Optimizing the Mental Health & Emotional Wellbeing of Immigrants and Refugees in Winnipeg: A Conceptual Framework

December 12, 2014

A collaborative report for the Immigrant & Refugee Partners, supported by The Winnipeg Regional Health Authority
There is no wellbeing without emotional wellbeing!

*Adapted from WHO

The Winnipeg Regional Health Authority’s (WRHA) Immigrant & Refugee Working Group engages many partners in a collaborative process of working together to optimize the health and well being of Immigrants and Refugees. In this paper the WRHA Immigrant & Refugee Working Group focused on the mental health and emotional wellbeing of Immigrants and Refugees.

A WRHA Immigrant & Refugee Mental Health Working Group is also in place as a subcommittee of the WRHA Immigrant & Refugee Working Group. This subcommittee has focused on the need to develop a conceptual framework.

Under the collaborative facilitation of Jeanette Edwards and Susan Chipperfield, the WRHA utilized the knowledge and expertise of consultant Neil Koop to assist in preparing this Conceptual Framework.
KEY POINTS

- This paper sets out an overall conceptual framework that outlines the requirements of a comprehensive approach to optimizing the mental health & emotional wellbeing of immigrants and refugees in Winnipeg as well as identifies initial areas of action to implement the conceptual framework.

- A consultant was retained to research and prepare this paper in consultation with the WRHA Immigrant & Refugee Mental Health Working Group of the WRHA Immigrant & Refugee Working Group.

- Based on the immigration trends and the role of migration and culture on mental health & emotional wellbeing, a conceptual framework based on individual and system level values & principles; an articulation of the social determinants/factors of mental health of particular importance to immigrants and refugees; and an identification of components deemed essential in a mental health & emotional wellbeing system responding to the needs of immigrants and refugees was developed.

- Several key service delivery models were reviewed and an Immigrant & Refugee Mental Health & Emotional Wellbeing Stepped Care Service Model is proposed. The proposed stepped care model is mainstream, cross-sector and collaborative and integrates the WRHA plan for the redesign of the Community Mental Health Program as well as the plan for the WRHA Primary Care Networks and other primary care renewal initiatives.

- The proposed Immigrant & Refugee Mental Health & Emotional Wellbeing Stepped Care Service Model is based on a continuum of services that include emotional wellbeing promotion, early identification and intervention, as well as clinical treatment supports and services.

- Proposed areas for action include:

  Central to the Entire Continuum of Services of the Proposed I & R Mental Health & Emotional Wellbeing Stepped Care Service Model:

  - Environmental Scan:
    Members of the Immigrant & Refugee Mental Health & Emotional Wellbeing Working Group need to identify existing programs & services. Each of these services should relate to a step in the I & R Mental Health & Emotional Wellbeing Stepped Care Service Model. It is suggested that existing scans and inventories (e.g., CONTACT/Winnipeg Health Services Directory; Local Immigration Partnership Winnipeg [LIPW]) as well as lessons learned from BridgeCare and others could be used as a starting point for this activity.

  - Intersectoral Awareness and Education:
    Create opportunities for cross-learning and collaboration across all sectors (e.g., immigration & settlement; health/mental health; education; social services; legal; cultural & religious organizations). Research has shown that spirituality and cultural context often construct mental health and mental illness in very different ways. Religious affiliations may even be strengthened post-migration, whether for reasons of renewed religious belief or because religious institutions become locations of community support. (Khanlou, 2010) Example of cross-learning and collaboration is that of the Settlement Workers and BridgeCare.
• **Cultural Proficiency Awareness and Action:**
  In order to support ongoing excellence in service delivery, partners should explore opportunities to enhance cultural proficiency at all levels of this comprehensive service delivery model. (e.g., roll out and implementation of the new Geographic Based CMHP Interprofessional Teams; development and implementation of geographic based Primary Care; exploration of mechanisms to enhance cultural awareness and proficiency)

• **Establish a Mechanism for Joint Planning & Service Delivery:**
  Based on the environmental scan and the principles of diversity the Mental Health & Emotional Wellbeing Working Group needs to identify mechanisms for and engage in collaborative approaches to planning, implementation and evaluation of services.

• **Review Clinical Practice Guidelines and Pathways as appropriate:**
  Review existing clinical practice guidelines and pathways for applicability to and support of this framework.

**Mental Health Promotion and Capacity Building:**

• The Immigrant & Refugee Mental Health & Emotional Wellbeing Working Group needs to establish opportunities to discuss the role of culture on mental health & emotional wellbeing.

• Create opportunities for intersectoral groups to discuss, understand and honour the role of culture and community on mental health & emotional wellbeing.

• Identify supports that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections, and personal dignity (Joubart et al., 1996, cited in CAMH Best Practice Guidelines; 2012, p-17).

• Create mainstream information and education tools on mental health & emotional wellbeing that are culturally relevant and readily accessible. E.G: Universal Mental Health Promotion Strategies like Mental Health First Aide; Education kits & online supports like Bounce Back & Calm in the Storm; Identification/screening tools targeted for service providers and caregivers.

• Support community and organizational capacity-building within Immigrant & Refugee cultural, religious and community organizations in order to develop sustainable skills and abilities to support I & R mental health and emotional wellbeing. (WRHA: Community Development Framework – Updated 2014) Example of community capacity-building is Strengthening Families Program at Mount Carmel Clinic.

• To provide equity in mental health across all sectors, link this framework with the equity frameworks of each sector.

**Formal Mental Health Supports:**

• **Interpreters:**
  
  o Support the ongoing inclusion of Mental Health & Emotional Wellbeing in interpreter training.

  o Support the use of trained interpreters at appropriate steps in the I & R Mental Health & Emotional Wellbeing Stepped Care Service Model.

  o Support cross sector access to trained interpreters (e.g., justice, education, social services).
• Support Province-wide accessibility to interpreter supports and the use of technology (e.g., telehealth).

- Cultural Brokers:
  - Support the gathering of evidence regarding the role and use of cultural brokers in delivering mental health and emotional wellbeing services.

- Relational-based Services:
  - Support healthy relationships by supporting access to a broad range of available resources.

- Trauma-Informed Services:
  - Support access to culturally appropriate trauma-informed services. This is especially important regarding post traumatic stress relating to the life experiences of refugees. The need for this treatment response was identified in focus groups conducted in Winnipeg by Koop & Carter in 2011.

- Cross-cultural Consultation Model for I & R:
  - Gather evidence to inform the anticipated development of an interprofessional Cultural Consultation Team to support the work of culturally proficient mainstream mental health workers.

➢ To move forward, the importance of the role of culture on mental health must be understood and all services or interventions must be based on evidence-informed or evidence-based, culturally consonant practices. (Kirmayer & Pedersen, 2014)
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.3 WRHA Collaborative Care Model</td>
<td>58</td>
</tr>
<tr>
<td>12.4 I &amp; R Mental Health &amp; Emotional Wellbeing Stepped Care Service Model</td>
<td>60</td>
</tr>
<tr>
<td>13 An Integrated Model for Mental Health &amp; Emotional Wellbeing Services for Immigrants and Refugees: Areas for Action</td>
<td>62</td>
</tr>
</tbody>
</table>

**References**

**Appendix # 1:** The International Migrants Bill of Rights Initiative  
**Appendix # 2:** Fraser Health Mental Health and Substance Use (MHSU) Integrated Care Model  
**Appendix # 3:** Language Barriers Within the Winnipeg Regional Health Authority: Evidence and Implications
List of Figures

Figure # 1: How Immigrants come to Manitoba 28
Figure # 2: Manitoba Immigration 2000 to 2012 33
Figure # 3: Principles of Recovery 41
Figure # 4: Conceptual Framework of Requirements of a Comprehensive Approach to Optimizing the Mental Health & Emotional Wellbeing of Immigrants & Refugees 13 & 54
Figure # 5: Creating Flourishing Environments 57
Figure # 6: Moving Toward a Broad Collaborative Care Model for CMHP 59
Figure # 7: I & R Mental Health & Emotional Wellbeing Stepped Care Service Model 18 & 61
Figure # 8: I & R Mental Health & Emotional Wellbeing Stepped Care Service Model – Health Promotion and Capacity Building 21 & 64
Figure # 9: I & R Mental Health & Emotional Wellbeing Stepped Care Service Model - Formal Mental Health Supports 24 & 67

List of Tables

Table # 1: CANADA – Permanent Residents by Category, 2003 – 2012: 31
Table # 2: Manitoba – Permanent Residents by category, 2003 – 2012: 32
Table # 3: Manitoba – Permanent Residents Age by Children & Youth, 2008 – 2012: 32
Table # 4: Refugees Welcomed into Manitoba from 2003 – 2012: 34
Table # 5: Immigrants (all categories) by Top Ten Source Countries in 2012: 34
Table # 6: Refugees by Top 10 Source Countries in 2012: 35
Table # 7: Factors affecting refugee mental health and emotional wellbeing: 37
EXECUTIVE SUMMARY

Immigration Trends:

Canada and Manitoba depend on immigration for population and economic growth. According to Citizenship and Immigration Canada, Canada has admitted an average of 249,000 new permanent residents each year in the 10 years from 2003 to 2012. Included in this average number of new permanent residents is an average of 27,525 (11.0%) individuals classified as refugees. In the 5 years from 2008 to 2012, Canada has admitted an average of 257,000 new permanent residents per year. Included in this 5 year average number of new permanent residents is an average of 24,071 (9.4%) individuals classified as refugees. The influx of new permanent residents represents approximately 8% of Canada’s population (CIC Statistics, Backgrounder – 2014 Immigration Levels Planning: Public and Stakeholder Consultations).

In the 10 years from 2003 to 2012 Manitoba has welcomed an average of 11,300 new permanent residents each year and of these approximately 1,153 (11%) were classified as refugees. In the 5 years from 2008 to 2012, Manitoba has welcomed an average of 13,900 new permanent residents per year including 1,109 (8%) who were classified as refugees (CIC Statistics, Backgrounder – 2014 Immigration Levels Planning: Public and Stakeholder Consultations). In 2013, Manitoba welcomed the highest number of refugees per capita in Canada. Preliminary unpublished data indicate that the total number of refugees arriving in Manitoba in 2013 was 1484, an increase from 1140 (344 or 30.2%) over 2012.

Immigrants and refugees in ever increasing numbers have decided to make Winnipeg and Manitoba their home. A significant trend in the reception of refugees is that the proportion of Privately Sponsored Refugees (PSRs) vs. Government Assisted Refugees (GARs) has been rising from 12% (80) in 1998 to 66.2% (755) in 2012. Preliminary unpublished data also indicates that the trend toward greater numbers of PSRs continued in 2013 with 1002 PSRs (67.5%) vs. 389 GARs (26.2%) received by Manitoba. In 2013, Manitoba’s share of PSRs to Canada was 15.7% of the national total and the highest per capita in Canada. This is as a result of the high level of activity among Manitoba sponsors to sponsor refugees. This trend is likely to continue as it supports Citizenship and Immigration Canada’s policy direction to reduce the number of GARSs and increase PSRs. Changing federal policy is also impacting access to federally insured services. On July 1, 2012, CIC limited eligibility for extended health services (hospital, diagnostic, medication) under the Interim Federal Health Program (IFHP) reforms for PSRs and Refugee Claimants unless care is urgent or poses a risk to public health. Other benefits discontinued include prescription drugs, dental, vision and ambulance service. The trend of increasing the proportion of PSRs as well as the policy change regarding access to IFHP may have impacts on both the health and mental wellbeing of immigrants & refugees as well as on their health and mental wellbeing needs and supports.

Another significant trend in the reception of immigrants & refugees is the number of families with children and young people. In the 5 years from 2008 to 2012, the children & youth (0 to 19yrs) population has averaged 4782 or 34% of the total number of immigrants and refugees received in Manitoba. (Source: Manitoba Immigration and Multiculturalism) This is significant in terms of the child development, parental, psychosocial, and intergenerational issues that accompany the immigration and settlement/re-settlement experience.

In 2012 the top 5 Source Countries for immigrants (all classes) welcomed into Manitoba were: Philippines, (3,764); India (2,095); China (1,200); Nigeria (419); and Pakistan (337). In 2012 the top 5 Source Countries for refugees (PSRs & GARs) welcomed into Manitoba were: Eritrea (242); Democratic Republic of Somalia (227); Ethiopia (206); Democratic Republic of Congo (78); and Bhutan (41).
Mental Health & Emotional Wellbeing:

Our mental health is a vital component of our wellbeing. The World Health Organization (WHO) describes mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community” (WHO 2007). According to WHO (2007) without mental health there is no health. This state of wellbeing arises from interactions between the individual and his or her environment (Khanlou, Migrant Mental Health In Canada, 2010).

Laurence Kirmayer states that providing quality health care to immigrants and refugees requires recognition of the unique factors that affect their mental health. While immigrants tend to be healthier than the general population when they first arrive in Canada, over the years, their rates of mental disorders rise to the Canadian average. Refugees are at a higher risk for mental disorders than the general population, especially for conditions related to violence and torture such as post-traumatic disorder, depression, and somatic symptoms (Kirmayer, Mental Health of Immigrants and Refugees, 2012).

The health and mental wellbeing of the immigrant & refugee populations is influenced by complex and interrelated factors. While the immigrant & refugee populations are influenced by similar dimensions of social determinants as that of mainstream Canadians, additional determinants due to their immigrant & refugee status (e.g., social and economic integration barriers, access barriers to relevant social and health services due to language and cultural differences, lack of social networks) also may exert significant influences. Some argue that the migration and settlement process itself is a significant social determinant of health and mental Wellbeing (Khanlou, MMH in Canada, 2010).

Providing mental health care for immigrants and refugees requires an understanding of how culture impinges on mental health. Culture influences many aspects of mental illness and coping, including how consumers interpret and explain their symptoms, how they deal with them, what treatments they prefer and seek out, and the terms they use to define the treatment process and the relationship between themselves, their families, and the health care system. Kirmayer concludes that it is essential to understand the specific stressors associated with migration to develop a more accessible and culturally responsive approach that will help immigrants and refugees benefit from adequate mental health care (Kirmayer, Mental Health of Immigrants and Refugees, 2012).

While migration contingencies create mental health risk, not all immigrants and refugees develop mental illness. As a result of a decade-long study of Southeast Asian refugees who came to Canada between 1979 and 1981, Morton Beiser has identified that the nature of traumas, the coping strategies employed, and the phase of resettlement affect the degree to which risk is translated into illness. He indicates that when acculturation changes aspirations, but the means for achieving ambitions are slight, mental disorder is a highly likely result. Linguistic proficiency is one of the most important requirements for making one’s way in a new culture. Economic stability is another important requirement. Beiser further states that people with a significant other and/or a supportive like-ethnic community did not show the time-dependent spike in mental health risk. People with both an intimate relationship and a presumably supportive community were particularly resistant to the development of a disorder (Beiser, “Resettling Refugees and Safeguarding their Mental Health…”, 2009).

The Mental Health Commission of Canada (MHCC) in its’ statement on lessons learned regarding issues and options for improving mental health services for immigrant and refugee groups identifies five specific action areas that demand collaborative effort (Issue: Diversity, MHCC Website 2013).

**Prevention:** Services should focus on health promotion and illness prevention, supported by policies that address social determinants of health. **Stigma** needs to be minimized through campaigns specific to diverse populations.
**Inclusion:** Service provider organizations need to include members of the populations they serve among their employees. Organizations need to build their "cultural competence"—their understanding of different groups’ needs—with training and support for staff.

**Diversification:** Different models of care are needed for different populations. By sharing new and best models of care, planners and providers can develop strategies that can be tailored to their unique demographic needs.

**Language:** Approximately 6.2 million Canadians do not speak English or French as their mother tongue. A language strategy is required to improve services, including the translation of signage and documentation and the provision of interpreters trained in mental health.

**Access:** Some provinces, territories and regions have greater numbers of diverse populations to support than others. To ensure all can be reached and served, strategies such as establishing remote hospital services or clinics and online/smart phone-based resources may be helpful.

**Conceptual Framework:**

A conceptual framework of requirements of a comprehensive approach to optimizing the mental health & emotional wellbeing of immigrants and refugees was developed. The conceptual framework is based on a set of guiding values and principles, individual and system level; a listing of the social determinants/factors of mental health of particular importance to immigrants and refugees; and a listing of components deemed essential/foundational to optimize the mental health & emotional wellbeing of immigrants and refugees.
CONCEPTUAL FRAMEWORK OF REQUIREMENTS OF A COMPREHENSIVE APPROACH TO ADDRESSING THE MENTAL HEALTH & EMOTIONAL WELLBEING NEEDS OF IMMIGRANTS & REFUGEES:

GUIDING VALUES & PRINCIPLES

<table>
<thead>
<tr>
<th>Individual Level:</th>
<th>System Level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Respect and Dignity</td>
<td>✓ Accessibility</td>
</tr>
<tr>
<td>✓ Self Determination, Independence and Choice</td>
<td>✓ Mental Health Promotion</td>
</tr>
<tr>
<td>✓ Resilience</td>
<td>✓ Capacity Building</td>
</tr>
<tr>
<td>✓ Participation, Relationship and Social Inclusion</td>
<td>✓ Person &amp; Relationship Centred (“Driven”)</td>
</tr>
<tr>
<td>✓ Fairness and Equity</td>
<td>✓ Recovery Focused</td>
</tr>
<tr>
<td>✓ Security</td>
<td>✓ Support to Family / Community</td>
</tr>
<tr>
<td></td>
<td>✓ Education &amp; Support for Service Providers</td>
</tr>
<tr>
<td></td>
<td>✓ Diversity, Cultural Safety and Cultural Proficiency</td>
</tr>
<tr>
<td></td>
<td>✓ Comprehensive</td>
</tr>
<tr>
<td></td>
<td>✓ Holistic</td>
</tr>
<tr>
<td></td>
<td>✓ Integrated, Flexible, &amp; Seamless</td>
</tr>
<tr>
<td></td>
<td>✓ Mainstream Response to I &amp; R Needs / Issues</td>
</tr>
<tr>
<td></td>
<td>✓ Evidence Informed</td>
</tr>
</tbody>
</table>

Determinants/Factors of Mental Health & Emotional Wellbeing of Particular Importance to Immigrants and Refugees:

- Migration
- Income and Social Status: *Socio-economic status following migration:*
- Social Support Networks: *Isolation & absence of social support:*
- Education & Literacy: *Language:*
- Employment and working conditions
- Social and Physical Environments: *Housing*
- Personal Health Practices and Coping Skills: *Resilience*
- Healthy Child Development: *Child Rearing, Parental Practices*
- Biology and Genetic Endowment
- Health Services: *Barriers to accessing mental health*
- Gender
- Culture: *Cultural background, spirituality and religious background*
- Prejudice, Discrimination and Racism
- Age

Foundations of Immigrant & Refugee Mental Health & Emotional Wellbeing:

- Human Rights
- Culture
- Family
- Community
- Mental Health Promotion
- Recovery Focus

*The WRHA I & R Working Group notes that these values and principles should apply to all populations and Mental Health & Emotional Wellbeing Services.*
FIGURE # 4: Conceptual Framework of Requirements of a Comprehensive Approach to Optimizing the Mental Health & Emotional Wellbeing of Immigrants and Refugees:
Mental Health Service Models:

Our review of mental health service models for immigrants and refugees is predicated on a literature review and at the national level, especially on several recommendations that come from work done by the Mental Health Commission of Canada.

“The Diversity Task Group takes the position that the challenges faced by Immigrant, Refugee, Ethno-Cultural and Racialized (IRER) populations need a mainstream service response, while also increasing the diversity of services and providers. All services will need to be capable of offering equitable care to Canada’s diverse population.” (MHCC: The Diversity Task Group, p-6)

Our review of mental health service models for immigrants and refugees is framed by looking at mainstream mental health service models with the recognition that these mainstream models must be able to respond to specific and diverse needs by increasing the diversity of services and providers.

“There are five groups of actions required to improve mental health services for Immigrant, Refugee, Ethno-Cultural and Racialized (IRER) groups:
I. Changed focus: an increased emphasis on prevention and promotion
II. Improvement within services: develop organizational and individual cultural competence
III. Improved diversity of treatment: diversity of providers, evaluation of treatment options
IV. Linguistic competence: improved communication plans and actions to meet Canada’s diverse needs
V. Linking needs to expertise: plans to offer support by people and services with expertise to areas with lower IRER populations so they can offer high-quality care” (MHCC: The Diversity Task Group, p-7)

At a local level, the WRHA has published a framework on cultural proficiency. This framework is consistent with and complementary to the above listed MHCC recommendations on mental health service models for immigrants and refugees. The Cultural Proficiency & Diversity Framework is built on three levels of interventions:

1. Organizational Interventions: efforts to promote representative leadership and workforce that are racially/ethnically and culturally from diverse backgrounds.
   Organizational interventions include “diversity” and “minority recruitment” initiatives.
2. Structural Interventions: efforts to make the processes within the health care system more client-friendly and culturally appropriate to ensure that patients/clients have full access to quality health care.
   Structural interventions encompass a variety of measures that can be categorized as follows:
   • Interventions to support communication competency
   • Interventions to improve design and functioning of the health care system
   • Socio-cultural assessment of population
   • Community development and participation
   • Collaborative partnerships
3. Clinical Interventions: efforts to equip health care providers with the knowledge of how socio-cultural factors affect health and provide health care professionals with the tools and skills to manage socio-cultural factors in the clinical encounter.
   Clinical interventions involve cross-cultural (cultural proficiency) training programs that include: cross-cutting cultural/social knowledge, communication skills, know-how concerning cultural health assessment. These skills and tools are needed to ensure that health care providers do not make diagnostic and treatment decisions based on inaccurate information and/or biases. In addition, clinical interventions include having the know-how for dealing with specialized health care needs of immigrant and refugee populations.
The review of mental health service models for immigrants and refugees is framed by looking at continuum of service models that include emotional wellbeing promotion, earlier identification and intervention, as well as clinical treatment supports and services.

**Dual Continua Model** – In Manitoba’s strategic plan for mental health, *Rising to the Challenge*, the Dual Continua Model is described in the following statements:

“Mental health is more than the absence of mental illness. When people are mentally healthy, they experience satisfaction and purpose in life, productivity, personal growth, physical health and positive personal, family and community relationships. Mental health promotion involves collaborative efforts that focus on creating environments that promote and sustain these features of positive mental health and well-being. Healthy environments promote mental health and well-being by enhancing protective factors and decreasing risk factors. Manitoba’s whole-population approach to mental health promotion supports capacity building and resilience and includes targeted prevention activities for at-risk groups.

Research in mental health demonstrates that factors contributing to positive mental health and well-being - defined as flourishing, and the factors that contribute to poor mental health - defined as languishing, can be measured. (Keyes, C.L.M., 2007). The significance of this research is that it illustrates that individuals may have a mental illness and still flourish if they experience the features of positive mental health. Also a significant finding is that individuals without a diagnosed mental illness may have low mental health consistent with the definition of languishing and be at risk of developing a mental illness.

The benefits of mental health promotion extend to the general population; therefore, a whole population approach to mental health and emotional wellbeing is called for. While the treatment of mental health problems and illnesses remains a core service, an investment in mental health across the entire population, with a focus on healthy child development, will provide positive and more sustainable overall outcomes.” (Manitoba Health: Rising to the Challenge, p-8).

*Dual Continua Model (Keyes, 2005), Rising to the Challenge: A Strategic Plan for the Mental Health and Well-Being of Manitobans, 2011*
and mental illness. The dual continua model is a helpful perspective in developing an integrated model of service for the mental health and emotional wellbeing needs of immigrants and refugees. In order to respond to the needs of immigrants and refugees service planners and providers must listen to the diverse cultural definitions and experiences of mental health and mental illness and integrate them into the dual continua model.

**Community Based Interprofessional Collaborative Teams** – The WRHA Mental Health Program has been in a process of reviewing its Community Mental Health Program (CMHP) as to its purpose and service delivery structure. A 2010 WRHA discussion paper entitled *Geographic Based Community Mental Health Practice Model Redesign: A Discussion Paper* articulates the need for redesign is based on current and emerging evidence informed practice. The discussion paper speaks to the integration of mental health, primary health and social services as well as to a broader based continuum of community based accessible services. The redesign of the Geographic Based CMHP Model of Services proposes the establishment of integrated Community Based Interprofessional Collaborative Teams.

The discussion paper utilizes a quadrant approach to identify service need & intensity as well as to articulate the role and function of these CMHP Teams in reference to these needs. In Quadrant 1, **Low Mental Illness & Low Other Complexity**, the primary focus is on capacity building, promotion and consultation. In Quadrant 2, **Low Mental Illness & High Other Complexity**, the overall focus is on primary prevention for at risk populations and consultation. In Quadrant 3, **High Mental Illness & Low Other Complexity**, the focus is on collaborative practice and on recovery through assessing, addressing and restoring mental health along with maintaining & enhancing natural support networks. In Quadrant 4, **High Mental Illness & High Other Complexity**, the focus is on holistic services working toward integrated treatment for concurrent disorders or complex needs. A more detailed description of these quadrants is depicted in Figure # 6: Moving Toward a Broad Collaborative Care Model for CMHP (page – 59).

Coinciding with the CMHP redesign, Primary care in Manitoba has made significant progress in recent years. The Province of Manitoba is supporting primary care practices and RHAs in a number of ways, including the development or enhancement of **Primary Care Networks**. Primary Care Networks will be built around strong partnerships. Teams of care providers will work together to plan and deliver services for a geographic area or specific community or population. Primary Care Networks are less about physical space, and more about leveraging and building on existing services and enhancing them so that consumers are offered more coordinated and comprehensive care. (Retrieved from Manitoba Health website [http://www.gov.mb.ca/health/primarycare/pcn/index.html](http://www.gov.mb.ca/health/primarycare/pcn/index.html) In Winnipeg, the Primary Care Networks have been aligned geographically and include Family Practice and Mental Health.

The proposed CMHP redesign promotes a mainstream, population based service that offers a broad continuum of services from emotional wellbeing promotion to clinical supports and services. To ensure that this CMHP redesign can better respond to the needs of immigrants and refugees it requires cultural proficiency on behalf of service planners and providers to integrate appropriate service responses to the needs of immigrants and refugees into the various service quadrants.

**Stepped Care Service Model** – We would now like to present a mainstream mental health & emotional wellbeing service model with adaptations to make it applicable to the mental health & emotional wellbeing needs of immigrants and refugees. The service model is based on stepped care, is integrated with health and social services, is inclusive of a broad continuum of care, requires collaboration, and portrays an increasing intensity of service responses. It incorporates the mental health and mental illness concepts of the Dual Continua Model by Keyes and fits with the WRHA Geographic Based CMHP Interprofessional Community Teams redesign.

The proposed model is a series of stairs with the intensity of services increasing as the stairs ascend. The 1st level or stair represents the broadest possible application with a focus on universal mental health promotion strategies integrated with a population health approach. These strategies are about
promoting emotional wellbeing as a component of healthy living. Mental Health First Aide (MHFA) is an example of a universal mental health promotion strategy. Although this strategy is mainstream, attention is being given to creating MHFA courses that incorporate the significant cultural diversities of immigrants and refugees. **Service delivery requires cross-sector collaboration inclusive of non-government organizations, community groups, cultural and religious organizations.**

The next 3 levels or stairs pertain to supports focused on assisting people with increasing their knowledge of mental health and mental illness and enhancing their coping skills. They focus on capacity building, creating information/education kits, developing online supports, and supported self-management. Two examples of services are: Bounce Back and Calm in the Storm. **Cross-training in cultural proficiency regarding mental health & emotional wellbeing and immigration/ settlement issues is a vital adaptation to this mainstream service approach. Service delivery requires cross-sector collaboration inclusive of non-government organizations, community groups, cultural and religious organizations.**

The last 2 levels or stairs pertain to more specialized, more intense mental health supports and services (smallest application). The **focus is on mental health therapeutic interventions, psychiatric and psychological consultations, and direct clinical interventions and supports (inclusive of inpatient treatment).** While the formal mental health program assumes a greater role and responsibility for these services, they continue to do so in collaboration with primary health care and other social, cultural, and religious organizations. **Navigation to and within these services is an important mainstream issue and is of special significance to immigrants and refugees. Cross-training in cultural proficiency and immigration/settlement issues is especially important in being able to provide culturally proficient treatment responses.** Based on the work of Kirmayer et al (*Cultural Consultation: Encountering the Other in Mental Health Care*, 2014), a specialized Mental Health Cross-Cultural Consultation Model is an essential component to the mainstream mental health service model. (Please see Figure # 7, I & R Mental Health & Emotional Wellbeing Stepped Care Service Model)
Figure #7:
I & R Mental Health & Emotional Wellbeing Stepped Care Service Model: Cross-sector, Collaborative and Mainstream

Mental Wellness Promotion & Capacity Building

- FLOURISHING
- Online Supports & Apps
- Universal Mental Health Promotion Strategies
  - Mental Health First Aide

Life Experiences (both ways)

- Supported Self-Management
- Mental Health Toolkits & Resources
- Capacity Building
  - Information/Education Kits (Bounceback, Calm in the Storm)
  - Cultural Proficiency Awareness and Action

Formal Mental Health Supports

- LANGUISHING
- Direct Support & Collaborative Team-Based Consults
- Therapy Intervention

Formal Mental Health Supports

- Navigation
- Mental Health (I&R) Consultation Model
- Culturally Proficient Treatment Responses

Adapted from MB TRAM TEAM 2013
Adapted from NUKA Health Care
Adapted from Dual Continua Model
An Integrated Model for Mental Health & Emotional Wellbeing Services for Immigrants and Refugees: Areas for Action:

Based on the immigration trends that have been identified, the role of migration and culture on mental health & emotional wellbeing, the conceptual framework that has been developed, and the proposed I & R Mental Health & Emotional Wellbeing Stepped Care Service Model, the following areas have been identified for action:

CENTRAL TO THE ENTIRE CONTINUUM OF SERVICES OF THE PROPOSED I & R MENTAL HEALTH & EMOTIONAL WELLBEING STEPPED CARE SERVICE MODEL: (Figure # 7)

- **Environmental Scan:**
  To determine the strengths and gaps of existing services, and utilizing the I & R Mental Health & Emotional Wellbeing Stepped Care Service Model, members of the Immigrant & Refugee Mental Health & Emotional Wellbeing Working Group need to identify existing programs & services. Each of these services should relate to a step in the I & R Mental Health & Emotional Wellbeing Stepped Care Service Model. It is suggested that existing scans and inventories (e.g., CONTACT/Winnipeg Health Services Directory; Local Immigration Partnership Winnipeg [LIPW]) as well as lessons learned from BridgeCare and others could be used as a starting point for this activity.

- **Intrsectoral Awareness and Education:**
  To support capacity building, create opportunities for cross-learning and collaboration across all sectors (e.g., immigration & settlement; health/mental health; education; social services; legal; cultural & religious organizations). Research has shown that spirituality and cultural context often construct mental health and mental illness in very different ways. Religious affiliations may even be strengthened post-migration, whether for reasons of renewed religious belief or because religious institutions become locations of community support. (Khanlou, 2010) Example of cross-learning and collaboration is that of the Settlement Workers and BridgeCare.

- **Cultural Proficiency Awareness and Action:**
  Many sectors & organizations have a focus on cultural proficiency awareness & action. In order to support ongoing excellence in service delivery, partners should explore opportunities to enhance cultural proficiency at all levels of this comprehensive service delivery model. (e.g., roll out and implementation of the new Geographic Based CMHP Interprofessional Teams; development and implementation of geographic based Primary Care; exploration of mechanisms to enhance cultural awareness and proficiency)

- **Establish a Mechanism for Joint Planning & Service Delivery:**
  There are currently many programs and services for immigrants and refugees offered by various sectors, non-government organizations, cultural organizations, community and religious groups. The services range from basic immigration and re-settlement support, support with daily living and aspects of the determinants of health, psychosocial supports, universal mental health promotion, to more formal mental health supports and interventions. Based on the environmental scan and the principles of diversity, the Mental Health & Emotional Wellbeing Working Group needs to identify mechanisms for and engage in collaborative approaches to planning, implementation and evaluation of services.

- **Review Clinical Practice Guidelines and Pathways as appropriate:**
  Review existing clinical practice guidelines and pathways for applicability to and support of this framework.
MENTAL HEALTH PROMOTION AND CAPACITY BUILDING: (Figure # 8)

- The Immigrant & Refugee Mental Health & Emotional Wellbeing Working Group needs to establish opportunities to discuss the role of culture on mental health & emotional wellbeing.

- Create opportunities for intersectoral groups to discuss, understand and honour the role of culture and community on mental health & emotional wellbeing.

- Identify supports that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections, and personal dignity (Joubart et al., 1996, cited in CAMH Best Practice Guidelines; 2012, p-17).

- Create mainstream information and education tools on mental health & emotional wellbeing that are culturally relevant and readily accessible. E.G: Universal Mental Health Promotion Strategies like Mental Health First Aide; Education kits & online supports like Bounce Back & Calm in the Storm; Identification/screening tools targeted for service providers and care givers.

- Support community and organizational capacity-building within Immigrant & Refugee cultural, religious and community organizations in order to develop sustainable skills and abilities to support I & R mental health and emotional wellbeing. (WRHA: Community Development Framework – Updated 2014) Example of community capacity-building is Strengthening Families Program at Mount Carmel Clinic.

- To provide equity in mental health across all sectors, link this framework with the equity frameworks of each sector.
Figure #8:

I & R Mental Health & Emotional Wellbeing Stepped Care Service Model: Cross-sector, Collaborative and Mainstream

Mental Wellness Promotion & Capacity Building

- Mental Health First Aide
- Capacity Building
- Information/Education Kits (Bounce Back, Calm in the Storm)
- Cultural Proficiency Awareness and Action

Adapted from MB TRAM TEAM 2013
Adapted from NUKA Health Care
Adapted from Dual Continua Model
FORMAL MENTAL HEALTH SUPPORTS: (Figure # 9)

- Development of culturally proficient treatment responses:

  Due to the complexities of mental health and mental illness and since culture is an important factor in influencing mental health / mental illness, it is important that the mainstream mental health & emotional wellbeing system is able to ensure culturally proficient treatment responses.
  
  - Interpreters:
    
    “…interpretation refers to the process by which a spoken or signed message in one language is relayed, with the same meaning, into another language. This definition recognizes the complexity of the task of interpretation.” (Bowen, Language Barriers Within the Winnipeg Regional Health Authority: Evidence and Implications, 2004, p-3).

  Sarah Bowen in a WRHA paper entitled, “Language Barriers Within the Winnipeg Regional Health Authority: Evidence and Implications”, indicates that a lack of language access services presents barriers to first contact for most health services. She further states that language barriers have been demonstrated to decrease participation in health promotion and prevention programs – programs that have important implications for the long term health of the population – and delay presentation for care (Bowen, Language Barriers Within the Winnipeg Regional Health Authority: Evidence and Implications, 2004). (Please see Appendix # 3 for Key Points of this paper.)

  Kirmayer indicates that professional medical interpreters may be the single most important resource to ensure access to, and quality of, mental health services (Kirmayer, Immigrants and Refugees: Two Realities, 2012).

    o Support the ongoing inclusion of Mental Health & Emotional Wellbeing in interpreter training.
    o Support the use of trained interpreters at appropriate steps in the I & R Mental Health & Emotional Wellbeing Stepped Care Service Model.
    o Support cross sector access to trained interpreters (e.g., justice, education, social services).
    o Support Province –wide accessibility to interpreter supports and the use of technology (e.g., telehealth).

  - Cultural Brokers:

    “Even when linguistic communication is established, cultural formulation may require the use of culture brokers or mediators, that is, resource people or professionals with in-depth knowledge of the specific cultural and social background of the patient as well as knowledge of the medical systems who can function as go-betweens, brokering mutual understanding and collaboration.”  (Kirmayer, Laurence J., et al. (2012). Guidelines for Training in Cultural Psychiatry. The Canadian Journal of Psychiatry, Vol 57, No 3, pg-4)

    o Support the gathering of evidence regarding the role and use of cultural brokers in delivering mental health and emotional wellbeing services.

  - Relational-based Services:
• Support healthy relationships by supporting access to a broad range of available resources.

• Trauma – Informed Therapy:
  o Support access to culturally appropriate trauma-informed services. This is especially important regarding post traumatic stress relating to the life experiences of refugees. The need for this treatment response was identified in focus groups conducted in Winnipeg by Koop & Carter in 2011.

• Cross-cultural Consultation Model for I & R:

  Kirmayer et al in their recently published book, Cultural Consultation: Encountering the Other in Mental Health Care, promote the use of an Interprofessional Cultural Consultation Team to support the work of culturally proficient mainstream workers (Kirmayer, 2014). The purpose of the consultation team is to consult, support, train, and empower mainstream workers in providing culturally proficient mental health supports and services.

  Interprofessional Cultural Consultation Team could be developed as a virtual team with specialists from various sectors and organizations. Team members to bring culturally proficient specialized skills together to provide consultation to mainstream health and primary health care networks, (e.g., Psychiatry, Psychology, Community Mental Health Workers, Interpreters, Cultural Brokers).

  o Gather evidence to inform the anticipated development of an Interprofessional Cultural Consultation Team to support the work of culturally proficient mainstream mental health workers

CONCLUDING COMMENTS:

To move forward, the importance of the role of culture on mental health must be understood and all services or interventions must be based on evidence-informed or evidence-based, culturally consonant practices. (Kirmayer & Pedersen, 2014)
Figure #9:

I & R Mental Health & Emotional Wellbeing Stepped Care Service Model: Cross-sector, Collaborative and Mainstream

Formal Mental Health Supports

- Life Experiences (both ways)
- LANGUISHING
- Direct Support & Collaborative Team-Based Consults

Therapy Intervention

- Navigation
- Mental Health (I & R) Consultation Model
- Culturally Proficient Treatment Responses

Adapted from MB TRAM TEAM 2013
Adapted from NUKA Health Care
Adapted from Dual Continua Model
SECTION 1: INTRODUCTION:

Canada and Manitoba depend on immigration for population and economic growth. According to Citizenship and Immigration Canada, Canada has admitted an average of 249,000 new permanent residents each year in the 10 years from 2003 to 2012. Included in this average number of new permanent residents is an average of 27,525 (11.0%) individuals classified as refugees. In the 5 years from 2008 to 2012, Canada has admitted an average of 257,000 new permanent residents per year. Included in this 5 year average number of new permanent residents is an average of 24,071 (9.4%) individuals classified as refugees. The influx of new permanent residents represents approximately 8% of Canada’s population (CIC Statistics, Backgrounder – 2014 Immigration Levels Planning: Public and Stakeholder Consultations).

In the 10 years from 2003 to 2012 Manitoba has received an average of 11,300 new permanent residents each year and of these approximately 1,153 (11%) were classified as refugees. In the 5 years from 2008 to 2012 Manitoba has received an average of 13,900 new permanent residents per year including 1,109 (8%) who were classified as refugees (CIC Statistics, Backgrounder – 2014 Immigration Levels Planning: Public and Stakeholder Consultations). In 2013, Manitoba welcomed the highest number of refugees per capita in Canada. Preliminary unpublished data indicate that the total number of refugees arriving in Manitoba in 2013 was 1484, an increase from 1140 (344 or 30.2%) over 2012.

Laurence Kirmayer has indicated that nearly 20% of the Canadian population is foreign-born. Complementing this fact is the large annual admission of immigrants and refugees as new permanent residents to Canada and Manitoba. Kirmayer states that providing quality health care to immigrants and refugees requires recognition of the unique factors that affect their mental health. While immigrants tend to be healthier than the general population when they first arrive in Canada, over the years, their rates of mental disorders rise to the Canadian average. Refugees are at a higher risk for mental disorders than the general population, especially for conditions related to violence and torture such as post-traumatic disorder, depression, and somatic symptoms (Kirmayer, Mental Health of Immigrants and Refugees, 2012).

Access to mental health services is often difficult. Kirmayer stresses that access to mental health service is especially difficult for people who are not proficient in English or French. While many immigrants use English or French in day-to-day situations, mental health care requires a higher level of proficiency to adequately describe one’s social and emotional states and to fully understand recommendations made by clinicians. Providing mental health care for immigrants and refugees requires an understanding of how culture impinges on mental health. Culture influences many aspects of mental illness and coping, including how consumers interpret and explain their symptoms, how they deal with them, what treatments they prefer and seek out, and the terms they use to define the treatment process and the relationship between themselves, their families, and the health care system. He concludes that it is essential to understand the specific stressors associated with migration to develop a more accessible and culturally responsive approach that will help immigrants and refugees benefit from adequate mental health care (Kirmayer, Mental Health of Immigrants and Refugees, 2012).

The Mental Health Commission of Canada (MHCC) released Canada’s 1st National Mental Health Strategy, Changing Directions Changing Lives in May 2012 (Changing Directions Changing Lives, The Mental Health Strategy for Canada, May 2012). In keeping with developing this national strategy, the MHCC has led and supported a number of projects to help develop strategies that will promote strong, healthy resilient communities across Canada – and improve the service needed by people from diverse backgrounds and cultures who are living with mental health problems or illnesses.

MHCC’s lessons learned (Issue: Diversity, MHCC Website 2013). Improving the mental health services and supports available to immigrants, refugees and distinct ethno-cultural groups requires involvement from
the private, voluntary and public sectors—and from members of the various communities themselves. The MHCC’s Issues and Options report identifies five specific action areas that demand collaborative effort:

**Prevention:** Services should focus on health promotion and illness prevention, supported by policies that address social determinants of health. Stigma needs to be minimized through campaigns specific to diverse populations.

**Inclusion:** Service provider organizations need to include members of the populations they serve among their employees. Organizations need to build their "cultural competence”—their understanding of different groups’ needs—with training and support for staff.

**Diversification:** Different models of care are needed for different populations. By sharing new and best models of care, planners and providers can develop strategies that can be tailored to their unique demographic needs.

**Language:** Approximately 6.2 million Canadians do not speak English or French as their mother tongue. A language strategy is required to improve services, including the translation of signage and documentation and the provision of interpreters trained in mental health.

**Access:** Some provinces, territories and regions have greater numbers of diverse populations to support than others. To ensure all can be reached and served, strategies such as establishing remote hospital services or clinics and online/smart phone-based resources may be helpful.

In keeping with these realities, the Winnipeg Regional Health Authority's (WRHA) Immigrant/Refugee Working Group has been striving to better assess the realities of immigrants and refugees in Winnipeg, health and mental health services utilized and/or required, access to integrated health and mental health services, access to specialized health and mental health services, partnerships required to provide an holistic and recovery based approach to health and mental health care, and developed and published a Framework for Action – Cultural Proficiency & Diversity (Framework for Action – Cultural Proficiency & Diversity, WHRA, September 2011). More recently, a WRHA Immigrant/Refugee Mental Health Working Group was formed as a subcommittee of the WRHA Immigrant/Refugee Working Group. The purpose of this working group is to assist with the development of an overall conceptual framework that outlines the requirements of a comprehensive approach to optimizing the mental health & emotional wellbeing of immigrants and refugees in Winnipeg.

1. **PURPOSE:**

Based on the previous development work done on a framework to address the mental health & emotional wellbeing of immigrants and refugees in Winnipeg, the purpose of this project is to:

- Finalize an overall conceptual framework that outlines the requirement of a comprehensive approach to addressing the needs of this population in Winnipeg.

- Based on a review of current state and identified gaps that have already been articulated, define an action oriented strategy that acts as a guide for the integration of this framework into current strategy development and planning processes for the immigrant/refugee population.

2. **DEVELOPMENT OF CONCEPTUAL FRAMEWORK:**

The WRHA initially reported on the mental health status of immigrants and refugees in 2004 as part of their Community Health Assessment Report (WRHA, Community Health Assessment Report, 2004). The report indicated that mental health and communicable diseases are the most significant health concerns for the immigrant and refugee population in Canada. It provided a profile of immigrants and refugees in Winnipeg as well as highlighted the fact that immigrants and refugees had low health service utilization rates.
Since 2004 the WRHA has initiated or sponsored several studies and reports on the health of immigrants and refugees in Winnipeg. These include the following:

- **The Health of Refugees in Winnipeg**, Report prepared as part of the requirements of a Masters in Community Health Sciences, Jennifer Magoon, May 2005 (unpublished).

- **Immigrant / Refugee Health in the WRHA: An Evidence Informed Strategy; Phase 1: Principles and Service Delivery Model**, WRHA Research & Evaluation Unit, July 2008 (unpublished)


Since 2009 several other studies and reports on the health and/or mental health of immigrants and refugees in Winnipeg or Manitoba were sponsored by provincial or federal Government Departments. These include the following:

- **Healthy Lifestyles for Newcomers in Manitoba: Needs Assessment for Healthy Living**, A Report for Manitoba Health and Healthy Living and the Public Health Agency of Canada describing the health status of newcomers to Manitoba, the barriers they face in maintaining adequate physical activity and nutrition and best practices of addressing these barriers, Rudy Ambtman & Ray Ali, April 2009 (unpublished).


While the initial focus of the studies and reports was on the health needs of immigrants and refugees, they have consistently referenced the mental health issues of immigrants and refugees.

In early 2012 the WRHA Mental Health Program created a **WRHA Immigrant/Refugee Mental Health Working Group** as a subcommittee of the WRHA Immigrant/Refugee Working Group. The purpose of this working group is to focus on the mental health & emotional wellbeing of immigrants and refugees and to assist with the development of an overall conceptual framework that outlines the requirements of a comprehensive approach to optimize the mental health & emotional wellbeing of immigrants and refugees in Winnipeg.

Initial planning on the development of a framework to address the mental health needs of immigrants and refugees included working with a University of Manitoba Community Health Sciences master’s student. During a 12 week practicum the student focused on mental health and the needs of immigrants and refugees in Winnipeg. The student provided: a review of the current work; researched other jurisdictions; and interviewed key informants. The practicum project resulted in a first draft of a conceptual model that will be used in finalizing a conceptual framework (Providing Services to Canadian Newcomers based on
3. KEY CONCEPTS AND DEFINITIONS FOR DESCRIBING IMMIGRATION:

3.1 Migrant:

UNESCO’S indicates that “the term migrant should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned, for reasons of ‘personal convenience’ and without intervention of an external compelling factor” (UNESCO website, September 18, 2013).

Figure #1: How Immigrants come to Manitoba:

*Source: Manitoba Immigration and Multiculturalism (2012)

3.2 Immigrant and Refugee:

Although the terms “immigrant” and “refugee” are often coupled, there is an important distinction between these two categories: Immigrants are people who choose to come to Canada; refugees are those who are forced to flee their country of origin to seek safety in Canada. It is important to note that many refugees do not identify themselves as immigrants since they had no intention of leaving their country – they were forced into exile. Because of the difference in migration experience (and the implications of this experience for health) it is useful to differentiate between immigrants and refugees in health services planning.
3.3 Immigrant Status:

Immigrant status refers to the policy category under which either an immigrant or refugee is designated as they arrive in Canada. Immigrants come to Canada either as a) permanent residents, or as b) temporary residents.

3.3.1 Permanent residents come to Canada in one of three categories: Economic Class, Family Class, or Refugee Class. Provincial and federal immigration policies have a direct bearing on the number of persons coming to Canada within each category.

a. **Economic Class:** immigrants selected for their skills and ability to contribute to Canada’s economy, including business immigrants, federal skilled workers, live-in caregivers, and, in Manitoba, participants in the Manitoba Provincial Nominee Program (MPNP).

- Business immigrants – Canada encourages the admission of business people whose business skills and capital will contribute to the nation’s economy and create job opportunities. There are three business classes: the investor, the entrepreneur, and the self-employed.
- Federal Skilled workers – are individuals selected for their flexible skills, which will ensure their success in a fast-changing labour market and benefit the Canadian economy. Skilled workers must possess education, English or French language abilities, and work experience.
- The Live-in Caregiver Program – brings temporary workers to Canada for certain kinds of live-in work when there are not enough Canadian to fill the available positions. Employees hired under this program care for children, seniors or people with disabilities, without supervision, in a private household. Participants in the Live-in Caregiver Program may apply for permanent resident status in Canada after completing two years of live-in caregiving employment within three years of their arrival in Canada.
- Manitoba Provincial Nominee Program (MPNP) – is an immigration program established under the Canada-Manitoba Immigration Agreement in recognition of the fact that the province knows what its economic needs are in terms of immigration. MPNP allows the Province of Manitoba to receive applications from potential immigrants and nominate them for Permanent Resident Status in Canada. The MPNP seeks qualified workers and business people with a strong likelihood of becoming successfully established in Manitoba.

b. **Family Class:** immigrants who have been sponsored by family members already living in Canada and are Canadian citizens or permanent residents. This includes spouses and partners, dependent children, parents and grandparents.

c. **Refugee Class:** convention refugees and others in refugee-like situations that require protection under international law. The United Nations High Commissioner for Refugees (UNHCR) defines a “refugee” as “any person who owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it” (United Nations High Commissioner for Refugees (UNHCR), 2011). Refugees come to Manitoba as Privately Sponsored Refugees (PSR), Government Assisted Refugees (GAR), Joint Assisted Sponsored Refugees JAS), or as Refugees Landed in Canada:

- Privately Sponsored Refugee – commitment by the sponsor to provide supports, formally up to 1 year,
- Joint Assisted Sponsored Refugee – commitment by government and private sponsor to provide supports, formally up to 2 years,
Given the three categories of permanent residents, it is possible that both voluntary immigrants (economic & family) and refugees seeking residence could arrive from the same country, leaving behind or escaping similar circumstances, and land in Canada as differently categorized permanent residents. For example, a person landing in Canada as a refugee may apply to sponsor other family members using a Family Class application. Hence, even though all members of the family may have had the same war related experiences, they would have been accepted as permanent residents to Canada through different immigration categories. Recent Quebec research, for example, found that 61% of economic and 50% of family class immigrants indicated that they left their homeland because of the political situation there (Focused Community Health Assessment I, November 2010).

Changing federal policy is impacting access to federally insured services. On July 1, 2012, CIC limited eligibility for extended health services (hospital, diagnostic, medication) under the Interim Federal Health Program (IFHP) reforms for PSRs unless care is urgent or poses a risk to public health. Other benefits discontinued include prescription drugs, dental, vision and ambulance service.

3.3.2 Temporary Residents of Canada include: international students, foreign workers, and refugee claimants. Refugees who are accepted as permanent residents (the vast majority of those arriving in Manitoba) should not be confused with “refugee claimants” or “asylum seekers”. Refugee claimants arrive in Canada asking to be accepted as refugees. They apply for refugee status once in country and while waiting for their immigration application to be processed. While waiting to hear on their application for permanent residency, refugee claimants do not have the same rights as permanent residents. As a result, they are not covered by Canada’s universal health insurance program—Medicare. However, they are covered until their claim as been accepted and they are eligible under Manitoba Health, or up to 12 months by the Interim Federal Health Program (IFHP). Changing political policy is impacting access to federally insured services. On July 1, 2012, CIC limited eligibility for extended health services (hospital, diagnostic, medication) under the Interim Federal Health Program (IFHP) reforms for Refugee Claimants unless care is urgent or poses a risk to public health. Other benefits discontinued include prescription drugs, dental, vision and ambulance service.

Temporary residents coming to Canada have been increasing in recent years, as part of a national strategy to respond to labor market needs. Temporary workers and foreign students do not have the same health care coverage as permanent residents. Eligibility for health coverage depends on the duration of stay, and varies although the minimum time period is generally one year. Many temporary workers eventually apply for landed immigrant status, and then qualify for the same coverage as other landed immigrants. In the meantime, they are usually covered by private insurance purchased by their employers, which is then deducted from their wages (Focused Community Health Assessment I, November 2010).

4. IMMIGRATION TRENDS:

Canada and Manitoba depend on immigration for population and economic growth. According to Citizenship and Immigration Canada, Canada has admitted an average of 249,000 new permanent residents each year in the 10 years from 2003 to 2012. Included in this average number of new permanent residents is an average of 27,525 (11.0%) individuals classified as refugees.

In the 5 years from 2008 to 2012, Canada has admitted an average of 257,000 new permanent residents per year. Included in this 5 year average number of new permanent residents is an average of 24,071 (9.4%) individuals classified as refugees. The influx of new permanent residents represents approximately 8% of Canada’s population (CIC Statistics, Backgrounder – 2014 Immigration Levels Planning: Public and Stakeholder Consultations).
### Table # 1: CANADA – Permanent Residents by Category, 2003 – 2012 (Stats from CIC Facts & Figures 2012):

<table>
<thead>
<tr>
<th>Category</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td><strong>Family Class</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>65,120</td>
<td>29.4</td>
<td>62,275</td>
<td>26.4</td>
<td>63,373</td>
</tr>
<tr>
<td><strong>Economic Immigrants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>121,038</td>
<td>54.7</td>
<td>133,746</td>
<td>56.7</td>
<td>156,309</td>
</tr>
<tr>
<td><strong>Refugees</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>25,979</td>
<td>11.7</td>
<td>32,687</td>
<td>13.9</td>
<td>35,776</td>
</tr>
<tr>
<td><strong>Other immigrants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9,196</td>
<td>4.2</td>
<td>7,115</td>
<td>3.0</td>
<td>6,778</td>
</tr>
<tr>
<td><strong>Category not stated</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Province or territory not stated</strong></td>
<td>15</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>221,349</td>
<td>100.0</td>
<td>235,823</td>
<td>100.0</td>
<td>262,242</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td><strong>Family Class</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>65,577</td>
<td>26.5</td>
<td>65,207</td>
<td>25.9</td>
<td>60,223</td>
</tr>
<tr>
<td><strong>Economic Immigrants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>149,026</td>
<td>60.3</td>
<td>153,491</td>
<td>60.9</td>
<td>186,916</td>
</tr>
<tr>
<td><strong>Refugees</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21,854</td>
<td>8.8</td>
<td>22,850</td>
<td>9.1</td>
<td>24,696</td>
</tr>
<tr>
<td><strong>Other immigrants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10,736</td>
<td>4.3</td>
<td>10,623</td>
<td>4.2</td>
<td>8,845</td>
</tr>
<tr>
<td><strong>Category not stated</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>0.0</td>
<td>1</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Province or territory not stated</strong></td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>247,247</td>
<td>100.0</td>
<td>252,172</td>
<td>100.0</td>
<td>280,689</td>
</tr>
</tbody>
</table>

*Source: CIC Facts & Figures 2012

Canada has consistently admitted over 200,000 I & R each year with an average of 249,000 over the last decade. Admission of I & R increased in the 5 years from 2008 to 2012 to an average of 257,000 annually with a peak of 280,689 in 2010. This 10 year average of refugees admitted is 27,525 (or 11% of the total I & R admissions) and in the 5 years from 2008 to 2012 this average drops to 24,071 (or 9.4% of the total I & R admissions). In the 5 years from 2008 to 2012 the number of refugees admitted to Canada peaked in 2011 with 27,872.

In the 10 years from 2003 to 2012 Manitoba has welcomed an average of 11,300 new permanent residents each year and of these approximately 1,153 (11%) were classified as refugees.

In the 5 years from 2008 to 2012 Manitoba has welcomed an average of 13,900 new permanent residents per year including 1,109 (8%) who were classified as refugees (CIC Statistics, Backgrounder – 2014 Immigration Levels Planning: Public and Stakeholder Consultations).
Table #2: Manitoba – Permanent Residents by Category, 2003 – 2012:

<table>
<thead>
<tr>
<th>Category</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Family Class</td>
<td>1,043</td>
<td>16.0</td>
<td>1,118</td>
<td>15.1</td>
<td>1,192</td>
</tr>
<tr>
<td>Economic Immigrants</td>
<td>4,079</td>
<td>62.7</td>
<td>4,999</td>
<td>67.3</td>
<td>5,724</td>
</tr>
<tr>
<td>Refugees</td>
<td>1,234</td>
<td>19.0</td>
<td>1,252</td>
<td>16.9</td>
<td>1,094</td>
</tr>
<tr>
<td>Other immigrants</td>
<td>147</td>
<td>2.3</td>
<td>57</td>
<td>0.8</td>
<td>86</td>
</tr>
<tr>
<td>Total</td>
<td>6,503</td>
<td>100.0</td>
<td>7,426</td>
<td>100.0</td>
<td>8,096</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Family Class</td>
<td>1,385</td>
<td>12.3</td>
<td>1,359</td>
<td>10.1</td>
<td>1,377</td>
</tr>
<tr>
<td>Economic Immigrants</td>
<td>8,694</td>
<td>77.5</td>
<td>10,905</td>
<td>80.7</td>
<td>13,274</td>
</tr>
<tr>
<td>Refugees</td>
<td>972</td>
<td>8.7</td>
<td>1,098</td>
<td>8.1</td>
<td>1,032</td>
</tr>
<tr>
<td>Other immigrants</td>
<td>167</td>
<td>1.5</td>
<td>159</td>
<td>1.2</td>
<td>124</td>
</tr>
<tr>
<td>Total</td>
<td>11,218</td>
<td>100.0</td>
<td>13,521</td>
<td>100.0</td>
<td>15,807</td>
</tr>
</tbody>
</table>

* Source: CIC Facts & Figures 2012

While Manitoba has averaged an annual reception of 11,300 I & R per year in the 10 years from 2003 to 2012, it has shown a significant increase in the 5 years from 2008 to 2012, averaging 13,900 new permanent residents per year. This represents an increase of approximately 18.7%. This 10 year average of refugees received by Manitoba is 1153 (or 11% of total I & R) and has shown a slight decrease over the 5 years from 2008 to 2012 in which the average annual refugee receptions declined to 1109 (or 8% of total I & R). In 2013, Manitoba welcomed the highest number of refugees per capita in Canada. Preliminary unpublished data indicate that the total number of refugees arriving in Manitoba in 2013 was 1484, an increase from 1140 (344 or 30.2%) over 2012.

Another significant trend in the reception of immigrants & refugees is the number of families with children and young people. In the 5 years from 2008 to 2012, the children & youth (0 to 19yrs) population has averaged 4782 or 34% of the total number of immigrants and refugees received in Manitoba. (Source: Manitoba Immigration and Multiculturalism) This is significant in terms of the child development, parental, psychosocial, and intergenerational issues that accompany the immigration and settlement/re-settlement experience.

Table #3: Manitoba - Permanent Residents Age by Children & Youth, 2008 – 2012:

<table>
<thead>
<tr>
<th>Category</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>0 – 4</td>
<td>948</td>
<td>8.5</td>
<td>1037</td>
<td>7.7</td>
<td>1258</td>
<td>8.0</td>
</tr>
</tbody>
</table>
### Table

<table>
<thead>
<tr>
<th></th>
<th>Family</th>
<th>Federal Economic</th>
<th>PNs</th>
<th>Refugees</th>
<th>Total I &amp; R</th>
<th>Total C &amp; Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 – 9</td>
<td>1109</td>
<td>9.9</td>
<td>1330</td>
<td>9.8</td>
<td>1638</td>
<td>10.4</td>
</tr>
<tr>
<td>10 – 14</td>
<td>1045</td>
<td>9.3</td>
<td>1298</td>
<td>9.6</td>
<td>1519</td>
<td>9.6</td>
</tr>
<tr>
<td>15 – 19</td>
<td>840</td>
<td>7.5</td>
<td>1078</td>
<td>7.9</td>
<td>1187</td>
<td>7.5</td>
</tr>
<tr>
<td>Total C &amp; Y</td>
<td>3,942</td>
<td>35.2</td>
<td>4,739</td>
<td>35.0</td>
<td>5,602</td>
<td>35.5</td>
</tr>
<tr>
<td>Total I &amp; R</td>
<td>11,218</td>
<td>100.0</td>
<td>13,521</td>
<td>100.0</td>
<td>15,807</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*(Source: Manitoba Immigration and Multiculturalism)*

The lower number of immigrant and refugee arrivals in 2012 was largely due to a decrease in the number of provincial nominee arrivals. This was mainly caused by the federal cap to the Manitoba Provincial Nominee Program (MPNP) as well as a decrease in the number of dependents per MPNP application (the MPNP has seen a trend towards smaller family size and the nomination of more single individuals). Increased processing times at Citizenship and Immigration Canada visa posts as well the timing of MPNP nominations in previous years were also factors.

### Figure # 2: Manitoba Immigration 2000 to 2012:

In 2003, Manitoba renewed and amended a Canada-Manitoba Immigration Agreement (CMIA) with the Federal Government. It is important to note that in 2003, as part of its overall immigration strategy, Manitoba began setting immigration targets, with an initial target of 10,000 new immigrants annually. By 2006, the province had met and exceeded its initial annual goal of 10,000 new immigrants. This CMIA also included the first tri-level private refugee sponsorship initiative in Winnipeg.

Manitoba has a history of receiving a larger proportion of refugees than the Canadian average. In 2008, for example, the percentage of all immigrants who were refugees was 4.4% (Canada), 8.3% (Manitoba), and 11.3% (Winnipeg). Of particular note is the proportion of Privately Sponsored Refugees (PSRs) in Manitoba which has been steadily rising from 12% (80) in 1998 to 66.2% (755) of all refugees arriving in 2012. Over the 10 years from 2003 to 2012 the average percentage of PSRs is 52.4% with the last 5 years from 2008 to 2012 showing an increase to 56.5%. Preliminary unpublished data also indicates that the trend toward greater numbers of PSRs continued in 2013 with 1002 PSRs (67.5%) vs. 389 (26.2%) received by Manitoba. **In 2013, Manitoba’s share of PSRs to Canada was 15.7% of the national total and the highest per capita in Canada.** This is as a result of the high level of activity among Manitoba sponsors to sponsor refugees. This trend is likely to continue as it supports Citizenship and Immigration Canada’s policy direction to reduce the number of GARSs and increase PSRs. **The trend to greater and greater number**
of refugees being privately sponsored has significance in terms of impacts on health and mental wellbeing needs and supports.

Manitoba received 11,537 refugees from 2003 to 2012 (Table # 4). Of the refugees received into Manitoba, approximately 95% settled in Winnipeg. Since 2003, Winnipeg has seen an increase in the number of refugees with complex physical and emotional issues and needs. The complexity of these issues has and continues to provide major challenges to both the refugees and the service providers in the resettlement process.

Table # 4: Refugees Welcomed into Manitoba from 2003 – 2012:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PSR</td>
<td>597</td>
<td>608</td>
<td>493</td>
<td>633</td>
<td>577</td>
<td>493</td>
<td>576</td>
<td>514</td>
<td>795</td>
<td>755</td>
<td>6041 (52.4%)</td>
<td>3133 (56.5%)</td>
</tr>
<tr>
<td>GAR</td>
<td>539</td>
<td>548</td>
<td>492</td>
<td>522</td>
<td>517</td>
<td>439</td>
<td>490</td>
<td>460</td>
<td>444</td>
<td>327</td>
<td>4778</td>
<td>2160</td>
</tr>
<tr>
<td>Refugees Landed in Canada (Asylum)</td>
<td>91</td>
<td>63</td>
<td>90</td>
<td>61</td>
<td>46</td>
<td>29</td>
<td>17</td>
<td>38</td>
<td>44</td>
<td>38</td>
<td>517</td>
<td>166</td>
</tr>
<tr>
<td>Dependents Abroad</td>
<td>8</td>
<td>33</td>
<td>19</td>
<td>25</td>
<td>30</td>
<td>11</td>
<td>15</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>201</td>
<td>86</td>
</tr>
<tr>
<td>Total</td>
<td>1235</td>
<td>1252</td>
<td>1094</td>
<td>1241</td>
<td>1170</td>
<td>972</td>
<td>1098</td>
<td>1032</td>
<td>1303</td>
<td>1140</td>
<td>11,537 (1153)</td>
<td>5545 (1109)</td>
</tr>
</tbody>
</table>

*Source: Manitoba Immigration and Multiculturalism

5. SOURCE COUNTRIES:

The Philippines, India and China have consistently ranked as the top three source countries for immigrants to Manitoba. In 2012, immigration from the Philippines and China decreased while numbers from India increased.

Table # 5: Immigrants (all categories) by Top Ten Source Countries in 2012:

<table>
<thead>
<tr>
<th>SOURCE COUNTRY</th>
<th>Number</th>
<th>Percentage</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines</td>
<td>3,764</td>
<td>28.3</td>
<td>1</td>
</tr>
<tr>
<td>India</td>
<td>2,095</td>
<td>15.7</td>
<td>2</td>
</tr>
<tr>
<td>China</td>
<td>1,200</td>
<td>9.0</td>
<td>3</td>
</tr>
<tr>
<td>Nigeria</td>
<td>419</td>
<td>3.1</td>
<td>4</td>
</tr>
<tr>
<td>Pakistan</td>
<td>337</td>
<td>2.5</td>
<td>5</td>
</tr>
<tr>
<td>Korea, Republic of</td>
<td>324</td>
<td>2.4</td>
<td>6</td>
</tr>
<tr>
<td>Source Country 2012 PSRs</td>
<td>Source Country 2012 GARs</td>
<td>Source Country 2012 Combined</td>
<td>Rank</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------</td>
<td>-----------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Eritrea</td>
<td>Democratic Republic of Somalia</td>
<td>Eritrea</td>
<td>1</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Democratic Republic of Congo</td>
<td>Democratic Republic of Somalia</td>
<td>2</td>
</tr>
<tr>
<td>Democratic Republic of Somalia</td>
<td>Bhutan</td>
<td>Ethiopia</td>
<td>3</td>
</tr>
<tr>
<td>Democratic Republic of Congo</td>
<td>Iraq</td>
<td>Democratic Republic of Congo</td>
<td>4</td>
</tr>
<tr>
<td>Democratic Republic of Sudan</td>
<td>Kenya</td>
<td>Bhutan</td>
<td>5</td>
</tr>
<tr>
<td>Republic of South Africa</td>
<td>Federal Republic of Cameroon</td>
<td>Iraq</td>
<td>6</td>
</tr>
<tr>
<td>Egypt</td>
<td>Uganda</td>
<td>Democratic Republic of Sudan</td>
<td>7</td>
</tr>
<tr>
<td>Syria</td>
<td>Ethiopia</td>
<td>Kenya</td>
<td>8</td>
</tr>
<tr>
<td>Republic of Yemen</td>
<td>Eritrea</td>
<td>Republic of South Africa</td>
<td>9</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>People’s Republic of Congo</td>
<td>Federal Republic of Cameroon</td>
<td>10</td>
</tr>
</tbody>
</table>

Total Top Ten 719  Total Top Ten 259  Total Top Ten
Other Countries 36  Other Countries 68  Other Countries
Total 755  Total 327  Total

*Source: Manitoba Immigration and Multiculturalism
6. KEY CONCEPTS AND DEFINITIONS FOR DESCRIBING MENTAL HEALTH:

6.1 Definition of Mental Health:

Our mental health is a vital component of our well-being. The World Health Organization (WHO) describes mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community” (WHO 2007). According to WHO (2007) without mental health there is no health. This state of well-being arises from interactions between the individual and his or her environment (Khanlou, Migrant Mental Health In Canada, 2010).

The health and mental wellbeing of the immigrant & refugee populations is influenced by complex and interrelated factors. The social determinants of health, which are the socio-economic conditions that influence the health of individuals, communities and jurisdictions, affect both physical health and mental wellbeing. While the immigrant & refugee populations can be influenced by similar dimensions of social determinants as that of mainstream Canadians, additional determinants due to their immigrant & refugee status (e.g., social and economic integration barriers, access barriers to relevant social and health services due to language and cultural differences, lack of social networks) also may exert significant influences. Some argue that the migration and settlement process itself is a significant social determinant of health and mental Wellbeing (Khanlou, MMH in Canada, 2010).

Premigration contexts also affect subsequent postmigration health outcomes. In cases of war-torn countries, post-traumatic stress disorder may be a potential health risk that needs addressing in the postmigration context. In the case of family separations, mental health risk factors may be exacerbated. Those who have migrated to Canada as the only economic hope for a larger family in the country of origin, bear a tremendous burden to be economically successful (Khanlou, MMH in Canada, 2010).

The migration context as well as the postmigration context affects subsequent health and mental wellbeing outcomes. The length and context of the migration (flight) impact health and mental wellbeing. The context surrounding postmigration resettlement can itself create trauma and trigger premigration traumatic stress.

6.2 Prevalence of Mental Illness in Immigrants & Refugees:

When immigrants first arrive in Canada, their health status is often superior to the Canadian-born population – a phenomenon known as the “healthy immigrant effect”. Arrival and resettlement in a new country often involves a period of significant readjustment and stress. The literature suggests that, despite this, Canadian immigrants initially experience fewer mental health problems than their Canadian counterparts, demonstrating the healthy immigrant effect. Ali found that the risk of experiencing depression and anxiety was lower for recent immigrants (in Canada for less than 10 years) compared with both non-recent immigrants (10+ years) and the Canadian–born population. Malenfant found that suicide rates in all foreign-born migrants were approximately half those of the Canadian-born population. While there is evidence of an initial mental health advantage, there are significant variations by gender and socioeconomic status, with female, low-income immigrants generally being at greater risk than their male counterparts (Hyman & Jackson, The Healthy Immigrant Effect: A Temporary Phenomenon?, December 2010). Refugees are observed to have lower levels of health upon arrival and are more likely to transition to a state of poor health, while economic immigrants report the highest levels of self-assessed health (Newbold, 2009).

Research has shown increasing rates of mental health problems with length of stay in Canada. Significant declines in immigrants’ health status are noted within as little as two years post-arrival (Newbold, 2009).

Systematic reviews and meta-analyses confirm that refugees are at substantially higher risk than the general population for a variety of specific psychiatric disorders – related to their exposure to war, violence, torture, forced migration and exile and the uncertainty of their status in the countries where they seek...
asylum – with up to 10 times the rate of post-traumatic stress disorders as well as elevated rates of depression, chronic pain and other somatic complaints. Exposure to torture is the strongest predictor of symptoms of post-traumatic stress disorder among refugees. Exposure to racism and discrimination has been shown to have negative effects on the mental health of immigrants and refugees (Kirmayer, et al., Common mental health problems in immigrants and refugees: general approach in primary care, July 2010).

6.3 Migration and its affect on Mental Health & Emotional Wellbeing:

Rates of mental disorders vary in different migrant groups, but these differences do not simply reflect the rates in the countries of origin. Prevalence of specific types of problems and rates of health care use in particular groups can be linked to migration trajectories in terms of adversity experienced before, during and after resettlement and to policies and practices that determine who gains admittance to Canada. The following table lists some of the migration-related factors that influence mental health. The effect of these factors varies greatly with their severity and with their specific meaning for migrants, their families and their communities, as well as for the wider society. Postmigration factors that moderate effects of premigration stress and that ensure employment and economic stability are especially important in ensuring good health outcomes (Kirmayer, et al., Common mental health problems in immigrants and refugees: general approach in primary care, July 2010).

Table # 7: Factors affecting refugee mental health and well-being:

<table>
<thead>
<tr>
<th>Premigration factors:</th>
<th>Potentially traumatic events (PTEs) in home country</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single or multiple</td>
</tr>
<tr>
<td></td>
<td>Discrete event or continuing situation</td>
</tr>
<tr>
<td>Living conditions</td>
<td>Socioeconomic circumstances</td>
</tr>
<tr>
<td></td>
<td>Family situation</td>
</tr>
<tr>
<td></td>
<td>Situation of membership group (ethnic, religious, etc.)</td>
</tr>
<tr>
<td>Personal history</td>
<td>Vulnerability factors</td>
</tr>
<tr>
<td></td>
<td>Protective (resiliency) factors</td>
</tr>
</tbody>
</table>

| Transit factors:      | Direct trip to destination country vs. stays in transit locations |
|                       | If transit through other locations                  |
|                       | refugee camps (internal or in transit country)      |
|                       | stays in transit countries                          |
|                       | - Clandestine (nonstatus) or with status            |
|                       | - Economic situation, access to care, etc.          |
|                       | - Detention linked to migratory status              |
| Travel with official documents or false documents | If obtained from a smuggler                        |
|                       | Cost and impact on the person’s finances            |
| Exposure to PTEs during transit                     | Exploitation by smugglers                          |
|                       | Poverty                                            |
|                       | Protracted experience of marginalization, helplessness, being struck (e.g., refugee camp) |
|                       | Physical injuries or mental stress linked to clandestine entry (e.g., exposure to the elements, hunger, confinement) |
| Strengths acquired during transit                     |

<table>
<thead>
<tr>
<th>Postmigration factors:</th>
<th>Obstacles upon arriving in destination country</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Interviews by immigration officers</td>
</tr>
<tr>
<td></td>
<td>Detention</td>
</tr>
</tbody>
</table>
While migration contingencies create mental health risk, not all immigrants and refugees develop mental illness. As a result of a decade-long study of Southeast Asian refugees who came to Canada between 1979 and 1981, Morton Beiser has identified that the nature of traumas, the coping strategies employed, and the phase of resettlement affect the degree to which risk is translated into illness. He indicates that when acculturation changes aspirations, but the means for achieving ambitions are slight, mental disorder is a highly likely result. Linguistic proficiency is one of the most important requirements for making one’s way in a new culture. Economic stability is another important requirement. Beiser further states that people with a significant other and/or a supportive like-ethnic community did not show the time-dependent spike in mental health risk. People with both an intimate relationship and a presumably supportive community were particularly resistant to the development of a disorder (Beiser, “Resettling Refugees and Safeguarding their Mental Health…”, 2009).

7. USING A RECOVERY PHILOSOPHY:

Recovery has been identified as a primary goal for behavioral health care. In August 2010, leaders in the behavioral health field, consisting of people in recovery from mental health and substance use problems and Substance Abuse & Mental Health Services Administration (SAMHSA – U.S. Department of Health and Human Services), met to explore the development of a common, unified working definition of recovery. Prior to this, SAMHSA had separate definitions for recovery from mental disorders and substance use disorders.

Building on these efforts and in consultation with many stakeholders, SAMHSA has developed a working definition and set of principles for recovery. A standard, unified working definition will help advance recovery opportunities for all, and help to clarify these concepts for peers, families, funders, providers, and others.

In February 2012, SAMHSA’s Working Definition of Recovery was published (SAMHSA, February 2012).
7.1 Working definition of recovery from mental disorders and/or substance use disorders:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

- **Health**: overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- **Home**: a stable and safe place to live;
- **Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community**: relationships and social networks that provide support, friendship, love, and hope.

7.2 Guiding principles of recovery:

**Recovery emerges from hope**: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

**Recovery is person-driven**: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

**Recovery occurs via many pathways**: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds (including trauma experiences) that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. (Manitoba also utilizes a harm reduction approach.) Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

**Recovery is holistic**: Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.
Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one’s self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and emotional wellbeing. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations (including values, traditions, and beliefs) are keys in determining a person’s journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual’s unique needs.

Recovery is supported by addressing trauma: The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one’s self are particularly important.

The Mental Health Commission of Canada’s Changing Directions, Changing Lives: The Mental Health Strategy for Canada was published in May 2012. In this strategy the concept of recovery refers to living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems and illnesses. The approach to recovery is broadened to include the concept of well-being, so that, with some adaptations to the different stages of life, the principles of recovery can apply to everyone (MHCC, Changing Directions, May 2012).
SECTION 2: FRAMING THE CONTEXT:

8. GUIDING VALUES & PRINCIPLES:

A comprehensive approach to optimizing the mental health & emotional wellness of immigrants and refugees is underpinned and driven by values and principles. The following values and principles are intended to guide the development of a comprehensive approach and influence policies, programs and services that optimize the mental health & emotional wellness of immigrants and refugees.

The Individual Level of Values and Principles as well as the System Level of Values and Principles are evidence informed and derived from a literature review. The literature review included numerous publications related to mental health & emotional wellbeing as well as to immigration and settlement & resettlement.

8.1 Individual Level Values and Principles:

Respect and Dignity:

Respect and dignity are essential to recovery. Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and
meaningful sense of identity, and regaining belief in one’s self are particularly important. (SAMHSA’s Principles of Recovery) Having a sense of self-worth and feeling accepted are particularly important for immigrants and refugees. Many have come from countries and life experiences where they have experienced discrimination, marginalization and persecution for who they are.

Self Determination, Independence and Choice:

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives. (SAMHSA’s Principles of Recovery) Pathways to achieving self determination are influenced by diverse cultures, customs, and practices. (e.g., self determination within a family or communal culture)

Resilience:

Resilience has been defined as “the ability to manage or cope with significant adversity or stress in ways that are not only effective, but may result in an increased ability to respond to future adversity” (Health Canada, 2000, p-8) (Health Canada, 2000. Risk, Vulnerability, Resilience: Health System Implications. Ottawa: Supply and Services Canada) Resilience consists of a balance between stress and adversity on one hand and the ability to cope and availability of support on the other. Resilience is based on the strengths of the individual as well as the strength of support surrounding the individual.

Participation, Relationship and Social Inclusion:

Being involved, staying active and taking part in the community, being consulted and having one’s views considered. Being active in all facets of life (socially, economically, politically); having a meaningful role in daily affairs; enjoying what life has to offer; engaging in relationships; participating in available programs and services; and being involved and engaged in activities of daily living. Social participation and relationships with others are facilitated and essential to recovery. (MHCC: Guidelines for Seniors) Being involved with others, supports and builds individual strength and resilience, encourages language acquisition, provides exposure to customs and practices and protects immigrants and refugees from the negative effects of isolation. Participation helps to build one’s self worth and ensure that programs and supports are person-centred.

Fairness and Equity:

Having immigrants and refugees real needs, in all their diversity, considered equally to those of other Canadians e.g., having equitable access (socially, economically, politically) to available resources and services; not being discriminated against on the basis of immigrant status; immigrant category; culture; age; gender; and being treated and dealt with in a way that maximizes inclusion of immigrants and refugees. . (MHCC: Guidelines for Seniors)

Security:

Immigrants and refugees value financial, physical, and psychological security. Having adequate income while settling /resettling, and having access to a safe and supportive living environment (e.g., financial, security to meet daily needs; physical security – including safe living conditions, sense of protection form crime, discrimination and persecution); access to family and friends. Knowing that help is available when needed and being able to plan for the future is important to immigrant and refugees’ sense of security. . (MHCC: Guidelines for Seniors)
8.2 System Level Values and Principles:

Accessibility:

Immigrants & refugees have equitable and timely access to culturally appropriate and effective programs, services, treatments and supports. Accessibility is also about removing any social, educational, cultural, economic or physical barriers to programs so that immigrants & refugees are aware of them and can choose to use them. Information, communication and adaptations appropriate for diverse cultures of immigrants & refugees will facilitate access and enable them to make the most of their abilities. (MHCC: Guidelines for Seniors)

Mental Health Promotion:

Mental health promotion is a process of facilitating the capacity of individuals and communities to take control over their lives and improve their mental health*. It seeks to increase self-esteem, coping skills and capacities, and family and community supports, as well as to modify the broader social and economic environments that influence mental health. Mental health promotion strategies are integrated into all components of a comprehensive mental health system for immigrants & refugees, including into the service system/treatment components. (MHCC: Guidelines for Seniors)

* Mental health is not simply the absence of mental illness. Mental health is distinct from mental illness and each is on a separate continuum. The mental illness continuum has severe illness on one end and no illness on the other, while the mental health continuum, has “flourishing” at one end and “languishing” at the other (Keyes, 2007). Mental health can be promoted and supported (or neglected and undermined) whenever the individual is situated on these continua. A person with a mental illness can have better (flourishing) or worse (languishing) mental health as can a person without a mental illness. (MHCC: Guidelines for Seniors, p-29)

Capacity Building:

Capacity building is a purposeful process of personal and organizational development to assist in resource building. Capacity building reflects the principles of empowerment and equality and is focused on strengthening the capabilities of individuals and communities. Capacity building is a key focus of a comprehensive mental health system for immigrants & refugees. (CAMH: Best practice guidelines for mental health promotion programs: Refugees)

Person & Relationship Centred (“Driven”):

Individualized and person-centred care is embedded in an understanding of the culture, social and economic context in which the immigrant / refugee lives. Respect for individuals’ cultural values, migration experience and promotion of dignity are fundamental. Immigrants and refugees are the best sources of information about their mental health distress. Being person-centered also means understanding the person in their context and includes acknowledging the strong connections to family, friends, and community.

Person “driven” care refers to the system being led by the context and need of the individual. Services are matched to the individual and include concerns for equity as well as for advocacy.

Recovery Focused:

A recovery focused system is built on the beliefs that people with mental health problems and illnesses can and do recover. For the service system, a focus on recovery means that the whole system of services needs to focus its concern on providing support that allows people with mental health problems and illnesses to function as full citizens in society. (Mb Strategy)
Immigrants & refugees living with mental health problems and illnesses are empowered and supported in their journey of recovery and Wellbeing. In particular, this includes giving purpose to life and enhancing quality of life, fostering hope and strengthening resilience. Policies, programs and services adopt and reflect a recovery orientation that is embedded in the functions required to support people living with mental illness and to prevent illnesses and promote good mental health for all immigrants & refugees. (MHCC: Guidelines for Seniors)

Support to Family / Community:

Policy, programs and services recognize the role of families, friends and cultural communities in promoting well-being and providing care, and their needs are supported through practical and emotional support and education. Many immigrants and refugees mental emotional wellbeing is defined in a culture that acknowledges strong connections to family, friends and community. Family, friends and cultural communities are supported in their role as promoting and supporting mental health / emotional wellbeing.

Education & Support for Service Providers:

Service providers (current and future) are educated about the unique needs of immigrants & refugees with or at risk of mental illness, and supported in carrying out their roles through access to cultural, clinical and ethical education, training, and consultation.

Diversity, Cultural Safety and Cultural Proficiency:

Consideration of diversity, cultural safety and cultural proficiency are embedded in programs and practices which are promoted, designed and resourced to ensure inclusiveness.

Comprehensive:

A comprehensive service system, makes use of a variety of professionals, resources and support personnel, and develops inter-sectoral partnerships, in order to promote and support the mental health of all immigrants & refugees and to provide a comprehensive range of services in and across settings to prevent and to treat mental health problems and illnesses. A comprehensive service system for immigrants & refugees also integrates traditional and non-traditional (from diverse cultures) resources and supports in responding to the mental health /emotional wellbeing needs of individuals and communities.

Holistic:

Holistic refers to an approach that includes the whole of a particular individual, system or community; integrating mind, body and spirit. (Mb Strategy glossary) Not only is mental health essential for well-being and functioning in every setting, but mental, physical, and spiritual health influence one another. (MHCC Recovery) A holistic approach to immigrant & refugee mental health / emotional wellbeing understands and integrates the importance of the role and function of mind, body and spirit within diverse cultures.

Integrated, Flexible, & Seamless:

Programs, services, treatment and supports are seamlessly integrated with appropriate information sharing around the needs of immigrants & refugees and their families. The unique needs and strengths of diverse groups & cultures are taken into consideration. Coordination of policy and of programs ensures that “every door is the right door” (i.e. that every part of the system can lead anyone to the appropriate service) and that the right service is offered in the right place at the right time. Formal mechanisms to ensure collaboration and effective communication and consultation across sectors and settings must be in place. (MHCC: Guidelines for Seniors)
Mainstream Response to I & R Needs / Issues:

Programs, services, treatment and supports for immigrants and refugees and their families are integrated into the mainstream health and mental health system. The mainstream health and mental health system is flexible and able to respond to specific, unique concerns of the immigrant and refugee population.

Evidence Informed:

Actions are informed by the best evidence based on multiple sources of knowledge (including experiential), outcomes are measured, and research is advanced. Evidence includes incorporating the lived personal experience of immigrants & refugees and their families; practice based experience and evidence from clinical, population and cultural based health research. (MHCC: Guidelines for Seniors)

9. DETERMINANTS OF MENTAL HEALTH:

Determinants of health are those personal, social, economic and environmental factors that influence the health of individuals and populations. Determinants of health do not act alone but interact with each other in often complex ways. The Public Health Agency of Canada has produced the following listing of health determinants that are applicable to all: (website)

1. Income and Social Status
2. Social Support Networks
3. Education and Literacy
4. Employment/Working Conditions
5. Social Environments
6. Physical Environments
7. Personal Health Practices and Coping Skills
8. Healthy Child Development
9. Biology and Genetic Endowment
10. Health Services
11. Gender
12. Culture

While these determinants influence the mental health & emotional wellbeing of all, there are certain determinants and factors that are particularly important to the mental health & emotional wellbeing of immigrants and refugees. Although responsibility for these determinants lies largely outside of the mental health and broader health system, awareness of their impact and collaboration with others to address them does not. Acknowledgement of the impact of these determinants of mental health across the migration and settlement/resettlement experience as well as through the life course underpins the recommendations made in this Conceptual Framework. (MHCC: Guidelines for Seniors)

9.1 Determinants/Factors of Mental Health & Emotional Wellbeing of Particular Importance to Immigrants and Refugees:

Migration:

MHCC’s Diversity Task Group has stated that pre-migratory stress in refugee groups and trauma such as war, torture, rape and natural disasters increase the risk of developing common mental health problems (anxiety and depression) as well as post-traumatic stress disorder. The process of migration and acculturation can be stressful and may increase risk for mental health problems and illness. (Diversity Task Group 2009)

Nazilla Khanlou has reported that migration status also influences access to healthcare. Immigrants and refugees may at least in theory be able to access basic healthcare services. Those with precarious status
or no legal status have uncertain or no access to healthcare services which leaves them extremely vulnerable to negative mental health outcomes. (Khanlou, 2010)

**Income and Social Status:** *Socio-economic status following migration:*

The MHCC’s Diversity Task Group indicates that there is a strong link between low income levels, income inequality, financial insecurity, poverty and mental health problems and illness. These factors are more prevalent with the immigrant & refugee populations and apply to all age groups. (Diversity Task Group 2009)

Many refugees experience a discrepancy between their social status prior to and after migration, which often leads to poverty. Often refugees lose their assets, important documents certifying their education and training credentials which are a barrier to employment. Language acquisition and getting professional skills accredited also create barriers to employment. Sustained periods of underemployment or unemployment are common among immigrants and refugees and this can negatively affect mental health. (CAMH Best Practice, 2012)

**Social Support Networks:** *Isolation & absence of social support:*

A significant problem for immigrant and refugee groups is the fact that social support networks may be broken or lost when people move. Family and social networks of migrants can be an important source of support in the resettlement context and promote mental Wellbeing. Research findings reveal that immigrants tend to rely first and foremost on extended family members (especially those who have been in the country longer) for settlement related needs and also for a social support network. Social support networks outside of the family tend to revolve around the ethnic community, and religious organizations that cater specifically to that ethnic community. (Khanlou, 2010)

CAMH has identified numerous factors that contribute to the isolation of refugees and a lack of overall support in the host country. Factors include: being separated from their friends & family in the migration process; an absence of similar ethno-cultural communities; a lack of language skills; and racism. Women and seniors are at heightened risk for isolation because they are more likely to be unemployed and to spend more time within the home than men and children. All these factors increase the risk for refugees’ developing mental health problems. (CAMH Best Practice, 2012)

**Education & Literacy:** *Language:*

Many immigrants and refugees have not had opportunities for education prior to arriving in Manitoba. For others, their education or learning has been interrupted. Language is a huge issue as immigrants and refugees not fluent in English or French have great difficulties expressing themselves. The literature indicates that language is especially important in expressing cultural nuances as they pertain to mental wellbeing / illness as well as in understanding recommendations made by professional clinicians.

**Employment and working conditions:**

Many immigrants and refugees face under- or unemployment upon arrival. Meaningful and equitable employment helps to build one’s self worth and provides greater access to financial resources. The increased financial resources allow for immigrants and refugees to make choices that improve their quality of life, social status and escape the realities associated with living in poverty.

**Social and Physical Environments:** *Housing:*

According to the MHCC’s Diversity Task Group, people from immigrant and refugee groups are more likely to live in poverty and therefore to live in areas that are poor. Immigrants and refugees are more likely to
Personal Health Practices and Coping Skills: **Resilience:**

Resilience has been defined as “the ability to manage or cope with significant adversity or stress in ways that are not only effective, but may result in an increased ability to respond to future adversity” (Health Canada, 2000, p-8) (Health Canada, 2000. *Risk, Vulnerability, Resilience: Health System Implications.* Ottawa: Supply and Services Canada) Resilience consists of a balance between stress and adversity on one hand and the ability to cope and availability of support on the other. Resilience is based on the strengths of the individual as well as the strength of support surrounding the individual.

**Healthy Child Development: Child Rearing, Parenting Practices:**

Immigrant & refugee families bring with them their diverse culturally relevant practices of child rearing and parenting practices. These cultural practices may be at odds with the culture of child rearing and parenting practices post immigration and settlement/resettlement. The MHCC has indicated that over a third of immigrant children live in poverty in Canada. As a result of this, children are exposed to a significant number of social and environmental risks that can negatively impact their mental health. (Diversity Task Group 2009) The MHCC has also indicated that by the time Canadian children & youth reach the age of 25, approximately 20% will have developed a mental illness. To help prevent serious mental health problems later in life, early intervention is essential. (Issue Children & Youth: What We’ve Learned 2014) A balanced approach between a youth-centred and family-centred approach is promoted by the MHCC. (Issue Children & Youth: What We’ve Learned 2014)

**Biology and Genetic Endowment:**

The basic biology and organic make-up of the human body are a fundamental determinant of health.

Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic endowment appears to predispose certain individuals to particular diseases or health problems. (PHAC: Underlying Premises and Evidence Table: [http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#genetic](http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#genetic)) This fundamental determinant of health is mainstream and evidence was not found to indicate a greater influence regarding immigrants and refugees.

**Health Services: Barriers to accessing mental health:**

Language and cultural barriers often impact refugees as they may be unaware of how and where to access mental health & emotional wellness services and financial barriers may prevent them from accessing treatment.

Many refugees perceive mental health & emotional wellness services in Canada as being culturally inappropriate because of different beliefs about the origins of mental illness. Some refugees believe mental illness is a result of religious factors and others believe that it is a result of a lack of balance between mind, body and spirit. In contrast, Western methods of treating mental illness are based on an individualized, biomedical model that many refugees view as culturally inappropriate or ineffective. Traditional healing methods sought out by refugees are often not available or covered by health insurance plans.

Stigma is another barrier to refugees’ accessing mental health services. Stigma around mental illness in ethnoracial communities is often so severe that people may not seek help from mental health services. (CAMH Best Practice, 2012)
Gender:

Khanlou indicates that gender is a significant influence on health status and intersects with other influences. Because women often migrate as dependents of their male relatives, their unique migration trajectories and specific health needs are often not incorporated into policy formulation, the focus being on male migrants thereby undermining their access to healthcare services. Women experience sexual and domestic violence, depression, anxiety and psychological distress to a larger extent than men.

Culture:  *Cultural background, spirituality and religious background*:

Mental health & emotional wellness services that attempt to fit immigrants & refugees into categories of western clinical knowledge, do not capture the cultural and spiritual or religious factors that may be involved in migrant mental health. Research in ethnically diverse cities has shown that spirituality and cultural context often construct mental health and mental illness in very different ways. Religion in particular plays an important role in the lives of different groups of immigrants & refugees, and their religious affiliations may even be strengthened post-migration, whether for reasons of renewed religious belief in the context of marginalization of religious identities, or because religious institutions become locations of community support. (Khanlou, 2010)

Prejudice, Discrimination and Racism:

According to MHCC’s Diversity Task Group, perceived racial discrimination is a risk factor for mental health problems and illnesses that are more commonly experienced by immigrant & refugee groups. They indicate that this complex social problem has its impacts at a number of different levels: from racial abuse or attack, through to more subtle forms, such as stereotypes in the media. (Diversity Task Group 2009)

Khanlou has indicated that while it may be difficult to measure racism, perceptions of racism have been found to have an effect on mental health, and subsequent service utilization by immigrants and refugees. She further states that research continually shows connections between systemic discrimination, underemployment or unemployment and mental health outcomes. (Khanlou, 2010)

Age:

Khanlou has stated that the age at which people migrate can have an important impact on their subsequent health status. Adolescents have both specific challenges as well as resiliencies in the postmigration context. Caught between their own identity development and having to mediate the new culture for their parents, youth often take on roles far beyond the capacity of their actual age. Female refugee youth in particular, face settlement and migration challenges that may put them at added risk for negative mental health outcomes, given the often traumatic premigration contexts they are coming from and the postmigration identity development they have to contend with. (Khanlou, 2010)

According to the MHCC’s Diversity Task Group, there is a higher risk of mental illness in people who migrate after 65 years of age. This group may have problems adapting to a new culture because of language problems and limited access to lessons. More than any other group, seniors have to rely on their children and grandchildren to assist them in daily activities. Unlike younger age groups who are able to socialize at school or work, the elderly are much more isolated in that their families may be their only social contacts. (Diversity Task Group 2009)

10. FOUNDATIONS OF IMMIGRANT & REFUGEE MENTAL HEALTH & EMOTIONAL WELLBEING:

A mental health & emotional wellness system is transformed to better meet the needs of the immigrant and refugee populations by being sensitive and responsive to their contexts. The following components are considered to be foundational in a mental health & emotional wellness system responding to the needs of
immigrants and refugees: human rights, culture, family, community, mental health promotion and a recovery focus.

Human Rights:

Human rights are rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible. Basic human rights include freedom; equality; autonomy; access to the necessities of life (i.e., water and food, clothing, and shelter); personal security; rights protected by law; absence of discrimination; recognition as a person; and freedom from arbitrary arrest, imprisonment, torture, or cruel or inhuman punishment. The enjoyment of the highest attainable standard of physical and mental health is also recognized as a fundamental human right. (WRHA: Promoting Health Equity, Operational Glossary, October 2012)

In 2008 an International Migrants Bill of Rights (IMBR) Initiative was started through Georgetown Law’s Global Law Scholars Program. In 2010 an IMBR was established and for the first time a single legal framework protects the rights of all international migrants. The IMBR affirms that all migrants are entitled to human rights protection. “Individuals are migrants regardless of whether their migration is temporary, lawful, regular, irregular, forced, for protection, for economic reasons, or for any other reason.” (IMBR, Georgetown Law, 2010) Please see appendix for a copy of the IMBR.

“A new era may well be dawning for the human rights of migrants and for human rights generally, through the growing recognition that adequately protecting one of the most vulnerable groups in many societies is today the true measure of our humanity.”

(Ryszard Cholewinski, ILO Specialist in Migration Policies; IMBR, Georgetown Law, 2010)

Culture:

Laurence Kirmayer indicates that cultural diversity poses many challenges to mental health care. “These stem from the ways that culture configures illness experience, contributing to the causes and mechanisms of psychopathology, the modes of expressing suffering, and the strategies of coping, help seeking, healing, and recovery.” (Kirmayer, Cultural Consultation, 2014, p-v) He further indicates that cultures, as systems of knowledge and practice, give our lives identity, meaning, and purpose – shaping every aspect of experience including health and illness. According to Kirmayer, “culture is the constantly evolving medium through which we articulate our deepest values and greatest aspirations. Human biology, behavior, and experience are culturally shaped and mental health practice must respond to the resulting diversity.” (Kirmayer, Cultural Consultation, 2014, p-1) According to Kirmayer, social and cultural processes shape the mechanisms of disease, the symptoms of distress, and subsequent ways of coping or help seeking. “Systems of healing reflect cultural models of body, self, and person that are grounded in distinctive ontologies or notions of what constitutes the individual and the world. Experiences of physical or emotional distress and other types of conflict mobilize cultural systems of knowledge and meaning in an effort to make sense of the problem or affliction. These systems of knowledge then shape the experience, course, and outcome of illness.” (Kirmayer, Cultural Consultation, 2014, p-1)

Research in ethnically diverse cities has shown that spirituality and cultural context often construct mental health and mental illness in very different ways. Religion in particular plays an important role in the lives of different groups of immigrants & refugees, and their religious affiliations may even be strengthened post-migration, whether for reasons of renewed religious belief in the context of marginalization of religious identities, or because religious institutions become locations of community support. (Khanlou, 2010)
“Providing mental health care for migrants requires an understanding of how culture impinges on mental health. Culture influences many aspects of mental illness and coping, including how consumers interpret and explain their symptoms, how they deal with them, what treatments they prefer and seek out, and the terms they use to define the treatment process and the relationship between themselves, their families, and the health care system.” (Kirmayer, Mental Health of Immigrants and Refugees, 2012)

Family:

Many immigrants and refugees come from cultural backgrounds where family members are usually consulted about any health problem and accompany patients to physicians’ visits. The migration process can stress and fragment families; close members may be left behind, sometimes in dangerous circumstances. Kirmayer states that “the tendency to focus on the patient in primary care must be supplemented by close attention to the family system and social network, which can include crucial members in other countries.” (Kirmayer et al, Common Mental Health Problems.., 2010, p-6) Acknowledging and connecting with the family soon before meeting alone with a patient can be an important step in building trust and a source of valuable information. Involvement of a key family member or a trusted family ally can strengthen the therapeutic alliance, empower the family and provide necessary support to the patient. Kirmayer suggests that disclosure of diagnostic issues and family secrets (especially about traumatic events) must be approached carefully, with an understanding of what is at stake for the family. (Kirmayer et al, Common Mental Health Problems.., 2010)

Community:

Resettlement after migration is strongly affected by policies, practices and opportunities of the resettlement society as well as existing ethnocultural community organizations and religious institutions. “The presence of welcoming links within ethnic communities or religious congregations can buffer the effects of migration losses, isolation and discrimination.” (Kirmayer et al, Common Mental Health Problems.., 2010, p-6) Kirmayer suggests that becoming familiar with existing community and religious organizations can help practitioners identify and mobilize psychosocial support and other resources. Groups specific to various ethnic backgrounds can provide a sense of belonging and support for a particular ethnocultural identity. It is important to know which community the immigrant or refugee feels part of and not assume that they will feel comfortable with a group that shares aspects of national, religious or ethnic identity. (Kirmayer et al, Common Mental Health Problems.., 2010)

Mental Health Promotion:

CAMH refers to mental health promotion as “the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections, and personal dignity (Joubart et al., 1996, cited in CAMH Best Practice Guidelines; 2012, p-17).

Resilience is influenced by risk factors and protective factors. Risk factors are variables or characteristics associated with an individual that make it more likely that he or she will develop a problem. They are “vulnerability factors that increase the likelihood and burden of a disorder” (CDHAC, 2000, cited in CAMH Best Practice Guidelines; 2012, p-19). They can be biological or psychosocial and may reside in the person, family or social network, or the community or institutions that surround the person. Protective factors buffer a person “in the face of adversity and moderate…the impact of stress on social and emotional well-being, thereby reducing the likelihood [that] disorders will develop” (CDHAC, 2000, cited in CAMH Best Practice Guidelines, 2012, p-19). They can be internal or external and enable the person to protect their
emotional and social-well-being. Protective factors act as a buffer against stress and may be drawn upon in dealing with stressful situations (CAMH Best Practice Guidelines; 2012).

The goals of mental health promotion are to increase resilience and protective factors; decrease risk factors; and to reduce inequities (goals & following descriptions taken from CAMH Best Practice Guidelines, 2012 p-21-22):

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

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

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

- anxiety
- depression
- stress and distress
- sense of helplessness
- abuse, violence and social exclusion
- problematic substance use
- suicidal ideation or history of suicide attempts.

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

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

Mental health promotion aims to reduce inequities by:

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

A recovery focused system is built on the beliefs that people with mental health problems and illnesses can and do recover. For the service system, a focus on recovery means that the whole system of services needs to focus its concern on providing support that allows people with mental health problems and illnesses to function as full citizens in society. (Mb Strategy)

Immigrants & refugees living with mental health problems and illnesses are empowered and supported in their journey of recovery and wellbeing. In particular, this includes giving purpose to life and enhancing quality of life, fostering hope and strengthening resilience. Policies, programs and services adopt and reflect a recovery orientation that is embedded in the functions required to support people living with mental illness and to prevent illnesses and promote good mental health for all immigrants & refugees. (MHCC: Guidelines for Seniors)
11. CONCEPTUAL FRAMEWORK OF REQUIREMENTS OF A COMPREHENSIVE APPROACH TO OPTIMIZING THE MENTAL HEALTH & EMOTIONAL WELLBEING OF IMMIGRANTS & REFUGEES:

### GUIDING VALUES & PRINCIPLES

<table>
<thead>
<tr>
<th>Individual Level:</th>
<th>System Level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Respect and Dignity</td>
<td>• Accessibility</td>
</tr>
<tr>
<td>• Self Determination, Independence and Choice</td>
<td>• Mental Health Promotion</td>
</tr>
<tr>
<td>• Resilience</td>
<td>• Capacity Building</td>
</tr>
<tr>
<td>• Participation, Relationship and Social Inclusion</td>
<td>• Person &amp; Relationship Centred (“Driven”)</td>
</tr>
<tr>
<td>• Fairness and Equity</td>
<td>• Recovery Focused</td>
</tr>
<tr>
<td>• Security</td>
<td>• Support to Family / Community</td>
</tr>
<tr>
<td></td>
<td>• Education &amp; Support for Service Providers</td>
</tr>
<tr>
<td></td>
<td>• Diversity, Cultural Safety and Cultural Proficiency</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive</td>
</tr>
<tr>
<td></td>
<td>• Holistic</td>
</tr>
<tr>
<td></td>
<td>• Integrated, Flexible, &amp; Seamless</td>
</tr>
<tr>
<td></td>
<td>• Mainstream Response to I &amp; R Needs / Issues</td>
</tr>
<tr>
<td></td>
<td>• Evidence Informed</td>
</tr>
</tbody>
</table>

Determinants/Factors of Mental Health & Emotional Wellness of Particular Importance to Immigrants and Refugees:

- Migration
- Income and Social Status: *Socio-economic status following migration:*
- Social Support Networks: *Isolation & absence of social support:*
- Education & Literacy: *Language:*
- Employment and working conditions
- Social and Physical Environments: *Housing*
- Personal Health Practices and Coping Skills: *Resilience*
- Healthy Child Development: *Child Rearing, Parental Practices*
- Biology and Genetic Endowment
- Health Services: *Barriers to accessing mental health*
- Gender
- Culture: *Cultural background, spirituality and religious background*
- Prejudice, Discrimination and Racism
- Age

Foundations of Immigrant & Refugee Mental Health & Emotional Wellness:

- Human Rights
- Culture
- Family
- Community
- Mental Health Promotion
- Recovery Focus

*The WRHA I & R Working Group notes that these values and principles should apply to all populations and Mental Health & Emotional Wellbeing Services.*
SECTION 3: AN INTEGRATED MODEL FOR MENTAL HEALTH & EMOTIONAL WELLBEING SERVICES FOR IMMIGRANTS & REFUGEES:

12. MENTAL HEALTH SERVICE MODELS:

The focus of section one of this report has been to provide a Canadian and provincial context regarding the status and trending of the migration experience of immigrants & refugees as well as providing the key concepts and definitions for describing mental health. Section two of this report focused on developing a conceptual framework of requirements of a comprehensive approach to optimizing the mental health & emotional wellbeing of immigrants and refugees. Figure # 4 (page 54) provides a summary of this conceptual framework.

In section three of this report we will utilize the knowledge and information from the 1st two sections to focus discussions on models of mental health services for immigrants & refugees. Our review of mental health service models for immigrants and refugees is predicated on a literature review and at the national level, especially on several recommendations that come from work done by the Mental Health Commission of Canada.

“The Diversity Task Group takes the position that the challenges faced by Immigrant, Refugee, Ethno-Cultural and Racialized (IRER) populations need a mainstream service response, while also increasing the diversity of services and providers. All services will need to be capable of offering equitable care to Canada’s diverse population.” (MHCC: The Diversity Task Group, p-6)

Our review of mental health service models for immigrants and refugees will be framed by looking at mainstream mental health & emotional wellness service models with the recognition that these mainstream models must be able to respond to specific and diverse needs by increasing the diversity of services and providers.

“There are five groups of actions required to improve mental health services for Immigrant, Refugee, Ethno-Cultural and Racialized (IRER) groups:
I. Changed focus: an increased emphasis on prevention and promotion
II. Improvement within services: develop organizational and individual cultural competence
III. Improved diversity of treatment: diversity of providers, evaluation of treatment options
IV. Linguistic competence: improved communication plans and actions to meet Canada’s diverse needs
V. Linking needs to expertise: plans to offer support by people and services with expertise to areas with lower IRER populations so they can offer high-quality care”
(MHCC: The Diversity Task Group, p-7)

At a local level, in 2011 the WRHA published a framework on cultural proficiency entitled Framework For Action – Cultural Proficiency & Diversity. This framework is consistent with and complementary to the above listed MHCC recommendations on mental health service models for immigrants and refugees. The Cultural Proficiency & Diversity Framework is built on three levels of interventions:

1. Organizational Interventions: efforts to promote representative leadership and workforce that are racially/ethnically and culturally from diverse backgrounds.

Organizational interventions include “diversity” and “minority recruitment” initiatives.

2. Structural Interventions: efforts to make the processes within the health care system more client-friendly and culturally appropriate to ensure that patients/clients have full access to quality health care.
Structural interventions encompass a variety of measures that can be categorized as follows:

- Interventions to support communication competency
- Interventions to improve design and functioning of the health care system
- Socio-cultural assessment of population
- Community development and participation
- Collaborative partnerships

3. **Clinical Interventions**: efforts to equip health care providers with the knowledge of how socio-cultural factors affect health and provide health care professionals with the tools and skills to manage socio-cultural factors in the clinical encounter.

Clinical interventions involve cross-cultural (cultural proficiency) training programs that include: cross-cutting cultural/social knowledge, communication skills, know-how concerning cultural health assessment. These skills and tools are needed to ensure that health care providers do not make diagnostic and treatment decisions based on inaccurate information and/or biases. In addition, clinical interventions include having the know-how for dealing with specialized health care needs of immigrant and refugee populations.

(WRHA: Framework For Action – Cultural Proficiency & Diversity, p – 8)

Our review of mental health service models for immigrants and refugees will be framed by looking at continuum of service models that include emotional wellbeing promotion, earlier identification and intervention, as well as clinical treatment supports and services. As identified in Section 1, direct mental health supports and services must be based and focused on a recovery philosophy (approach).

### 12.1 Dual Continua Model:

In Manitoba’s strategic plan for mental health, **Rising to the Challenge**, the dual continua model is described in the following statements:

“Mental health is more than the absence of mental illness. When people are mentally healthy, they experience satisfaction and purpose in life, productivity, personal growth, physical health and positive personal, family and community relationships. Mental health promotion involves collaborative efforts that focus on creating environments that promote and sustain these features of positive mental health and well-being. Healthy environments promote mental health and well-being by enhancing protective factors and decreasing risk factors. Manitoba’s whole-population approach to mental health promotion supports capacity building and resilience and includes targeted prevention activities for at-risk groups.

Research in mental health demonstrates that factors contributing to positive mental health and well-being - defined as flourishing, and the factors that contribute to poor mental health - defined as languishing, can be measured. (Keyes, C.L.M., 2007). The significance of this research is that it illustrates that individuals may have a mental illness and still flourish if they experience the features of positive mental health. Also a significant finding is that individuals without a diagnosed mental illness may have low mental health consistent with the definition of languishing and be at risk of developing a mental illness.

The benefits of mental health promotion extend to the general population; therefore, a whole population approach to mental health and emotional wellbeing is called for. While the treatment of mental health problems and illnesses remains a core service, an investment in mental health across the entire population, with a focus on healthy child development, will provide positive and more sustainable overall outcomes.” (Manitoba Health: Rising to the Challenge, p-8).
Keyes dual continua model pertains to the whole population in terms of mental health promotion and emotional wellbeing (flourishing) as well as poor mental health and languishing. This mainstream mental health promotion model provides a positive, emotional wellbeing approach to understanding mental health and mental illness. The dual continua model is a helpful perspective in developing an integrated model of service for the mental health needs of immigrants and refugees. In order to respond to the needs of immigrants and refugees service planners and providers must listen to the diverse cultural definitions and experiences of mental health and mental illness and integrate them into the dual continua model.

12.2 Fraser Health Mental Health and Substance Use (MHSU) Integrated Care Model:

In August 2012 the British Columbia Ministry of Health published a paper entitled, Integrated models of primary care and mental health & substance use care in the community: Literature review and guiding document. The Fraser Health Mental Health and Substance Use Integrated Care Model is a service model that integrates mental health with primary care. It also utilizes a stepped care model to portray service responses and responsibilities as the service intensity along the continuum of care increases. They indicate that the higher the intensity of mental health service required, the more integrated mental health and primary care services need to be. (Please see Appendix 2 to view the model).

Locally, in 2008 the WRHA published a framework document on chronic disease management entitled, Lifting the Burden of Chronic Disease: What’s Worded, What Hasn’t, What Next – Directional Document. This framework document states that strong evidence supports the integration of the chronic disease management delivery system within primary care.
The Integrated Care Model is population based and again requires cultural proficiency on behalf of service planners and providers to ensure that appropriate service responses to the needs of immigrants and refugees are integrated into the various steps/components of the model.

12.3 WRHA Collaborative Care Model:

The WRHA Mental Health Program has been in a process of reviewing its Community Mental Health Program (CMHP) as to its purpose and service delivery structure. A 2010 WRHA discussion paper entitled Geographic Based Community Mental Health Practice Model Redesign: A Discussion Paper articulates the need for redesign is based on current and emerging evidence informed practice. The discussion paper speaks to the integration of mental health, primary health and social services as well as to a broader based continuum of community based accessible services. The redesign of the Geographic Based CMHP Model of Services proposes the establishment of integrated Community Based Interprofessional Collaborative Teams.

The discussion paper utilizes a quadrant approach to identify service need & intensity as well as to articulate the role and function of these CMHP Teams in reference to these needs. In Quadrant 1, Low Mental Illness & Low Other Complexity, the primary focus is on capacity building, promotion and consultation. In Quadrant 2, Low Mental Illness & High Other Complexity, the overall focus is on primary prevention for at risk populations and consultation. In Quadrant 3, High Mental Illness & Low Other Complexity, the focus is on collaborative practice and on recovery through assessing, addressing and restoring mental health along with maintaining & enhancing natural support networks. In Quadrant 4, High Mental Illness & High Other Complexity, the focus is on holistic services working toward integrated treatment for concurrent disorders or complex needs. A more detailed description of these quadrants is depicted in Figure # 6: Moving Toward a Broad Collaborative Care Model for CMHP (page – 59).

Coinciding with the CMHP redesign, Primary care in Manitoba has made significant progress in recent years. The Province of Manitoba is supporting primary care practices and RHAs in a number of ways, including the development or enhancement of Primary Care Networks. Primary Care Networks will be built around strong partnerships. Teams of care providers will work together to plan and deliver services for a geographic area or specific community or population. Primary Care Networks are less about physical space, and more about leveraging and building on existing services and enhancing them so that consumers are offered more coordinated and comprehensive care. (Retrieved from Manitoba Health website http://www.gov.mb.ca/health/primarycare/pcn/index.html In Winnipeg, the Primary Care Networks have been aligned geographically and include Family Practice and Mental Health.

The proposed CMHP redesign promotes a mainstream, integrated, population based service that offers a broad continuum of services from emotional wellbeing promotion to clinical supports and services. To ensure that this CMHP redesign can better respond to the needs of immigrants and refugees it requires cultural proficiency on behalf of service planners and providers to integrate appropriate service responses to the needs of immigrants and refugees into the various service quadrants.
### Quadrant 4: High Mental Illness & High Other Complexity

Long term follow up services for persons with complex needs including:
- Engagement with individuals in their homes or on the streets as required
- Assessment of behavioural health, suicide risk and substance use
- Case management in partnership with Winnipeg Integrated Services (WIS) for management of health & social services needs along with brokerage, mediation, and advocacy in seeking other required services with individualized service plans that focus on strengths, harm reduction and risks management
- Collaborative primary care including administering and monitoring medication and management of risk for physical illness & chronic disease
- Symptom assessment and management through solution focused therapy
- Rehabilitation with life skills teaching and assistance with housing, employment and education
- Legal assistance when involved with the justice system
- Education, support, and consultation to individuals, their families, and other major caregivers

The focus is on holistic services working toward integrated treatment for concurrent disorders or complex needs.

### Quadrant 3: High Mental Illness & Low Other Complexity

Collaborative practice within primary care environments with follow up mental health support to maintain and enhance natural support networks, including the following range of processes and interventions:
- Assessment including behavioural health assessment, suicide assessment and substance use assessment
- Brief counselling and solution focused therapy (individual, couple, family & group) for conflict resolution, psychiatric / psychological issues, couple family issues
- Collaborative primary care and management of risk for physical illness & chronic disease
- Integrated health & social services for people with serious mental disorders
- Crisis intervention
- Case management
- Rehabilitation (assistance with housing, employment and education)
- Consultation with family and care providers

The focus is on recovery through assessing, addressing and restoring mental health along with maintaining & enhancing natural support networks.

### Quadrant 1: Low Mental Illness & Low Other Complexity:

Capacity building with other stakeholders working toward an emotional wellbeing focus for the population, including Promotion and Prevention Activities.

The mental health role is one of general capacity building with individuals and their communities as a broad range of community resources are needed to address the vast needs of the population.

The desired processes & interventions for Mental Health Services include processes & interventions such as:

- Information & Referral
- Consultation
- Community Development / Networking
- Prevention / Promotion Services
- Relapse Prevention
- Psychosocial Emergency Response to Disasters

### Quadrant 2: Low Mental Illness & High Other Complexity:

The overall focus is Primary Prevention for at risk populations. Consultation as required to other health and social services with a focus on primary prevention for individuals and targeted high risk groups, through early detection and brief treatment.

The desired processes & interventions for Mental Health Services are to assist in stabilization and establishing a new normal in complex situations utilizing the following processes & interventions:

- Stress Management
- Behavioral Health Management
- Skills Building
- Change Management
- Treatment Adherence
- Chronic Disease Management
- Response to Traumatic Immigration
- Family Intervention
- Psycho-education

*Adapted from WRHA Geographic Based CMHP Practice Model Redesign: A Discussion Paper (Final Draft 2010)*
12.4 I & R Mental Health & Emotional Wellbeing Stepped Care Service Model

We would now like to present a mainstream mental health & emotional wellbeing service model with adaptations to make it applicable to the mental health & emotional wellbeing needs of immigrants and refugees. The service model is based on stepped care, is integrated with health and social services, is inclusive of a broad continuum of care, requires collaboration, and portrays an increasing intensity of service responses. It incorporates the mental health and mental illness concepts of the Dual Continua Model by Keyes, fits with the WRHA Geographic Based CMHP Interprofessional Community Teams redesign, and is complementary to the stepped care model presented by the Fraser Health Mental Health and Substance Use Integrated Care Model.

The proposed model of mental health & emotional wellbeing services is portrayed in Figure # 7, I & R Mental Health & Emotional Wellbeing Stepped Care Service Model (page-61). The model is a series of stairs with the intensity of services increasing as the stairs ascend. The 1st level or stair represents the broadest possible application with a focus on universal mental health promotion strategies integrated with a population health approach. These strategies are about promoting emotional wellbeing as a component of healthy living. Mental Health First Aide (MHFA) is an example of a universal mental health promotion strategy. Although this strategy is mainstream, attention is being given to creating MHFA courses that incorporate the significant cultural diversities of immigrants and refugees. Service delivery requires cross-sector collaboration inclusive of non-government organizations, community groups, cultural and religious organizations.

The next 3 levels or stairs pertain to supports focused on assisting people with increasing their knowledge of mental health and mental illness and enhancing their coping skills. They focus on capacity building, creating information/education kits, developing online supports, and supported self-management. Two examples of services are: Bounce Back and Calm in the Storm. Cross-training in cultural proficiency regarding mental health and immigration/ settlement issues is a vital adaptation to this mainstream service approach. Service delivery requires cross-sector collaboration inclusive of non-government organizations, community groups, cultural and religious organizations.

The last 2 levels or stairs pertain to more specialized, more intense mental health supports and services (smallest application). The focus is on mental health therapeutic interventions, psychiatric and psychological consultations, and direct clinical interventions and supports (inclusive of inpatient treatment). While the formal mental health program assumes a greater role and responsibility for these services, they continue to do so in collaboration with primary health care and other social, cultural, and religious organizations. Navigation to and within these services is an important mainstream issue and is of special significance to immigrants and refugees. Cross-training in cultural proficiency and immigration/settlement issues is especially important in being able to provide culturally proficient treatment responses. Based on the work of Kirmayer et al (Cultural Consultation: Encountering the Other in Mental Health Care, 2014), a specialized Mental Health Cross-Cultural Consultation Model is an essential component to the mainstream mental health service model.
I & R Mental Health & Emotional Wellbeing Stepped Care Service Model: Cross-sector, Collaborative and Mainstream

Mental Wellness Promotion & Capacity Building

- Mental Health First Aide
- Universal Mental Health Promotion Strategies

- Online Supports & Apps
- FLOURISHING

- Life Experiences (both ways)
- Supported Self-Management

- Mental Health Toolkits & Resources

Formal Mental Health Supports

- LANGUISHING
- Direct Support & Collaborative Team-Based Consults
- Therapy Intervention

- Navigation
- Mental Health (I&R) Consultation Model
- Culturally Proficient Treatment Responses

Adapted from MB TRAM TEAM 2013
Adapted from NUCA Health Care
Adapted from Dual Continua Model

61
Immigrants and refugees in ever increasing numbers have decided to make Winnipeg and Manitoba their home. Statistical data indicates that Manitoba has averaged an annual reception of 13,900 Immigrants and Refugees in the 5 years between 2008 and 2012.

The average annual reception of refugees during the 5 years between 2008 and 2012 has been 1109. In 2013, Manitoba welcomed the highest number of refugees per capita in Canada. Preliminary unpublished data indicate that the total number of refugees arriving in Manitoba in 2013 was 1484, an increase from 1140 (344 or 30.2%) over 2012. A significant trend in the reception of refugees is that the proportion of Privately Sponsored Refugees vs. Government Assisted Refugees has been rising from 12% (80) in 1998 to 66.2% (755) in 2012. Preliminary unpublished data also indicates that the trend toward greater numbers of PSRs continued in 2013 with 1002 PSRs (67.5%) vs. 389 GARs (26.2% received by Manitoba. In 2013, Manitoba's share of PSRs to Canada was 15.7% of the national total and the highest per capita in Canada. This is as a result of the high level of activity among Manitoba sponsors to sponsor refugees. This trend is likely to continue as it supports Citizenship and Immigration Canada’s policy direction to reduce the number of GARs and increase PSRs. Changing federal policy is also impacting access to federally insured services. On July 1, 2012, CIC limited eligibility for extended health services (hospital, diagnostic, medication) under the Interim Federal Health Program (IFHP) reforms for PSRs and Refugee Claimants unless care is urgent or poses a risk to public health. Other benefits discontinued include prescription drugs, dental, vision and ambulance service. The trend of increasing the proportion of PSRs as well as the policy change regarding access to IFHP may have impacts on both the health and mental wellbeing of immigrants & refugees as well as on their health and mental wellbeing needs and supports.

Another significant trend in the reception of immigrants & refugees is the number of families with children and young people. In the 5 years from 2008 to 2012, the children & youth (0 to 19yrs) population has averaged 4782 or 34% of the total number of immigrants and refugees received in Manitoba. (Source: Manitoba Immigration and Multiculturalism) This is significant in terms of the child development, parental, psychosocial, and intergenerational issues that accompany the immigration and settlement/re-settlement experience.

Based on the proposed I & R Mental Health & Emotional Wellbeing Stepped Care Service Model, we will identify several areas for action.

CENTRAL TO THE ENTIRE CONTINUUM OF SERVICES OF THE PROPOSED I & R MENTAL HEALTH & EMOTIONAL WELLBEING STEPPED CARE SERVICE MODEL  (Figure # 7)

- **Environmental Scan:**
  To determine the strengths and gaps of existing services, and utilizing the I & R Mental Health & Emotional Wellbeing Stepped Care Service Model, members of the Immigrant & Refugee Mental Health & Emotional Wellbeing Working Group need to identify existing programs & services. Each of these services should relate to a step in the I & R Mental Health & Emotional Wellbeing Stepped Care Service Model. It is suggested that existing scans and inventories (e.g., CONTACT/Winnipeg Health Services Directory; Local Immigration Partnership Winnipeg [LIPW]) as well as lessons learned from BridgeCare and others could be used as a starting point for this activity.

- **Intersectoral Awareness and Education:**
  To support capacity building, create opportunities for cross-learning and collaboration across all sectors (e.g., immigration & settlement; health/mental health; education; social services; legal; cultural & religious organizations). Research has shown that spirituality and cultural context often construct mental health and mental illness in very different ways. Religious affiliations may even be
strengthened post-migration, whether for reasons of renewed religious belief or because religious institutions become locations of community support. (Khanlou, 2010) Example of cross-learning and collaboration is that of the Settlement Workers and BridgeCare.

- **Cultural Proficiency Awareness and Action:**
  Many sectors & organizations have a focus on cultural proficiency awareness & action. In order to support ongoing excellence in service delivery, partners should explore opportunities to enhance cultural proficiency at all levels of this comprehensive service delivery model, e.g.: roll out and implementation of the new Geographic Based CMHP Interprofessional Teams; development and implementation of geographic based Primary Care; exploration of mechanisms to enhance cultural awareness and proficiency.

- **Establish a Mechanism for Joint Planning & Service Delivery:**
  There are currently many programs and services for immigrants and refugees offered by various sectors, non-government organizations, cultural organizations, community and religious groups. The services range from basic immigration and re-settlement support, support with daily living and aspects of the determinants of health, psychosocial supports, universal mental health promotion, to more formal mental health supports and interventions. Based on the environmental scan and the principles of diversity, the Mental Health & Emotional Wellbeing Working Group needs to identify mechanisms for and engage in collaborative approaches to planning, implementation and evaluation of services.

- **Review Clinical Practice Guidelines and Pathways as appropriate:**
  Review existing clinical practice guidelines and pathways for applicability to and support of this framework.

**MENTAL HEALTH PROMOTION AND CAPACITY BUILDING:** (Figure # 8)

- The Immigrant & Refugee Mental Health & Emotional Wellbeing Working Group needs to establish opportunities to discuss the role of culture on mental health & emotional wellbeing.

- Create opportunities for intersectoral groups to discuss, understand and honour the role of culture and community on mental health & emotional wellbeing.

- Identify supports that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections, and personal dignity (Joubart et al., 1996, cited in CAMH Best Practice Guidelines; 2012, p-17).

- Create mainstream information and education tools on mental health & emotional wellbeing that are culturally relevant and readily accessible. E.G: Universal Mental Health Promotion Strategies like Mental Health First Aide; Education kits & online supports like Bounce Back & Calm in the Storm; Identification/screening tools targeted for service providers and care givers.

- Support community and organizational capacity-building within Immigrant & Refugee cultural, religious and community organizations in order to develop sustainable skills and abilities to support I & R mental health and emotional wellbeing. (WRHA: Community Development Framework – Updated 2014) Example of community capacity-building is Strengthening Families Program at Mount Carmel Clinic.

- To provide equity in mental health across all sectors, link this framework with the equity frameworks of each sector.
Figure #8:

I & R Mental Health & Emotional Wellbeing Stepped Care Service Model: Cross-sector, Collaborative and Mainstream

Mental Wellness Promotion & Capacity Building

- Mental Health First Aide
- Capacity Building
- Information/Education Kits (Bounce Back, Calm in the Storm)
- Cultural Proficiency Awareness and Action

Adapted from MB TRAM TEAM 2013
Adapted from NUKA Health Care
Adapted from Dual Continua Model
FORMAL MENTAL HEALTH SUPPORTS: (Figure # 9)

- **Development of culturally proficient treatment responses:**

  Due to the complexities of mental health and mental illness and since culture is an important factor in influencing mental health / mental illness, it is important that the mainstream mental health & emotional wellbeing system is able to ensure culturally proficient treatment responses.

  - **Interpreters:**

    "...interpretation refers to the process by which a spoken or signed message in one language is relayed, with the same meaning, into another language. This definition recognizes the complexity of the task of interpretation." (Bowen, Language Barriers Within the Winnipeg Regional Health Authority: Evidence and Implications, 2004, p-3).

    Sarah Bowen in a WRHA paper entitled, “Language Barriers Within the Winnipeg Regional Health Authority: Evidence and Implications”, indicates that a lack of language access services presents barriers to first contact for most health services. She further states that language barriers have been demonstrated to decrease participation in health promotion and prevention programs – programs that have important implications for the long term health of the population – and delay presentation for care (Bowen, Language Barriers Within the Winnipeg Regional Health Authority: Evidence and Implications, 2004). (Please see Appendix # 3 for Key Points of this paper.)

    Kirmayer indicates that professional medical interpreters may be the single most important resource to ensure access to, and quality of, mental health services (Kirmayer, Immigrants and Refugees: Two Realities, 2012).

    - Support the ongoing inclusion of Mental Health & Emotional Wellbeing in interpreter training.
    - Support the use of trained interpreters at appropriate steps in the I & R Mental Health & Emotional Wellbeing Stepped Care Service Model.
    - Support cross sector access to trained interpreters (e.g., justice, education, social services).
    - Support Province –wide accessibility to interpreter supports and the use of technology (e.g., telehealth).

  - **Cultural Brokers:**

    “Even when linguistic communication is established, cultural formulation may require the use of culture brokers or mediators, that is, resource people or professionals with in-depth knowledge of the specific cultural and social background of the patient as well as knowledge of the medical systems who can function as go-betweens, brokering mutual understanding and collaboration.” (Kirmayer, Laurence J., et al. (2012). Guidelines for Training in Cultural Psychiatry. The Canadian Journal of Psychiatry, Vol 57, No 3, pg-4)

    - Support the gathering of evidence regarding the role and use of cultural brokers in delivering mental health and emotional wellbeing services.

- **Relational-based Services:**
- Support healthy relationships by supporting access to a broad range of available resources.

- **Trauma-Informed Therapy:**
  - Support access to culturally appropriate trauma-informed services. This is especially important regarding post traumatic stress relating to the life experiences of refugees. The need for this treatment response was identified in focus groups conducted in Winnipeg by Koop & Carter in 2011.

- **Cross-cultural Consultation Model for I & R:**

  Kirmayer et al in their recently published book, *Cultural Consultation: Encountering the Other in Mental Health Care*, promote the use of an Interprofessional Cultural Consultation Team to support the work of culturally proficient mainstream workers (Kirmayer, 2014). The purpose of the consultation team is to consult, support, train, and empower mainstream workers in providing culturally proficient mental health supports and services.

  Interprofessional Cultural Consultation Team could be developed as a virtual team with specialists from various sectors and organizations. Team members to bring culturally proficient specialized skills together to provide consultation to mainstream health and primary health care networks. (e.g., Psychiatry, Psychology, Community Mental Health Workers, Interpreters, Cultural Brokers).

  - Gather evidence to inform the anticipated development of an Interprofessional Cultural Consultation Team to support the work of culturally proficient mainstream mental health workers.
Figure #9:

I & R Mental Health & Emotional Wellbeing Stepped Care Service Model: Cross-sector, Collaborative and Mainstream

Formal Mental Health Supports

- Life Experiences (both ways)
- LANGUISHING
- Direct Support & Collaborative Team-Based Consults
- Therapy Intervention

- Navigation
- Mental Health (I & R) Consultation Model
- Culturally Proficient Treatment Responses

Adapted from MB TRAM TEAM 2013
Adapted from NUKA Health Care
Adapted from Dual Continua Model
CONCLUDING COMMENTS:

This paper sets out an overall conceptual framework that outlines the requirements of a comprehensive approach to optimizing the mental health & emotional wellbeing of immigrants and refugees in Winnipeg. The paper also identifies initial areas of action to facilitate the implementation and integration of this conceptual framework into current strategy development and planning processes with the immigrant & refugee population in Winnipeg. It is important to note that this conceptual framework is congruent with and supports other WRHA documents such as Framework For Action: Cultural Proficiency; health for all: Building Winnipeg’s Health Equity Action Plan; Community Development Framework; Advancing Collaborative Care Teams: A Guide for Teams and Facilitators; Moving Forward Together: Aboriginal Health Programs Strategy 2011 – 2016; and The A,B,C,Ds of Dignity Conserving Care (http://www.wrha.mb.ca/healthinfo/news/video/081021_dignity.php).

To move forward, the importance of the role of culture on mental health must be understood and all services or interventions must be based on evidence-informed or evidence-based, culturally consonant practices. In a recently published paper on global mental health, Lawrence Kirmayer & Duncan Pedersen provide the following succinct comments in support of the role of culture on mental health:

“Current efforts in global mental health (GMH) aim to address the inequities in mental health between low-income and high-income countries, as well as vulnerable populations within wealthy nations (e.g., indigenous peoples, refugees, urban poor). The main strategies promoted by the World Health Organization (WHO) and other allies have been focused on developing, implementing, and evaluating evidence-based practices that can be scaled up through task-shifting and other methods to improve access to services or interventions and reduce the global treatment gap for mental disorders. Recent debates on global mental health have raised questions about the goals and consequences of current approaches. Some of these critiques emphasize the difficulties and potential dangers of applying Western categories, concepts, and interventions given the ways that culture shapes illness experience. The concern is that in the urgency to address disparities in global health, interventions that are not locally relevant and culturally consonant will be exported with negative effects including inappropriate diagnoses and interventions, increased stigma, and poor health outcomes. More fundamentally, exclusive attention to mental disorders identified by psychiatric nosologies may shift attention from social structural determinants of health that are among the root causes of global health disparities.”

(Kirmayer & Pedersen, 2014, p – 759)
References:

African Communities of Manitoba Inc.  *A Profile of the African Communities of Manitoba*, Dr. K.C. Asagwara, Retrieved from: [http://www.acomi.ca/MBAfrica-Profile.htm](http://www.acomi.ca/MBAfrica-Profile.htm)


Gottlieb, Katherine. *The Nuka System of Care: improving health through ownership and relationships.* Int J Circumpolar Health 2013, 72: 21118. [http://www.dx.doi.org/10.3402/ijch.v72i0.21118](http://www.dx.doi.org/10.3402/ijch.v72i0.21118)


Rauf, Tahir. (2012). *Providing Services to Canadian Newcomers based on populations’ Mental Health (MH) and psychosocial needs*. Report prepared as part of the requirements of Masters in Public Health, October 2012, unpublished.


Appendix # 1:

THE INTERNATIONAL MIGRANTS BILL OF RIGHTS INITIATIVE

“A new era may well be dawning for the human rights of migrants and for human rights generally, through the growing recognition that adequately protecting one of the most vulnerable groups in many societies is today the true measure of our humanity.”

— Ryszard Cholewinski, ILO Specialist in Migration Policies

PURPOSE

The International Migrants Bill of Rights (IMBR) creates, for the first time, a single legal framework that protects the rights of all international migrants. This framework is a tool for migrants and advocates seeking to protect the rights of migrants and for states reforming migration policy to better comply with existing international law.

The IMBR draws from various areas of international law, including human rights law, refugee law, and labor law. Inspired by the Guiding Principles on Internal Displacement, which consolidated different areas of international law related to the treatment of internally displaced persons, the IMBR compiles this law to make clear that a comprehensive set of fundamental human rights protects all migrants. The IMBR also provides a margin of enhancement to existing law that advances positive developments in migration law and practice consistent with progressive values. In 23 articles and 80 pages of commentary, the IMBR presents a dynamic blueprint for the protection of the rights of all migrants.

WHO IS A MIGRANT?

The IMBR affirms that all migrants are entitled to human rights protections, regardless of the cause of their migration. In the IMBR, a migrant is any person who is “outside of a State of which he or she is a citizen or national.” Individuals are migrants regardless of whether their migration is temporary, lawful, regular, irregular, forced, for protection, for economic reasons, or for any other reason.

ABOUT THE IMBR INITIATIVE

The IMBR Initiative started in 2008 as a student-led project through Georgetown Law’s Global Law Scholars Program. It has evolved through the collaborative effort of students and scholars from Georgetown Law, the Center for Migration and Refugee Studies at American University in Cairo, the Minerva Center for Human Rights at the Hebrew University of Jerusalem and the Migration Studies Unit at the London School of Economics.
INTERNATIONAL MIGRANTS BILL OF RIGHTS  

**PRINCIPLES**

Every migrant has the right to **dignity, including physical, mental, and moral integrity.**

Every migrant has the right, without any discrimination, to the **equal protection of the law of any State in which the migrant is present.**

Vulnerable migrants, including children, women, and disabled migrants, have the right to the **protection and assistance required by their condition and status and to treatment which takes into account their special needs.**

Every migrant has the **inherent right to life.**

Every migrant has the right to **liberty and security of person.**

Every migrant has the right to **recognition everywhere as a person before the law.**

Every migrant has the right to **an effective remedy.**

Every migrant has the right to **due process of law.**

Every migrant victim of crime has the right to **assistance and protection, including access to compensation and restitution.**

Every migrant has the right to **protection against discriminatory or arbitrary expulsion or deportation, including collective expulsion.**

Every migrant has the right to **seek and to enjoy in other countries asylum.**

Every migrant has the right **against refoulement.**

Every migrant has the right to **a nationality.**

Every migrant family has the right to **protection by society and the State.**

Every migrant has the right to **freedom of thought, conscience, and religion or belief.**

Every migrant has the right to **freedom of opinion and expression.**

Every migrant has the right to **freedom of peaceful assembly and association.**

Every migrant has the right to **participate in the civil and political life of his or her community and in the conduct of public affairs.**

Every migrant has the right to be **free from slavery, servitude, or forced or compulsory labor.**

Every migrant has the right to **work and to just and favorable conditions of work.**

Every migrant has the right to the **highest attainable standard of physical and mental health.**

Every migrant has the right to **an adequate standard of living.**

Every migrant has the right to **education.**

Every migrant has the right to **enjoy the migrant’s own cultures and to use his or her own languages, either individually or in community with others, and in public or private.**
Appendix # 2:

Fraser Health Mental Health and Substance Use (MHSU) Integrated Care Model

Appendix # 3:

LANGUAGE BARRIERS WITHIN THE WINNIPEG REGIONAL HEALTH AUTHORITY

EVIDENCE AND IMPLICATIONS

KEY POINTS

• The proportion of Manitobans facing language barriers to health care is projected to increase in the coming years – not decrease as is commonly assumed.

• Language barriers have perverse effects on health service utilization – they decrease utilization of primary care and preventive services, and increase utilization of higher intensity services (such as diagnostic testing), and both hospital admission and length of stay.

• The international literature provides consistent evidence that language barriers are associated with increased instances of misdiagnosis, poorer health outcomes, poorer patient adherence, and lower satisfaction.

• Failure to address the risks to informed consent and confidentiality presented by language barriers presents increased risks to organizational liability.

• While there are costs associated with establishing language access programs, failing to address language barriers also has important cost implications. The cost implications of language barriers have been identified.

• Appropriate language access services are a critical element in organizational strategies to address health disparities, improve quality, and manage risk.

• Provision of trained interpreters provides important benefits to individual providers and the health system, as well as to clients.

• Language access services appear to be most efficient and cost effective when organized at a regional, rather than facility, level.

*Bowen, Sarah. Language Barriers Within the Winnipeg Regional Health Authority: Evidence and Implications, Winnipeg Regional Health Authority, September 2004.