounds that differ widely from Canadian culture

Information barriers

1.1
- some solutions may be too costly
- methods should be discussed with communities to ensure effectiveness

1.2
- translation costs may be prohibitive

1.3
- regarding orientation programs for immigrants and refugees, are there sufficient resources to conduct classes, who will pay, and how do you attract

Acceptability barriers

2.1
- stigma is a major societal problem
- to reduce stigma, increase immigrants and refugees' awareness that a) mental health problems are common in this

society and b) even in the client's culture, his or her case is not unique

Cultural

3.2 - What if the family does not want to be involved in escort programs?
- Add in: Make assessment in client's home, if possible
3.5 - Concerns that religious leaders are not available in some ethnocultural communities. Qualify last 3 remedies with "if possible".

Language

4.1 - Some ethnocultural communities do not have bilingual professionals - qualify statement with "if possible".

Physical/geographic

5.1 - Transportation remains a problem in the urban area. It is still sometimes a long distance, even to community based services.
5.2 - Existing resources may work.
- In some cultures, schools are not appropriate for mental health services as they are too public for the clients to feel comfortable.

Operational

6.1 - Do all clients have phones? Feel comfortable using them?
6.2 - Screening before seeing a psychiatrist may not be appropriate for immigrants and refugees.
6.3 - Scheduling of "off hour" appointments is important, for all clients.
6.5 - Research is needed to obtain data regarding the most appropriate and effective service modalities

Administrative

7.5 - Who will pay for the remedies

Omissions to the document

- The rural perspective: There are some clients in rural areas and there are extremely limited resources.
(This viewpoint was shared by a focus group participant who indicated that very few immigrants and refugees settle in rural areas).

Other

- The number of ethnic groups in Manitoba is large, with small numbers in each group, which makes it difficult to make therapeutic processes culturally sensitive for each group.
- Cultural patterns and issues within each group are sufficiently diverse to make culturally sensitive therapy difficult to deliver by non-indigenous therapists.

APPENDIX G

INCREASING ACCESS

DEVELOPING CULTURALLY ACCESSIBLE MENTAL HEALTH AND SOCIAL SERVICES FOR IMMIGRANTS AND REFUGEES

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INCREASING ACCESS:

DEVELOPING CULTURALLY ACCESSIBLE

MENTAL HEALTH SERVICES

FOR IMMIGRANTS AND REFUGEES

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In addition, many individuals representing a wide range of services were extremely helpful in providing information and suggestions for revision, and although they are not individually named, the author is indebted to them for their valuable contributions.

Finally, Ms. Tracie Thompson and other CMHA staff must be thanked for their willing assistance in completing typing and many other tasks throughout the duration of this project. The assistance of Ms. Claudette Cormier of the Child And Family Services Research Group is also very much appreciated.

HOW TO USE THIS DOCUMENT

This document is intended for mental health and social services planners, managers, and evaluators who are interested in the accessibility of services by immigrants and refugees. The aim is to provide a thorough identification of the barriers faced by immigrants and refugees in accessing mental health services and practical suggestions for reducing the barriers. The implementation of these suggestions will increase accessibility not only for immigrants and refugees, but will likely have positive spin-off effects for many other individuals.

If you would like to obtain a brief overview of the entire document, read the INTRODUCTION immediately following the TABLE OF CONTENTS. Refer to the GLOSSARY for definitions of the major terms used throughout the document.

The document is essentially divided into two major parts. The first part, BARRIERS AND REMEDIES, discusses barriers to mental health services and ways of increasing accessibility. For a brief summary of all the barriers which are addressed in the document, refer to the QUICK CHECKLIST OF 30 BARRIERS which is at the beginning of PART 1 immediately following the Overview.

The second part of the document, A REVIEW OF THE LITERATURE, reviews the current literature related to immigrants, refugees, and mental health, and provides the reader with the background to the barriers and remedies.

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INTRODUCTION

The purpose of this document is to identify the barriers experienced by immigrants and refugees who seek mental health care, to develop indices of culturally and linguistically accessible mental health services, and to catalyze efforts to increase the accessibility of mental health and social services. The document is intended for use by mental health and social services planners, managers, and evaluators, but it is hoped that it will also be useful for those involved with a range of services which should be available to immigrants and refugees.

Following a brief glossary of terms, the first major part of the document provides the reader with a discussion of the potential barriers which may be faced by immigrants and refugees along with specific recommendations to lower them. At the beginning of the first part is a checklist which is intended to be used by planners, managers, and evaluators as a quick guide for assessing their own organizations' barriers and accessibility. It is meant to assist in both planning new programs, and evaluating and improving existing ones. The second part of the document provides the reader with an overview of the policies, demographic data, and research related to accessibility of mental health and various counselling services by immigrants and refugees.

The review of the research which was conducted at the beginning of the project to serve as a base for the document was comprehensive within certain parameters. Emphasis was placed on reviewing work completed in the last decade and the review was confined largely to literature produced in Canada and the United States. The intent of the project was to address accessibility of mental health and social services by immigrants and refugees, and thus care for Aboriginal groups, transient migrants, temporary workers, and foreign students was excluded.

Although immigrants and refugees are generally mentioned together in this document, it is important to recognize that the two groups have experiences and problems which differ, and that not all immigrants nor all refugees have the same experiences and problems. On the other hand, it also must be noted that the manifestations of mental health problems of immigrants and refugees are the same as those of the rest of the population, and that many of the difficulties related to accessibility of mental health and social services are faced by the population at large.

In addition to reviewing both published and unpublished works in the area from across Canada and the United States, two local programs that are reputed to be exemplary in their service provision to immigrants and refugees were studied. Information was gathered about the programs to assess the extent to which the hypotheses based upon theoretical and/or studies conducted in geographically distant locales were applicable in "real life" situations at the local level. Although descriptions of the programs are not presented in this document, the content, particularly with respect to the recommendations, is partially

based upon data obtained from these programs.

The draft document was also reviewed by a number of service planners, managers, and evaluators, as well as individuals representing various ethnocultural groups (See Appendix A for a list of names). Comments were received in focus group sessions and in written submissions, and were utilized in the finalization of this document.

It is clear to those involved with immigrants and refugees that there are no easy answers to the many complex barriers and accessibility issues related to mental health care. However, the thorough identification of all the barriers and some of the possible solutions will serve as a step toward creating more effective utilization of mental health and social services among immigrants and refugees as well as the population at large.

GLOSSARY

This glossary is intended to provide working definitions for several of the frequently used terms in this document that have various meanings both in ordinary use and in the mental health/social service field. The terms are listed in alphabetical order, with a definition and brief discussion of any issues relating to the term which are relevant for this document.

Accessibility - refers to the ease of entry to or use of a service.

The definitions provided by Funk and Wagnalls (1982) include "the state or quality of being approachable" or "attainable; obtainable". Writers in the mental health field have also discussed the concept in terms of the ease of getting to services (Stefl and Prosperi, 1985). The term has also been used more broadly to include other attributes such as affordability, acceptability, and accommodation. Although there has been some lack of consistency in its definition, accessibility has most frequently referred to ease of entry to and to use of the service, and to something beyond the mere existence or availability of a service. It is in this sense that the term is used in this document.

Availability - refers to the existence of a service.

A service can be available, but not accessible. This would imply, for example, that a service which is not equally easy for all individuals to use exists in the community.

Barrier - something that hinders or restricts.

Barriers refer to obstacles which impede progress but are not necessarily impassable. These impediments may be physical (e.g. stairs outside a building may obstruct the entrance for an individual in a wheelchair) or circumstantial.

With respect to the health, social services, and mental health fields, barriers have come to be defined in terms of multiple attributes, and the common ones relate to availability, accessibility, acceptability, and affordability (Stefl & Prosperi, 1985).

Immigrant - an individual who comes to a country of which he/she is not a native in order to establish permanent residence.

Canada's Immigration Act (1976) identifies three basic classes of immigrants:

> Family class - Canadian citizens or permanent residents of Canada who are over 18 years of age may sponsor relatives from abroad including, but not limited to, spouses, fiancé(e)s, unmarried children, parents, and grandparents. Specific criteria for sponsorship are outlined in Section 6 of the Act.
>
> Convention refugees - based upon the definition set forth in the United Nations Convention and Protocol Relating to the Status of Refugees. See **Refugee.**
>
> Independent immigrants - assisted relatives other than members of the family class, retirees, entrepreneurs, investors, self-employed persons and others applying on their own initiative. Specific selection criteria are used in the assessment of individuals applying for immigration in this class.

In this report it is recognized that "immigrant" may in fact refer to all three classes of immigrants, including Convention refugees. The phrase "immigrants and refugees" therefore may technically have some overlap but since "immigrant" in ordinary use does not always include refugees, the entire phrase is used in this report when all classes are to be included.

It should be noted that while non-refugee immigrants and refugees have many commonalities, they also differ in ways that have important implications for mental health and social services (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988a). For example, an individual who has chosen to immigrate may have very different needs and family supports than one who has been forced to flee his/her home country and possibly experienced torture and/or life in a refugee camp.

Mainstream - refers to the general population, rather than emphasizing membership in a specific ethnocultural group.

The intent in this report is to define mainstream organizations as those who offer services to the general population as opposed to being geared primarily to serving one or more specific ethnocultural groups.

Mental health and social services - institutional and community-based programs that provide counselling and related services for individuals who have psychological and/or social problems.

These programs will include inpatient, outpatient, emergency, and/or transitional services, which typically draw upon one or more professional disciplines including psychiatry, social work, psychology, and psychiatric nursing (Barker, 1987; Health and Welfare Canada, 1988).

Refugee - any individual who can be selected from abroad on humanitarian grounds in one of the three categories: Convention refugees, members of a designated class, or refugees admitted under special humanitarian measures.

The class of Convention refugees is based upon the definition in the United Nations Convention and Protocol Relating to the Status of Refugees:

> "any person, who, by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion, (a) is outside the country of his nationality and is unable or, by reason of such fear, is unwilling to avail himself of the protection of that country, or, (b) not having a country of nationality, is outside the country of his former habitual residence and is unable or, by reason of such fear, is unwilling to return to that country."

Members of a designated class are individuals who are in need of resettlement but who do not meet the definition of Convention refugee. Designated classes are Indochinese (from Cambodia, Laos, and Vietnam) and political prisoners and oppressed persons (Chile, El Salvador, and Guatemala).

Special humanitarian measures can be used to admit individuals who do not meet other eligibility requirements. These include people who have close relatives in Canada whose countries are encountering emergency situations such as war or natural disaster. Primary beneficiaries are citizens of Lebanon, Sri Lanka, Iran, Guatemala, and El Salvador. (Employment and Immigration Canada, 1989a, 1990).

Social services - see Mental health and social services

PART I: BARRIERS AND REMEDIES

Overview

In general, when discussing accessibility of services, attention frequently turns to the types and extent of barriers involved. Identification of barriers is required to facilitate identification of the potential remedies, or ways of reducing the barriers.

When all the research to date is compiled, it becomes apparent that studies have identified many barriers to mental health services for immigrants and refugees. Although there are several ways to group barriers, the categorization outlined in Table 1 is used in this document. The categorization is based upon the research in the area, and input of a number of service providers and other individuals expert in the area of services to immigrants and refugees. The dimensions of access that relate to each category are noted in parentheses. A full discussion of these dimensions is provided in Part II: A Review of the Literature.

TABLE 1

Categorization of Barriers

Barrier Category	Dimensions of Access
1. Information/Outreach	(*accessibility, accommodation*)
2. Acceptability	(*acceptability*)
3. Cultural	(*accommodation*)
4. Language	(*acceptability, accommodation*)
5. Physical/Geographical	(*accessibility*)
6. Operational	(*accommodation, acceptability*)
7. Administrative	(*accommodation, acceptability*)
8. Financial	(*affordability*)

Within each category, specific barriers that have been identified in the literature are listed. For each barrier, potential remedies or recommendations for reducing the barrier are provided. References are provided to the published material utilized, although each listing also takes into account other information gathered in the preparation of this document.

As is discussed fully in the review of the literature, there are several policy and organizational options for providing services to immigrants and refugees. Each of three options ("multiculturalized" organizations, specialized units, linkages) appears to be viable with no demonstrated superiority of any one option. No one service approach is barrier-free. The option chosen by an organization simply means that

some barriers will need more attention than others and may need to be addressed by different methods.

It should be noted that many of the barriers are faced not only by immigrants and refugees, but also by the general population. However, the intensity of these barriers is greater for immigrants and refugees, particularly for those whose cultural backgrounds differ widely from Canadian culture. By implementing changes which reduce the barriers, accessibility to mental health and social services will not only increase for immigrants and refugees, but for all individuals in our society.

QUICK CHECKLIST OF 30 BARRIERS
to Mental Health Care

For suggestions on how to deal with each of these barriers, see the similarly numbered barriers and potential remedies in Part I.

1. Information

1.1 Immigrants and refugees lack information about the availability of specific services.

1.2 Information about services is in English only.

1.3 Immigrants/refugees lack information about services.

1.4 Agencies lack information about services available to immigrants/refugees.

1.5 The general public lacks information about services to immigrants/refugees.

2. Acceptability

2.1 Immigrants and refugees perceive stigma attached to mental health services.

2.2 Immigrants and refugees feel shame and fear what relatives may think when seeking mental health services.

3. Cultural

3.1 Cultural conceptions of mental health and mental illness influence help-seeking patterns.

3.2 Clients and providers have dissimilar expectations about communication.

3.3 Services are not culturally sensitive.

3.4 Providers are unfamiliar with various religious beliefs.

4. Language

4.1 Some clients lack ability to speak English or French.

4.2 Lack of ability to speak English or French affects a range of services.

5. Physical/Geographic

5.1 Clients are unable to obtain transportation to services.

5.2 Clients may have difficulty travelling, or do not want to travel, to services alone.

5.3 Too much time is involved in travel.

5.4 The large size of institutions may be overwhelming and confusing.

5.5 The physical environment may not fit with culturally sensitive intervention.

6. Operational

6.1 Limited telephone reception (restricted hours/answering machines) is often the case.

6.2 Too much waiting is involved in getting to appointments.

6.3 Clients cannot always attend during business hours.

6.4 Forms used by clients are lengthy, confusing, in English.

6.5 Methods of service delivery are not appropriate for immigrants/refugees.

7. Administrative

7.1 Services lack culturally sensitive staff.

7.2 Services lack multicultural staff.

7.3 There is lack of sensitivity towards immigrants/refugees in planning and evaluation.

7.4 Services required by immigrants and refugees are fragmented.

7.5 Services lack information about immigrants/refugees needed to administer.

8. Financial

8.1 Immigrants and refugees may be unable to pay for services.

8.2 Immigrants and refugees may be unable to bear the indirect costs associated with obtaining services.

1. INFORMATION/OUTREACH

General Statement

Barriers related to information result from both lack of information and misinformation. Information barriers refer to difficulties in the flow of information from service providers to clients, among service providers (including both formal and informal supports), and from clients to service providers. Some lack of information, particularly to clients, is attributable to shortcomings in the outreach efforts of service providers.

Lack of information and misinformation generally fall into five major areas: immigrants and refugees do not know about the availability of services, information is available only in English, potential clients are not familiar with the service system in general, service providers lack information (e.g. about services, needs, impact of torture), and lack of public awareness.

1.1 Barrier

Immigrants and refugees do not always know that services are available or where they are located.

Potential Remedies

- Services should be publicized using methods that are likely to reach immigrants and refugees:
  - Utilize daily, local community, and ethnic newspapers.
  - Obtain television and radio coverage (talk shows, advertising).
  - Distribute brochures to other services used by immigrants and refugees (e.g. immigrant serving agencies, doctors' offices and walk-in clinics, employment services).
  - Post brochures and utilize displays in locations such as YM/YWCAs, schools, libraries, religious institutions, community colleges, universities.
  - Arrange for speaking engagements to ethnocultural groups and English as a Second Language (ESL) classes.
- Addresses, phone numbers, and contact people must be clearly presented regardless of the mode of publicity.
- Note that some methods of communicating information may be more effective with particular groups of immigrants and refugees, and service providers may need to consult with ethnocultural groups or other knowledgeable individuals to determine the most effective methods.

1.2 Barrier

Information about services is in English only.

Potential Remedies

- Printed and other public relations materials (e.g. videotapes, television advertising) must be available in translations.
- Printed materials should make considerable use of illustrations, maps, etc.
- Translations of printed materials will be more effective with some immigrants and refugees than others (e.g. depends on degree of literacy, habit of reading to obtain information).
- Translations must take into account the literacy level of ethnocultural group members in their own languages.

1.3 Barrier

Some immigrants and refugees may not understand mental health service systems. There may be confusion about the nature of the mental health services in general, the role of the individual practitioner, and fears about immigration status or deportation as a result of having mental health problems.

Potential Remedies

- Orientation programs are needed for immigrants and refugees that provide basic information about the human services system. Mental health and social service providers should collaborate with immigrant serving agencies and ethnocultural groups to undertake orientation activities.
- Lectures or workshops conducted in settings such as hospitals, community centers, public libraries, and ESL classes should be considered.
- Mental health and social services should attempt to present themselves as more acceptable to immigrants and refugees by modifying the way they portray themselves and disseminate information.

1.4 Barrier

Individual agencies may lack information about other services that are available to immigrants/refugees and about the needs of immigrants and refugees. Not all service providers are aware enough of the prevalence and impact of traumatic events that are experienced by some of their clients prior to immigration.

Potential Remedies

- Agency brochures and information about services need to be distributed regularly to other service providers.
- Incoming information about other services needs to be distributed or circulated to administrative and direct service staff.
- Inter-organizational networks need to be developed where they do not exist and maintained to exchange information about immigrant and refugee needs and services. The use of existing local interagency groups and planning bodies should also be considered as a vehicle for exchanging information.
- Develop an awareness of the cultural and language characteristics of potential clients.

1.5 Barrier

The general public is not aware of available services for immigrants and refugees. This limits the amount of "word of mouth" information that could flow from friends, neighbours, etc. to immigrants and refugees.

Potential Remedies

- Publicize available services (noting relevant language capabilities and culturally sensitive practices) to the community at large using methods including:
  - Daily and local community newspapers.
  - Radio and television coverage.
  - Speaking engagements at schools, businesses, universities.
  - Posting of brochures and/or development of displays for stores, shopping malls, medical services, religious institutions, community centers, libraries, community colleges, universities.

References

The research used to identify relevant the information/outreach barriers and remedies includes: Brodsky (1988), Canadian Task Force (1988a), Doyle (1989), Doyle and Visano (1987b), Flaskerud (1986), Hoang and Erickson (1985), and Zane et al. (1982).

2. ACCEPTABILITY

General Statement

Lack of acceptability of mental health services is a primary factor inhibiting service utilization for the population at large, as well as specifically for immigrants and refugees. Primary issues relate to the stigma attached to having mental health problems and to receiving services, and, especially for some immigrants and refugees, feelings of fear and shame. In addition, there is frequently a lack of trust in authority figures (including service providers), especially for victims of torture.

The stigma attached to receiving mental health services has generally been difficult to change. In some situations, it has been possible to reduce the stigma by defining the client's problems in terms that are more acceptable to the potential client group than "mental health problems". In many cultures, however, the prevalent attitude is that personal or family problems are not to be discussed outside of the family.

2.1 Barrier

The stigma attached to receiving mental health services is felt acutely by immigrants and refugees.

Potential Remedies

- Efforts generally made to reduce stigma should be given at least as much emphasis in serving immigrants and refugees as with the general population. For example:
  - Increase immigrant/refugee knowledge of the Canadian conception of mental health and the nature of mental health services.
  - Increase the awareness of immigrants and refugees that mental health problems are common in Canadian society, and that even with respect to their own culture, each case is not unique.
  - Take active steps against discrimination and prejudice such as developing race relations and affirmative action policies, and opportunities for education.
  - Avoid the use of unnecessary "labelling" of clients.
  - Be cautious to avoid stigmatizing names of services.
  - Consider the incorporation of mental health services with other more generally accepted services.
  - Ensure privacy for clients when they receive services.
  - Group approaches, particularly self-help groups, should be considered.

2.2 Barrier

Although also present in the population at large, feelings of shame and fear of what relatives might think may be particularly intense for some immigrants and refugees.

Potential Remedies

- Incorporate family members, including extended kin network, in mental health interventions. Attend to cultural expectations regarding the nature of appropriate involvement.
- Assess the degree to which the individual client's social network beyond family and his/her ethnocultural community may impact on intervention.
- Provide information to ethnocultural communities about available mental health and social services (see Information/Outreach) and obtain consultation about the ways in which services could be defined in order to be culturally acceptable. Close contact with immigrant and refugee communities is needed to ensure adequate understanding of various cultures' views of mental health.

References

Research used in the acceptability category includes: Beiser (1988), Boehnlein (1987), Canadian Task Force (1988a), Doyle and Visano (1987b), Egawa, Tashima, and Murase (1981), Flaskerud (1986), Health and Welfare Canada (1988), Henry and Accommodation (1985), and Quan (1987).

3. CULTURAL

General Statement

Many efforts to address the general issue of accessibility to services and categorize barriers have not taken culture into consideration. However, cultural barriers are now among the most commonly cited barriers regarding access to mental health services by minorities and by immigrants and refugees.

Issues related to differing conceptions of health and mental health, expectations related to the helping process, cultural beliefs, and communication styles have far-reaching implications for the delivery of culturally accessible services to immigrants and refugees.

3.1 Barrier

Cultural conceptions of mental health and mental illness influence attitudes towards and utilization of mainstream mental health services, other formal and informal services, and natural support systems.

Potential Remedies

- Educate service providers regarding various cultural conceptions of health, mental health, and mental illness.
- Liaise with natural support networks in ethnocultural communities to understand needs and perceptions of the communities related to mental health.
- Respect differing belief systems and be open to exploring clients' experiences and behaviours in view of their beliefs.
- Increase the awareness of immigrants and refugees regarding Canadian conceptions of health, mental health, and service systems as needed.
- Use or refer to religious leaders, traditional healers, and other supports identified by specific communities as feasible.

3.2 Barrier

Expectations regarding styles of communication between service providers and immigrant/refugees may not be similar.

- A service provider may expect verbal expressiveness; a client from some cultural backgrounds may utilize nonverbal communication and silence.
- A service provider may expect a formal, distant relationship with clients; some clients may anticipate informality and exchange of personal information, while others may be reserved.

Potential Remedies

- Be aware of communication styles unique to the cultural background of the immigrant/refugee client, and make adaptations as necessary and feasible.
- Utilize therapists who share the cultural background of the client.
- Use co-therapists or paraprofessionals from the client's cultural background.

3.3 Barrier

In many areas cultural background affects the way services must be delivered to be culturally sensitive. Areas in which an immigrants and refugees may differ greatly from the service provider include:

- beliefs about the family
- nature of interpersonal relationships (e.g. formal versus informal)
- attitudes towards sexuality and gender roles
- attitudes towards age
- beliefs about "being" (Eastern) versus "doing" (Western) and the impact on sense of urgency and punctuality
- values placed on traits such as passivity, dependency

Lack of familiarity with cultural traits may lead to inaccurate assessment results and erroneous judgments in intervention (e.g. misreading facial expressions or affect during conversation).

Potential Remedies

- Educate staff in cultural beliefs of ethno-cultural groups commonly encountered in clientele. In light of the aforementioned barriers, consider the following:
  - Are families viewed as patriarchal or matriarchal? What is the level of importance attached to the nuclear family? to the extended family?
  - What manner characterizes interpersonal relationships? Informal, formal? Reserved, outgoing?
  - What is the attitude towards sexuality (e.g. some cultures urge modesty; approaches to discussing topics related to sex must be indirect)?
  - Will therapists who are of a different gender than the client be acceptable?
  - How will the gender of the therapist influence acceptance of therapy content?
  - What value is attached to dependency, assertiveness, individualism, loyalty, and other relevant traits?

- Individualize client assessments and interventions in order to avoid risks related to oversensitivity to cultural differences (e.g. not all difficulties in therapy are related to cultural differences), inattention to intracultural differences, and the assumption that all clients are equally invested in their cultural background.
- Ensure access to cultural interpreters and other resources on an as needed basis to augment staff training and address information needs pertaining to infrequently encountered cultural backgrounds.
- Utilize bicultural staff.
- Build initial rapport and trusting relationships with clients, and recognize that this may take a considerable amount of time.
- One cannot assume that all immigrant and refugee clients will benefit from the same therapy approach. Active, brief therapy approaches are commonly advocated in the literature related to intervention for immigrants and refugees. Interventions that are relatively directive, immediate, and activity based are frequently suggested as they may be congruent with clients' expectations regarding assistance and include practical measures that are perceived to be relevant. Additional research is needed to obtain more data about the most appropriate and effective modalities.

3.4 Barrier

Lack of familiarity with religious beliefs leads to inaccurate diagnoses and inappropriate intervention. Religious beliefs influence beliefs about health and mental health, and the subsequent use of services.

Potential Remedies

- Educate staff in religious beliefs commonly encountered in clientele.
- Utilize religious leaders as consultants if possible.
- Work along with religious leaders/traditional healers as feasible.
- Refer clients to religious leaders/traditional healers as appropriate.

References

Research used to identify relevant cultural barriers and remedies includes: Brown (1982), Canadian Task Force (1988a, 1988b), Crystal (1989), Egawa et al. (1981), Fischman, Fraticelli, Newman, and Sampson (1983), Flaskerud (1986), Hoang and Erickson (1985), Humm-Delgado and Delgado (1986), Indochinese Psychiatric Clinic (1986), Longres (1991), Orr, Miller, and James (1984), Stefl and Prosperi (1985), Quan (1987), Rogler et al. (1987), and Westermeyer (1985).

4. LANGUAGE

General Statement

Along with cultural barriers, language barriers are the most often cited in the literature related to immigrant and refugee mental health. Bridging the gap between client and service provider begins with the ability to communicate in a shared language or through an interpreter. Some difficulties in using bilingual staff and interpreters have increasingly been identified, with specific recommendations regarding the appropriate use of interpreters and bilingual staff gradually being provided.

The emphasis placed on providing linguistically accessible services will likely remain a necessity as only 41% to 54% of all immigrants to Manitoba in the 1980s had a knowledge of English (Employment and Immigration Canada, 1989b). In the refugee/designated class category of immigration, only 14% reported having knowledge of one or both of the official languages. Access to English rather than French services is generally assumed to be required, but it is also important to remember that some non-English speaking immigrants and refugees are fluent in French as a second language.

4.1 Barrier

Lack of ability to speak English or French leads to difficulties in communicating with service providers.

Potential Remedies

- Employ bilingual staff when available for languages spoken by large proportions of clients. Bilingual staff have the potential added advantage of understanding a client's culture. Bilingual professionals who have a second language other than English or French should be recognized as having a language asset. However, having bilingual workers on staff is not feasible for meeting all language needs, nor do all clients wish to be seen by a member of their ethnocultural community.
- Develop a resource pool of bilingual professionals who could provide direct services on a fee-for-service basis.
- Utilize interpreters. Interpreters should be highly trained and should not be volunteers when used in a professional capacity. With respect to the use of interpreters, be aware of the following:
  - Interpreters must be accessible during the same hours as services are provided (e.g. inpatient programs need 24 hour accessibility).
  - An interpreter may be needed even if there appears to be a common language between client and worker if the language ability is insufficient to permit communication of feelings.

- Speaking in a second language may require such effort that information provided is brief or emotions are inaccurately transmitted.
- Potential interpreters must have some mental health training: e.g. understanding of counselling process, knowledge of psychiatric, medical and psychological terminology, awareness of confidentiality issues.
- Interpretation involves not only translation of words from one language into another, but also the transmission of the connotative meaning, particularly in view of the potential cultural differences between client and worker.
- Interpreters should not be untrained translators obtained on short-notice, or family members such as children who are put in an awkward position (e.g. having too much information, control, responsibility).
- Clients should be made aware that interpreters are acting in a specialized role and are bound by confidentiality.
- Arguments have been made that interpreters should not be volunteers, and that payment will lead to more highly trained and more accessible interpreters.
- Training for interpreters may include workshop-style instruction, observation of experienced, trained interpreters, and on-the-job interpretation under supervision.
- In some situations, it may be important for the client and interpreter to be of the same sex. Differences in the client's and interpreter's characteristics such as age, ethnic group, social class, and political stance should be considered, as similar language alone does not imply there will be a trust between the individuals.

4.2 Barrier

Immigrants and refugees are unable to obtain a variety of services if they are unable to speak English or French.

Potential Remedies

- Be aware of available English-language training programs.
- Develop or obtain a list of professionals and services in the community with various linguistic abilities in order to assist in referring clients.
- Be aware of services that use interpreters and how to assist clients in obtaining interpreters.

References

The research used to identify the barriers and remedies in the language category includes: Boehnlein (1987), Canadian Task Force (1988a), Doyle and Visano (1987a), Egawa et al. (1981), Fischman et al. (1983), Flaskerud (1986), Hoang and Erickson (1985), O'Brien (1985), Quan (1987), Rogler et al. (1987), and Westermeyer (1990).

5. PHYSICAL/GEOGRAPHIC

General Statement

When facilities are inconveniently located, or have deterring physical characteristics, lack of client use in the general population is a result. For immigrants and refugees, barriers in the physical/geographical category generally relate to transportation difficulties, time involved in travelling, and feelings of discomfort related to physical features such as large size of institutions, the presence of a majority of other racial/ethnic groups, unfamiliar surroundings, and a cold, sterile atmosphere.

5.1 Barrier

Clients are unable to obtain transportation to reach service settings.

Potential Remedies

- Locate services in the community where clients live, preferably being within walking distance.
- Locate services so that they are easily accessible using public transportation (e.g. near major bus routes).
- Individual providers may wish to offer appointments to clients in their homes as feasible and appropriate.
- Provide services in community centers and other local facilities.
- Develop a volunteer transportation program.

5.2 Barrier

Potential immigrant and refugee clients may have difficulty travelling, or do not want to travel, to services alone.

Potential Remedies

- Encourage family members to be a part of the intake and treatment process.
- Adopt referral/escort practices in which providers assist clients in obtaining other services. Clients may be accompanied by a worker (or by someone from an ethnocultural community or immigrant serving agency) for at least the initial contact, and the worker may be involved in providing language/cultural interpretation to the other service.
- Give instruction to clients as needed regarding travel.
- Complete assessments and provide services in clients' homes as feasible and appropriate.

5.3 Barrier

Too much time is spent in travel by clients to obtain services or by workers to make home visits.

Potential Remedies

- Locate the services in the clients' community.
- Use existing local facilities such as community centers, religious institutions, and schools. Take into account the degree to which the specific type of facility will be acceptable to various ethnocultural communities.

5.4 Barrier

The large size of institutions can be confusing and overwhelming, leading to lack of utilization of services by immigrants and refugees.

Potential Remedies

- Locate services in small facilities or other familiar community structures.
- Post multilingual signs and/or use symbols/pictures in larger institutions in key areas such as entrances, information desks, waiting rooms, to provide basic information about the services.
- Provide magazines in waiting rooms in languages used by clients.
- Use volunteer hosts and guides to greet and direct clients.

5.5 Barrier

Physical spaces may not be conducive to providing culturally appropriate services (e.g. rooms too small to allow for family members).

Potential Remedies

- Take into account interventions which will be culturally sensitive for immigrants and refugees and plan space accordingly.

- Ensure a warm and pleasant atmosphere to foster social interaction.
- Arrange space in rooms so that it is culturally comfortable.

References

Research utilized to identify the barriers and remedies in the physical/geographical category includes: Doyle and Visano (1988a, 1988b), Flaskerud (1986), Hagebak and Hagebak (1980), Orr et al. (1984), Stefl and Prosperi (1985), and the Women and Mental Health Project (1976).

6. OPERATIONAL

General Statement

The operational category of barriers refers to characteristics of the day-to day contact of the service with clients that reduce its accessibility. This category includes barriers related to procedures for obtaining services, as well as to therapeutic approaches.

As with many of the barriers, operational barriers are faced by the general client population. However, they are more acute for some immigrants and refugees due to cultural factors and their situational circumstances. For example, an immigrant/refugee may be less accustomed to waiting to see a worker or may be less able to take time off work to attend appointments.

6.1 Barrier

Telephone reception services are limited in terms of their hours of availability and use of answering machines may be difficult for immigrants and refugees.

Potential Remedies

- Provide telephone reception services beyond normal business hours (up to 24 hour coverage if feasible/warranted).
- If it is apparent that the client or caller cannot speak the language, make arrangements for a bilingual staff or interpreter to take the call or phone back.
- Utilize answering services, rather than answering machines as feasible.
- If using an answering machine, familiarize new clients with its hours of operation and, if needed, review procedures for responding.

6.2 Barrier

Waiting for appointments may be very unfamiliar to immigrants and refugees, and difficult for some whose tendency may be to wait until a crisis develops before seeking services.

Potential Remedies

- Where feasible, use group and/or short-term intervention approaches to increase service capacity.
- Limit the time required to obtain an appointment. For example, have an early intake interview even if services must be provided somewhat later.

- When a long waiting period is involved prior to receiving an appointment, provide information about other services available (e.g. crisis services) and, if possible, organize ethnocultural community supports while clients are waiting.
- Limit the waiting time in the office.
- Accommodate walk-in clients in some manner (obtain referral information, provide agency brochure, arrange for client to be seen, etc.).
- Stress cancellation of appointments in advance so that other clients can be accommodated.
- Provide telephone reception services beyond normal business hours (up to 24 hour coverage if feasible and warranted).
- Emphasize prevention strategies.

6.3 Barrier

Immigrant and refugee clients are not always able to attend appointments scheduled during regular business hours as a result of factors such as employment, attendance at educational programs, and lack of alternate child care.

Potential Remedies

- Provide some regular evening and/or weekend services as scheduling "off hour" appointments is important for all clients.
- Be flexible in scheduling appointments with clients.

6.4 Barrier

Forms that clients must complete are often long and confusing, and in English only.

Potential Remedies

- Simplify and shorten forms.
- Offer individual assistance to clients in completing forms (e.g. additional explanation, translation).
- Utilize translation of forms for languages commonly spoken by clients. Translations of the forms must be made relevant to the culture (e.g. "Do you feel blue?" may lose meaning if directly translated).
- Arrangements must be made to translate information provided by a client in another language into English or French so it can be read by other staff as needed.

6.5 Barrier

The procedures used in delivering services may not be appropriate for immigrant and refugee clients.

Potential Remedies

- Increase the ability to provide bilingual/bicultural services at the intake/reception level.
- Allow for the necessary time needed to build rapport with clients.
- Take into account the extra time and costs involved in providing services when the provider and client do not speak the same language in planning and budgeting for services.
- Obtain detailed past histories and address areas such as life in the homeland, experiences during migration/escape, refugee camp experiences, and adjustment to Canada, as well as discussing current problems and concerns about the future.
- Depending on their cultural backgrounds, immigrants and refugees may initially focus on somatic complaints. The use of pharmacotherapy, or social and psychological interventions that are targeted at somatic presentations, should be considered to bring intervention more in line with cultural expectations.
- Cultural differences must be taken into account in planning service delivery (e.g. medical versus psychotherapeutic model; hierarchical versus egalitarian counselling relationships).
- Incorporate client advocacy services as a part of mental health intervention (e.g. escorting clients to other services, providing concrete types of assistance such as translation).
- Mental health and social services should be closely integrated with health and other services such as English language training, education, and employment.

References

Research used to identify relevant operational barriers and remedies includes: Boehnlein (1987), Canadian Task Force (1988b), Doyle and Visano (1987b), Egawa et al. (1981), Flaskerud (1986), Hoang and Erickson (1985), Indochinese Psychiatric Clinic (1986), Orr et al. (1984), and Stefl and Prosperi (1985).

7. ADMINISTRATIVE

General Statement

In contrast to the barriers related to the day-to-day operation of a service, administrative barriers are those that relate to governance, overall management, policies, planning and evaluation. Researchers have stressed the importance of taking a comprehensive approach to increasing accessibility, rather than changing only one aspect of a service.

To reduce administrative barriers, all aspects of services should be addressed including personnel policies, staff training, board/advisory group composition, data needs, and interagency collaboration.

7.1 Barrier

Immigrants and refugees have limited access to culturally sensitive service providers.

Potential Remedies

- Ensure that cross-cultural training of staff is a priority and that inservice programs are ongoing and have mandatory attendance requirements.
- Canadian-born service providers should be sensitized to immigration and escape experiences as a part of cross-cultural training.
- Liaise with other services regarding the possibilities of joint or reciprocal staff training.
- Increase resource materials available to staff relevant to cross-cultural mental health services (e.g. books, journals, culturally-sensitive assessment and therapeutic tools).
- Advocate for cross-cultural training to be a part of the academic preparation for professionals. Consider establishing prerequisites for entering field placements such as training in cross-cultural issues.

7.2 Barrier

Services lack multicultural staff which may enhance the ability to meet the needs of immigrants and refugees.

Potential Remedies

- Adopt recruitment and hiring policies that increase the number of bilingual/bicultural staff and increase the cultural diversity in staff. Organizations must ensure that such bilingual/bicultural staff are not overly depended upon to the exclusion of developing cultural sensitivity in all staff.

- Provide flexibility in the geographical boundaries and other limitations to service placed on bilingual/bicultural staff (e.g. can serve a client from a different area of the city or age group).
- Integrate foreign-trained professionals and paraprofessionals in the service system. The availability of ethnic mental health professionals has been limited by professional licensing and registration requirements, and the difficulties that immigrants and refugees encounter in obtaining credentials has become an important issue. Possible actions include the orientation of professionals prior to immigration, advocating for the broadening of criteria for licensure, increasing the opportunities for training for immigrants and refugees, and hiring uncredentialled professionals in some capacities.
- Utilize "culture brokers" to assist in bridging cultural gaps between clients and workers. Culture brokers (Canadian Task Force, 1988a) are individuals who can explain professional jargon and attitudes to a client while helping staff to understand the client's culture.

7.3 Barrier

There is a lack of sensitivity towards immigrants and refugees in the planning, management, and evaluation of services.

Potential Remedies

- Ensure representation from culturally diverse groups on boards, advisory groups, and in management staff.
- Involve immigrants and refugees in planning and evaluating servic es.
- Arrange for training of board/advisory group members in cross-cultural and immigrant/refugee issues.
- Utilize needs assessment information related to immigrant and refugee communities that fall within the agency's mandate and catchment area.

7.4 Barrier

Services required by immigrants and refugees are fragmented, and collaboration among service providers, and between the formal and informal network, is inadequate.

Potential Remedies

- Develop linkages with other service providers regarding immigrant/refugee needs and services.
- Increase collaboration with informal support networks (e.g. use regular linkages with ethnocultural groups).

- In policies which address referrals to other agencies, facilitate workers' abilities to provide adequate follow-up (e.g. support the time involved, escort practices).

7.5 Barrier

Service providers lack information needed in planning and administering culturally sensitive services for immigrants and refugees.

Potential Remedies

- Conduct needs assessments of immigrant/refugee communities particularly in relation to services required, outreach, and publicity techniques.
- Utilize existing data sources regarding immigrant and refugee communities.
- Determine information needs regarding clients and develop efficient data retrieval systems.
- Increase the communication between service providers, researchers, and policy makers.
- Share existing practical resource materials with other service providers to avoid unnecessary re-invention of new materials of new materials and approaches for developing culturally sensitive services.
- Publicize efforts to make services culturally sensitive through presentations at conferences, provision of workshops, and publications.
- Evaluate utilization of services by immigrants and refugees.

References

The research used to identify the barriers and remedies in the administrative category includes: Canadian Task Force (1988a, 1988b), Doyle and Visano (1988a, 1988b), Flaskerud (1986), Humm-Delgado and Delgado (1986), and Yelaga (1990).

8. FINANCIAL

General Statement

Financial barriers experienced by immigrants and refugees in accessing mental health and social services relate to both the fees directly charged by the services and the indirect costs incurred as a result of obtaining services. Indirect costs include those pertaining to child care, time off work, and transportation.

Researchers in the United States have found that lack of affordability of mental health services is the dominant barrier for the population at large. Although the affordability barrier may be lessened in Canada as a result of universal health care plans, not all mental health and social services are covered. Moreover, immigrants and refugees often do not have extended employment-related health insurance which may provide some additional benefits with respect to mental health and social services. The fact that funding does not follow the client also leads to difficulty in accessing services.

8.1 Barrier

Immigrants and refugees may be unable to pay for services.

Potential Remedies

- Refer clients to other services consistent with their insurance coverage and ability to pay for services.
- Ensure that clients have adequate information about fees for services, and procedures for obtaining subsidies or insurance benefits if applicable.
- Sensitize funders to the mental health needs of immigrants and refugees to increase resources to defray costs.

8.2 Barrier

Immigrants and refugees may be unable to bear the indirect costs associated with obtaining mental health and social services.

Potential Remedies

- Reduce indirect transportation costs by locating services within walking distance of clients' residences, making home visits, and/or subsidizing public transportation costs (e.g. providing bus tickets).
- Reduce child care costs by providing on-site care or facilitating use of a nearby day care.
- Arrange appointments with clients so they do not have to take time off work without pay.

References

Research used to compile information in the financial category of barriers and remedies includes: Boehnlein (1987), Canadian Task Force (1988a), Doyle and Visano (1987b), and Stefl and Prosperi (1985).

PART II: A REVIEW OF THE LITERATURE

The purpose of this literature review is to address topics which are related to mental health care and social services for immigrants and refugees. The initial two sections on multiculturalism and immigration give an overview of the changing attitudes, policies, and demographics in Canada which impact in a global way on mental health services. Sections on cross-cultural counselling and access and barriers to services summarize developments in the attempts to provide culturally appropriate and accessible services. Finally, research directly pertaining to mental health needs of and services for immigrants and refugees is presented.

Multiculturalism

Canada has been described as a land of immigrants throughout its history (Dickenson, 1975). Although Canada's people have always included many cultures, in the first fifty years of Confederation all individuals were basically expected to assimilate into the Anglo-Canadian culture (Task Force on Multiculturalism, 1988). The initial appearance of a cultural mosaic became evident in the 1920s. Subsequently a gradual erosion of Anglo conformism took place, but official support for cultural diversity remained minimal until the 1960s.

In 1971, multiculturalism was officially inaugurated with the introduction of a federal policy. The first legislation which directly recognized the multiculturalism policy was the 1982 Canadian Charter of Rights and Freedoms of the Constitution Act. Multiculturalism has increasingly become a part of Canadian society in a number of pieces of legislation including the Canadian Multiculturalism Act passed in 1988 (Sheridan, 1989).

Efforts by individual provinces to develop specific provincial policies and legislation with respect to multiculturalism have varied considerably. Officially, multiculturalism was recognized in Manitoba as early as 1970 when the provincial government clearly indicated its support for the Manitoba cultural mosaic (Task Force on Multiculturalism, 1988). Following a series of initiatives related to multiculturalism in the 1970s and 1980s, the Manitoba government published Manitoba's Policy for a Multicultural Society in 1990.

Across Canada, however, multiculturalism policies have had a limited effect on educational and service-oriented institutions. Many Canadians are not aware of the principles espoused in the policies and there continues to be a gap between the ideals stated in the policies and actual attitudes or behaviour. As noted by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988a), more public education is needed regarding the benefits of cultural pluralism as well as the contributions of immigrants and refugees.

Immigration

National Trends

At the time of the first national census in 1871, the majority of the Canadian population was of British ancestry (Friesen, 1985). The peak of European immigration occurred between 1896 and 1914, and at that time, most of the immigrants were British. Since then, immigration has largely been reflective of a "swinging door" policy which opened when labour was in demand and closed when jobs and assistance were needed.

The two World Wars and the Depression of the 1930s greatly reduced immigration and during this period immigrants from northern and western Europe were virtually the only ones permitted to enter Canada. After World War II, the immigration policy was relaxed to include primarily southern and eastern Europeans, and a second surge of European immigration occurred.

In the 1960s racial barriers were eliminated from immigration laws and immigrants began to arrive from Third World countries. The most recent immigration legislation is the 1976 Immigration Act which promotes non-discrimination and family reunification, describes Canada's obligations to refugees and outlines demographic, economic, social, and cultural goals.

Immigration patterns over the years have significantly changed the ethnic proportions in the total population since the first census. Table 2 provides a summary of the changing ethnic patterns (Dreidger, 1989; Ledoux & Pendakur, 1990; White, 1990).

TABLE 2

Ethnic Origins of Canadian Population

Year of Census	British	French	British&French	Other Ethnic
1871	61%	31%	-	8%
1986	34%	24%	5%	37%*

Note. Prior to 1981, multiple ethnic responses were not permitted.
*One third of this group also reported English and/or French origins.

Ethnic patterns in Canada will continue to change as recent immigrants have largely come from non-European countries. In the period from 1981 to 1986, 43% of immigrants were from Asia, and 20% from South and Central America, the Caribbean, and Africa (White, 1990).

Canada also has a history of providing assistance to refugees and since World War II approximately half a million refugees have resettled

in Canada. In the 1960s and 1970s, generally less than 2000 refugees entered annually. However, beginning in 1979 there was a large increase in the number of refugees and, in 1989 alone, over 34,000 were admitted. According to the U.S. Committee for Refugees (cited in Filion, 1990), Canada has the second highest ratio of refugees to total population in the world (preceded only by Sweden and matched by Australia).

According to the Immigration Act, levels of immigration were to be established annually. Recently, however, the federal government has introduced a five-year plan for immigration and announced that immigration would increase to 220,000 in 1991, and then to 250,000 annually until 1995 (Employment and Immigration Canada, 1990). In terms of future projections, in addition to the increased levels of immigration, it is also important to stress the changes in source countries of immigrants. In contrast to the primarily European immigration which existed up until the 1970s, by the mid 1980s almost three-quarters of the total number of immigrants came from Asia, Africa, and Latin America.

Demographic shifts have also been occurring with the percentage of the Canadian population born in the Third World having risen considerably from .6% twenty years ago to 5% in 1986. In 1988, Simmons predicted that by 2010 this percentage will increase to 10% (cited in Social Planning Council of Ottawa-Carleton, 1989). In addition, based upon the immigration, emigration, fertility, and mortality levels of 1981-1986, the population has been projected to be 20% foreign born by 2015 (Beaujot and Rappak, cited in Social Planning Council of Ottawa-Carleton, 1989). There will be an accompanying shift in the influence and centrality of European ethnic groups due to their relative decline in size.

> As noted by the Social Planning Council of Ottawa-Carleton (1989): The impact of these population dynamics may be expected to place a greater strain on immigrant aid organizations, increase the need for language classes, culturally sensitive interpretation, anti-discrimination education and increase pressure from visible minority groups for access to mainstream services and participation in Canadian society. (p.15)

Manitoba's Trends

As a general rule Manitoba has received its share of the national number of immigrants based on the province's proportion of the total Canadian population (Manitoba Family Services, 1989). For the last two decades, Manitoba's population has been 4% and 5% of the total Canadian population. Immigration intake for Manitoba has been approximately 4% of the Canadian total during the last ten years, with a slight reduction to just over 3% in the late 1980s (Employment and Immigration Canada, 1989b). During the last decade, international immigration to Manitoba has ranged from a low of approximately 3,400 in 1985 to a high of

approximately 7,700 in 1980. The provincial government has supported the federal policy of moderate, controlled growth in immigration for 1990.

The shift in the source countries at the provincial level has been similar to the national pattern, with the dominant sources since 1986 being the Philippines (16%), Poland (10%), Hong Kong (8%), and Vietnam (7%). With respect to categories of immigration, the number of immigrants in the family and independent classes in 1989 totalled just over 4,100. The number of refugees (including Convention refugees and members of designated classes) has increased steadily in the last few years with almost 1,900 refugees arriving in 1989.

The vast majority of immigrants who came to Manitoba in 1989 were destined for Winnipeg (91%). In order of decreasing frequency, other destinations were Brandon (2%), Thompson (0.9%), Winkler (0.7%), and Steinbach (0.5%). The other 4.9% of immigrants went to other destinations in Manitoba including centers such as Selkirk, The Pas, Portage La Prairie, and Flin Flon with less than .2% each (Manitoba Family Services, 1989).

The changing source countries and general growth in immigration means that the province will continue to increase its cultural diversity. The increasingly multicultural nature of Manitoba has implications for a wide range of services, including those offered by mental health and social service agencies.

Cross-cultural Counselling

Along with the increasing emphasis towards multiculturalism in Canadian society in general, there has been a growing trend toward the provision of a wide range of services in a manner that is consistent with the client's cultural background. Researchers and practitioners in a number of fields including health, education, and social services have increasingly attended to cultural factors in service delivery in the last twenty years. Although "multiculturalism" has been coined as a result of Canadian usage (Department of Secretary of State, 1987), other countries, particularly the United States, have also experienced a surge of interest in developing "cross-cultural" counselling and therapy since the mid-1960s (Lonner, 1985).

The professional literature in the areas of multicultural and cross-cultural services has also grown with many new journals specializing in the field. At the beginning of the 1970s, there were virtually no books on the topic of counselling and culture, and now there are many (e.g. Pedersen, 1985; Pedersen, Draguns, Lonner, & Trimble, 1989; Sue, 1981).

According to Draguns (1989), cross-cultural counselling has generally provoked little controversy, and the notion of modifying

counselling techniques to meet the needs of culturally different clients has been widely accepted. Generally speaking, proponents of cross-cultural counselling agree on the following basic assumptions:

- The counselling process becomes more complicated as the gap between the counsellor and the client increases.
- Beliefs about the nature of the helping process are cultural.
- The frequency of specific complaints and symptoms varies between cultural groups.
- Culturally sensitive counsellors need to be able to translate cultural characteristics into subjective goals for individual clients.

Cross-cultural research, however, has been limited in deriving empirically based guidelines for practitioners as to when and how culture should be taken into consideration for specific cultural groups (Lopez & Hernandez, 1986). In addition, qualitative, culture-specific differences in symptomatology have only been comprehensively analyzed in a few instances in the literature.

Access and Barriers to Mental Health Services

Considerable research has been devoted to estimating mental health needs in the general population as well as to the study of mental health service utilization. The Canadian Mental Health Association has estimated that one-third of Canadians suffer from significant emotional problems at some point in their lives, and that for one in six Canadians (17%), these problems will be severe enough to require professional assistance (Manitoba Health Organizations Inc., 1990). In the United States, estimates have been comparable, with the federal government reporting that 15% of the U.S. population requires mental health care at any given time (Stefl & Prosperi, 1985).

In many social service and mental health systems, there is a large gap between the estimate of the need for services and the actual rate of service utilization. Researchers in Canada and the United States have reported that approximately one out of five individuals who need mental health care receive formal, specialized mental health services (Canadian Task Force, 1988a; Stefl & Prosperi, 1985). Studies pertaining to specific subpopulations such as immigrants and refugees have indicated that they use formal mental health care to even a lesser extent (Canadian Task Force, 1988b; Munroe-Blum, Boyle, Offord, & Kates, 1989).

The gap between need and service utilization is often assumed to be related to difficulties with access to services, and attention then turns to the types and extent of barriers which may influence access

(Stefl & Prosperi, 1985). The importance of focusing on access and identification of barriers has been stressed by researchers as central to meeting clients' needs (Doyle & Visano, 1987b).

Although the concept of access has frequently been discussed with respect to service utilization, the term is ambiguous and has been used in various ways by researchers and policy makers. Standard definitions of access in the program evaluation literature have included both the entry and continuation of clients in programs. Rossi and Freeman (1989), for example, described access as referring to "the structural and organizational arrangements that facilitate participation in the program"(p. 197). In contrast, other researchers and planners have argued that access and utilization are two different components of service use, and that access refers to functions occurring prior to the actual delivery of services (Doyle & Visano, 1987b).

In a study devoted to the definition of access in health policy and services, Penchansky and Thomas (1981) found from their review of the literature that access was most frequently described as relating to an individual's ability to enter into or make use of a service system. Similarly, Donabedian (1973) had previously described accessibility as not only concerned "with the propensity to seek care but with a 'lack of fit' even when the source of care and the client are brought together" (p. 424).

Penchansky and Thomas proposed that access is in fact a general concept composed of the five dimensions of availability, accessibility, accommodation, affordability, and acceptability. Although they acknowledged that these dimensions are difficult to separate, the following descriptions were given:

Availability - pertains to the adequacy of the supply of services.

Accessibility - refers to the relationship between the location of services and the client's location.

Accommodation - the way in which service systems are organized to accept clients, (e.g. includes hours of operation, arrangement of appointments) and the clients' perceptions of their appropriateness and willingness to adapt.

Affordability - the relationship between the cost of services to the client and the client's ability to pay.

Acceptability - refers to clients' attitudes towards characteristics of service providers as well as to the providers' attitudes toward client characteristics.

Although there is still no universally accepted definition of access, within the mental health and social services fields its usage

has generally been as a comprehensive, multi-dimensional term. Similarly, Stefl and Prosperi (1985) list common attributes of barriers to access as being availability, accessibility, acceptability (includes the issue of stigma), and affordability. In comparison to the Penchansky and Thomas taxonomy, the primary omission in this list is the accommodation attribute.

In this document, access has also been viewed broadly as referring to a client's ease of entry to and use of a service. The focus will be on identifying barriers to entry, or initiation of service, but to some extent barriers to continuation of service will also be addressed.

The primary specific attributes of access which will be considered are the geographic and physical aspects of a service (accessibility), and the previously described Penchansky and Thomas dimensions of accommodation, affordability, and acceptability. Accommodation, although not a common barrier in the general population according to Stefl and Prosperi, is especially important in view of this document's focus on immigrants and refugees. Many barriers connected to service systems' adaptation to clients' language and cultural diversity relate to the accommodation dimension.

In contrast, the attribute of availability, when defined as the supply of services, will not be emphasized as the purpose of this report is to assist in making existing services more accessible, rather than addressing modifications to the supply of services.

In this document, "accessibility" is generally used broadly and refers to the ease of access including all of its dimensions, rather than narrowly pertaining to the relationship between the location of a service and its clients.

The final point to be made with regard to access relates to the importance of the principle of equity. The public policy goal of "equal access" has been interpreted in different ways (Penchansky & Thomas, 1981), but researchers are in agreement that equity is central to access. In a report specifically addressing the needs of diverse cultural and racial groups, Doyle and Visano (1987b) argued that:

> Access means that members of minority groups have equal opportunities to be served by and to participate in the organization established for their benefit. (p. 32)

Issues Pertaining to Immigrants/Refugees and Mental Health

Mental health needs

Mental health problems have been shown to be remarkably similar across cultures, and virtually all mental disorders have been found in all countries, although with varying prevalence rates and symptoms for some disorders (Law, 1985). Sufficient evidence has also been gathered

problems be kept within the family, and the use of informal support systems (Canadian Task Force, 1988a; Rogler, Malgady, Costantino, & Blumenthal, 1987). In addition, those immigrants and refugees who do initiate service consumption from mainstream agencies are frequently dissatisfied, and may terminate services prematurely (Canadian Task Force, 1988a). Cultural beliefs have been described as having a major role in determining ongoing utilization, and Rogler et al. (1987) noted that the closer the client's and provider's beliefs about illness and treatment, the more likely that professional services will be sought and retained.

In actuality, however, there is often a very wide gap between the client's cultural background and that of the provider in a mainstream mental health service. To bridge the gap, considerable emphasis has been placed on sensitizing providers to cultural differences.

Several points have been raised with respect to increasing sensitivity of providers. First of all, as Brown (1982) has noted, learning about the cultures of all immigrant and refugee groups would be impossible for the typical service provider. Increased sensitivity to cultural differences cannot reasonably translate into expectations that each provider become an expert on all cultures.

Secondly, providers must not only be sensitive to the client's cultural background, but also to the client's level of adherence to cultural beliefs (Rogler et al., 1987). Service providers should be aware of the client's traditional culture, the culture of the host country, and perhaps an emerging combination of the two cultures. The resulting point is that intervention must be individualized to be culturally sensitive.

Thirdly, service providers must also be aware of the differences that may exist between subgroups of a given culture, and the individual differences that will occur within a specific group (Canadian Task Force, 1988b; Rogler et al., 1987). Finally, placing too much weight on cultural background (oversensitivity), or cultural stereotyping has sometimes led to difficulties in the provision of services (Canadian Task Force, 1988b).

Although much of the focus of the literature has been on immigrant and refugee underutilization of mainstream mental health services, it should be noted that utilization rates vary across the service spectrum and some services may in fact be overutilized. Cheung and Snowden's (1990) study suggested that, at least with respect to ethnic minority populations, there is an overrepresentation in inpatient services. As discussed previously, however, immigrants and refugees have been reported to considerably underutilize community-based services and private practitioners. The primary need at this time is for all services to become more accessible to immigrants and refugees, so as not to discourage appropriate utilization or require unnecessary hospitalization.

Potential Models of Service Delivery

Difficulties pertaining to immigrants' and refugees' access to mental health and social services in host countries have increasingly been recognized and studied during the past decade. As a result, many barriers have been identified and recommendations have frequently been made in an attempt to reduce barriers and provide more culturally-sensitive services. Although much of the attention has been devoted to providing practitioners with specific recommendations, several researchers have also discussed the policy and organizational options for the provision of services that would be culturally accessible.

As early as 1978, Sue (cited in Zane, Sue, Castro & George, 1982) outlined three major possibilities for increasing the fit between clients and mental health services in a multiethnic society. The possibilities are summarized as follows:

1. Find the right service for the client. This strategy assumes that appropriate, culturally relevant services are available. Tasks are to overcome barriers related to effective referral and public awareness of services.
2. Change the client to fit the service. According to this strategy emphasis is placed upon preparation of the client prior to actual service delivery (e.g. explanation of intervention process)
3. Change the service to accommodate clients from diverse cultures. According to Sue, this option is the most responsive, but also the most difficult to implement.

The potential policy design options relating to culturally accessible services have essentially focused on Sue's third strategy of changing services to better meet the needs of immigrants and refugees. Some of the barriers to mental health and social services faced by immigrants and refugees would also be addressed by Sue's first two strategies, but the majority of the barriers will be overcome only by modifying the services.

As a result of studying how best to meet mental health needs of a particular minority group, Uba (1982) proposed three prototypes of culturally accessible services:

1. Services are delivered by **integrated (or multiculturalized) mainstream organizations** in which **all** personnel are trained to be culturally sensitive.

2. **Mainstream services establish specialized units** in which culturally sensitive services are provided by specially trained staff.

3. Services are delivered by **parallel** organizations that are **physically segregated from mainstream services** and specialize in one or more cultural groups.

Other researchers have subsequently used similar categories of services when reviewing policy options, although a fourth approach has also since been proposed (Allmen, 1990; Canadian Task Force, 1988a; Doyle & Visano, 1987a; Frankel, 1990; VanArsdale, 1988).

> 4. Mainstream services are **"bridged" or linked** to ethnocultural and immigrant serving organizations by a program designed to support the delivery of mainstream services to immigrants and refugees.

Doyle and Visano (1987a) suggested that linkages could be developed at both administrative and direct service levels, and could involve joint arrangements pertaining to areas including planning, funding, administrative support, personnel, and program implementation.

Each of the four options has a range of advantages and disadvantages. The first option of "multiculturalizing" entire mainstream services may reduce actual and perceived discrimination in service delivery and among staff. The main advantage, according to Frankel (1990), is that all potential clients have access to the full range of mental health services regardless of their ethnocultural background. VanArsdale (1988) pointed out that culturally sensitive services provided throughout mainstream agencies avoids the potentially damaging isolation in service delivery.

Limitations of this option include the major modifications needed in the formal education of new mental health professionals and the training required of mental health practitioners already working in the field. Considerable resistance to changes in training and qualifications may be encountered among universities, professional associations, licensing bodies, and employers. Some researchers have also suggested that it is impossible for all service providers to become knowledgeable about all cultures, (e.g. Brown, 1982) although this may not be the intent of a multiculturalized service strategy.

In the second option of a specialized unit or team within a mainstream service, a major advantage is that not all staff require the special training, and yet cultural sensitivity could be increased throughout the organization as a result of consultation with the specialized unit. In addition, clients would have the option of receiving either "regular" or "culturally specialized" services within the same mainstream organization according to their needs. Limitations relate to the fact that there may be some duplication of administrative tasks when two somewhat separate services operate within the same organization (Uba, 1982). In addition, when programs are operating at capacity, clients may be steered to one of the services not based on their needs but upon waiting lists. In general, competition may result between various units/teams of organizations for scarce resources (Frankel, 1990). Finally, staff outside the specialized unit may not become culturally sensitive when staff training is not made mandatory (Canadian Task Force, 1988a).

The third "segregated service" prototype suggested by Uba (1982) has also been referred to as the parallel services approach (Canadian Task Force, 1988a). Arguments have been made that services that are established parallel to mainstream services for a specific cultural group may be more accessible due to heightened awareness of the service and potential close proximity to clients. Research studies have demonstrated that increased use has been made of mental health services by ethnic minorities when they are culturally-specific (e.g. Indochinese Psychiatric Clinic, 1986). However, increased access appears to be the case primarily when the ethnocultural groups live in concentrated areas of a city, and may not apply when immigrants and refugees are scattered across an area. Difficulties with parallel service delivery include high cost, lack of stable funding, fragmentation of services, and impracticalities when numbers of an ethnocultural group are small. There is a danger that the separate services would not serve some groups well due to insufficient resources and it would be difficult to provide the whole spectrum of services for each ethnocultural group. In addition, separate services would result in limited opportunity or pressure for mainstream services to become more culturally sensitive.

A primary advantage of the fourth "linkage" option is the ability to provide culturally sensitive services for even small ethnocultural groups (Frankel, 1990). Linkages also facilitate the bridging of formal and informal mental health supports in a routine manner (Allmen, 1990). This approach does not require that all staff in mainstream service are specially trained, yet ideally over time all staff would become culturally sensitive. However, as has been noted with respect to the option of developing specialized units, staff may not become sensitized unless training is mandatory. Another disadvantage is that linkages alone may be insufficient to influence some service providers to modify their service delivery practices. Finally, this approach depends on a considerable amount of interagency coordination (Frankel, 1990).

Uba (1982) indicated that research studies did not support the superiority of any of the first three options, and she and others subsequently have argued that the choice of an option depends upon the situation. Recently, however, the general trend has been more clearly in the direction of making mainstream services more accessible, with little support given to the parallel services option (Allmen, 1990; Canadian Task Force, 1988a). The Canadian Task Force (1988a) concluded that "It is not feasible to create 'parallel' mental health services for each language and cultural group in Canada, and it is not needed" (p. ii).

With respect to the remaining three options of "multiculturalized" organizations, specialized units, or linkages, all appear to be viable, but each situation must be assessed to determine the most suitable approach. Conditions influencing the choice include the numbers of clients from a specific ethnocultural group, the geographic concentration of the ethnocultural group, the number of different groups that should be served, the size of the service, and the existing

coordinating mechanisms in the service system. All of the options require flexibility in service delivery, political will, and a genuine commitment to make services for immigrants and refugees culturally accessible.

The pattern of the aforementioned conditions in a particular situation and the choice of service approach influence the barriers which arise in meeting the service needs of immigrants and refugees. It is clear from the discussion that no one approach is barrier-free. Certain conditions and types of service simply mean that providers should attend to some barriers more than others and by different methods.

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APPENDIX A (of Increasing Access)

List of Individuals who Provided Feedback on the Draft Document

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Note. Some additional individuals have given feedback about the draft, but have asked not to be included in this list.

APPENDIX B (of Increasing Access)

Resources to Contact for Additional Information regarding Services for Immigrants and Refugees

Cross Cultural Counselling Unit
Mount Carmel Clinic
886 Main Street
Winnipeg, MB R2W 5L4
Ph.: (204) 582-2311

Cross-Cultural Mental Health Specialist
Winnipeg Region Mental Health Services
Manitoba Health
4th Floor, 189 Evanson St.
Winnipeg, MB R3G 0N9
Ph.: (204) 945-8309

Employment and Immigration Canada
Manitoba Regional Office
500-259 Portage Ave.
Winnipeg, MB R3B 2A9
Ph.: (204) 983-3928

Immigrant Access Service
Manitoba Culture, Heritage and Citizenship
294 William Ave.
Winnipeg, MB R3B 0R1
Ph.: (204) 945-6300

Immigrant/Refugee Health Program
Planned Parenthood Manitoba, Inc.
206-819 Sargent Ave.
Winnipeg, MB R3E 0B9
Ph.: (204) 774-2501

Immigration and Settlement Services Branch
Manitoba Culture, Heritage and Citizenship
304-379 Broadway Ave.
Winnipeg, MB R3C 0T9
Ph.: (204) 945-2800

Manitoba Council for Multicultural Health Inc.
2nd Floor, 406 Edmonton St.
Winnipeg, MB R3B 2M2
Ph.: (204) 949-1479

Multiculturalism And Citizenship Canada
Manitoba Regional Office
201-303 Main St.
Winnipeg, MB R3C 3G7
Ph.: (204) 983-3601

APPENDIX H

TELEPHONE SURVEY

Respondent's Name _____ Designate's Name _____

Title _____ Organization _____

Phone number _____

Date _____ Time begun _____

INTRODUCTION

This is Bettina Nyman from the Canadian Mental Health Association, Manitoba Division. I am the Coordinator of a project aimed at increasing the accessibility of mental health and social services for immigrants and refugees.

Our office sent you a copy of the document called Increasing Access in December. Did you receive it? (If no, arrange to have one sent, and discontinue call).

I would like to ask you a few questions about the document. (Ensure that he/she has read or used it to some extent. If not, ask to speak to the person in the organization who is most knowledgeable about the document.)

Do you have a few minutes now? (If no, ask for a recontact time)

(Deal with any concerns of the respondent; e.g. explain that individual responses will be kept confidential.)

SURVEY QUESTIONS

1. Has the document been kept by your organization?

1 NO
2 YES

If yes, where has it been stored?

If no, what was done with it?

Why was it not kept?

2. How has the document been used?

Probe: for program planning,
for review and evaluation of existing programs,
for staff training
for board training

3. What have you found useful about the document?

4. What is not useful about the document?

5. What changes, if any, are needed in the content of the document?

6. What changes, if any, are needed in the layout or visual presentation of the document?

7. Would the document be more useful if you had the opportunity to meet with someone for advice or to participate in a training session?

1 NO
2 YES

Comments:

8. Have you been able to implement any of the remedies suggested in the document?

1 NO
2 YES

If not, why not?

If yes, which ones?

9. What suggestions do you have for future versions of the document?

Time ended _____

Thank you very much for taking the time to answer these questions.

APPENDIX I

Mail Survey

THE USEFULNESS OF THE DOCUMENT

INCREASING ACCESS

DEVELOPING CULTURALLY ACCESSIBLE
MENTAL HEALTH AND SOCIAL SERVICES
FOR IMMIGRANTS AND REFUGEES

A SURVEY OF THE DOCUMENT'S INITIAL RECIPIENTS

CANADIAN MENTAL HEALTH ASSOCIATION

MANITOBA DIVISION INC.

2-836 Ellice Avenue
Winnipeg, Manitoba R3C 0C2

Telephone: 775-8888
Fax: 775-3497

SURVEY #

Your comments will be very valuable in helping us to improve the document "Increasing Access". Please complete and return this questionnaire to the Canadian Mental Health Association, Manitoba Division, in the envelope provided for your convenience.

1. Did you receive a copy of Increasing Access? (Circle number)

1 NO
2 YES
3 DO NOT KNOW

If you did not receive a copy, please contact our office at 775-8888 to obtain one.

If yes, where is the document kept?

2. Was the document shared outside of your organization? (Circle number)

1 NO
2 YES
3 DO NOT KNOW

If yes, with whom?

3. Approximately how many staff are there within your organization that have read the document?

_____ (number)

4. Compared to other service planning and evaluation guides how easy is this document to understand? (Circle number)

1 VERY MUCH MORE DIFFICULT TO UNDERSTAND
2 A LITTLE MORE DIFFICULT
3 ABOUT THE SAME AS OTHER GUIDES
4 QUITE A BIT EASIER
5 VERY MUCH EASIER TO UNDERSTAND

5. Generally how informative did you find the document? (Circle number)

1 NOT AT ALL INFORMATIVE
2 A LITTLE INFORMATIVE
3 SOMEWHAT INFORMATIVE
4 QUITE INFORMATIVE
5 VERY INFORMATIVE

6. Has or will the document been used for: (Circle all that apply)

1 SENSITIZING STAFF TO ISSUES
2 EVALUATING EXISTING PROGRAMS
3 PLANNING NEW PROGRAMS
4 BOARD TRAINING
5 STAFF TRAINING
6 TRAINING OF GROUPS EXTERNAL TO YOUR AGENCY
7 OTHER (specify) _____

7. Please rate the usefulness of each section of the document listed below. (Circle your answers)

Section	Degree to which the section is useful				
Barriers	NOT AT ALL	VERY LITTLE	SOMEWHAT	QUITE	VERY
Remedies	NOT AT ALL	VERY LITTLE	SOMEWHAT	QUITE	VERY
Review of Literature	NOT AT ALL	VERY LITTLE	SOMEWHAT	QUITE	VERY
Quick Checklist	NOT AT ALL	VERY LITTLE	SOMEWHAT	QUITE	VERY
References	NOT AT ALL	VERY LITTLE	SOMEWHAT	QUITE	VERY
Glossary	NOT AT ALL	VERY LITTLE	SOMEWHAT	QUITE	VERY

8. Is the document too long? (Circle number)

1 NO
2 YES
If yes, what should be removed?

9. Is the document too brief? (Circle number)

1 NO
2 YES
If yes, what should be added?

10. What changes, if any, are needed in the layout or visual presentation of the document?

11. What changes, if any, are needed in the content of the document?

12. Does the document appear to be generalizable to: (Circle all that apply)

1 ABORIGINALS
2 NON-IMMIGRANT CULTURAL MINORITIES
3 GENERAL PUBLIC
4 OTHER (specify) _____

13. Is the content of the document suitable for use in the Canadian context? (Circle number)

1 NO
2 YES

14. Would it be useful to add members of the clergy as potential interpreters in the sections of the document that address language barriers? (Circle number)

1 NO
2 YES

15. Does the document deal sufficiently with barriers to service experienced by immigrant and refugee children? (Circle number)

1 NO
2 YES

16. Overall, do you find the document: (Circle number)

1 TOO BASIC
2 ABOUT RIGHT
3 TOO ADVANCED

17. Have you been able to implement any of the remedies suggested in the document? (Circle number)

1 NO
2 YES

If no, why not?

If yes, which ones?

18. Would the document have been more helpful if you had the opportunity to consult with a knowledgable person about it? (Circle number)

1 NO
2 YES

19. Would the document have been more useful if you had the opportunity to attend a training session? (Circle number)

1 NO
2 YES

20. Please list any other suggestions which you might have to improve the document.

We would appreciate some information about your organization for interpretive purposes.

21. Approximately how many clients does your organization provide service to on a yearly basis? (Circle number)

1 LESS THAN 100
2 101 TO 500
3 501 TO 1000
4 OVER 1000
5 DOES NOT APPLY

22. What percentage of your present client population would you consider to be immigrants or refugees? (Circle number)

1 0%
2 1-10%
3 11-25%
4 26-50%
5 OVER 50%
6 DOES NOT APPLY

23. Does your organization offer: (Circle all that apply)

1 INPATIENT OR OTHER SERVICES PROVIDED TO CLIENTS WHO RESIDE IN YOUR FACILITY
2 OUTPATIENT OR OTHER SERVICES PROVIDED TO CLIENTS LIVING IN THEIR OWN HOMES OR OTHER COMMUNITY PLACEMENTS
3 OTHER (specify) _____

22. What is your job title?

_____

Thank you very much for your assistance!

April 5, 1991

APPENDIX J

Letter to Advisory Group

RE: CULTURALLY ACCESSIBLE MENTAL HEALTH SERVICES PROJECT

Thank you very much for agreeing to serve as an advisor to the CMHA project pertaining to the accessibility of mental health services by immigrants and refugees. As we have discussed, this project has just begun and is expected to be completed within approximately six months.

One of the major purposes of the project is the development of a document that will attempt to specify a model and characteristics of culturally accessible mental health services. In order to prepare the document, a comprehensive literature review will be completed and one or two programs that are reputed to provide culturally accessible services in Winnipeg will also be described.

Once the document has been drafted, selected representatives of ethnocultural community organizations, mental health services and immigrant serving agencies will be invited to attend forums to discuss the draft. Revisions will be made as necessary, and the final document will then be distributed to mental health service providers across Winnipeg.

As you are aware, several individuals representing various groups have been asked to serve as advisors to the project. I do not necessarily foresee regular meetings of this group, but would like to be able to obtain your input at various key stages of the project (e.g. choice of programs to be described, selection of representatives to be invited to forums).

I very much appreciate your assistance in this project and look forward to working with you. If you have any questions, or would like any additional information, please contact me.

Sincerely,

April 23, 1991

APPENDIX K

Letter inviting Participation of Exemplary Programs

RE: CULTURALLY ACCESSIBLE MENTAL HEALTH SERVICES PROJECT

Further to your recent telephone conversations with Dr. Sid Frankel, Faculty of Social Work, University of Manitoba, I am writing to provide you with an overview of the CMHA project pertaining to the accessibility of mental health services by immigrants and refugees in Manitoba.

This project has received funding by Immigration and Settlement Services and began in March, 1991, with an anticipated duration of approximately six months. The research conducted within the project has received approval by the Ethics Review Committee, School of Social Work, at the University of Manitoba.

One of the major purposes of the project is the development of a document that will attempt to specify a model and characteristics of culturally and linguistically accessible mental health services. In order to prepare the document, a comprehensive literature review will be completed and two programs that are reputed to provide culturally accessible services in Winnipeg will also be described. The program descriptions will assist in the development of the model, but will not appear in the actual document.

The description will entail my completing interviews of approximately one hour each with two staff and, if feasible, one client, a review of relevant written documents (e.g. program brochures, forms used by clients, policy manuals), and a brief on-site visit. The intention of the interviews is to gain information about the accessibility of the service and individuals interviewed will not be identified in any subsequent reports.

I very much appreciate your assistance in the completion of this project and would be happy to answer any questions you may have. At the completion of the project, I would be pleased to send you a copy of the final document.

Sincerely,

Canadian
Mental Health
Association

Manitoba Division

2-836 Ellice Avenue
Winnipeg, Manitoba
Canada, R3G 0C2
(204) 775-8888
Fax: 775-3497

APPENDIX L

Correspondence regarding

Focus Groups

July 12, 1991

Winnipeg, Manitoba

Dear :

RE: CULTURAL ACCESSIBILITY OF MENTAL HEALTH SERVICES

As you may be aware, the Canadian Mental Health Association, Manitoba Division is currently sponsoring a project aimed at increasing the accessibility for immigrants and refugees to mental health and social services. The project was funded through a grant awarded by the Immigration and Settlement Services Branch of Manitoba Culture, Heritage and Citizenship.

One of the major outcomes of the project will be a document intended for service providers in evaluating and planning to improve the cultural sensitivity of their services. The purpose of the document is to identify barriers to services and characteristics of culturally accessible services. A draft of the document has now been completed and is enclosed with this letter.

You are invited to attend a meeting on August 19, 1991 at 7:00 p.m. which will be held to obtain feedback from key community representatives regarding this document. You have been specially selected to attend as a result of your expertise in this area, and you are being invited to respond as an individual rather than as a representative of your organization. If you cannot attend on August 19, an alternate meeting will be held on August 21, 1991 at 2:00 p.m.

The meetings will be in the Board room of the Canadian Mental Health Association, office (lower level, 836 Ellice Avenue). Please return the enclosed response sheet by August 9, 1991 to indicate whether or not you will attend.

Your feedback on the draft document will be extremely useful in preparing the final document which will be widely distributed to mental health service providers. At the meetings, discussion about the document will proceed in categories that are listed on the enclosed "Feedback Form" which you are invited to complete for your own use or submit. Please note that in order to ensure that the discussion is properly captured, the meetings will be videotaped. Written comments will also be accepted and can be submitted at the meeting or by mail before August 23, 1991.

We feel that this document will be an important step in improving access to services for immigrants and refugees. I will be happy to answer any questions you may have. Thank you very much for your participation in this project.

Sincerely,

Bettina Nyman, M.A.
Project Coordinator

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Canadian Mental Health Association

Manitoba Division

2-836 Ellice Avenue
Winnipeg, Manitoba
Canada, R3G 0C2
(204) 775-8888
Fax: 775-3497

PARTICIPANT RESPONSE SHEET

Please return this sheet as soon as possible to CMHA - at the latest by August 9, 1991 - in the enclosed envelope or by fax.

_____
Name

_____ Will attend the forum I have been scheduled for on August 19, 1991

_____ Will attend the alternate forum on Aug. 21, 1991.

_____ Will not attend.

_____ Cannot attend, but will submit written comments.

If you agree to have your name included in the final document, in the list of individuals who were invited to provide feedback on the draft document, please give your name as you would like it to appear.

_____

If you would like a copy of the final document, please note the mailing address you would like used.

_____

_____

_____

THANK YOU!

FEEDBACK FORM

This form is intended to serve as a guide for making comments about the draft document. Please complete it and bring it with you to the meeting for your own use, or feel free to use it as a basis for submitting written comments.

Comments about the
BARRIERS

1. Information/Outreach
2. Acceptability
3. Cultural
4. Language
5. Physical/geographic
6. Operational
7. Administrative
8. Financial

Comments about the
SOLUTIONS

1. Information/Outreach
2. Acceptability
3. Cultural
4. Language
5. Physical/geographic
6. Operational
7. Administrative
8. Financial

PRESENTATION STYLE OF THE DOCUMENT

OMISSIONS

OTHER

November 21, 1991

APPENDIX M

Cover Letter sent with Increasing Access

RE: INCREASING ACCESS
Developing Culturally Accessible Mental Health and Social Services for Immigrants and Refugees

Early in 1991, a project was begun which was aimed at increasing the accessibility of mental health and social services for immigrants and refugees. The project was administered by the Canadian Mental Health Association, Manitoba Division and funded through a grant awarded by the Immigration and Settlement Services Branch of Manitoba Culture, Heritage and Citizenship.

One of the major outcomes of the project is the enclosed document which is intended for use by mental health and social services planners, managers, and evaluators. Its purpose is to identify the barriers faced by immigrants and refugees which prevent them from obtaining service. It also describes the characteristics of culturally accessible services which result when these barriers are lowered. Increasing Access is based upon a thorough review of the literature and the input of human service administrators, professionals, and representatives of ethnocultural groups.

This document is currently being distributed across Manitoba to a large number of mental health and social service agencies, as well as to individuals interested in the area of services to immigrants and refugees.

Some time after the distribution has been completed, a survey will be conducted to obtain the views of its recipients. Survey results will contribute to the improvement of any future versions of the document, as well as to the continued planning and additional projects which will be undertaken to improve the accessibility of services. We hope that you take the time to respond to this survey.

We feel that Increasing Access will be an important step in creating more effective utilization of mental health and social services by immigrants, refugees, and the population at large. Please contact me if you have any questions about the document or the project.

Sincerely,