



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

The Case for Diversity

Building the Case to Improve
Mental Health Services for
Immigrant, Refugee, Ethno-cultural
and Racialized Populations

**REPORT TO THE
MENTAL HEALTH COMMISSION OF CANADA**

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First Edition October 2016



Ce document est disponible en français.

This document is available at <http://www.mentalhealthcommission.ca>

SUGGESTED CITATION: Mental Health Commission of Canada. (2016). *The Case for Diversity: Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Populations*, Ottawa, ON: Mental Health Commission of Canada.

Production of this document is made possible through a financial contribution from Health Canada.

The views represented herein solely represent the views of the Mental Health Commission of Canada.

Digital ISBN: 978-1-77318-035-9

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Introduction



Canada is one of the most diverse countries in the world. More than 20 per cent of people living in Canada were born outside of the country, approximately 20 per cent belong to populations that are racialized, and, on average, more than 200,000 immigrants and an estimated 25,000 refugees come to Canada each year.^{1,2}

The Mental Health Commission of Canada (MHCC) has been a leader in recognizing the need for better services to meet the needs of everyone living in Canada. In 2008, the MHCC began to critically examine the ability of the mental health system to respond to the diverse needs of immigrant, refugee, ethno-cultural and racialized (IRER) populations. A Diversity Task Group was assembled to investigate the challenges and potential solutions that would help improve mental health services for IRER populations and in 2009 the group released the report *Improving Mental Health Services for Immigrant, Refugee, Ethno-Cultural and Racialized Groups: Issues and Options for Service Improvement (Issues and Options)*.³ The report looked closely at Canadian demographic characteristics, rates of mental illness in IRER populations, barriers to care and social factors that influence mental health. Research evidence featured in the report revealed that IRER populations in Canada are more exposed to the known social determinants that contribute to mental health problems and illnesses, tend to access mental health services less often and face numerous barriers when accessing services.³ The report put forward 16 recommendations to improve mental health services for IRER populations, encouraging policy makers to use local data and evidence to plan and develop population-based and flexible services in collaboration with stakeholders, communities and people with lived experience.

In 2012, MHCC released *Changing Directions, Changing Lives: The Mental Health Strategy for Canada (Strategy)*,⁴ in which it identified improving services for Canada's diverse populations as one of six strategic directions for a transformed mental health system. Subsequent provincial and federal strategies, however, have generally not addressed the needs of IRER groups in any depth.⁵ At the time that publications were examined for this report, the only provincial strategy that specifically identified initiatives and set priorities for culturally appropriate and safe services for immigrant and refugee groups was *Alberta's Addiction and Mental Health Strategy*.⁶

In the fall of 2014, MHCC decided it was time to help build the case – economic and social – for investing in culturally and linguistically appropriate and diverse mental health services. The Case for Diversity (CFD) Project was developed by researchers from the Centre for Addiction and Mental Health and the Wellesley Institute, in partnership with the MHCC's Knowledge Exchange Centre, picking up where the Diversity Task Group left off.

In other parts of the world, as well as in Canada, there have been significant advances in knowledge regarding how to improve the mental health of IRER populations. This report explores that knowledge and evidence from a Canadian perspective. It also offers direct-care staff, service planners and policy makers the knowledge and tools needed to build culturally safe, competent and diverse mental health services for IRER populations in Canada.⁴ The CFD Project takes a health equity approach, using up-to-date literature reviews and cost-benefit analyses as well as providing a library of Canadian practices of interest. It offers state-of-the-art evidence to show why there is an urgent need to develop more appropriate services for IRER populations and what can be done to improve existing services.

The Case for Diversity focuses only on IRER populations and does not include First Nations, Inuit and Métis (FN-I-M) peoples. Although Indigenous peoples and IRER populations may share experiences of racialization and discrimination, past and ongoing colonial processes have contributed to a unique set of urgent circumstances that greatly affect the mental health of FN-I-M peoples in Canada. Locally developed, culturally relevant and tailored responses are required to address the needs for mental health and wellness of FN-I-M populations. We recognize and acknowledge these significant differences, but do not address them in this report.

THIS REPORT INCLUDES:

1. An examination of Canadian published research on immigrants, refugee, ethno-cultural and racialized peoples' mental health in Canada.
2. Promising practices to better serve IREER populations.
3. An economic evaluation of IREER mental health service use.

It cannot be overstated that the conditions in which people live, work and grow, along with the wider set of forces and systems that influence people's lives – known as the social determinants of health – have a tremendous impact on their mental health and well-being.⁷ These social determinants can increase or decrease a person's risk of developing a mental health problem or illness, as well as affect access to appropriate and adequate mental health care. For a number of reasons, IREER populations are disproportionately affected by social determinants that undermine mental health and they face barriers to accessing the services that they need. As the evidence and promising practices featured in this report demonstrate, it is vital that Canada's mental health system respond swiftly, adequately and collaboratively to the needs of IREER populations. With committed leadership, strategic alignment of services and increased resources, Canada's mental health system can begin to meet the diverse needs of all people living in Canada.

Terminology

This report builds the case for improving mental health care for Canada's IREER populations. The choice to use IREER as a category is, in large part, a response to the available evidence and data. An area of concern that is not directly addressed in this report, although it is covered in the *Issues and Options* report, is the need for more population-specific mental health data and research in Canada. In particular, the relationship between race or visible minority status and mental health outcomes is not well documented in Canada, nor does research to date adequately distinguish between the mental health outcomes and needs of racialized populations born in Canada and those of racialized immigrants and refugees. There is also a paucity of studies addressing the myriad differences found within immigrant and racialized groups and how these may relate to mental health outcomes. For example, more information is needed on differences in outcomes according to country of origin or between generations. IREER populations are often grouped together in studies, which can create an inaccurate picture of the rates of mental health problems and illnesses and of the service needs of specific groups.³ For this reason, the *Issues and Options* report recommends that each province gather data on the size and the mental health needs of each of the IREER populations and plan services accordingly.

For the purposes of clarity, common terms used throughout this report are defined here.

COMMON TERMINOLOGY

Immigrants

Immigrants are persons born outside of Canada who have been granted the right to live in Canada permanently.⁸

Refugees

Refugees are people who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group or political opinion, are outside the country of their nationality and are unable to or, owing to such fear, are unwilling to avail themselves of the protection of that country.⁹

Throughout this report, "refugee" is used to describe both convention refugees (persons accepted as refugees by the Canadian government) and refugee claimants (asylum seekers who are waiting for their refugee claims to be decided on by the Canadian government).

COMMON TERMINOLOGY

Ethno-cultural group

Ethno-cultural group is a group that shares a common ancestry and cultural characteristics.⁸

Racialized

Racialized is a term that has replaced the outdated and often inaccurate terms “racial minority,” “visible minority,” “person of colour” or “non-White.”¹⁰ This term acknowledges race as a social construct. The term “racialized” is used throughout this report, except in selected instances when results from articles or sources use different terminology (visible minority, Black, White, Hispanic, Caucasian, South Asian, etc.) are discussed. In those instances, we use the original terminology from the literature.

Social determinants of health

Social determinants of health are the conditions in which people are born, grow, work, live and age and the wider set of forces and systems shaping the conditions of daily life.⁷

Canada’s Racial, Ethnic and Cultural Diversity

Canada has a particular interest in initiatives that can improve the health of IRER populations. Canada’s prosperity, growth and strength are tied to the diversity of the nation. Immigration is the driver of population growth and is needed to expand the economy and replace the baby boom generation, Canada’s largest generation, which is currently moving out of the labour market. Between 2001 and 2011, immigration increased significantly in every province and territory.¹¹ On average, more than 200,000 immigrants, and an estimated 25,000 refugees, come to Canada each year, giving Canada the highest percentage of foreign-born people among the G8 countries (20.6 per cent).^{1,2,12}

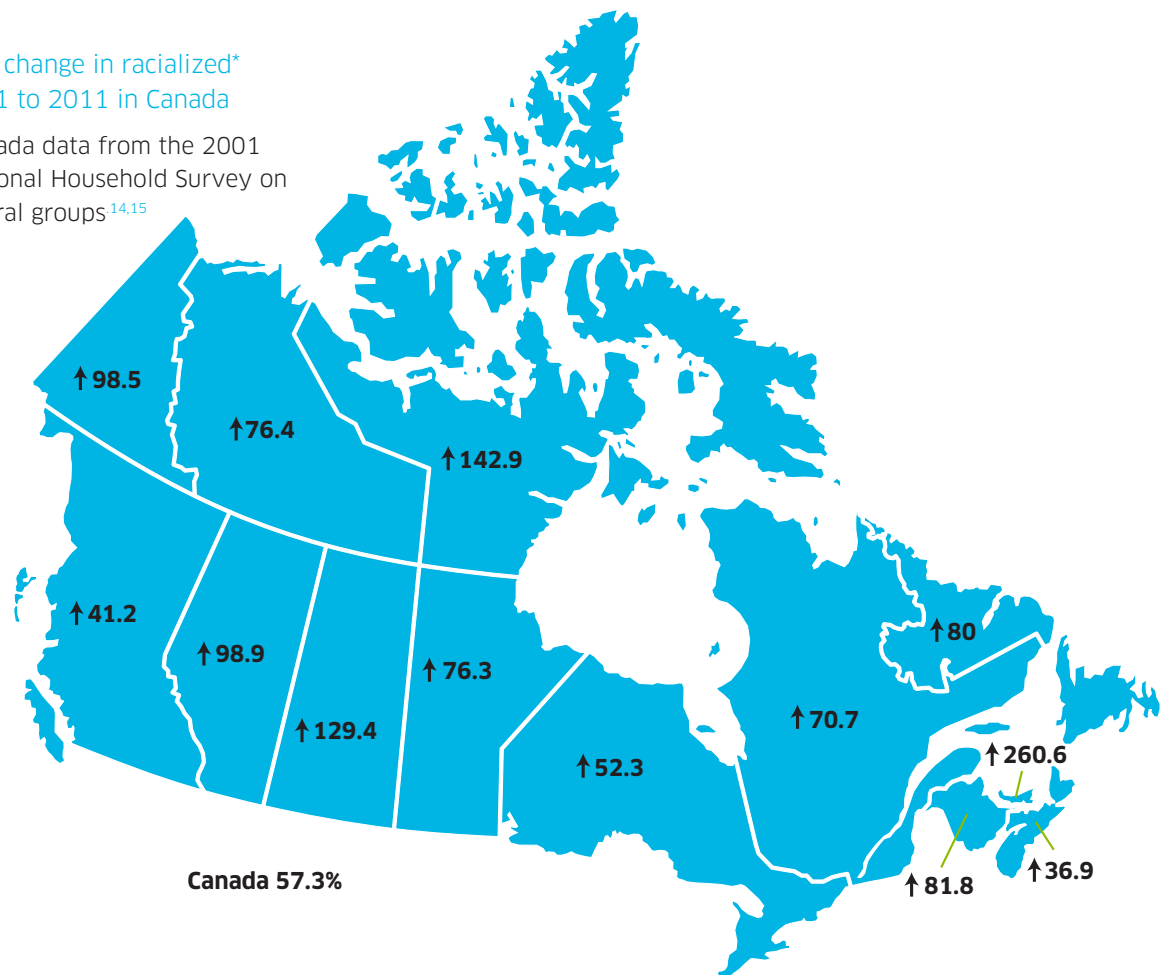
In recent decades, Canadian patterns of immigration have changed. Whereas in 1961 over 90 per cent of immigrants were from Europe, this figure dropped to 15 per cent by 2011.¹² Recent data show that over 200 ethnic groups are represented in Canada’s population.¹² Of these, only about one-third identify their origins as Canadian (10.6 million) according to the 2011 census. Among European ethnic groups, there are large German (3.2 million), Italian (1.5 million), Ukrainian (1.2 million), Dutch (1.0 million) and Polish (1.0 million) populations. Racialized groups make up a significant proportion of the Canadian population¹³ and this proportion has grown in recent years (Figure 1).^{14,15} Nearly 20 per cent of the population identifies as a member of a racialized group; of those who identify as racialized, 61 per cent identify as South Asian, Chinese or Black. Individuals of South Asian origin (1.6 million) constitute the largest racialized group living in Canada.¹²

Adding to the diversity of Canadian ethno-cultural makeup is linguistic diversity. More than 200 languages were reported as a home language or mother tongue in the 2011 National Household Survey.¹⁵ These include Canada’s two official languages (English and French), Indigenous languages and other languages. French is the first official language of 7.7 million Canadians, or 23.2 per cent of the population, and 5.8 million Canadians are bilingual in Canada’s two official languages.^{16,17} In addition, 6.8 million people, or 20.6 per cent, of the Canadian population have a mother tongue other than English or French.¹⁵

Overall, immigrants arrive in Canada with better mental and physical health than the Canadian-born population, but after seven years in Canada this “healthy immigrant effect” is lost. Evidence suggests that, in particular, immigrants from racialized groups and refugees are at risk for deteriorating health soon after arrival.¹⁸⁻²⁰ International reports of higher rates of mental illness, substance use problems and poorer use of services by IRER groups corroborate findings in Canada regarding racialized immigrants and ethno-cultural groups born in Canada.²¹ Canada urgently needs to develop a mental health service response to meet the needs of these populations if it is to foster Canada’s diversity.

Figure 1. Percentage change in racialized* population from 2001 to 2011 in Canada

*Source: Statistics Canada data from the 2001 census and 2011 National Household Survey on racialized ethno-cultural groups^{14,15}



Current Context

Globalization and international migration have led to the need for many high-income countries to develop systems of mental health care for increasingly diverse populations. In high-income countries, disparities in exposure to risk factors, rates of mental illness, service use and outcomes have been reported for IREER populations when compared with general populations. In many instances, the rates of mental health problems are lower in IREER groups than in the general population. There are, however, elevated rates of post-traumatic stress disorder (PTSD) and common mental health disorders (anxiety and depression) among refugees; and increased risk of substance misuse and suicide in some second- and third-generation immigrant groups.^{22,23} Among people living with mental health problems or illnesses from IREER populations, health service use is low, although in general, service use by IREER populations is increasing. Low use of health services in general may mask higher use of costly, more intensive services, such as inpatient care (patient care provided in a hospital or other facility) and emergency services.

In order to better serve IREER populations, mental health services and systems need to be fully congruent with practices that work to eliminate health inequities and reduce disparities between populations in a given area. A health equity approach is best suited to planning services by targeting avoidable differences in health and health service provision between populations. By taking action on the social determinants of health and by developing culturally responsive, safe and accessible services that meet the mental health needs of IREER populations, systems can decrease identified disparities in rates of illness and outcomes.

Methodology

The research methods used in the CFD Project are outlined in detail in Appendix A. These included three literature reviews, a secondary analysis of existing data and a national call for promising practices.

The first literature review identified peer-reviewed papers focused on mental health and substance use in IRER groups published between January 2009 and December 2014. The second review looked at Canadian and international research studies on best, promising or emerging practices for supporting, treating or developing programs for IRER populations with mental health or substance use problems, published between January 2000 and December 2014. The third literature search aimed to identify papers published up to May 2015 on mental health service use and costs for IRER populations in high-income countries.

The CFD team also conducted a secondary analysis of existing data, which was a retrospective descriptive study, to assess the cost of mental health service use for immigrants and refugees compared with non-immigrants in Ontario.

Once the information was assembled, consultations were hosted in Vancouver, Calgary, Ottawa, Toronto and Halifax to validate the usefulness of the information that had been collected and to test potential knowledge-translation approaches.

Review of Canadian Literature

RATES OF MENTAL HEALTH PROBLEMS AND ILLNESSES AND OF SUBSTANCE USE PROBLEMS

The rates of mental health problems and illnesses vary considerably among different IRER populations and within particular IRER groups. These variations likely reflect differences in exposure to and effects of social risk factors on specific populations and groups within these populations.

Research before 2009 mainly reported rates of mental health problems or illnesses for immigrants in general, with little information on differences in results according to country of origin or between generations. Although newer research continues to compare immigrant and non-immigrant groups, it also includes some more finely grained analyses of ethno-cultural and racialized populations. It demonstrates that “one size does not fit all” when considering the rates of mental illness in Canada’s IRER populations.

The CFD identified primary research articles published between 2009 and 2014 reporting rates of mental illness or substance use problems for IRER populations in Canada. The articles focused primarily on depression and anxiety. Studies reported that when immigrant, refugee, ethno-cultural or racialized populations are investigated as a single group, rates of mental health problems were low compared with the general population or non-immigrant populations.²⁴⁻³⁰ However, investigation of some specific IRER population groups revealed differences in rates of mental health problems, with some groups exhibiting higher or lower rates.

These findings underscore the importance of local data and needs assessments when planning services for IRER populations.

Further issues of interest from research articles include the following:

1. Context matters: the same group may have different rates in different circumstances.

- Asylum seekers who are detained in immigration holding centres upon arrival in Canada report significantly higher rates of PTSD (31.97 per cent), depression (77.87 per cent) and anxiety (63.11 per cent) compared with asylum seekers who have never been detained (PTSD: 18.18 per cent; depression: 51.52 per cent; anxiety: 46.97 per cent).³¹ Differences were observed even after a short duration in detention (median stay of 17.5 days).³¹

2. Inter-group and intra-group differences are prevalent within IRER groups in Canada.

- In a study of youth (aged 16 to 25) in British Columbia,²⁷ the lifetime use of cannabis, alcohol and club drugs (ecstasy, magic mushrooms, gamma hydroxybutyrate [GHB], or ketamine) were found to be similar between

Chinese and South Asian youth, but East/Southeast Asian youth were four times more likely than Chinese youth to report lifetime use of club drugs.²⁷

- While immigrants generally report lower rates of mental health problems in Canada, one study found that South Asian immigrants report statistically significantly higher rates of diagnosed anxiety (3.44 per cent) than the South Asian population born in Canada (1.09 per cent).³²

3. Time in Canada matters: rates of mental illness in specific populations vary according to the amount of time living in Canada.

- Refugees living in Alberta between one and six years report improved mental health compared with when they first arrived in Canada.³³
- Recent immigrants in Canada are less likely to report depression than longer-term immigrants, whose reported rates are more similar to the Canadian-born population.^{34,35} The longer people reside in Canada, the higher their risk for developing a mood disorder, although this risk flattens eventually.³⁶

Reviews of Canadian studies show that having better health than Canadian-born populations at the time of immigration does not hold true for all immigrant groups;³⁷ likewise, the deterioration of mental health over time varies across groups.³⁸ What this means is that one size does not fit all: different IRER population groups living in different contexts, and who have been in Canada for different amounts of time, have different rates of illness.³⁹ The identities and experiences of different population groups and how these factors may interact with one another to affect mental health, require more attention. This is often called “intersectionality” – the various overlapping social identities that people hold or society ascribes to them.^{40,41} The literature increasingly considers this “intersectionality” important. Service providers and services need to acknowledge these intersections and the fact that people do not fit neatly into one identity. Therefore, quality care should not be generalized, but should acknowledge the intersections and fluidity of identity,⁴⁰⁻⁴² as well as the relationship between health care practitioners and clients and the “social location” (position an individual holds in society based on race, gender, socio-economic status, ability, religion, sexual orientation, etc.) of both.⁴¹⁻⁴⁷ Furthermore, local, up-to-date information needs to be collected on a continual basis in order to determine the rates of mental health and substance use problems in specific IRER groups.

RISK AND PROTECTIVE FACTORS

Social factors associated with mental health, referred to as “social determinants,” can either increase or decrease someone’s risk of developing a mental health problem or illness.³ IRER populations are more likely than the general population to be exposed to social determinants that increase the likelihood of developing a mental illness or substance use problem. In addition, they may face novel social determinants that are rarely encountered by those who are not part of IRER populations. Increased exposure to the negative impacts of the social determinants of health may increase the risk of mental health problems and poorer outcomes from treatment. While this section will focus more heavily on risk, it is important to note that each social determinant is also capable of serving as a protective factor.

Issues and Options identified 15 key social determinants from Canadian research (see box). Three of these are unique to IRER populations: migration issues, perceived discrimination and language.³



Social Determinants of Health in *Issues and Options*³

- | | | |
|-------------------------------------|--|--------------------|
| 1. Income and social status | 6. Physical environments | 11. Culture |
| 2. Social support networks | 7. Personal health practices and coping skills | 12. Age |
| 3. Education and literacy | 8. Healthy child development | 13. Migration |
| 4. Employment or working conditions | 9. Health services | 14. Discrimination |
| 5. Social environments | 10. Gender | 15. Language |

More recent studies add to the 15 key determinants. The new risk factors most commonly studied are:

1. Safety from or exposure to victimization or violence⁴⁸⁻⁵¹
2. Parents' mental health or substance use problems⁵²⁻⁵⁶
3. Food (security or insecurity)^{32,34,57-59}
4. Caregiver burden or health of a family member^{60,61}

While these four risk factors are not unique to IRER populations, these groups are more likely to be exposed to them.³ These factors may have increased impact because they interact with each other and with other determinants discussed in the Issues and Options report.

Safety From or Exposure to Victimization or Violence

Exposure to violence is an important health issue because of its direct physical and psychological consequences as well as long-term health impacts. Individuals who live in areas of high crime or experience violence (domestic or due to criminal activities) are at a much greater risk of developing chronic anxiety, depression, suicidal ideation and substance abuse.⁶²⁻⁶⁵ Stress from unrealized expectations, lowered social standing, failure to meet cultural expectations, an ethos of non-disclosure due to fear of shame and a lack of social support effect immigrants and refugees disproportionately and may aggravate interpersonal relationships, which in turn, can contribute to violence and mental health problems.^{50,51} A Canadian study reported a higher rate of emotional spousal abuse among recent immigrant women compared with Canadian-born women.⁶⁶

Parents' Mental Health or Substance Use Problems

Mental health problems and illnesses or substance use problems experienced by parents may have an impact on the mental health of their children.⁶⁷⁻⁷⁰ Mental health problems may affect parents' ability to support their children, resulting in increased vulnerability to stress and poorer mental health in their children.⁵⁵ Fear and stigma surrounding their parents' mental health problem or illness may be a significant burden for children.

Food Security or Insecurity

Food insecurity is defined in the academic articles included in this review as lack of regular or uncertain access to adequate, safe and nutritious food or insufficient food intake.^{34,58} Food insecurity has been linked to poorer mental health in general populations.⁷¹⁻⁷³ Some IRER populations are at risk of food insecurity for a number of reasons, including poverty, unemployment and lack of social supports. For example, the number of racialized families living in poverty in Toronto increased 362 per cent between 1980 and 2000.⁷⁴ The 2006 census revealed that, while the overall poverty rate in Canada was 11 per cent, the poverty rate among racialized persons was 22 per cent,⁷⁴ which means that an increasing segment of Canada's racialized population is at risk of food insecurity. New immigrants form one of the groups most likely to experience poverty in Canada and refugees are more likely to experience chronic low income than other classes of immigrants.^{75,76} Several studies have explored the experience of food insecurity in IRER populations.^{32,34,57-59} One study found that recent immigrants experiencing food insecurity were less likely to report mental health problems than non-immigrants experiencing food insecurity.³⁴ In contrast, a group-specific study of South Asians found immigrants experiencing food insecurity to be nearly three times more likely to have a diagnosed mood disorder compared with South Asian immigrants with food security.³²

Caregiver Burden

There are significant emotional and physical impacts that can accompany caring for a family member or loved one living with a long-term health condition, a physical or mental health problem or illness, or aging-related needs.⁷⁷ Caregiver burden, however, may be increased in some IRER populations because extended support systems are less available. In addition, there may be cultural expectations that are difficult to meet or specific health problems that may be stigmatized. In general, caregivers in Canada report high levels of stress associated with caregiving demands and these demands can increase the risk of mental health problems in caregivers.⁷⁷ Caregiver burden is associated with depression in IRER families.⁶¹

SERVICE USE

This section aims to provide a broad overview of the existing evidence concerning barriers faced or shared by IREER populations. There is a need for more Canadian research focused on barriers to mental health services for distinct populations. For example, refugee claimants, newly arrived immigrants and racialized persons born in Canada may face distinct barriers to mental health care that warrant further investigation. IREER groups tend to seek help for mental health problems less frequently than the general Canadian population.⁷⁸⁻⁸⁵ Using data from the Canadian Community Health Survey comparing Canadians who experienced a major depressive episode, findings indicate that people who self-identified in the survey as Black, South Asian or as belonging to a subgroup consisting of Japanese, Chinese and Korean respondents, were 60 per cent, 85 per cent and 74 per cent less likely, respectively, than respondents who identified as White to seek treatment.⁸¹ Access to care, and the pathways and time taken to receive care, have stark consequences on treatment outcomes.⁸⁶ Recent research points to six potential barriers to seeking help:

1. Service accessibility
2. Provider-patient interaction
3. Circumstantial challenges
4. Language
5. Stigma
6. Fear

Service Accessibility

Many factors related to the accessibility of current services act as barriers for IREER populations. The most pertinent is the cultural incompatibility of existing services.^{7,83,87-89} Other commonly reported barriers include long wait lists,^{81,87,88,90} complicated procedures to use services,^{87,90} shortages of medical professionals (especially in rural communities)^{83,88,89,91} and inconvenient hours of available services.⁹⁰

Patient-Provider Interaction

The greatest patient-provider barrier for members of IREER populations is that insufficient time is provided for conversation with their health care providers.^{50,87,92,93} In some cases, this results in the health care provider underestimating the seriousness of the condition, in a lack of personal connection between patients and providers and in a lack of awareness of individuals' history and experiences.^{7,50,87,92,93} Often, IREER individuals are unaccustomed to the social distance maintained by many health care providers in Canada.⁹²

Circumstantial Challenges

Circumstantial challenges include such things as transportation, additional costs (financial constraints, insurance coverage issues), weather, isolation and competing demands (employment, personal and family responsibilities).^{50,81,89,92,94-96} These barriers may be more common for children and seniors, who are dependent on other family members and whose mental health problems may be given a lower priority because of more immediate stressors.^{92,95}

Language

When English or French is not one's mother tongue, the ability to convey intended meaning, understand instructions, read prescriptions and understand medical terms (jargon) in either of those languages is more difficult. Language proficiency is a major barrier for some members of IREER populations and not only for recent immigrants and refugees.^{50,87-89,92,94,97-99} For anyone seeking help, it is extremely important that they be able to communicate in their language of choice.^{87,89,90,98-101}

Stigma

There is stigma surrounding mental health problems and illnesses in most cultures. It is not uncommon to believe that they bring shame to the individual and the family.^{7,90,98,101,102} This may delay help-seeking, as there may be reluctance to believe the problem is real.^{95,98} The desire to hide the problem or the need for privacy to avoid the judgment of others in the community may also impede help seeking.^{7,98} Some choose not to seek care because they fear being discriminated against by their own ethno-cultural community or family.^{92,94}

Fear

Fear is a powerful barrier to seeking mental health care. Some IRER populations have had negative experiences with services and fear using them. For example, individuals may believe that they will be given medication when they prefer psychotherapy.⁹⁴ Others are concerned that contact with services will lead to seizure of their children by child protective services; others with “precarious” immigration status (see box)¹⁰³ in Canada may be concerned that use of mental health services could affect their status in Canada.^{94,102} Some immigrant groups worry that use of mental health services will change the way they are viewed by Canadian society, that they will be seen as a burden on society who should be sent back to their original country.⁷

“Precarious” status refers to various forms of less-than-full legal status. Specifically, it is marked by any of the following: the absence of permanent residence; lack of work authorization; depending on a third party for residence or employment rights; restricted or no access to public services and protections available to permanent residents (e.g. health care, education, workplace rights); and deportability.¹⁰³

Evidence for Promising Practices

The CFD Project has identified programs, policies, treatments and supports that have the capacity to effectively address disparities in service delivery as “promising practices.” During consultations, stakeholders stated clearly that, in order to provide better services and supports for IRER populations, they needed evidence on what was working internationally and across Canada.

From a health equity perspective, the routes to improving service responses for IRER populations are two-fold:

1. Decrease the negative impact of the social determinants of health that produce disparities in rates of illness.
2. For those who need care, decrease disparities in access and outcome of care through the development of more appropriate service models built on the needs of diverse populations.

The CFD team conducted a scoping review of international literature on promising practices, divided into two sections: frameworks (see Appendix B) and practices (see Appendix C). Practices from the Canadian context will be referred to in this report as “practices of interest.” These practices were either submitted online or identified by the research team.

INTERNATIONAL FRAMEWORKS AND PRACTICES

Promising Frameworks

Frameworks aimed at improving services for diverse populations have been developed in the United Kingdom, United States and Australia. Frameworks are to evidence-based interventions what a building’s blueprints are to the building itself. Because these frameworks have been developed in different places for different populations, it is not possible to develop a synthesis or simple “how-to” document. Instead, we present summaries of the approaches and encourage service planners to choose those best suited to the needs of their populations (see Appendix B).

Promising Practices from International Literature

A scoping review of international literature revealed a number of articles on promising practices. Some of them were experimental and observational quantitative and qualitative studies of promising practices. Others explored and explained the development and implementation of specialized programs, retention of clients in programs and the feasibility and effectiveness of specific programs. Summaries of these and all other identified studies can be found in Appendix C.

Systematic reviews and meta-analyses are considered the highest level of medical evidence.^{104,105} Reviews of systematic reviews arguably go one step further by taking the best evidence available and collating it. Several systematic reviews and meta-analyses were identified and examined through the promising practices scoping review. To demonstrate the knowledge now available on promising practices to improve services for IRER groups in high-income countries worldwide, a summary of this review is presented here.

SNAPSHOT: INTERNATIONAL EVIDENCE ON PROMISING PRACTICES

1. Cultural competence has cachet, but the research to support its effectiveness needs to be better developed.
2. Culturally-adapted psychotherapies improve outcomes, but the impact is greater for some groups than for others.
3. Developing specific stepped or integrated-care pathways adapted for an ethnic group may improve outcomes.
4. Specific culturally-adapted treatments for ethno-cultural and racialized youth seem to be effective.
5. Cultural adaptation improves outcomes for substance misuse treatment.
6. There is evidence that specific interventions such as narrative exposure therapy and cognitive behavioural therapy, separately and in combination with medication or eye movement desensitization and reprocessing and exposure therapy are effective treatments for refugees who have experienced trauma.
7. Improvements in rural health care for IRER populations require a structured approach to service development.
8. E-health methods and modalities such as tele-psychiatry and tele-counselling may be useful ways of offering quality care to rural or remote diverse populations.

This review offers clear guidance on the following key themes:

1. The role of cultural competence in improving care is supported by evidence, but this evidence could be better developed.

Cultural competence training is effective in increasing knowledge among health care providers and satisfaction among service users, but the evidence for direct impacts on patient care has not been established.¹⁰⁶⁻¹⁰⁸ This may be partly because, in order for cultural competence to produce changes in services and outcomes for IRER populations, interventions must be implemented at all levels of organizations and systems – leadership, management and service delivery.

There have been seven systematic reviews of cultural competence or organizational and system changes to improve outcomes for diverse populations. These reviews highlight a number of paths an organization may take to improve its ability to offer equitable care for diverse populations.^{106,108-113} One framework organizes cultural competence into three areas of intervention:¹¹⁴

- a) Organizational culturally-competent interventions: efforts to ensure diverse leadership and workforce representation of the clientele. Essentially, the aim is to ensure that the organization is nested within its communities.
- b) Structural culturally-competent interventions: guarantees full access to quality care for all (includes such things as interpretation services).

- c) Clinical culturally-competent interventions: efforts to enhance health provider knowledge about the relationship between sociocultural factors and health beliefs and behaviour (such as cross-cultural training).¹¹⁴

2. Culturally-adapted psychotherapies improve outcomes.

Eight systematic reviews and meta-analyses have concluded that cultural adaptation of psychotherapy improves outcomes.¹¹⁵⁻¹²²

These reviews included 408 studies involving 41,920 people. They offer significant evidence for the effectiveness of culturally-adapted psychotherapy. Strong adaptations adhered to an evidence-based framework and core principles of the original psychological therapy in order to preserve fidelity to the treatment approach.¹¹⁸ Common elements in the adaptation process were the selection of a theory-driven class of therapy, consultation with a variety of stakeholders and pilot testing to evaluate the therapy.¹¹⁸

The reviews reported evidence that therapies adapted for a specific cultural group are more likely to be effective than those targeting a culturally-mixed group of participants.¹²⁰ The impact of cultural adaptation on outcomes was greater in adults than in children and youth. It was also greater when specific ethnic groups (effect size = 0.51, 95% confidence interval [CI] 0.40, 0.63) were targeted compared with when mixed ethnic groups were included.

Other findings were that psychotherapy groups with same-race participants were four times more effective than groups comprising participants from different racial backgrounds and that matching therapists by language was twice as effective as not matching.¹¹⁹ The impacts were also greater for some ethnic groups than others. The strongest effect was for Asian-Americans, followed by African-Americans and then Hispanic or Latino(a)-Americans (effect size = 0.47).¹²¹

3. Developing specific stepped care, collaborative-care or integrated-care pathways that are adapted for an ethnic group may improve outcomes (see box).

For example, one review¹²⁸ investigated randomized control trials for depression in low-income Latino adults in primary care settings in the United States. Programs delivered under a collaborative-care program model were more effective in reducing depressive symptoms than usual care and increased accessibility to appropriate “guideline-congruent” care as well.¹²⁸

4. Specific culturally-adapted treatments for ethno-cultural and racialized youth are effective.

One review identified studies that dealt with anxiety, attention deficit/hyperactivity disorder, depression, conduct problems, substance use problems, trauma-related syndromes and other clinical problems.¹²⁹ The authors conducted a meta-analysis (25 studies) comparing an active treatment with a control group (no treatment, placebo or treatment-as-usual) and found that 67 per cent of treated participants were better off at post-treatment than the average control participant (effect size = 0.44, standard error = 0.06, 95% CI 0.32, 0.56). An example of a treatment that is probably effective is multidimensional family therapy, which builds competencies through multiple levels (family, school and peer group) to treat drug use among ethnic minority youth.¹²⁹ Only a few of the studies examined the outcomes beyond post-treatment and these focused mainly on youth with conduct disorders.¹²⁹

Stepped care is a model that seeks to provide evidence-based treatment at the lowest appropriate service tier in the first instance (e.g. primary care), only “stepping up” to intensive or specialist services as clinically required.^{123,124}

An integrated care pathway is “a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes.”¹²⁵

Collaborative care is a systematic approach to the treatment of mental health problems or illnesses that involves several health care providers (e.g. psychiatrist, primary care physician, case manager) working together with patients and their families to more proactively manage mental disorders.^{126,127}

5. Cultural adaptation improves outcomes of substance misuse treatment.

A review of published articles suggested that culturally adapting substance misuse prevention and treatment interventions can improve outcomes for target groups.¹³⁰ Culturally-adapted interventions maintain core components of an evidence-based treatment but translate it to be more relevant and consistent with the ideas, values, beliefs, norms, attitudes and knowledge of the target group.¹³⁰

6. There is good evidence to support interventions that improve the mental health of refugees.

There have been four reviews of treatment of mental health problems in refugees. There is support for a number of treatments for trauma and migration stress¹³¹⁻¹³⁴ and a variety of psychotherapy treatments have been effective.¹³⁴ Successful interventions use a multidisciplinary approach, consider cultural sensitivity, locally adapt the methods, use trained paraprofessionals and use the native language(s) of the refugees.¹³⁴ The role of medication as part of psychological, social and biological treatment approach is not controversial, but its role as a sole treatment for refugee mental health problems linked to migration and trauma is not clear. One review reported that medication by itself was effective,¹³³ while another review came to the opposite conclusion.¹³¹

7. Improvements in rural health care to respond to the needs of IRER populations must involve a structured approach to service development.

An analysis of studies in the United States concluded that there are three integrated dimensions of rural health care for IRER populations:⁴⁵

- a) Connections: Build relationships between and within groups. Communication and trust are essential. Have a shared mission to improve the health of residents, which leads to authenticity and a connection to the community beyond service activity.
- b) Community: Investment by multiple partners in resources and shared responsibility. Build on community connections to work toward a common goal while responding to the community's needs. Build infrastructure that leads to self-sufficiency, which is important in helping programs become sustainable.
- c) Culture: Lead activities to orient health care workers and the wider community to each other's cultures. Best practice must be applied, considering context, mission and the values of the community.⁴⁵

8. E-health may be a useful way of offering quality care to rural or remote IRER populations in some but not all circumstances.

Two reviews of tele-psychiatry and e-health were included in this review.^{135,136} Although e-health technologies are uniquely suited to providing services to remote and rural populations, there is a lot of work to do to determine whether culturally and linguistically appropriate mental health outcomes can be achieved electronically and to determine which platforms work best.¹³⁶ More depth was offered by a review of the effectiveness of tele-counselling for adults of a minority racial or ethnic group.¹³⁵ Eight independent studies, conducted with Hispanic, Latin-, Asian- and African-American groups, met inclusion criteria. The authors found insufficient overlap between the studies to perform meta-analysis of the effect sizes.¹³⁵ The evidence is promising. Programs were effective, with moderate to large improvements across measures of depression and anxiety in the short term. Longer-term effects are uncertain, since three studies reported inconsistent findings.¹³⁵

CANADIAN PRACTICES OF INTEREST

As part of the CFD Project, organizations were invited to submit promising practices through an online submission form. These include mental health services that are specifically designed to meet the needs of IRER populations and that have been, or are currently being, implemented in Canada.

The call for promising practices generated 35 responses from 32 organizations in 21 cities. Of the 35 responses, 22 focused on programs being implemented for IRER populations in Canada and are included in this report. While all submitted practices are examples of excellent programs and services for IRER populations, most of them have not undergone formal evaluation; therefore, they are considered “practices of interest.”

In addition to the call for promising practices, the project team identified 34 other practices from across Canada through an online scan and first-hand knowledge of practices of interest by the project team (see Appendix D, available on the website, for descriptions).

Practices of interest in Canada, totalling 55, fall into four broad categories and seven sub-categories, listed below. While each practice strives to improve mental health outcomes for IRER populations in its own unique way, some practices have garnered wider recognition beyond the community they serve. In the table, one practice is highlighted for each sub-category.

SNAPSHOT: CANADIAN PRACTICES OF INTEREST

I. Decreasing the impact of the social determinants of health

- i) Social determinants of health – programs addressing the broader social needs of IRER populations.

The Muslim Food Bank's ASPIRE program (British Columbia) provides mental health screening, case worker services, social and emotional support and food hampers to immigrant and refugee populations.

- ii) Prevention and promotion – Programs promoting wellness among IRER populations.

The Community-based Immigrant Mental Health Education Project and Culturally Responsive Mental Health Intervention Model (Alberta) seeks to address the full continuum of culturally relevant and responsive prevention, early intervention and intervention on mental health issues within immigrant, refugee and newcomer communities.

II. Access to services and service structure

- i) Education – Education for IRER populations on mental health issues and for service providers on the needs of IRER populations.

The Refugee Mental Health Project (Ontario) builds the knowledge and skills of health services providers, settlement workers and social workers regarding refugee mental health; it also promotes inter-sector and inter-professional collaboration. This project includes two accredited online courses, a community of practice, a toolkit of resources, a webinar series and a monthly e-newsletter.

- ii) Community engagement – Programs fostering dialogue between communities and service providers.

The Promise of Partnership Project (Ontario) provides mental health supports to resettled refugees in the Kitchener-Waterloo community and builds the mental health sector's capacity to respond to the needs of refugees.

III. Improving services

- i) Services – Programs providing culturally appropriate care and therapy.

The Cultural Consultation Service (Quebec) provides comprehensive assessment and evaluation of patients from diverse cultural backgrounds, including immigrants, refugees and members of ethno-cultural communities.

IV. Regional or provincial initiatives

- i) Services – Programs for service providers to improve care.

The Provincial Language Service (British Columbia) is a program of the Provincial Health Services Authority (PHSA) that provides interpretation and translation services to the British Columbia Health Authorities. Interpretation services for PHSA, Vancouver Coastal Health, Fraser Health and Providence Health Care are consolidated and funded under a centralized budget.

- ii) Tools – Resources for service providers to improve services.

The Health Equity Impact Assessment (HEIA) Tool (Ontario) is a practical decision-support tool that helps to identify and address potential unintended health impacts of a program, policy or similar initiative on vulnerable or marginalized groups. The HEIA tool was developed by the Ontario Ministry of Health and Long-Term Care to advance health equity and reduce avoidable health disparities between population groups.

The annual economic cost of mental illness in Canada is approximately \$50 billion (2.8 per cent of Canada's 2011 gross domestic product) and 84.6 per cent of those costs are health care related.¹³⁷ In times of fiscal prudence, decision makers are interested in measures that decrease costs and improve health outcomes.

REVIEW OF INTERNATIONAL LITERATURE

There is evidence from a significant body of research that investing in programs that address the mental health needs of IRER populations can result in cost savings for the health care system and for the economy as a whole.¹³⁸

However, the situation is complex. Studies conducted in the United Kingdom and the United States report that service use and costs are generally lower for racial and ethnic minority populations compared to White populations.¹³⁹⁻¹⁴² That being said, different populations and different diagnoses create multiple, distinct scenarios. For instance, because diagnosed rates of psychosis are generally higher in minority groups, they tend to use more expensive services such as inpatient and emergency care.^{81,143-146} Data shows that specific populations with high rates of psychosis, such as individuals of African-Caribbean origin in the United Kingdom, have greater mental health care costs compared with White populations.^{147,148}

A further complication is that underuse of services is linked to a delay in receiving services; low use of appropriate services, in turn, leads to poorer outcomes and the use of more expensive services in the long term. Conversely, early intervention improves outcomes and has the potential to reduce costs over time.

Trends in indirect economic impacts, such as involvement with the criminal justice system or the impacts of lack of treatment of mental health problems or illnesses, should be considered when analyzing costs to the system. However, these have not been properly included in existing economic models.

One study¹³⁸ assessed the costs and benefits of reducing racial and ethnic disparities in mental health care in the United States between 2004 and 2010. This investigation found that eliminating Black-White disparities in outpatient mental health care (a unit of a hospital or medical facility that provides health and medical services to individuals who do not require hospitalization overnight and may also provide primary care) would translate to cost savings of \$30 million in emergency department expenditures and \$833 million in inpatient expenditures. Moreover, eliminating Latino-White disparities in outpatient mental health care would translate to cost savings of \$584 million in total inpatient expenditure.¹³⁸

Studies clearly illustrate that lower use of general services by IRER populations is a temporary phenomenon that eventually leads to increased use of more expensive services. For instance, lower use of primary care services by IRER populations may lead to increased emergency department use or hospital admissions. Similarly, lower use of early intervention services increases the likelihood of using hospital and forensic psychiatric services (a subspecialty of psychiatry that concerns the intersection of psychiatry and the law). These findings lead to the conclusion that services for IRER populations will produce an increasing cost pressure unless Canada introduces interventions that increase access and use of services by IRER populations early in mental illness.

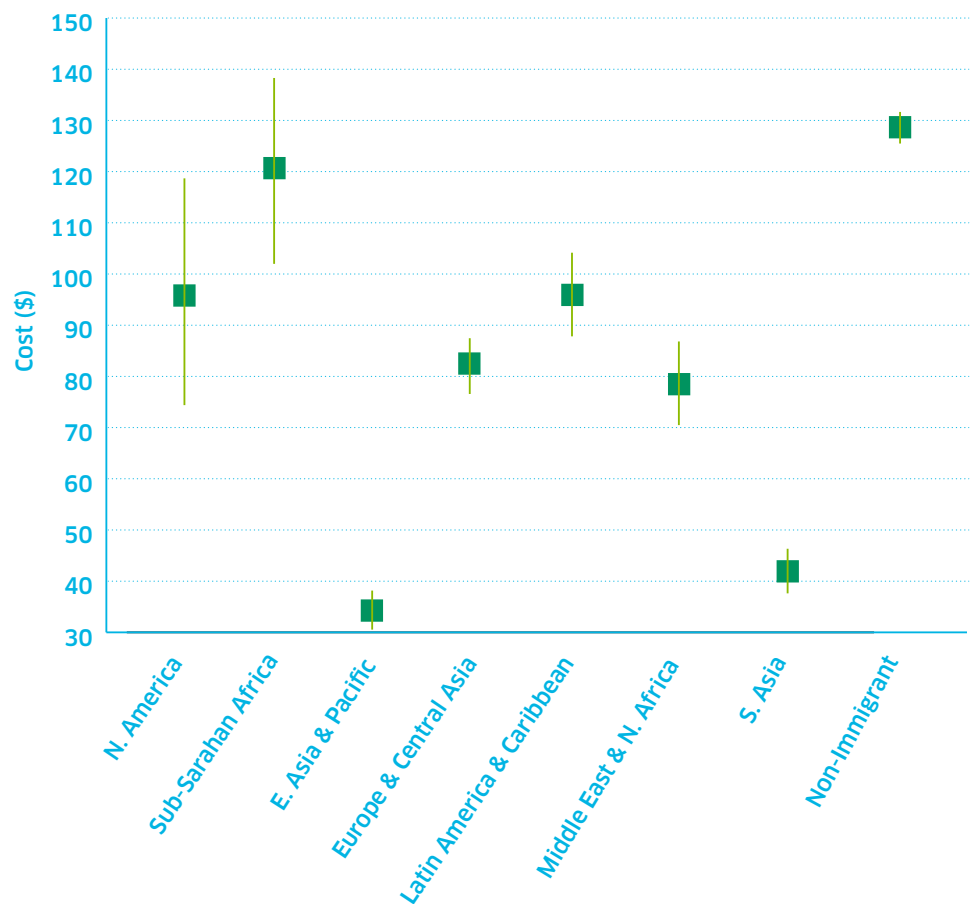
SECONDARY DATA ANALYSIS – CASE STUDY OF ONTARIO

Because there were no Canadian studies available that included an economic analysis of the service use of IRER populations, the CFD Project undertook a secondary analysis of data available in Ontario to determine the average cost of mental health services per person annually based on status: refugee, immigrant or non-immigrant. This descriptive study was a retrospective analysis conducted in conjunction with the Institute for Clinical Evaluative Sciences. Patient-level data on medically necessary hospital and physician services (hospitalizations, emergency visits and physician visits)¹⁴⁹ for mental health reasons funded under the Ontario Health Insurance Plan (OHIP) were linked with data from Citizenship and Immigration Canada, which has records of all immigrants and refugees entering Ontario since 1985. This means that individuals who immigrated before this time or to another Canadian province first may be captured in the non-immigrant population. Also, populations not covered by OHIP (such as refugee claimants) at that time were not included in this analysis.

This economic analysis was only on immigration status, because there are no provincial data on racialized populations and ethno-cultural populations. While a large body of research indicates that race and ethnic background play a crucial role in health status, quality of care received and outcomes, these data are not routinely collected in health care settings in Canada.¹⁵⁰ Results from this descriptive study are similar to those found in the literature review. Findings suggest that first-generation refugees and immigrants are both less likely to use mental health services (9.6 per cent and 6.3 per cent, respectively) compared with the non-immigrant population (12.5 per cent).

Lower use corresponds to lower total costs to the mental health system for immigrants and refugees in the short term. The average age- and sex-adjusted costs of mental health service use per immigrant (\$56.48) and refugee (\$104.99) are lower than the per-person cost for the non-immigrant population (\$128.71, all figures from 2008 data adjusted to 2012 Canadian dollars). When place of birth is considered, only the cost of mental health service use (\$120.68) for sub-Saharan African immigrants and refugees (combined) is similar to those of the general population (\$128.67). The costs of mental health service use for all other immigrant or refugee groups in 2008 are significantly lower than those of the non-immigrant population (see Figure 2).

Figure 2. Mental health costs for immigrants and refugees per person, by region of origin. Averages are shown (bars are 95 per cent confidence interval), adjusted by sex and age (2008 data, adjusted to 2012 Canadian dollars).



In general terms, the average cost to the mental health system for immigrants is 56 per cent less than the cost to the system incurred by non-immigrants. Refugees incur 18 per cent less mental health costs than non-immigrants. The per-person cost to the mental health system for immigrants and refugees from sub-Saharan Africa is 26 per cent higher, on average, than the per-person cost for immigrants and refugees from North America (both the United States and Mexico) or from Latin America and the Caribbean.

Results from this secondary analysis illustrate the stark disparity in service use between immigrants and refugees and non-immigrants in Canada. This mirrors findings from previous studies that show immigrants and refugees use services at much lower rates than their health needs would otherwise necessitate.^{78,80,81,108} As the international literature discussed in the previous section has illustrated, this current underuse of mental health services may be more costly to Canadian health systems in the long term.

A deeper cost-benefit analysis to explore the potential cost savings from reducing IRER disparities in mental health care in Canada could not be undertaken because of lack of data. The Issues and Options report recommended that provinces gather data on the size and needs of their IRER populations to adequately plan services, and this recommendation is still relevant today.

Most other service use and incidence data in Canada mirror findings from the United States and the United Kingdom. Therefore, there is no reason to believe that the results stemming from persistent disparities in mental health would be any different in Canada than in either of these countries.

Conclusion

Diversity has been a hallmark of contemporary Canadian society and it should be foundational to the planning and delivery of mental health services at all levels. Meeting the needs of IRER populations is an urgent priority for the Canadian mental health system and its service providers. Even when taking the healthy immigrant effect into account, evidence shows that, on average, immigrants and refugees have similar or higher rates of mental illnesses compared with non-immigrants in Canada. However, a closer look shows that rates also vary widely between different ethno-cultural groups. The research also demonstrates that IRER populations access mental health services less frequently. The Case for Diversity Project's descriptive study highlights the disparities in health costs in Ontario and the need for improved collection and evaluation of data on ethno-racial background.

International research demonstrates that targeted, culturally-adapted programs and psychotherapies can help reduce overall costs. Furthermore, programs that take into consideration the diversity of their participants are beneficial because they increase client satisfaction and compliance and produce better health outcomes. Ultimately, by working to reduce disparities in access to services, the appropriateness of services used and mental health outcomes, Canada can reduce overall system costs. Addressing the social determinants of health for these populations will be paramount to an effective strategy. Canada can and must improve mental health services for IRER populations. With committed leadership, coordination between services and sectors (health, settlement, education, etc.), strong evidence and increased investment, Canada's existing systems can meet the needs of everyone living within its borders.

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Appendices

Appendix A: Methodology

Appendix B: International Frameworks for Promising Practices

Appendix C: Review of International Promising Practices

Appendix D: Canadian Practices of Interest

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Appendix A

Methodology

The research methods used in the Case for Diversity (CFD) Project included literature reviews, secondary analysis of existing data and a national call for promising practices. Once the information was assembled, the CFD team hosted consultations in Vancouver, Calgary, Ottawa, Toronto and Halifax to validate the usefulness of the information that had been collected and to test possible knowledge-translation approaches.

LITERATURE REVIEWS

The CFD Project aimed to build a library of information from which to offer a synthesis. The team used three methodological search strategies, developed and conducted with the help of the Centre for Addiction and Mental Health Library Services.

The first literature search strategy identified Canadian peer-reviewed papers focusing on mental health and substance use in immigrant, refugee, ethno-cultural and racialized (IRER) groups published since the completion of the Mental Health Commission of Canada (MHCC) report *Improving Mental Health Services for Immigrant, Refugee, Ethno-Cultural and Racialized Groups: Issues and Options for Service Improvement* (Issues and Options).³ The purpose of this search was to collect all published papers between January 2009 and December 2014.

The second search was a scoping review of Canadian and international literature on best, promising or emerging practices for supporting, treating or developing programs for IRER populations with mental health or substance use problems. Research studies published between January 2000 and December 2014 that were conducted in Canada, Australia, New Zealand, the United Kingdom and the United States were included. Given the large number of promising practices highlighted in the literature, this report provides the main messages from this body of knowledge and also offers summaries of each article for further review. Summaries have been collated using the study types from the National Institute for Health and Care Excellence (NICE) public health guidance ¹⁰⁴ (Appendix C).

The third literature search aimed to identify papers published up to May 2015 on the level of mental health service use and costs for IRER populations in high-income countries. A combination of Medical Subject Headings (MeSH) terms and keywords were used. These were specific to the three databases searched: Scopus, Medline and PsycINFO. All articles in English or French were considered.

SECONDARY DATA ANALYSIS – CASE STUDY OF ONTARIO

The CFD team conducted a retrospective descriptive study in order to assess the cost of mental health service use for immigrants and refugees compared with non-immigrants in Ontario. This study was conducted in conjunction with the Institute for Clinical Evaluative Sciences. Patient-level data on medically-necessary hospital and physician services (hospitalizations, emergency visits and physician visits for mental health)¹⁴⁹ funded under the Ontario Health Insurance Plan were linked with data from Citizenship and Immigration Canada, which has records of all immigrants and refugees entering Ontario since 1985.

CONSULTATIONS

The CFD team conducted a series of consultations in Nova Scotia, Ontario, Alberta and British Columbia. The consultations were planned in collaboration with the Mental Health Commission of Canada, local contacts and partner agencies. Members of the project team travelled in person to present the information and to lead focus groups with policy makers, decision makers, managers and frontline clinical staff from provincial bodies and health care organizations. These meetings were used to validate the messages and the information collected, as well as to engage with leaders and front-line staff in the fields of health, mental health, settlement, policy and social services to ensure the relevance of the CFD Project.

Appendix B

International Frameworks for Promising Practices

Experts have offered frameworks to help develop better services for diverse populations. In addition to frameworks for developing services, there are also frameworks for developing service content. Frameworks have been developed in the United Kingdom, the United States and Australia, all of which have been trying to improve services for their diverse populations.

Frameworks are to evidence-based interventions what a building's blueprints are to the building itself. Because these frameworks have been developed in different places for different populations, it is not possible to develop a synthesis or simple "how-to" document. Instead, we present summaries of the approaches and encourage service planners to choose those best suited to the needs of their populations.

- Peer-Reviewed Publicationspage 32
- Grey Literature Reports.page 35

PEER-REVIEWED PUBLICATIONS

"Health service delivery for newly arrived refugee children: A framework for good practice" Woodland, L., Burgner, D., Paxton, G., & Zwi, K. (2010). *Journal of Pediatrics and Child Health*, 46, 560–567.

This framework outlines good practices that promote improved access, equity and quality of care in service delivery for refugee children in Australia. The framework identifies 10 elements that should be reflected in systems change for protection and prevention of health and mental health problems for refugee children. The elements are:

1. Routine comprehensive health screening;
2. Coordination of initial and ongoing health care;
3. Integration of physical, developmental and psychological health care;
4. Consumer participation;
5. Culturally- and linguistically-appropriate service provision;
6. Inter-sectoral collaboration;
7. Accessible and affordable services and treatments;
8. Data collection, monitoring and evaluation;
9. Capacity building and sustainability; and
10. Advocacy.

The authors conclude that the challenges in optimizing physical, developmental and mental health outcomes are not unique to refugee children and their families.

"Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals" Muñoz, R. F., & Mendelson, T. (2005). *Journal of Consulting and Clinical Psychology*, 73(5), 790–799.

This work describes building content for a program that was primarily for Spanish-speaking Latinos at the San Francisco General Hospital. The framework involves three steps:

1. Select therapeutic principles and techniques that are relevant to the population;
2. Identify culturally appropriate interventions:
 - involve ethnic minorities in the intervention development, to provide not merely translations but rather adaptations of universal principles;
 - acknowledge and address cultural values in the intervention;
 - be willing to inquire about, acknowledge and incorporate spiritual themes;

- create a safe environment for discussion of cultural differences and expectations in the “new” culture; and
 - be prepared to acknowledge the reality of racism, prejudice and discrimination and create a safe space for discussion;
3. Evaluate intervention outcomes – all evaluations are valuable. Group-specific adaptation of interventions is effective and the principles and approach often have broader relevance across groups.

“Components of Cultural Competence in Three Mental Health Programs” Siegel, C., G. Haughland, L. Reid-Rose, and K. Hopper. 2011. *Psychiatric Services*, 62(6): 626-631.

The article identifies the components of a community-defined evidence-based program to serve as a guide to improve the cultural competence of any program. The guide involves nine components across three program activity levels:

1. Engagement:
 - cultural communication competence – appropriate language, colloquialisms and expressions;
 - staff in culturally-acceptable roles (e.g. mentor, family member or teacher);
 - culturally-framed trust-building; and
 - culturally-framed stigma reduction;
2. Service delivery:
 - culturally-framed milieu; and
 - culturally-modified or new services;
3. Supports and outreach:
 - cultural group peer involvement (when appropriate);
 - culturally-acceptable family member involvement; and
 - culturally-acceptable community involvement (e.g. clergy, seniors).

These components are considered a starting point for evaluation and enhancement of programs.

“Guidelines for establishing a telemental health program to provide evidence-based therapy for trauma-exposed children and families” Jones, A. M., Sheely, K. M., Reid-Quiñones, K., Moreland, A. D., Davidson, T. M., López, C. M., Barr, S. C., & de Arellano, M. A. (2014). *Psychological Services*, 11(4), 398-409.

The article provides guidelines for planning and establishing a tele-mental health program. The authors recommend nine key components:

1. Community partnerships – local community organizations have existing relationships with community members that may help enhance trust and build bridges;
2. A memorandum of understanding – clearly articulate common expectations for all parties involved;
3. Equipment setup and technological resources;
4. Videoconferencing software – should consider policies and ALL clinical staff should receive training;
5. Physical setup – satellite clinic space should mimic a therapy room as much as possible;
6. Clinic administration – satellite sites should have a designated liaison who communicates directly with the designated liaison at the tele-mental health site;
7. Service reimbursement and start-up costs need to be considered for sustainability;
8. Therapy delivery modification – clinicians need to give some thought to adjusting session materials and activities; and
9. Delivering culturally-competent services to rural and remote areas – understanding of broader diversity issues as well as local contextual cultural values.

“Telepsychology: Research and practice overview” Nelson, E. L., Bui, T. N., & Velasquez, S. E. (2011). *Child and Adolescent Psychiatric Clinics*, 20, 67–79.

The purpose of this review was to describe the principles of telepsychiatry. The authors identify 10 principles for the effective delivery of tele-psychiatry:

1. Basic standards of professional conduct are not altered by the use of telehealth technologies;
2. Confidentiality and integrity of the information being shared are essential;
3. All clients directly involved in a tele-health encounter must be informed about the process, risks, benefits and their rights and responsibilities; as well, they must provide adequate informed consent;
4. Services provided via tele-health must adhere to the basic assurance of quality and professional health care in accordance with each health care discipline’s clinical standards;
5. Each health care discipline must examine how its patterns of care delivery are affected by tele-health and produce its own process for assuring competence in the delivery of health care via tele-health technologies;
6. Documentation requirements for tele-health services must be developed that assure documentation of each encounter, with recommendations and treatment, communication with other health care providers as appropriate and adequate protections for client confidentiality;
7. Clinical guidelines in the area of tele-health should be based on empirical evidence;
8. Integrity and therapeutic value of the relationship between client and practitioner should be maintained and not diminished by the use of tele-health;
9. Health care professionals do not need additional licensing to provide services via tele-health technologies; and
10. The safety of clients and practitioners must be ensured.

“The Psychotherapy Adaptation and Modification Framework: Application to Asian Americans” Hwang, W. C. (2006). *American Psychologist*, 61(7), 702–715.

The Psychotherapy Adaptation and Modification Framework (PAMF) contains six domains and 25 therapeutic principles. It is designed to help adapt other empirically supported treatments and improve clinical training. The six domains are:

1. Dynamic issues and cultural complexities;
2. Orientation;
3. Cultural beliefs;
4. Client–therapist relationships;
5. Cultural differences in expression and communication; and
6. Cultural issues of salience.

The PAMF builds on the cultural competence movement and provides specific guidelines for applying cultural adaptations to therapy and evidence-based treatments to support the mental health of Asian-Americans.

“Transforming an evidence-based intervention to prevent perinatal depression for low-income Latina immigrants” Le, H. N., Zmuda, J., Perry, D. F., & Muñoz, R. F. 2010. *American Journal of Orthopsychiatry*, 80(1), 34–45.

The article describes the five-step iterative process to adapt the Depression Prevention Course, a cognitive behavioural therapy (CBT) intervention program, for Latinas with postpartum depression in San Francisco and Washington, D.C. The process steps are:

1. Identify the need;
2. Gather information with regard to feasibility and need with clinic staff or community centre staff and determine the scope of the clientele to identify high-risk groups who may benefit from a prevention intervention;
3. Design adaptation – identify the tool and make structural and contextual changes to reflect the culture and context of the target population;
4. Implement, evaluate and refine adaptation;
5. Replicate and disseminate the results. Issues of culture and class should not be overlooked when implementing evidence-based interventions.

“Organizational cultural competence consultation to a mental health institution” Fung, K., Lo, H. T., Srivastava, R., & Andermann, L. (2012). *Transcultural Psychiatry*, 49(2), 165–184.

This article outlines an approach to evaluate organizational cultural competence and develop a framework to do so. The authors suggest that there are eight domains for evaluating cultural competence at the organization level:

1. Principles and commitment (organizational values, mission and strategic direction need to reflect cultural competence and diversity);
2. Leadership (commitment from all levels – senior and middle management, as well as practice leaders and physicians);
3. Human resources (recruitment, retention, training and education of a diverse workforce);
4. Communication (development of a comprehensive language-support strategy);
5. Patient care (culturally competent at the individual and program levels);
6. Family and community engagement;
7. Environment and resources (e.g. diversify displays and recognize cultural events); and
8. Data and planning (collect patient outcome data and use these data in planning).

GREY LITERATURE REPORTS

“Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches” Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *The Commonwealth Fund, Publication No. 576.*

This report evaluates definitions of cultural competence, identifies models of culturally competent care, outlines the key components of cultural competence and provides recommendations for implementing culturally competent interventions in the United States. The cultural competence models outlined in the document include academic, government and community health centre models.

***Delivering Race Equality in Mental Health Care: An Action Plan for Reform Inside and Outside Services.* United Kingdom Department of Health. (2005).**

This is an action plan for achieving equality and tackling discrimination in mental health services in the United Kingdom for all people of black and minority ethnic status, including those of Irish or Mediterranean origin and east-European migrants. The action plan lays out expectations and recommendations for improved services and includes information on planning appropriate and responsive services, engaging communities and improving information collection and dissemination.

“Best Practices in Diversity Competency: Literature Review and Environmental Scan” Arnold, S., & de Peuter Chick, J. (2008). *Healthy Diverse Populations. Healthy Living, Alberta Health Services.*

A review commissioned by the Calgary Health Region for the development of services that are accessible and appropriate for diverse individuals, families and communities. The report presents best practices from the academic and grey literature and from interviews with key informants from four Canadian health regions. Best practices at the systems or organization level and provision of competent care, education and assessment are provided, as well as a review of challenges facing health services.

“Best Practices in Diversity Liaison Services: Literature Review and Environmental Scan” Arnold, S., & de Peuter Chick, J. (2008). *Healthy Diverse Populations. Healthy Living, Alberta Health Services.*

Diversity liaison services have the potential to reduce barriers to health care by facilitating relationships among diverse populations and the health care system. This review was intended as an evidence base for liaison programs and to provide direction as those roles expand in the Calgary Region. The report highlights a number of areas in which best practices in diversity liaison services have been identified.

“Best Practices in Interpretation and Translation Services: Literature Review and Environmental Scan” Arnold, S., & de Peuter Chick, J. (2008). *Healthy Diverse Populations*. Healthy Living, Alberta Health Services

The purpose of this report is to identify best practices in interpretation and translation services and to identify ways in which the Calgary Health Region can continue to expand these services. The rationales for providing interpretation and translation services and the benefits of providing linguistically competent health care for a diverse Canadian population are outlined. The report also includes information on the Region’s centrally administered interpretation service.

Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices. SAMHSA. (2010). Retrieved from <http://nrepp.samhsa.gov/>

This registry includes three programs and practices of interest:

- Acceptance and commitment therapy (ACT) is a contextually focused form of cognitive behavioural therapy that uses mindfulness and behavioural activation to increase psychological flexibility. ACT has been used in studies to reduce symptoms of depression, obsessive-compulsive disorder, to relieve distress from hallucinations and delusions and improve general mental health.
- Cultural adaptation of cognitive behavioural therapy (CBT) for Puerto Rican youth. This entry specifically describes a CBT program adapted for Puerto Rican youth aged 13 to 17 with depression.
- Families Unidas Preventive Intervention. A family-based program for Hispanic families with children aged 12-17. The program is designed to prevent conduct disorders, as well as the use of illicit drugs, alcohol and cigarettes.

Appendix C

Review of International Promising Practices

Promising practices in this report are programs, policies, interventions, etc. that have the ability to effectively address disparities in service delivery for immigrant, refugee, ethno-cultural and racialized (IRER) communities. The Case for Diversity (CFD) research team used the study types from National Institute for Health Care Excellence (NICE) public health guidance to help identify and organize the different approaches to assessing promising practices.¹⁰⁴ A summary of each study is provided.

PROMISING PRACTICES – QUANTITATIVE AND QUALITATIVE STUDIES OF TREATMENTS

Quantitative Studies: Experimental

Randomized Controlled Trials

“A home study-based spirituality education program decreases emotional distress and increases quality of life –A randomized, controlled trial” Moritz, S., Quan, H., Rickhi, B., Liu, M., Angen, M., Vintila, R., Sawa, R., Soriano, J., & Toews, J. (2006). *Alternative Therapies in Health and Medicine*, 12(6), 26–35.

A non-blinded randomized controlled trial (RCT) of a home-study program in spirituality was compared with a mindfulness, meditation-based, stress-reduction program and a wait-list control group in Calgary, Alberta. After eight weeks, depression scores and profile of mood states decreased for all three groups. The scores were significantly different for the two test groups compared with the control group. At a four-week follow-up, the mood disturbance scores were lower than baseline by 31.4 points on average for the spirituality group and by 22.1 points on average for the meditation group from baseline. Spirituality-based home intervention is an inexpensive, easily accessible program that can improve mood and quality of life in the short term.

“Effectiveness of the engagement and counseling for Latinos (ECLA) intervention in low-income Latinos” Alegria, M., Ludman, E., Kafali, E. N., Lapatin, S., Vila, D., Shrout, P. E., Keefe, K., Cook, B., Ault, A., Lia, X., Bauer, A. M., Epelbaum, C., Alcantara, C., Pineda, T. I. G., Tejera, G. G., Suau, G., Leon, K., Lessios, A. S., Ramirez, R. R., & Canino, G. (2014). *Medical Care*, 52(11), 989–997.

The purpose of this paper was to evaluate the two treatment formats of a culturally-adapted cognitive behavioural therapy (CBT) program (telephone or face-to-face) compared with usual care. Following treatment, the Patient Health Questionnaire (PHQ-9) and Harvard Symptoms Checklist scores were significantly lower for the two adapted treatment formats compared with usual care. Comparing the ECLA for the telephone treatment with the face-to-face treatment, no differences were noted for either the PHQ-9 or Harvard Symptoms scores. This RCT showed that the adapted program was associated with meaningful reductions in symptoms and functional impairment for Latinos in Boston, Massachusetts, and San Juan, Puerto Rico.

Quantitative Studies: Observational

Case-Control Study

“Culturally attuned Internet treatment for depression amongst Chinese Australians: A randomised controlled trial” Choi, I., Zuo, J., Titov, N., Dear, B.F., Li, S., Johnston, L., Andrews, G. & Hunt, C. (2012). *Journal of Affective Disorders*, 136, 459–468.

This study compared an internet-delivered CBT (iCBT) program with a delayed wait-list control group. The results of the study showed that the treatment group had significantly lower post-treatment Beck Inventory-I (Chinese version: CBDI) and patient health questionnaire (Chinese version: CB-PHQ-9) scores for depression than the control group. Participants were satisfied with the treatment, felt confident it would be successful at teaching techniques to manage symptoms and felt it was worth their time. At a three-month follow-up, score reductions were sustained in the treatment group and 84 per cent no longer met diagnostic criteria for major depression. iCBT programs that are sensitive to cultural models and beliefs provide potential to deliver culturally attuned evidence-based therapies (EBTs) to a mass audience with fidelity.

Cohort Studies

“The effectiveness of cultural adjustment and trauma services (CATS): Generating practice-based evidence on a comprehensive, school-based mental health intervention for immigrant youth” Beehler, S., Birman, D., & Campbell, R. (2012). *American Journal of Community Psychology*, 50, 155–168.

This study describes a comprehensive, school-based mental health program for immigrant youth and tests the relationship between distinct treatment elements and outcomes. The results of the study show that functional impairment decreased as a result of greater cumulative totals of supportive therapy, trauma-focused CBT and CBT. There was an interaction between the three services, in that students who received more of a combination of the services had better improvements. Post-traumatic stress disorder (PTSD) symptoms decreased as a result of trauma-focused CBT and coordinating services; however, combined services did not make a difference. Different service components of the CATS program affected outcomes differently and a combination of service components can be beneficial in effectively supporting clients' mental health.

“Development and Implementation of the Culturally Competent Program with Cambodians: The pilot psycho-social-cultural treatment group program” Han, M., Valencia, M., Lee, Y.S., & De Leon, J. (2012). *Journal of Ethnic & Cultural Diversity in Social Work*, 21, 212–230.

This pilot study describes the components of a psycho-social-cultural treatment group (PSCTG) and tests its effectiveness with Cambodian refugees. PSCTG is a 12-week program that: addresses compounded trauma (pre- and post-migration) and disruption of cognition; addresses somatization as a characteristic of PTSD; and addresses perception of trauma and adaptation process within a cultural value system. The participants of the pilot study all reported lower Harvard Trauma Questionnaire PTSD scores from before the program start to the end of the program. The authors conclude that the combination of techniques used in the program, cultural considerations and community involvement can support the improvement of mental health.

“Retention in mental health care of Portuguese-speaking patients” Gonçalves, M., Cook, B., Mulvaney-Day, N., Alegria M., & Kinrya, G. (2013). *Transcultural Psychiatry*, 50(1), 92–107.

This study examined the effect of a dedicated language and culturally-competent service on adequacy of care, emergency department use and inpatient care among Portuguese-speaking people in the New England Health Care System. The Portuguese Mental Health Program (PMHP) is a culturally and linguistically competent clinic housed within an urban safety-net hospital in the northeastern United States. The results of the study show that clients of PMHP were more likely to receive adequate care based on EBT treatment guidelines for depressive disorder compared with Portuguese-speaking clients in usual care. There were no differences noted in the use of emergency department care or inpatient care between the PMHP clients and usual-care clients.

Correlation Studies

“Language brokering context and behavioral and emotional adjustment among Latino parents and adolescents” Martinez Jr., C.R., McClure, H.H., & Eddy, J.M. (2009). *Journal of Early Adolescence*, 29(1), 71–98.

The article examines the relationships between children as language brokers, on the one hand, and mental health and addictions, on the other. The study recruited families through an established parent-training program for recent Latino families with children. They found that fathers in high language-brokering (HLB) families (in which neither parent speaks English) had significantly higher levels of depression and occupation stress than those in low language-brokering (LLB) families. LLB adolescents were significantly less likely to report tobacco, alcohol or substance use than HLB adolescents (80 per cent of HLB adolescents were current users). The article concludes that using children as a language brokers puts high levels of strain on all family members.

“Feasibility and effectiveness of telepsychiatry services for Chinese immigrants in a nursing home” Yeung, A., Johnson, D. P., Trinh, N. H., Weng, W. C. C., Kvedar, J., & Fava, M. (2009). *Telemedicine and e-Health*, 15(4), 336–341.

This was a longitudinal pilot study of the feasibility, acceptability and usefulness of tele-psychiatry services with elderly Chinese immigrants diagnosed with anxiety, depression, dementia or obsessive-compulsive disorder. The study found that videoconferencing was not difficult, improvements were seen in most of the participants and everyone was

satisfied with the process. Videoconferencing allows a psychiatrist to assess mental status in person so that they are not reliant on indirect reports, but a multidisciplinary approach is necessary.

“Determinants and consequences of child culture brokering in families from the former Soviet Union” Jones, C. J., Trickett, E. J., & Birman, D. (2012). *American Journal of Community Psychology*, 50, 182-196.

This study explored the predictors and consequences of using children in a culture-broker role on Russian immigrants and refugees from the former Soviet Union. The study found direct relationships between family disagreements, child emotional distress and culture brokering. Families with parents with lower English proficiency used children as culture brokers to a greater extent, which led to more child emotional distress. Children who brokered for their parents had more family disagreements, which in turn led to more emotional distress.

“Telepsychiatry services for Korean immigrants” Ye, J., Shim, R., Lukaszewski, T., Yun, K., Kim, S.Y., & Rust, G. (2012). *Telemedicine and e-Health*, 18(10), 797-802.

This tele-psychiatry pilot study used bilingual and bicultural mental health practitioners who reside in California to support the mental health of Korean immigrants living in Atlanta, Georgia. Participants liked the convenience and easy access of the services, the security and privacy and the fact that they were linked with the mental health practitioners by cultural and linguistic factors. Technical issues and difficulties establishing rapport and trust were noted by some participants. Using a patient’s primary language to communicate helps the patient to articulate feelings, emotional discomforts or social stressors, but the technological infrastructure needs to be in place to properly support tele-psychiatry services.

Interrupted Time Series

“International Family, Adult, and Child Enhancement Services (FACES): A community-based comprehensive services model for refugee children in resettlement” Birman, D., Beehler, S., Harris, E. M., Everson, M. L., Batia, K., Liautaud, J., Frazier, S., Atkins, M., Blanton, S., Buwalda, J., Fogg, L., & Cappella, E. (2008). *American Journal of Orthopsychiatry*, 78(1), 121-132.

The article describes the International FACES program and examines clinical outcomes for refugee children and adolescents. FACES is a community-based mental health program that provides comprehensive services to children, adolescents and their families. Staff use a multidisciplinary and multi-ethnic team approach. There is a shared responsibility for meeting clients’ needs. This study found that the average scores of participants for child and adolescent functioning improved over time.

Qualitative Studies

Focus Groups

“Promising group practices to empower low-income minority women coping with chemical dependency” Washington, O. G. M., & Moxley, D. P. (2003). *American Journal of Orthopsychiatry*, 73(1), 109-116.

Participants of two group therapies provide their viewpoints on the role that adapted therapies played in their recovery. Cognitive group interventions allow reflection on personal circumstances and the ability to complete structured activities in a safe environment. Experiential group therapy helps participants “calm their spirits.” It encourages catharsis through reduction of emotionality and constructive expression of suppressed feelings. Both therapies offer distinctive benefits to the recovery process and together help align specific recovery outcomes to reduce the pervasiveness of addictions.

“Group cognitive-behavioral therapy for depression in Spanish: Culture-sensitive manualized treatment in practice” Aguilera, A., Garza, M. J. & Muñoz, R. F. (2010). *Journal of Clinical Psychology: In Session*, 66(8), 857-867.

The Healthy Management of Reality is a 16-week group treatment for depression, with four modules: thoughts (cognitive interventions), activities (behavioural activation), people (interpersonal skills training), and health (addresses physical health and treatment). The program is designed as a continuous group with rolling patient enrolment, meeting weekly, with two to three tasks selected from the menu of exercises. The program developers also describe two new e-health techniques that are currently in pilot and usability testing: an audio coach and Txt4Mood.

“Multi-family psycho-education group for assertive community treatment clients and families of culturally diverse background: A pilot study” Chow, W., Law, S., Andermann, L., Yang, J., Leszcz, M., Wong, J., & Sadavoy, J. (2010). *Community Mental Health Journal*, 46, 364–371.

This study explored the acceptance of a multi-family psycho-education group (MFPG) approach, and its effectiveness to reduce perceived burden and improve psychological well-being for family members. It was a pilot study with Tamil and Chinese family members of clients who are part of an Assertive Community Treatment program in Toronto. The MFPG appears to be a useful program to reduce family burden from mental health problems, as well as to reduce stigma and shame in culturally diverse populations. Family members who participated in the program had a greater understanding of their family member’s condition, which improved the relationships between the client and family members.

Interview Studies

“Cultural consultation: A model of mental health service for multicultural societies” Kirmayer, L.J., Groleau, D., Guzder, J., Blake, C., & Jarvis, E. (2003). *Canadian Journal of Psychiatry*, 48(3), 145–153.

The article describes and evaluates a cultural consultation service in Montreal, Quebec, and provides case study examples. The service offered three forms of consultation: a direct assessment of the client; a consultation meeting with the referring clinician; or a meeting with the referring community organization. The findings suggest that referring clinicians were highly satisfied with the service offered, that they would use it again and would recommend it to colleagues.

“Cognitive-behavioral therapy for pathological gambling: Cultural considerations” Okuda, M., Balán, I., Petry, N.M., Oquendo, M., & Blanco, C. (2009). *The American Journal of Psychiatry*, 166(12), 1325–1330.

A case study of modified CBT techniques for pathological gambling is described in this article. The implications of this case study example are that cultural beliefs can contribute to the etiology of psychiatric disorders. Rather than challenging and minimizing cultural norms directly, subtle and progressive adjustment to CBT techniques may prove more effective.

“Culturally adapted cognitive-behavior therapy: Integrating sexual, spiritual, and family identities in an evidence-based treatment of a depressed Latino adolescent” Duarte-Vélez, Y., Bernal, G., & Bonilla, K. (2010). *Journal of Clinical Psychology: In Session*, 66(8), 895–906.

This is a case study involving a description of an adolescent client diagnosed with major depression who participated in an RCT for a culturally-adapted CBT program. The description illustrates how culturally-adapted CBT can maintain fidelity to the protocol for CBT while being flexible to address the patient’s values, preferences and contexts. The integrity of evidence-based treatments is not undermined by being flexible to the uniqueness of client characteristics.

“Working with culture: culturally appropriate mental health care for Asian Americans” Park, M., Chesla, C. A., Rehm, R. S., & Chun, K. M. (2011). *Journal of Advanced Nursing*, 67(11), 2373–2382.

A narrative analysis of interviews with 20 health care providers who used adapted services for Asian Americans. Common characteristics across the adapted services include the use of cultural brokers, support for families in transition and the use of cultural knowledge to enhance care. There was recognition by health care providers of the crucial role of Asian families in a person’s recovery and the providers’ efforts to assist families throughout the course of treatment. Culturally-sensitive care is nuanced and context-specific; to get meaningful results, care may need to include a larger group than just the patient, including family and friends.

Other

“The Transcultural Wellness Center: Rehabilitation and recovery in Asian and Pacific Islander mental health care” Cameron, R. P., Ton, H., Yang, C., Endriga, M.C., Lan, M. F., & Koike, A. K. (2008). *Journal of Social Work in Disability & Rehabilitation*, 7(3/4), 284–314.

The Transcultural Wellness Center (TWC) is a partnership established in 2006, administered by Asian Pacific Community Counselling, Inc. (APCC) and developed in collaboration with Sacramento County Department of Health and Human Services as part of the Mental Health Services Act (MHSA) of California in 2004. The MHSA provided the foundation for innovative care services that are responsive to the diverse population living in the region. This case study is a historical description of the development of the TWC, the partnerships involved in the APCC, the hiring of staff at TWC and the model of care offered at TWC; these were made possible by the enactment of the MHSA.

PROMISING PRACTICES—REVIEWS

Meta-Analyses

“Culturally adapted mental health interventions: A meta-analytic review” Griner, D. & Smith, T. (2006). *Psychotherapy: Theory, Research, Practice, Training*, 43(4), 531–548.

The purpose of this meta-analysis was to synthesize the empirical literature of outcomes associated with culturally-adapted mental health services. Seventy-six studies covering a variety of treatments and ethnic groups (African-American, Hispanic/Latino, Asian-American, Native American and European-American) were identified through the search. The random effects weighted effect size was 0.45 (standard error [SE] = 0.04, 95% confidence interval [CI] 0.36, 0.53) with high variability ($Q(75) = 459.0$), meaning that the overall effect size was likely moderated by other factors. Interventions with groups of same-race participants were four times more effective than interventions with mixed-race participant groups. Language matching was twice as effective as not matching. All research was included, regardless of quality and therefore the results may reflect the current state of research rather than actual magnitude of effect.

“Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis” Benish, S.G., Quintana, S., & Wampold, B.E. (2011). *Journal of Counseling Psychology*, 58(3), 279–289.

This meta-analysis had two purposes: to determine the efficacy of culturally-adapted psychotherapy and to examine theories about why culturally-adapted psychotherapies may be more effective. Articles published before January 2010 were included: 59 studies were identified and 21 were classified as bona fide (based on previous criteria). Ten of the studies were adapted to the Illness myth in terms of the Barts Explanatory Model Inventory (BEMI). Effect size (all studies) favoured culturally-adapted psychotherapy as the primary outcome measure for each study (effect size = 0.41, 95% CI 0.34, 0.48) and on all measures (effect size = 0.33). The effect size for the bona fide studies on the primary measure favoured culturally-adapted psychotherapy (effect size = 0.32, 95% CI 0.21, 0.43). Only myth adaptation moderated the effect size results. Adaptation of the myth improved outcomes by 0.21 relative to culturally-adapted treatments without myth adaptation. It had no effect on the full model when including non-adapted treatments. Culturally-adapted psychotherapy produces superior outcomes for ethnic and racialized clients over conventional psychotherapy, but myth adaptation is a critical element in culturally-adapted psychotherapy outcomes.

“Culture” Smith, T. B., Rodriguez, M. D., & Bernal, G. (2011). *Journal of Clinical Psychology: In Session*, 67(2), 166–175.

This meta-analysis of literature published between January 2004 and July 2009 included studies of clients' experiences in mental health treatment that explicitly accounted for their culture, race or ethnicity. Clients receiving culturally-adapted treatments typically experienced superior outcomes than the control group (effect size = 0.46, 95%CI 0.36, 0.56). Studies with adults tended to have higher magnitude effect sizes than studies with children, adolescents and young adults. The outcome effect was greater when treatments were delivered to specific ethnic groups (effect size = 0.51, 95% CI 0.40, 0.63) than to mixed ethnic groups (effect size = 0.18, 95% CI -0.08, 0.44). The outcomes differed by ethnic group, with the strongest effect for Asian-Americans (effect size = 1.18), followed by African-Americans (effect size = 0.47) and Hispanic/Latino(a) Americans (effect size = 0.47). Culturally-adapted mental health treatments have moderately better outcomes than programs that do not explicitly incorporate cultural adaptations.

“Bridging the gap for ethnic minority adult outpatients with depression and anxiety disorders by culturally adapted treatments” van Loon, A., van Schaik, A., Dekker, J., & Beekman, A. (2013). *Journal of Affective Disorders*, 147, 9–16.

The purpose of this review and meta-analysis was to examine the outcomes associated with the use of culturally-adapted guideline-driven depression and anxiety interventions. Studies included in the review adapted psychotherapies based on CBT, panic-control therapy and exposure therapy for African-Americans, Asian-Americans and Latino-Americans. The pooled effect size for all participants was large (effect size = 1.06, 95% CI 0.52, 1.30). The treatments were more effective for anxiety (effect size = 1.73) than for depression (effect size = 0.35) and for Asian-Americans (effect size = 1.48) than for Latino-Americans (effect size = 0.50). Two studies assessed the effect of the adaptation compared with standard treatments, but the results were inconclusive. One study showed significant absolute post-treatment effect of culturally-adapted interventions, while the other found no significant effect over the control group. The results suggest that using adapted interventions may better suit ethnic minority groups.

“Evidence-based psychosocial treatments for ethnic minority youth” Huey Jr., S. J., & Polo, A. J. (2008). *Journal of Clinical Child & Adolescent Psychology*, 37(1), 262–301.

This literature review covered EBTs published from 1960 to 2006. The identified studies were measured on quality of EBT using the American Psychological Association Task Force Criteria for EBTs and Nathan and Gorman’s (2002) Criteria and Considerations for Ethnic Minority Youth. Identified studies that dealt with anxiety, attention deficit/hyperactivity disorder, depression, conduct problems, substance use problems, trauma-related syndromes and other clinical problems. For anxiety, group cognitive behavioral therapy (GCBT) was determined to be possibly efficacious for Hispanic/Latino and African-American youth (two studies). For depression, CBT was classified as probably efficacious for Latino youth (one study) and interpersonal psychotherapy was possibly efficacious (one study). Multidimensional family therapy is probably efficacious for drug-abusing ethnic-minority youth (one study) and multisystemic therapy is probably efficacious for drug-abusing African-American youth (two studies). The authors conducted a meta-analysis (25 studies) comparing an active treatment with no treatment, placebo or treatment as usual with medium effects for the treatment over control (effect size = 0.44, SE = 0.06, 95% CI 0.32, 0.56). Only a few of the studies examined the outcomes beyond post-treatment and these focused mainly on youth with conduct disorders.

“Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions and outcomes” Cabral, R.R., & Smith, T. B. (2011). *Journal of Counseling Psychology*, 58(4), 537–554.

The purpose of this meta-analysis was to analyze the effectiveness of racial/ethnic matching between therapists and clients in mental health services. The searches to identify literature were conducted over a number of years to include literature up to 2008. In total, 154 studies were identified (52 with effect sizes for participant preferences for racial/ethnic match; 81 with effect sizes for participant perceptions of therapists as function of racial/ethnic match; 53 with effect sizes specific to client outcomes as function of match). The meta-analysis found moderately strong preference for a matched therapist (effect size = 0.63, SE = 0.08, 95% CI 0.48, 0.78). Matched therapists were evaluated slightly better than unmatched therapists (effect size = 0.32, SE=0.07, 95% CI 0.19, 0.45), but there was almost no difference noted in treatment outcomes between matched and unmatched therapists (effect size = 0.09, SE = 0.02, 95% CI 0.05, 0.13). Results were contrasted across ethnic groups: African-Americans had effect sizes statistically significant from zero for all three categories; Asian-Americans showed mild preference for a matched therapist but evaluated them more positively; Hispanic/Latino(a) Americans expressed moderate preferences for matched therapists but did not evaluate them differently. Health improvement appears to occur independent of matching (except for perhaps African-Americans).

“Meta-analysis of the use of narrative exposure therapy for the effects of trauma among refugee populations” Gwozdziwycz, N., & Mehl-Madrona, L. (2013). *The Permanente Journal*, 17(1), 70–76.

This meta-analysis explores the effectiveness of short-term narrative exposure therapy (NET) to reduce PTSD or trauma among refugees compared with other methods. The seven studies that met criteria for this analysis generally found better results for the NET participants than for participants in other treatment methods based on the combined effect sizes. Using NET over other methods had medium effect for all studies (effect size = 0.63; 95% CI 0.29, 1.07). In studies using physicians, adequately trained graduate students, or both, there was a medium effectiveness for NET (effect size = 0.53, 95% CI -0.03, 1.09). The effect size was large in studies using refugees as counsellors (effect size = 1.02, 95% CI 0.83, 1.21). NET appears to compare favourably with other treatment methods, especially when it is given by locally-trained counsellors who are also refugees.

Systematic Reviews

“Can cultural competence reduce racial and ethnic health disparities? A review and conceptual model” Brach, C., & Fraser, I. (2000). *Medical Care Research and Review*, 57(S1), 181-217.

This review of articles (1990–1999) was written to develop a conceptual model of the potential of cultural competence to reduce health disparities. The review suggests that there are nine techniques to support disparity reduction: 1) interpreter services; 2) recruitment and retention; 3) staff training; 4) coordinating with traditional healers; 5) use of community health workers; 6) culturally-competent health promotion; 7) inclusion of family and/or community members; 8) immersion into another culture; and 9) administrative and organizational accommodations (e.g. clinic times, locations). The review found evidence that professional interpreters over ad hoc interpreters increase utilization of services and satisfaction, reduce non-adherence and help to eliminate disparities in quality of care and outcomes.

“Culturally competent healthcare systems: a systematic review” Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., Normand, J., and the Task Force on Community Preventive Services. (2003). *American Journal of Preventive Medicine*, 24(3S), 68-79.

This is a systematic review of evidence collected between 1965 and 2001 for five interventions: 1) staff retention and recruitment, 2) use of interpretation services, 3) cultural competence training for health care providers, 4) use of linguistically- and culturally-appropriate health education materials, and 5) culturally-specific health care settings. The authors “could not determine the effectiveness of any of these interventions, because there were either too few comparative studies or studies did not examine the outcome measures evaluated in this review: client satisfaction with care, improvements in health status and inappropriate racial or ethnic differences in use of health services or in received and recommended treatment.”

“Cultural competence in mental health care: a review of model evaluations” Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). *BMC Health Services Research*, 7, 15.

This systematic literature search (1985–June 2004) sought to define cultural competence in mental health care settings, describe models of cultural competence, and assess the effectiveness of cultural competence. Key characteristics of cultural competence, synthesized from the nine studies that met study-inclusion criteria a set of skills or processes that enable mental health professionals to provide culturally-appropriate services for the diverse populations they serve; attention to language differences, cultural influences on attitudes and help seeking; and genuine willingness and desire to learn about other cultures, not simply managerial requirement. There was limited evidence for the effectiveness of cultural competence, with findings suggesting culturally-competent people are able to acknowledge, accept and value cultural differences. The training is important, but the form and organizational frameworks to assess the impacts are under-developed.

“Program evaluation for organizational cultural competence in mental health practices” Whealin, J.M., & Ruzek, J. (2008). *Professional Psychology: Research and Practice*, 39(3), 320-328.

This synthesis was designed to produce a process to evaluate, enhance and document cultural competence for small mental health practices and clinics. There are 10 suggested steps in the process:

1. Obtain organizational support – this may require education and awareness raising of leadership and clinical staff;
2. Review and update mission and policies – they need to reflect the values for promoting respect for diversity and provide overarching framework for ongoing organizational evaluation;
3. Improve staff knowledge about community populations;
4. Evaluate and enhance cross-cultural skills;
5. Build cultural diversity among staff – at all levels, including board;
6. Assess clients’ needs and beliefs;
7. Adapt procedures, infrastructure and physical environments;
8. Facilitate verbal and written communication – use professional interpreters and provide material in the language(s) of the communities served;

9. Collaborate with spiritual leaders and traditional healers; and
10. Evaluate findings – identify goals and disseminate recommendations.

“The effectiveness of cultural competence programs in ethnic minority patient-centered health care—a systematic review of the literature” Renzaho, A. M. N., Romios, P., Crock, C., & Sønderlund, A. L. (2013). *International Journal for Quality in Health Care*, 25(3), 261–269.

This review examines the effectiveness of patient-centred care models that incorporate cultural competence. Thirteen studies published between January 2000 and August 2011 met the authors’ criteria. Outcome measures consisted of patient satisfaction, health outcomes, practitioner behaviour or knowledge, and awareness of patient-centred care or cultural competence issues. The review concludes that training in culturally-competent patient-centred care is effective in increasing knowledge levels, self-reported practice and patient satisfaction. There were no significant findings in terms of health outcomes, as only two studies attempted to measure outcomes.

“The contribution of cultural competence to evidence-based care for ethnically diverse populations” Huey Jr., S. J., Tilley, J. L., Jones, E. O., & Smith, C.A. (2014). *Annual Review of Clinical Psychology*, 10, 305–338.

This summary of literature addresses three questions:

1. Does psychotherapy work with ethnic minorities?
2. Do the effects of psychotherapy differ by ethnicity?
3. Does cultural tailoring enhance treatment effects?

The authors conclude that psychotherapy is generally effective in working with culturally-diverse youth and adults across a broad range of mental health issues. Psychotherapies appear to work equally well for Whites and ethnic minorities and culturally-tailored interventions are efficacious for ethnic minorities. Tailoring aimed at specific ethno-cultural groups is more effective than targeting a mixed group. The authors provide four recommendations on how to consider culture when providing mental health services:

1. Adopt cultural elements only when embedded within an existing evidence-based treatment;
2. Adopt a well-specified, empirically-based cultural adaptation model;
3. Adopt an empirically supported skills-based or process-oriented cultural competence model; and
4. Individualize the treatment to match the client or client population.

“A systematic review of depression treatment in primary care for Latino adults” Cabassa, L.J., & Hansen, M. C. (2007). *Research on Social Work Practice*, 17(4), 494–503.

The authors set out to evaluate the effectiveness of primary care treatments for depression in Latinos. They rated the quality of articles, including the adaptation strategy for the treatment modality, for RCTs (2003–2006) for depression in low-income Latino adults in primary care settings in the United States. The average quality score for the seven articles on the Methodological Quality Rating Scale (MQRS: 0 = poor quality, 17 = high quality) was 14. The CBT manual was adapted and translated for Spanish populations and the treatments provided educational and intervention material in Spanish and English. Programs delivered under a collaborative-care program model were more effective in reducing depressive symptoms than usual care and increased accessibility to appropriate “guideline-congruent” care as well. Two studies were identified that performed cost-effectiveness analyses for adapted models compared with medication. One reported that Latinos in CBT therapy had fewer depression burden days than those in usual care, for a cost of \$6,100 or less per quality-adjusted life-year (QALY); the same study reported no significant improvements in depression burden days for those on medication, which was not cost effective, as the estimated cost per QALY was more than \$90,000. The other study reported significantly more depression-free days for both CBT and pharmacotherapy compared with community care, but the costs per QALY were similar, at \$17,624 and \$16,068, respectively. The studies in this review did not determine how cultural and linguistic adaptations are linked to treatment effectiveness.

“The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review” Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J. D., Rahman, A., Verdeli, H., Araya, R., & Patel, V. (2014). *Psychological Medicine*, 44, 1131-1146.

This review has three purposes: describe procedures to adapt psychological treatment (PT) for depression, describe the extent and nature of adaptations, and assess effectiveness (meta-analysis) of adapted PT. Twenty studies met inclusion criteria (four cluster RCTs, 14 RCTs and two non-RCTs); however, only six of the studies followed all four stages of the Medical Research Council's framework for development and evaluation of complex interventions. CBT was the most frequently used PT (10 studies), followed by interpersonal therapy (IPT; four studies), psychoeducation (three studies), problem-solving therapy (two studies) and dynamically oriented therapy (one study). The adaptations were different, but relevant; all of the studies adhered to a basic adaptation framework as well as the core principles of the original PT to preserve fidelity to the treatment. Sixteen of the studies were included to determine in favour of the effectiveness of the adapted PTs over control conditions (standardized mean difference [SMD] = -0.72, 95 per cent CI -0.94, -0.49). Common elements in the adaptation process were the selection of a theory-driven class of PT, consultation with a variety of stakeholders and pilot testing to evaluate the PT. Adapting PTs for culturally-diverse populations can be achieved without compromising treatment effectiveness and may ultimately enhance effectiveness.

“Efficacy of depression treatments for immigrant patients: results from a systematic review” Antoniadou, J., Mazza, D., & Brijnath, B. (2014). *BMC Psychiatry*, 14, 176.

To evaluate the effectiveness of depression treatments for immigrant populations, the authors performed a synthesis of published literature from 2000 to 2013. Fifteen studies met criteria (nine quantitative, five mixed methods and one qualitative case study), with ethnic group representation for Latin-Americans, Chinese-Americans, Chinese-Australians, Korean-Americans and Turkish immigrants living in Austria. Seven of the studies used CBT, one used a culturally-adapted Behavioral Activation for Latinos, one used the Formative Method for Adapting Psychotherapies to create Problem Solving Therapy for Chinese Older Adults. Problem Solving Therapy for Primary Care was used in another study, Inter-Personal Therapy and logo-autobiography were also used as treatments. The authors suggest that culturally-adapted therapies may offer therapeutic benefits to immigrants, but it is uncertain whether these culturally-adapted interventions are adhered to more by migrant populations.

“The impact of medical interpreter services on the quality of health care: a systematic review” Flores, G. (2005). *Medical Care Research and Review*, 62(3), 255-299.

This systematic review of literature from 1966 to 2003 looks at the impact of interpreter services on quality of health care. In a mental health care setting, those who need but do not get interpreters have poor self-reported understanding of diagnosis and treatment plans. Clients report greater satisfaction in trained professionals and bilingual providers over ad hoc interpreters. One study reported outcome delays for treatment initiation, management and patient discharge in a psychiatric setting. In general, health outcomes are better in health settings, but no other study examined mental health outcomes. The author concludes that inadequate and ad hoc interpreter services affect quality of care in health care settings.

“Caring for migrant and refugee children: Challenges associated with mental health care in pediatrics” Nadeau, L., & Measham, R. (2006). *Developmental and Behavioral Pediatrics*, 27(2), 145-154.

This review highlights the challenges of health care utilization for migrant youth and presents avenues to expand psychiatric models of care. The authors make four key suggestions about how to rethink mental health services for immigrant and refugee youth: communication issues (e.g. use interpreters and culture brokers); ethnic matching (advantages: shared knowledge and identification with therapist may bring more comfort for youth; disadvantages: confidentiality may be more difficult to ensure in small communities, clients may feel a need to distance from their culture of origin); sensitivity to otherness and mediation (e.g. address tensions between migrant families and host country institutions through the use of traditional knowledge or healers); and contemplating time as a healer.

“A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers” Crumlish, N., & O’Rourke, K. (2010). *Journal of Nervous and Mental Disease*, 198(4), 237–251.

This review covers RCTs of the treatment for PTSD in refugees. Ten RCTs met the criteria: three studies of asylum seekers in Germany, five studies involving refugees in the United States and two studies of refugee camps in Uganda. The studies were conducted largely by two groups of researchers (eight of 10 studies). Treatment comparison differed from study to study, making it difficult to draw clear conclusions. There was moderate support for PTSD remission using NET, cautious support was found for PTSD remission using trauma-focused CBT and drug therapy was not supported by the literature.

“Review of refugee mental health interventions following resettlement: Best practices and recommendations” Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). *American Journal of Orthopsychiatry*, 80(4), 576–585.

This review covers empirical evaluations of therapeutic interventions in resettlement contexts from the past 20 years. Twenty-two studies met inclusion criteria; the treatment methods in those studies included CBT, eye-movement desensitization and reprocessing (EMDR), pharmacotherapy, expressive exposure and testimonial therapies, multi-family and empowerment mutual learning groups and individualized therapy. The evidence suggests that CBT, separately or in combination with pharmacotherapy, was effective in reducing traumatic and migration stress; however, the results were not consistent across all studies. EMDR, exposure therapy and stand-alone pharmacological therapies were reported to be effective in reducing traumatic stress.

“The use of community-based interventions in reducing morbidity from the psychological impact of conflict-related trauma among refugee populations: a systematic review of the literature” Williams, M. E., & Thompson, S. C. (2011). *Journal of Immigrant Minority Health*, 13, 780–794.

This systematic review uses a thematic analysis to describe the ability of community-based interventions to reduce morbidity caused by psychological impact of conflict-related trauma on refugees. Fourteen articles met the criteria (eight interventions took place in developing countries in temporary settings and six interventions took place in developed countries of resettlement). A variety of treatments were used: CBT, art and play, school-based therapy, group interpersonal psychotherapy and one-on-one psychosocial therapy. The authors concluded that successful interventions use a multidisciplinary approach, consider cultural sensitivity, locally adapt the methods, involve trained paraprofessionals and use the native language of refugees groups receiving services.

“Improved rural access to care: dimensions of best practice” Jensen, G. M., & Royeen, C. B. (2002). *Journal of Interprofessional Care*, 16(2), 117–128.

This qualitative analysis of case reports describes the processes and outcomes of 15 best-practice rural health training programs in the United States. The analysis suggests that there are three integrated dimensions of minority rural health care:

1. *Connections* – building relationships between and within groups, based on communication, trust and a shared mission to improve the health of residents, which can lead to authenticity and a connection to the community beyond service activity.
2. *Community* – involving multiple partners with investment of resources and responsibilities to be able to deliver flexible and value-added activities and respond to community needs. This approach helps to build self-sufficiency for community capacity when project funding is often not enough to build self-sufficiency and sustainability on its own.
3. *Culture* – defined as how we live and interpret the world. Culture is an important part of service provision and requires activities to orient health care workers and communities to each other’s culture. Best practices must be applied considering context, mission and values of community; it needs sustained funding and personnel and is grounded in community-centred care.

“Does cultural adaptation have a role in substance abuse treatment?” Burlew, A. K., Copeland, V. C., Ahuama-Jonas, C., & Calsyn, D. A. (2013). *Social Work in Public Health*, 28, 440–460.

This is a review of the literature to apply information on cultural adaptations of EBTs for substance abuse. A “one-size-fits-all” approach to EBT is not adequate. Culturally adapting substance-abuse prevention and treatment interventions

can improve outcomes for target groups. Culturally-adapted interventions maintain core components of EBT but translate it to be more relevant and consistent with ideas, values, beliefs, norms, attitudes and knowledge of target groups. There are six factors for determining when to adapt an EBT:

1. If existing research is applicable to a specific group.
2. If there is existing evidence of ineffective clinical engagement with the group.
3. If there are unique risk or resilience factors in a target group.
4. If there are unique symbols of disorder.
5. If there is evidence of limited effectiveness with a group.
6. If evidence suggests generic intervention is harmful.

There are a number of established frameworks and common approaches on how to adapt an EBT: community involvement, review of existing literature and consultation from experts in either cultural adaptation or the problem of bringing clients to treatment.

“Organizational cultural competence consultation to a mental health institution” Fung, K., Lo, H. T., Srivastava, R., & Andermann, L. (2012). *Transcultural Psychiatry*, 49(2), 165-184.

This article outlines an approach to evaluating organizational cultural competence and proposes a framework for doing so. The authors suggest that there are eight domains for evaluating cultural competence at the organizational level:

1. Principles and commitment (organizational values, mission and strategic direction need to reflect cultural competence and diversity);
2. Leadership (commitment from all levels – senior and middle management as well as practice leaders and physicians);
3. Human resources (the recruitment, retention, training and education of a diverse workforce);
4. Communication (development of a comprehensive language support strategy);
5. Patient care (culturally competent at the individual and program levels);
6. Family and community engagement;
7. Environment and resources (e.g. diversify displays and recognize cultural events); and
8. Data and planning (collect patient outcome data and use these data in planning).

“Using e-health to enable culturally appropriate mental healthcare in rural areas” Yellowlees, P., Marks, S., Hilty, D., & Shore, J.H. (2008). *Telemedicine and e-Health*, 14(5), 486-492.

This article reviews culturally-appropriate e-mental health care and makes recommendations for expanding services. There is a small but growing literature on e-mental health care with diverse communities. Current obstacles associated with developing culturally appropriate e-mental health care programs include: differing attitudes, access and affinity to technology and the socioeconomic environment – rates of poverty are magnified among rural ethnic minority groups. The article concludes that e-health technologies are uniquely suited to provide services to remote and rural populations. There is a lot of work to do to determine whether culturally and linguistically appropriate mental health outcomes can be achieved electronically and to determine which platforms work best.

“A systematic review of telecounselling and its effectiveness in managing depression amongst minority ethnic communities” Dorstyn, D.S., Saniotis, A., & Sobhanian, F. (2013). *Journal of Telemedicine and Telecare*, 19(6), 338-346.

The purpose of this review was to determine the effectiveness of tele-counselling for adults of a minority racial or ethnic group. Eight independent studies met inclusion criteria, which were conducted with Hispanic and Latino-, Asian- and African-American groups. There was insufficient overlap between the studies to perform meta-analysis of the effect sizes. Based on the Oxford Centre for Evidence-Based Medicine, five studies were assigned level 2 (grade B), and three were assigned level 3 (grade C). The evidence is promising. Participants were consistently satisfied with tele-counselling. Programs were effective, with moderate to large improvements across measures of depression and anxiety in the short term. Longer-term effects are uncertain, since three studies reported inconsistent findings.

Appendix D

Canadian Practices of Interest

The following practices were either submitted to the Mental Health Commission of Canada through a call for Promising Practices (December 2014-September 2015) or were identified by the Case for Diversity research team. The practices are grouped by province for ease of use.



NOVA SCOTIA

Identified by Project Team

Promising Practice Name: Newcomer Community Wellness Project
Organization: Immigrant Services Association of Nova Scotia
Target Population(s): Immigrant
Location: Halifax, Nova Scotia
Web Address: isans.ca/newcomer-community-wellness-projects-mental-health-report
Promising Practices Category: Community Engagement; Education

Promising Practice Name: Nova Scotia Interpreting Services
Organization: Nova Scotia Interpreting Services
Target Population(s): Immigrant; Refugee; Ethno-Cultural; Racialized
Location: Halifax, Nova Scotia
Web Address: interpretingservices.ca/Promising Practices Category: Services

Promising Practice Name: The Nova Scotia Home for Colored Children Restorative Inquiry
Organization: Government of Nova Scotia
Target Population(s): Racialized
Location: Halifax, Nova Scotia
Web Address: restorativeinquiry.ca
Promising Practices Category: Community Engagement; Social Determinants of Health



QUEBEC

Submitted to Call

Promising Practice Name: Cultural Consultation Service (CCS)
Organization: Jewish General Hospital
Target Population(s): Immigrants; Refugees
Location: Montreal, Quebec
Website: mcgill.ca/culturalconsultation/cultural-consultation-service-ccs
Promising Practices Category: Services

Identified by Project Team

Promising Practice Name: Regional Program for the Settlement and Integration of Asylum Seekers (PRAIDA)
Organization: CSSS de la Montagne
Target Population(s): Immigrant; Refugee
Location: Montreal, Quebec
Web Address: csssdelamontagne.qc.ca/en/care-and-services/asylum-seekers
Promising Practices Category: Services

Promising Practice Name: RIVO (Montreal)
Organization: RIVO (Montreal)
Target Population(s): Immigrant; Refugee
Location: Montreal, Quebec
Web Address: rivo-resilience.org/en_accueil
Promising Practices Category: Services



ONTARIO

Submitted to Call

Promising Practice Name: Across Boundaries: An Ethno-racial Mental Health Centre
Organization: Across Boundaries: An Ethno-racial Mental Health Centre
Target Population: Racialized Individuals
Location: Toronto, Ontario
Web Address: acrossboundaries.ca
Promising Practices Category: Services

Promising Practice Name: Learning Exchange Pilot Project (LEPP)
Organization: Gerstein Crisis Center and Ryerson University's Internationally Educated Social Work Professionals (IESW) Bridging Program
Target Population(s): Immigrant; Refugee
Location: Toronto, Ontario
Website: gersteincentre.org/education-and-training/learning-exchange
Promising Practices Category: Social Determinants of Health

Promising Practice Name: Promise of Partnership
Organization: Carizon, Reception House, Family and Children services, Canadian Mental Health Association Waterloo Wellington Dufferin (CMHAWWD)
Target Population(s): Refugees
Location: Kitchener, Ontario
Website: carizon.ca
Promising Practices Category: Community Engagement; Health Promotion and Prevention; Services

<i>Promising Practice Name:</i>	Clinical Counselling Program
<i>Organization:</i>	Ottawa Community Immigrant Services Organization (OCISO)
<i>Target Population(s):</i>	Immigrants, refugees (claimants and convention)
<i>Location:</i>	Ottawa, Ontario
<i>Website:</i>	ociso.org/ociso-programs/clinical-counselling
<i>Promising Practices Category:</i>	Services

<i>Promising Practice Name:</i>	Wellness Recovery Action Plan (WRAP) for Newcomers
<i>Organization:</i>	IESW Bridging Program, G. Raymond School of Continuing Education, Ryerson University
<i>Target Population(s):</i>	Immigrant; Refugee: Ethno-cultural; Racialized
<i>Location:</i>	Toronto, Ontario
<i>Website:</i>	gersteincentre.org
<i>Promising Practices Category:</i>	Services

<i>Promising Practice Name:</i>	The Opening Doors Project
<i>Organization:</i>	CMHA Toronto in partnership with Access Alliance and Across Boundaries, funded by Citizenship and Immigration Canada
<i>Target Population:</i>	Newcomers, Refugees, Youth, Mental Health consumers and Mental Health Service Providers
<i>Location:</i>	Toronto, Ontario
<i>Website:</i>	toronto.cmha.ca/programs_services/the-opening-doors-project
<i>Promising Practices Category:</i>	Education

<i>Promising Practice Name:</i>	Building A Safe Community for Us: South Asian Girls, Teens & Young Women Strategize for Change
<i>Organization:</i>	Social Services Network
<i>Target Population:</i>	South Asian youth
<i>Location:</i>	Markham, Ontario
<i>Website:</i>	socialservicesnetwork.org/Programs/YouthPrograms/BuildingtheSafeCommunityforUsSouthAsianGi.aspx
<i>Promising Practices Category:</i>	Education; Social determinants of health

<i>Promising Practice Name:</i>	Outburst! Movement of Young Muslim Women
<i>Organization:</i>	Barbra Schlifer Commemorative Clinic
<i>Target Population:</i>	Young Muslim women
<i>Location:</i>	Toronto, Ontario
<i>Website:</i>	outburstmovement.com
<i>Promising Practices Category:</i>	Education; Services

Promising Practice Name: Rehabilitation Action Programme (RAP)
Organization: Canadian Mental Health Association – Toronto Branch
Target Population: Individuals 16 years of age and older from Somali, Tamil, Dari and Pashto speaking communities who have been diagnosed with a serious mental illness and would benefit from intensive case management. As well, there is a capacity to serve other clients where there is an ethno-cultural component to their mental health presentation.
Location: Toronto, Ontario
Website: [toronto.cmha.ca/get-involved/volunteer/case-aide-rehabilitation-action-program-
rap/#.VMu7RC6J2dg](http://toronto.cmha.ca/get-involved/volunteer/case-aide-rehabilitation-action-program-rap/#.VMu7RC6J2dg)
Promising Practices Category: Services

Promising Practice Name: Diversity in Action Scarborough (DIAS)
Organization: East Metro Youth Services
Target Population: Refugee/ Immigrants - (Afghan, Tamil & Chinese) in Greater Toronto Area
Location: Scarborough, Ontario
Website: psychologyfoundation.org/index.php/programs/diversity-in-action
Promising Practices Category: Community Engagement; Education; Health Promotion and Prevention

Promising Practice Name: Newcomer Youth Program
Organization: East Metro Youth Services
Target Population: Refugee; Immigrant youth aged 12-21
Website: emys.on.ca/programs-services/newcomer-program
Location: Scarborough, Ontario
Promising Practices Category: Education

Promising Practice Name: OASIS Program
Organization: THRIVE Child and Youth Trauma Services
Target Population: Immigrant and refugee children, youth and their families
Location: Hamilton, Ontario
Website: oasisprogram.ca
Promising Practices Category: Community Engagement

Promising Practice Name: Mutual Aid Parenting Program
Organization: London Cross Cultural Learner Centre
Target Population: Government Assisted Refugees
Promising Practices Category: Education
Website: lcclc.org and merrymount.on.ca
Location: London, Ontario

Promising Practice Name: Client Support Services (CSS) Program
Organization: COSTI-Toronto; Reception House Waterloo Region-Kitchener; Wesley Urban Ministries-Hamilton; London Cross Cultural Learner Centre-London; Multicultural Council of Windsor & Essex County-Windsor; Catholic Centre for Immigrants-Ottawa
Target Population(s): Government Assisted Refugees (GARs)
Location: Toronto, Ottawa, Hamilton, Essex, Waterloo, London
Website: my.mycagta.org/netcommunity/page.aspx?pid=806
Promising Practices Category: Services

Identified by Project Team

Promising Practice Name: Measuring Health Equity
Organization: Toronto Central Local Health Integration Network (TCLHIN)
Target Population(s): Immigrant; Refugee; Ethno-cultural; Racialized
Location: Toronto, Ontario
Web Address: torontohealthequity.ca
Promising Practices Category: Social determinants of health; Tools

Promising Practice Name: Health Equity Impact Assessment Tool (HEIA)
Organization: Ontario Ministry of Health and Long-Term Care
Target Population(s): Immigrant; Refugee; Ethno-cultural; Racialized
Location: Ontario
Web Address: health.gov.on.ca/en/pro/programs/heia
Promising Practices Category: Social determinants of health; Tools

Promising Practice Name: Hong Fook Mental Health Association
Organization: Hong Fook Mental Health Association
Target Population(s): Immigrant, Refugee, Ethno-cultural, Racialized
Location: Toronto, Ontario
Web Address: hongfook.ca
Promising Practices Category: Services

Promising Practice Name: Assertive Community Treatment (ACT) Team
Organization: Mount Sinai Hospital
Target Population(s): Asian and South East Asian Canadians, Immigrants, Refugees,
Web Address: mountsinai.on.ca/patients/chinese/assertive-community-treatment-team-act-team
Location: Toronto, Ontario
Promising Practices Category: Services

Promising Practice Name: The Canadian Centre for the Victims of Torture (CCVT)
Organization: The Canadian Centre for the Victims of Torture (CCVT)
Target Population(s): Immigrant, Refugee, Ethno-cultural, Racialized
Location: Toronto, Ontario
Web Address: ccvt.org
Promising Practices Category: Services

Promising Practice Name: Punjabi Community (PCHS) Mental Health and Addiction Services
Organization: Punjabi Community Health Services (PCHS)
Target Population(s): South Asian, Immigrant, Refugee, Ethno-cultural, Racialized
Location: Mississauga, Ontario
Web Address: pchs4u.com
Promising Practices Category: Services

Promising Practice Name: COSTI Mental Health and Problem Gambling Services
Organization: COSTI Immigrant Services
Target Population(s): Immigrant, Refugee, Ethno-cultural
Location: Toronto, Peel Region, York Region, Ontario
Web Address: costi.org/community/pgs.php
Promising Practices Category: Services

Promising Practice Name: Culturally Adapted - Cognitive Behavioural Therapy (CBT)
Organization: Centre for Addiction and Mental Health
Target Population(s): Immigrant, Refugee, Ethno-cultural, Racialized
Location: Toronto, Ontario
Web Address: porticonetwork.ca/web/health-equity/learn/elearning/culturally-adapted-cbt
Promising Practices Category: Education; Tools

Promising Practice Name: Language Services Toronto
Organization: Toronto Central Local Health Integration Network (LHIN)
Target Population(s): Immigrant, Refugee, Ethno-cultural, Racialized
Description: Improved access to language supports was identified as a priority by the Toronto Central LHIN and Toronto area hospitals resulting in the creation of the Language Services Toronto (LST) in 2012. LST provides real-time, over-the-phone interpretation (OPI) services in more than 170 languages, 24 hours a day, 7 days a week to clients utilizing health care services in Toronto. The main objectives of the LST program are to eliminate language barriers to accessing quality service and to improve health outcomes by ensuring increased accurate communication between providers and patients through the use of professionally-trained interpreters. The TC LHIN covers the costs of the service for providers in Community Support Services, Community Mental Health and Addictions and Community Health Centres, while hospitals within the LHIN and hospitals/organizations outside the TC LHIN are able to join the program but pay the costs themselves.
Promising Practices Category: Services
Web Address: none available
Location: Toronto, Ontario

Promising Practice Name: Portuguese Mental Health and Addiction Services
Organization: Toronto Western Hospital
Target Population(s): Immigrant, Refugee, Ethno-cultural
Location: Toronto, Ontario
Web Address: uhn.ca/MCC/PatientsFamilies/Clinics_Tests/Portuguese_Addiction_Services/Pages/about_us.aspx
Promising Practices Category: Services

Promising Practice Name: Refugee Mental Health Project
Organization: Centre for Addiction and Mental Health
Target Population(s): Settlement and Healthcare providers
Location: Toronto, Ontario
Web Address: porticonetwork.ca/web/rmhp
Promising Practices Category: Education

Promising Practice Name: Wellness and Mental Health, and Problem Gambling Counselling
Organization: Polycultural Immigrant And Community Services
Target Population(s): Immigrant, Refugee, Ethno-cultural, Racialized
Location: Toronto, Ontario
Web Address: polycultural.org/what-we-do/wellness-and-mental-health
Promising Practices Category: Health Promotion and Prevention

Promising Practice Name: Walk-in Counselling Service
Organization: Ottawa Chinese Community Service Centre (OCCSC)
Target Population(s): Immigrant, refugee, Ethno-cultural; Racialized
Location: Ottawa, Ontario
Web Address: occsc.org/services/family-counselling
Promising Practices Category: Services

Promising Practice Name: Wellness Group
Organization: South Asian Women's Centre
Target Population(s): Ethno-Cultural; Racialized
Location: Toronto, Ontario
Web Address: sawc.org/programs-services
Promising Practices Category: Health Promotion and Prevention



MANITOBA

Identified by Project Team

Promising Practice Name: The Newcomer Therapy Program
Organization: Aurora Family Therapy Centre at the University of Winnipeg
Target Population(s): Immigrant; Refugee
Promising Practices Category: Services
Web Address: aurorafamilytherapy.com/newcomer.html
Location: Winnipeg, Manitoba

Promising Practice Name: Multicultural Wellness Program
Organization: Mount Carmel Clinic
Target Population(s): Immigrant; Refugee
Location: Winnipeg, Manitoba
Web Address: mountcarmel.ca/health-services-listing/?service=185
Promising Practices Category: Services, Education

Promising Practice Name: Psycho-social Support
Organization: N.E.E.D.S Inc.
Target Population(s): Immigrant; Refugee
Location: Winnipeg, Manitoba
Web Address: needsinc.ca/our-programs/psycho-social-support.html
Promising Practices Category: Services

Promising Practice Name: Language access interpreter services
Organization: Winnipeg Regional Health Authority
Target Population(s): Immigrant; Refugee; Ethno-Cultural; Racialized
Location: Winnipeg, Manitoba
Web Address: wrha.mb.ca/Professionals/language/index.php
Promising Practices Category: Services



ALBERTA

Submitted to Call

Promising Practice Name: Community-based Immigrant Mental Health Education Project and Culturally Responsive Mental Health Intervention Model
Organization: Multicultural Health Brokers Co-operative and Edmonton Mennonite Centre for Newcomers
Target Population(s): Children, youth, seniors, parents with immigrant, refugees and temporary resident background
Location: Edmonton, Alberta
Website: mchb.org
Promising Practices Category: Health Promotion and Prevention; Services

Promising Practice Name: Understanding Diversity - Online training available for health care providers
Organization: Alberta Health Services
Target Population(s): Immigrant; Refugee; Ethno-Cultural; Racialized
Location: Edmonton, Alberta
Web Address: albertahealthservices.ca/assets/info/hp/edu/if-hp-ed-cdm-div-understanding-diversity.pdf
Promising Practices Category: Education; Tools

Identified by Project Team

Promising Practice Name: At Home/Chez Soi
Organization: Mental Health Commission of Canada
Target Population(s): Immigrant, Refugee, Ethno-cultural, Racialized
Location: Canada (Calgary, Alberta)
Web Address: mentalhealthcommission.ca/English/initiatives-and-projects/home?terminal=38
Promising Practices Category: Services, Social determinants of health

Promising Practice Name: Mosaic Refugee Health Clinic
Organization: Mosaic Primary Care Network (PNC)
Target Population(s): Refugee
Web Address: mosaicpcn.ca/Programs/Pages/Refugee-Health-Clinic.aspx
Location: Calgary, Alberta
Promising Practices Category: Services; Education; Social determinants of health

Promising Practice Name: Immigrant Mental Health Counselling
Organization: ASSIST Community Services Centre
Target Population(s): Immigrant (English, Madarin and Cantonese speakers)
Location: Edmonton, Alberta
Web Address: assistcsc.org/en/immigrant-services-en/downtown-office-en/mental-health-counselling-en.html
Promising Practices Category: Services



BRITISH COLUMBIA

Submitted to Call

Promising Practice Name: ASPIRE
Organization: Muslim Food Bank
Target Population(s): Immigrants and refugees, persons accessing Muslim food bank
Location: Surrey, British Columbia
Website: muslimfoodbank.com/service/aspire-program
Promising Practices Category: Community Engagement; Health Promotion and Prevention

Promising Practice Name: Counselling Services for Women Survivors of Relationship Abuse or Childhood Sexual Abuse
Organization: Burnaby Family Life
Target Population(s): Immigrant mothers with young children
Location: Burnaby, British Columbia
Website: burnabyfamilylife.org
Promising Practices Category: Services

Promising Practice Name: Get It? Got It! Community Awareness Puppet Project
Organization: HeadWay, Victoria Epilepsy & Parkinson's Centre
Target Population(s): Newcomers - immigrant and refugee school age children (6-11)
Location: Victoria, British Columbia
Website: facebook.com/pages/Get-It-Got-It-The-Community-Awareness-Puppet-Project/653146528115461
Promising Practices Category: Education

Promising Practice Name: Referrals to Multicultural Therapist
Organization: Kamloops Immigrant Services in partnership with Interior Health
Target Population: Newcomers to Canada
Promising Practices Category: Services
Website: not available
Location: Kamloops, British Columbia

Promising Practice Name: Lens on Life
Organization: DIVERSEcity Community Resources Society
Target Population: Somali and Karen refugee and immigrant youth
Location: Surrey, British Columbia
Website: dcrs.ca/services/family-services/youth-powered-lens-on-life
Promising Practices Category: Health Promotion and Prevention

Identified by Project Team

Promising Practice Name: The Provincial Language Service
Organization: Provincial Health Services Authority (PHSA)
Target Population(s): Immigrant, Refugee, Ethno-cultural, Racialized
Location: British Columbia
Web Address: pls.phsa.ca
Promising Practices Category: Services

Promising Practice Name: Cross Cultural Clinic
Organization: Vancouver Coastal Health
Target Population(s): Immigrant; Refugee; Ethno-Cultural; Racialized
Location: Vancouver, British Columbia
Web Address: psychiatry.vch.ca/ccs.htm
Promising Practices Category: Services

Promising Practice Name: Chinese Peer Support Program
Organization: Richmond Mental Health Consumer and Friends' Society
Target Population(s): Immigrant; Refugee; Racialized
Location: Richmond, British Columbia
Web Address: rcfc-society.org/chinesepeersupport.php
Promising Practices Category: Education; Social determinants of health

Promising Practice Name: Chinese Family Support
Organization: Pathways Clubhouse
Target Population(s): Racialized
Web Address: pathwaysclubhouse.com/?page_id=91
Location: Richmond, British Columbia
Promising Practices Category: Education; Social determinants of health

Promising Practice Name: Community Mental Wellness Association Of Canada (CMWAC)
Organization: Community Mental Wellness Association Of Canada (CMWAC)
Target Population(s): Ethno-Cultural
Location: Richmond, British Columbia
Web Address: cmwac.ca/programs.html
Promising Practices Category: Services; Education

Promising Practice Name: Child & Youth Mental Health Counselling
Organization: DIVERSEcity Community Resources Society
Target Population(s): Immigrant; Refugee
Location: Surrey, British Columbia
Web Address: dcrs.ca/services/family-services/child-youth-mental-health
Promising Practices Category: Services; Education

Promising Practice Name: Vancouver Association for the Survivors of Torture
Organization: Vancouver Association for the Survivors of Torture
Target Population(s): Immigrant; Refugee
Location: Vancouver, British Columbia
Web Address: vast-vancouver.ca
Promising Practices Category: Services

Promising Practice Name: Engaging Newcomers in Mental Health Promotion
Organization: MOSAIC
Target Population(s): Immigrant; Ethno-cultural; Racialized
Location: Vancouver, British Columbia
Web Address: mosaicbc.com/publications/engaging-newcomers-mental-health-promotion
Promising Practices Category: Community Engagement; Health Promotion and Prevention



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Production of this document has been made possible through a financial contribution from Health Canada.
The views expressed herein represent the views of the Mental Health Commission of Canada.