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MENTAL HEALTH IN PUBLIC-HEALTH POLICY AND PRACTICE: PROVIDING CULTURALLY-APPROPRIATE SERVICES IN ACUTE AND POST-EMERGENCY SITUATIONS

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Mental Health in Public Health Policy and Practice:
Providing Culturally Appropriate Services in Acute and Post-Emergency Situations

Proceedings of a Workshop held at the Centre for Addiction and Mental Health

Toronto, Ontario, Canada
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ABSTRACT

This paper presents the proceedings of a workshop held at the University of Toronto following the tsunami that struck Southeast Asia at the end of December 2004. The workshop was organized as part of a local response by concerned scientists, physicians, Tamil professionals, and community leaders to the impact of the devastation on affected newcomer communities in Canada. Its purpose was to exchange information, experiences, and ideas concerning culturally appropriate mental distress relief for diaspora communities affected by disasters in their countries of origin. The goal was also to discuss related policy and practice implications, and to formulate recommendations and research priorities for culturally competent emergency public health planning. Workshop participants included local, national, and international experts and service providers from community and settlement organizations, health care centres, hospitals, schools, and municipal, provincial, and federal agencies. Participants reviewed the existing knowledge concerning trauma counseling and community mental health care in post-emergency situations, responded to presentations of good practice models, and then broke into working groups. The resulting joint recommendations for culturally competent distress relief are relevant for planning post-emergency public health services and enhancing community mental health services for cities and communities across Canada.

KEY WORDS: Community mental health, cultural competence, diaspora communities, disaster response, emergency planning, health care, policy, public health, settlement, Tamils, trauma.

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INTRODUCTION

In response to the devastating effects of the 26 December 2004, tsunami in Asia, a group of concerned scientists, physicians, and community leaders came together in Toronto to form a Local Distress Relief Network. The goal of the Network was to provide a locally targeted, responsive, and sustainable system of information, referral, and care to assist affected members of the Tamil community in Toronto (population 160,000)[1] – the largest Tamil diaspora in the world – which was deeply and directly affected by the disaster. This was not the first time the Tamil community had suffered. The Tamil population in Canada originated as refugees fleeing decades of war and persecution in Sri Lanka, and thus has endured previous dislocation, psychosocial trauma, and migration stress.[2] Even before the tsunami inundated their homeland, appropriate mental and other health services had not been available to meet the mental health needs of Toronto's Tamil community. In a multicultural society such as Canada's, where numerous diaspora communities bind us all to world events, a vision for more culturally appropriate and effective mental health services, during and after emergencies, has become critical.

As part of the Local Distress Relief Network's initiatives, we held a workshop composed of community leaders, academics, health practitioners, and policy makers to discuss culturally appropriate models of distress relief.[3] This workshop was designed to build on existing international and local expertise, and to explore implications for Canadian public health policy and practice. International and national experts on emergency mental health joined community-based service providers, scientists, and medical professionals in Toronto for a day of presentations and discussion. In addition to a specific concern with post-tsunami distress relief for the Tamil community in Toronto, we addressed a more general issue, namely, the provision of effective mental health services in a multicultural society. This report provides an initial outline of some of the emerging priority issues and concerns relating to the policies, systems, services, and research needed to provide culturally appropriate mental health care during and after emergencies.

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[1] Note that Census figures reported by the media for the Toronto Tamil population underestimated its size by more than half. The Local Distress Relief Network did not exclude Sinhalese Sri Lankans and Indonesians, but these populations in Toronto are relatively small by comparison, at 8,000 and >1,000, respectively.

[2] M. Beiser., L. Simich, and N. Pandalangat. 2003 "Community in Distress: Mental Health Needs and Help-seeking in the Tamil Community in Toronto," *International Migration* 41 (5), 233-245; D. Silove, A. Steel, P. McGorry, and P. Mohan. 1998 "Trauma Exposure, Post-Migration Stressors, and Symptoms of Anxiety, Depression, and Post-Traumatic Stress in Tamil Asylum-Seekers: Comparison with Refugees and Immigrants," *Acta Psychiatrica Scandanavica* 97, 175-181.

[3] The Local Distress Relief Network (LDRN) was initiated by Joanna Anneke Rummens, Laura Simich, and Tamil colleagues in the wake of the December 2004 Tsunami as a way of addressing the psychosocial needs of affected diaspora communities. Meetings of the LDRN were held on 20 January and 16 February at the Centre for Addiction and Mental Health. Subsequent community development activities included the linking of mental health practitioners with community-based agencies for training and counseling, dissemination of Tamil and English health promotion materials in community-based agencies, and development of resources for Toronto area teachers and parents to help affected children and families cope with their trauma and grief.

Background

The ongoing controversy in mental health over trauma counseling and appropriate responses to disaster, whether focused on mental health treatment or social interventions, has produced principles for training[4] and public health responses.[5] These principles commonly and clearly express the importance of community-based interventions in affected resource-poor countries. Not only are the survivors of natural disasters or conflict directly affected and at risk of mental distress, however, but also members of those societies living in Canada, particularly families of those injured or killed.[6] To date, little attention has been devoted to understanding these mental-health effects or devising an appropriate public-health response to support affected diaspora populations in immigrant-receiving countries. Despite its recognized cultural diversity, Canada, and other wealthy immigrant-receiving countries, remain 'resource-poor' in the culturally competent mental-health training and public-health services required to redress the situation. As well, development of emergency-response health systems in Canada is still at an early stage.

The emerging priority of mental health in public-health policy and practice raises questions such as these: What should be the role of trauma counseling in good mental-health practice after emergencies? What does this approach entail for diaspora and ethnocultural communities in Canada? What are the implications for public-health, hospital, and community mental-health practice in acute and post-emergency phases? Should mental-health and psychosocial interventions be separate or integrated, and if so, how? How can community-based, primary care and psychiatry render service collaboratively? What can we learn about these issues from the experiences of the Tamil community in Toronto, from mental-health practitioners and other participants in the Distress Relief Network? What are the implications for Canadian public-health policy? What directions for research are suggested?

Workshop Rationale

In order to address these issues, Drs. Laura Simich, Joanna Anneke Rummens, Ted Lo, and Lisa Andermann, all members of the Culture, Community, and Health Studies Program, Department of Psychiatry, University of Toronto, organized a one-day workshop that brought together international,

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[4] S. Weine, Y. Danieli, D. Silove, M. Van Ommeren, J. Fairbank, and J. Saul. 2002 "Guidelines for International Training in Mental Health and Psychosocial Interventions for Trauma Exposed Populations in Clinical and Community Settings." *Psychiatry* 65 (2): 156-164.

[5] M. Van Ommeren, S. Saxena, and B. Saraceno. 2005 "Mental and Social Health During and After Acute Emergencies: Emerging Consensus?" *Bulletin of the World Health Organization* 83 (1): 75-76; M. Weiss, B. Saraceno, S. Saxena, and M. Van Ommeren. 2003 "Mental Health in the Aftermath of Disasters: Consensus and Controversy." *The Journal of Nervous and Mental Disease* 191 (9): 611-615. World Health Organization. 2003 *Mental Health in Emergencies: Mental and Social Aspects of Health of Population Exposed to Extreme Stressors*. (Geneva: Department of Mental Health and Substance Dependence, WHO).

[6] K. Shu. 2005 *A Report on Developing Grief Counselling and Mental Health Services*. (Toronto: Vasantham - A Tamil Seniors Wellness Centre).

national, and local experts in health and disaster relief and community-based organizations to review the existing literature, share practical experience and community knowledge, and discuss the implications for distress relief initiatives for local affected ethnocultural populations. The workshop was held at the Centre for Addiction and Mental Health in Toronto on 26 May 2005.

Workshop Focus and Tasks

The central question addressed by workshop participants was as follows: How can we best provide and ensure culturally appropriate distress relief to diaspora communities in acute and post-emergency situations? Key workshop tasks were to:

1) consider existing mental distress relief models and culturally appropriate public health practices,

2) explore implications for Canadian health research, policy, and service delivery, and

3) develop initial guidelines through expert consensus.

The explicit purpose of the workshop was to summarize and harness existing research knowledge and programmatic experience in order to outline best practices for post-acute emergency distress relief initiatives for use in diaspora and ethno-cultural communities. The complete workshop agenda can be found in Appendix B.

Workshop Organizers, Speakers, and Participants

The workshop benefitted from the combined expertise and energy of participants from several sectors, including academics, community service providers, mental health professionals, and policy makers. Of the twenty-seven participants, four were from outside of Canada. Many of those joining the workshop from Toronto also possessed international experience with trauma and mental-health research and practice. For example, two of the workshop leaders (Simich and Rummens) are cultural anthropologists who have been Co-Investigators in psychiatric epidemiological research with the Tamil community in Toronto since 2000 (Principal Investigator, Morton Beiser). Drs. Lo and Andermann are psychiatrists and experts in cultural competence in mental health. They have since joined Tamil and other non-Tamil health-service providers, representatives of hospitals, municipal public-health departments, community health centres, immigrant settlement agencies, and the Toronto school system in planning for culturally-competent mental health service provision.

Invited workshop presenters included Dr. Jose Bertolote, Department of Mental Health and Substance Abuse, World Health Organization, Geneva; Dr. Daya Somasundaram, Department of Psychiatry, University of Jaffna; Patience Lamaro Onyut, Ph.D., Victim's Voice (VIVO) and Universitat Konstanz, Germany; Jack Saul, Ph.D., International Trauma Center, New York University; Dr. Clare

Pain, Clinical Director, Trauma Assessment Clinic, Mt. Sinai Hospital, Toronto; and Mr. Raymond Chung, Executive Director, Hong Fook Mental Health Association, Toronto. Other workshop participants were drawn from various ethno-cultural community organizations, community health-care centres and hospitals, settlement-service agencies as well as municipal, provincial, and federal government agencies (see Appendix A).

Workshop Organization

In order to maximize the usefulness of the workshop for all participants, select publications and background documents were distributed to all participants in advance of the session in order to assist in orientation and help frame the planned group discussion. The publications are summarized briefly in the **Summary of Key Findings from the Research Literature** section below.

The morning workshop program was devoted to presentations of both international and local distress-relief initiatives by invited experts. The ensuing group discussions also incorporated 'front-line' reports of local lessons and best practices by all workshop participants. Overall, the primary goal of the morning session was to provide participants with an opportunity to exchange information, experience, and ideas. In the afternoon portion of the workshop, small working groups were formed to discuss and develop policy, practice, and research recommendations for culturally competent distress-relief service provision with locally affected communities. This was followed by a full group discussion that pooled and summarized the various suggestions. The goal of the afternoon session was to reach consensus regarding the various guidelines proposed by participants. The list of guidelines was subsequently circulated to all workshop participants in order to ensure that the listing was complete, to facilitate additional input, and to ensure that there was group consensus regarding the recommendations put forward.

We expect to disseminate results of these joint deliberations via workshop proceedings, peer-reviewed journal submissions, and a summary of key principles for use by mental-health practitioners, settlement-service providers, community organizations, and policy makers. This workshop report summarizes the key lessons and joint research recommendations presented and discussed by participants.

MENTAL-DISTRESS RELIEF MODELS AND CULTURALLY-APPROPRIATE PUBLIC-HEALTH PRACTICES

Summary of Key Findings from the Research Literature

While acknowledging the burgeoning literature in the of area of psychological trauma and post-emergency situations, a short list of selected articles was circulated to workshop presenters and participants in advance in order to focus attention on workshop goals and key issues for discussion. These references are briefly summarized in the following section.

The tsunami of 26 December 2004, dealt a heavy blow to the already overburdened Tamil population in Toronto, which is currently estimated at well over 160,000 people. The *Community in Distress* study, completed prior to the tsunami, was the first survey of psychiatric epidemiology in this community and provided much-needed background into the mental-health needs of this population.[7] Issues relating to the Tamil refugee experience are described, along with their migration and resettlement experiences. With regards to the mental-health data uncovered by this study, about one-third of respondents were found to have experienced traumatic events including assault, rape, or witnessing combat. Of those who had experienced trauma, 36.2 per cent met criteria for Post-traumatic Stress Disorder (PTSD), and the overall prevalence in the community was 12 per cent. Fewer than 10 per cent of those included in this study had received any specific psychological treatment. While 70 per cent of people had seen a general practitioner for various reasons, fewer than 1 per cent had seen a mental-health worker or psychiatrist. These findings underscored the need for a discussion of the "poor fit" between mental-health needs and services, and a study of the many barriers encountered including language, lack of information, stigma, and preferences for traditional healing.

The World Health Organization (WHO) consensus statement "Mental and Social Health During and After Acute Emergencies: Emerging Consensus?"[8], was one of the key documents reviewed for the Workshop. It summarized the opinions of world experts in a field which, at times, has been controversial. The authors provide a very useful table of social and mental-health intervention strategies and a discussion about emergency responses in a stepwise and multi-level manner. Much of the workshop discussion was based on this model, with added emphasis on the local diaspora situation. The authors describe eight basic principles of mental health in emergencies:

1) contingency planning,

2) assessment,

3) long-term perspective,

4) collaboration,

5) integration into primary health care,

6) access to service for all,

7) thorough training and supervision, and

8) monitoring.

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[7] M. Beiser, L. Simich, and N. Pandalangat. 2003. "Community in Distress: Mental Health Needs and Help-seeking in the Tamil Community in Toronto." *International Migration* 41 (5): 233-245.

[8] M. Van Ommeren, S. Saxena, and B. Saraceno, B. 2005 "Mental and Social Health During and After Acute Emergencies: Emerging Consensus?" *Bulletin of the World Health Organization* 83 (1): 71-75.

Consideration of the WHO consensus statement was followed by an assessment of two subsequent Round Table discussions by Derrick Silove and Derek Summerfield. Silove argued that "the best immediate therapy for acute stress is social," and that this would include providing safety, family reunification, effective justice systems, returning to productive roles in work or study, and "re-establishing systems of meaning and cohesion – religious, political, social, and cultural."[9] When psychiatric disorders do occur and help is needed, Silove expressed support for the use of community mental-health programs integrated within primary care, however, he cautioned that in resource-poor situations, some external resources and specialized training may be needed.

Derek Summerfield critiqued the use of the PTSD concept in non-western populations, and expressed a concern that "psychosocial programs" imported to treat trauma in developing countries have tended to focus more on the psychological than the social.[10] In fact, he believes this to be a false distinction of western thought in which the dichotomy between mind and body is promoted, a distinction is a foreign idea in many other parts of the world. In response to emergency situations, Summerfield has argued: "lack of coherence is bad for people: if there is such a thing as a core fact about human response to disasters and violent upheavals, it is that survivors do well (or not) in relation to their capacity to re-establish social networks and a viable way of life. Western mental-health models have always paid too little attention on the role of social agency, including work, in promoting stable well-being and mental health."[11] This being said, he concluded that he largely was in agreement with the WHO consensus statement.

A broader discussion of the controversial opinions in the area of post-disaster psychiatry can be found in a survey of international experts conducted by Weiss and colleagues.[12] Issues addressed by them included the nature and diversity of disasters; the validity of the PTSD diagnosis; and the classification of traumatic stress responses, goals, and approaches for mental-health policy and future directions for research, from which the authors made several summarizing statements about the implications for mental health policy. Of relevance to the December 2004 tsunami, the general opinion held that it was less important to differentiate between human-made and natural disasters than to develop different approaches for single event *versus* enduring traumas. In addition, the level of destruction was felt to be more important for outcomes than the type of event. The importance of addressing sociocultural and community context was declared to be of primary importance. This would include a culturally sensitive needs assessment, using local expertise and recruiting local relief workers, and sustaining interventions over time as needed, with an emphasis on treating pre-existing psychiatric disorders. In addition, there must be a balancing of clinical and community interventions, with mental-health services being

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[9] D. Silove. 2005. "The Best Immediate Therapy for Acute Stress Is Social." *Bulletin of the World Health Organization* 83 (1): 75-76.

[10] D. Summerfield. 2005 "What Exactly Is Emergency or Disaster 'Mental Health'?" *Bulletin of the World Health Organization* 83 (1): 76-77.

[11] Ibid, 76.

[12] M. Weiss, B. Saraceno, and S. Saxena. 2003. "Mental Health in the Aftermath of Disasters: Consensus and Controversy." *The Journal of Nervous and Mental Disease* 191 (9): 611-615.

incorporated into primary health care. They advised against the development of stand-alone trauma services. Specifically, they argued: "aid programs should refrain from applying blanket trauma-focused clinical interventions to a large population, solely because the community as a whole has been exposed to disaster."[13]

Training issues have been thoroughly addressed by the consensus guidelines developed by the Task Force on International Training of the International Society for Traumatic Stress Studies (ISTSS).[14] These guidelines focus on four main issues:

1) values underlying international training;

2) contextual challenges in societies during and/or after conflicts;

3) core curricular elements of training; and

4) monitoring and evaluation.

For the members of this Task Force, training must be culturally sensitive, as well as feasible and sustainable in the local setting, with some access to supervision. Moreover, self-care of mental-health workers must be addressed. In addition, attention needs to be paid to monitoring, evaluation, and outcomes.

Although there is much written in the area of the importance of a cultural understanding of trauma and depression, one study by Eisenbruch on cultural bereavement in Southeast Asian refugees in the United States seemed particularly relevant for workshop participants in their quest to understand possible responses to the tsunami among Toronto Tamils, many of whom had already had direct experiences with trauma prior to coming to Canada.[15] Cultural bereavement has described by Eisenbruch as "the experience of the uprooted person – or group – resulting from loss of social structures, cultural values and self identity … not of itself a disease, but an understandable response to the catastrophic loss of social structure and culture."[16] Using semi-structured interviews and clinical vignettes to conduct an in-depth study of this syndrome, it was suggested that disabling psychological symptoms may mimic post-traumatic stress disorder, but in fact will not respond to biomedical treatments or western psychotherapy alone. Cultural bereavement, therefore, is an issue which goes beyond the symptoms of an individual.

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[13] Ibid, 614.

[14] S. Weine, Y. Daniele, D. Silove, M. Van Ommeren, J. A. Fairbank, and J. Saul. 2002. "Guidelines for International Training in Mental Health and Psychosocial Interventions for Trauma Exposed Populations in Clinical and Community Settings." *Psychiatry* 65 (2): 156-164.

[15] M. Eisenbruch. 1991 "From Post-traumatic Stress Disorder to Cultural Bereavement: Diagnosis of Southeast Asian Refugees." *Social Science and Medicine* 33 (6): 673-680.

[16] Ibid, 674.

In fact, Eisenbruch has raised the issue of the need to take a wider perspective by asking the following question:

> If some of the people in this community come to a mental health resource with complaints such as sleeplessness or flashbacks or some other hallmarks of post-traumatic stress disorder, how are we really to treat them? Treating the symptoms can be counterproductive, because the patient returns to a community that is in itself in a state of collective grief and the patient becomes more estranged from the parent culture.[17]

In the end, Eisenbruch provided as an answer the need for an emphasis on cultural meaning to achieve a truer understanding of the patient's experience, rather than a reliance on the collection of symptoms to be medicated.

In terms of the discussion of community analyses, Jack Saul has described strengths-based approaches to trauma which are grounded in the study of resilience.[18] Saul focused his interviews with traumatized elderly Albanian Kosovars as "solution-oriented conversations," rather than as standard psychological assessments, in order to decrease their isolation and increase the potential for a sense of hope and problem solving as well as a sense of the future. Moreover, he argued: "by focusing on an individual's strengths and solutions, his or her problems are not denied but rather set in an atmosphere in which the individual can examine problems from a perspective of enhanced dignity and a sense of agency."[19] Saul also addressed the importance of community structure, and acknowledged that "many of the strengths that enable people to cope with massive loss and trauma are embedded in a community's collective memory, culture, and religions," and, furthermore, "when drawing on these resources, the community is able to tap the symbols, rituals, and maps that have traditionally enabled it to navigate through very difficult like events and transitions."[20] Cultures each have their own "repertoire of healing mechanisms" and reconnecting people to these hidden or forgotten routes will enable them to overcome their traumatic experiences.

Together, Landau and Saul have described their work with the LINC community resilience model in post-9/11 New York and Buenos Aires, Argentina following a period of political and economic instability.[21] The family generally has been seen as the basic unit of 'community,' but the focus of intervention was broadened by them to include an emphasis on a wider group. Landau and Saul have identified four themes for community recovery, including:

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[17] Ibid, 678.

[18] J. Saul (with S. Ukshini, A. Blyta and S. Statovci) 2004. "Strengths-based Approaches to Trauma in the Aging," in F. Walsh and M. McGoldrick (eds.) *Living Beyond Loss: Death in the Family*. (New York: W.W. Norton), Chapter 13.

[19] Ibid, 300.

[20] Ibid, 300.

[21] J. Landau and J. Saul. 2004. "Facilitating Community Resilience in Response to Major Disaster," in F. Walsh and M. McGoldrick (eds.) *Living Beyond Loss: Death in the Family*. (New York: W.W. Norton), Chapter 14.

1) social connectedness as foundation for recovery;

2) collective storytelling;

3) re-establishing daily routines and collective healing rituals; and

4) developing positive visions for the future.

Community mapping has been described by them as a first step in problem solving, an approach that deliberately shifts the focus away from interventions on an individual level. Under this scenario, community members are approached as "natural change agents," with the goal of allowing the success of the project to belong to the community. An example of a successful outcome that resulted from the use of this approach involved a group of parents in New York who came together to renovate a school for their children who had been displaced after 9/11. This helped to create a sense of social connectedness, provided a location for mutual support and problem solving, and led to the development of further support groups and activities. This organic and community-led approach can be contrasted to the approach taken by the thousands of mental-health professionals from around the world who flooded into New York after 9/11 to do individual therapy.

The Vivo (Victim's Voice) organization is an NGO that has been developing a manualized short-term psychological intervention for post-traumatic stress disorder called Narrative Exposure Therapy or NET.[22] This approach also has been utilized with children.[23] While mindful of the importance of community approaches, the expertise of those involved in the development of NET was in the area of treating individuals who had become disabled by post-traumatic stress disorder and, therefore, had become unable to function in their current environment. While other brief treatments for PTSD exist, NET is unique in that it has been shown to be effective in post-conflict environments such as Uganda and Sri Lanka, can be done in the field with minimal resources, and most importantly, builds local competency through the use of trained laypersons. In practice, NET can be taught to selected community members, such as the residents of a refugee camp, in a short period of time. They, in turn, treat others, with ongoing supervision and evaluation. According to the literature, outcomes have been comparable to those involving treatment by experienced NET therapists. This transition from 'survivor' to 'agent of change' and community healer, therefore, can be of great importance for local capacity building.

Most of the published material thus far on the effects of the tsunami and the responses to it has been in the form of media reports. One recent publication by Balakumar et al, however, has provided a collection of reports and documents around topics related to health and emergency measures and post-

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[22] L. P. Onyut, F. Neuner, E. Schauer, V. Ertl, M. Odenwald, M. Schauer, and T. Elbert. 2004. "The Nakivale Camp Mental Health Project: Building Local Competency for Psychological Assistance to Traumatized Refugees." *Intervention* 2 (2): 90-107.

[23] L. P. Onyut, F. Neuner, E. Schauer, V. Ertl, M. Odenwald, M. Schauer, and T. Elbert. 2005. "Narrative Exposure Therapy as a Treatment for Child War Survivors with Posttraumatic Stress Disorder: Two Case Reports and a Pilot Study in an African Refugee Settlement." *BMC Psychiatry* 5 (7).

tsunami reconstruction.[24] The editors of that report emphasized the importance of listening to the concerns and preferences of the affected, and reminded the international community of their responsibility to follow-through on their commitments for assistance.

Summary of Invited Presentations

Laura Simich opened the workshop presentations with a brief overview of a prior mental-health survey conducted in the Toronto Tamil community.[25] She began by noting that Canada is one of the leading refugee-resettlement countries in the world today, and Sri Lanka is one of the world's leading refugee-producing countries. Toronto may well be North America's most diverse city, with 44 per cent of its population born outside of Canada at the time of the 2001 Canadian Census.[26] As well, 44 per cent of the quarter of a million immigrants who arrived in Canada in 2001 spoke neither English nor French. Despite a well-deserved reputation for its multiculturalism and universal health-care policies, Canada has not yet done enough to ensure that mental-health care is accessible to its diverse newcomer populations. Needs for culturally appropriate mental-health promotion, prevention, and care continue to outstrip the available mental-health services, even in normal times. This is one reason why Toronto Tamils, both as individuals and community organizations, approached Dr. Morton Beiser in the Culture, Community and Health Studies Program in 2000 to propose that he and his colleagues conduct a mental-health survey in the Toronto Tamil community. We must be aware that social determinants of health in Canada, as well as forced migration experiences, influence diaspora community mental health. Some of the current challenges facing the Tamil community are similar to those that can be associated with other immigrant and refugee groups. According to Simich, these include experiences of displacement and exposure to traumatic events; limited comfort with the use of English, especially among women; under-employment in Canada; difficulties for some seniors in terms of loss of freedom and social status; and lower-than-average household incomes during their early years in Canada.

Simich observed that Toronto Tamils form a well-educated community with a great deal of social capital. In the survey, the majority expressed the feeling that they have good social relations and support among family and friends. Moreover, though nearly half of those interviewed in the study were forced to seek asylum in Canada, 65 per cent now have become Canadian citizens. The study also uncovered a marked increase in prosperity after 10-15 years in Canada. As for mental health, the prevalence of PTSD was quite similar to that found for other refugee populations. However, most survey respondents said that they would not seek help for mental-health problems such as anxiety, extreme sadness, or fear. Most

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[24] R. Balakumar, A. Barath, G. Chanda, A. Kulan, G. Namanan, and D. Ravindran (eds.) *Resilience and Resurgence: Rehabilitation and Reconstruction After the Tsunami Disaster in Sri Lanka* (Toronto: Caldwell, 2005).

[25] The *Community in Distress* study was funded by the Canadian Institutes for Health Research, 2000-2003. Dr. Morton Beiser is the Principle Investigator; Dr. Laura Simich and Dr. Joanna Anneke Rummens are Co-Investigators.

[26] On Toronto's claims regarding its diversity see M. Doucet, *The Anatomy of an Urban Legend: Toronto's Multicultural Reputation*, Working Paper No. 16 (Toronto: Joint Centre of Excellence for Research on Immigration and Settlement - Toronto, 2001).

expressed the perception that these problems would simply go away on their own or be resolved without professional help. According to Simich, one conclusion we might reach from considering this trajectory is that we can do better in the area of multicultural health promotion. Another conclusion is that the Toronto Tamil community is poised to help build more appropriate mental-health services in Canada. The community response to the terrible tsunami on 26 December offers evidence of this capability.

Joanna Anneke Rummens indicated that the Local Distress Relief Network (LDRN) initiative had its origins in the commitment of Tamil Study's research team to both community collaboration and policy- and practice-relevant research. When the tsunami struck, the team sought ways to translate this commitment into support for the Tamil diaspora community of Toronto. Much of the immediate public attention was focused on disaster relief efforts overseas, and necessarily so. However, it was clear that there were also unmet needs for 'distress' relief more locally – from affected community members with worries or grief for loved ones back home, returnees from the region, and emergency disaster workers. The LDRN founders felt that the *first* area of pressing need was the facilitation of information flows between community organizations and concerned mental-health professionals, institutions, and other service providers within the broader community. The LDRN thus chose to devote its energies to this gap by providing a forum through which information could be shared regarding community-identified priority needs and initiatives, culturally-competent mental-health-care expertise, relevant institutional resources, and other Tsunami-related response initiatives by mental-health professionals, public-health officials, social-service providers, educators, researchers, students, and volunteers. The *second* identified priority area was the need to contribute to the linking of various types of expertise and the overall coordination of efforts in order to best meet local community needs. The goal of the network, therefore, became to effectively link people, knowledge, and resources, and to facilitate information exchange. LDRN activities have included:

a) an initial Information Exchange Meeting between community leaders and concerned members within the health care community;

b) preparation of a culturally-competent flyer written in Tamil script that outlined common symptoms of distress as well as ways to address them, and provided contact information for Tamil-speaker mental health care workers;

c) distribution of this brochure at a Community Vigil for tsunami victims, and via the internet to various organizations;

d) preparation of a letter providing information regarding the continuing impact of disasters on the well-being of children and their families for teachers and parents to be distributed via the school system;

e) translation of a photo-novella on Post-Traumatic Stress Disorder into Tamil; and

f) establishment of a Tamil Mental Health Resource Group. The LDRN also helped to directly inform the response of various university departments as well as public health offices regarding local distress-relief initiatives.

Lessons learned from this experience include the importance of beginning from where you are, and of focusing on what you can do. The LDRN succeeded *first* of all because it was based on an established working relationship between researchers and community members that was rooted in trust and mutual respect. This made it possible to readily identify the most pressing needs, and to focus on what was actually doable. It was critically important to let those affected within the community tell those willing to assist what they felt was most needed and wanted, and to subsequently support the community's own initiatives as much as possible in this regard. It was also important to divide respective tasks and responsibilities in order to ensure maximum efficiency, and, above all, to ensure actual response capacity before proceeding in order to be able to carry through on expectations raised. *Second*, it was made clear right from the start that although the network was started by a handful of colleagues, it really belonged to everyone. The operating principle was that if everyone contributed a little piece based on their expertise and possibilities, the whole would be greater than the sum of its parts. Thus, the network strove to become a 'coalition of leaders.' *Finally*, the timing of this initiative was critical. Response to the needs of the community were immediate, with a view to ramping up towards a long-term commitment to ensuring culturally-appropriate disaster relief and community health care well beyond the initial needs stemming from the precipitating event itself. The network's ultimate goal is to help put the issue of the need for more truly equitable, culturally-appropriate health promotion and service provision on the table, and to support the development of organizational structures and initiatives in this direction.

Thammi Ramanan presented on the Canadian Tamil community's response to the tsunami. She introduced Workshop participants to the Tamil Emergency Medical Services (TEMS), known by its motto "Peace through Health and Development." TEMS is a registered non-profit, non-governmental organization based in Canada whose mandate is to assist in the enrichment of the lives of people affected by war through rehabilitation and development. The organization has addressed pressing medical needs of communities in the North and East of Sri Lanka by bringing together various health-care professionals, students, and community leaders. TEMS' tsunami-related projects included the locally organized Tsunami Medical Supplies Relief Effort, a Baby Items Drive, and support for Ponambalam Hospital and for the Health Workers Training College. Tamil service providers in Toronto (members of the Tamil Service Providers' Coalition) provided support services to families and were also trained by Toronto Public Health in providing grief counseling. In addition, Tamil media organizations assisted in distress relief by mobilizing fundraising for immediate relief efforts and providing opportunities for individuals to talk about their suffering and comfort each other through call-in talk shows. Tamil places of worship also organized special prayer services throughout Toronto. Innumerable visits to disaster-affected areas in the homeland also were made by individual Tamil professionals and other community members to deliver material and emotional support directly, which has likely helped to assuage feelings of helplessness and loss and promote rehabilitation and mental health in the larger community.

Dr. Jose Bertolote, representing the World Health Organization, placed the day's issues in a global context. He noted that WHO had received "unprecedented" requests for mental-health assistance following the tsunami. Furthermore, ho observed that making mental health a priority would not have happened a mere five years ago. Nevertheless, he noted that most emergency mental-health responses remain ill prepared. In WHO's experience, the most important lesson is that local realities necessarily shape local interventions *and* external interventions. Bertolote said that it is not advisable to promote new mental-health services that are external to existing health services in emergency situations. In his view, however, it is valuable to promote social interventions that are outside conventional mental-health

services. He concurred with the belief that there was value in offering basic psychological support, or what we have called "distress relief," both inside and outside the existing health system.

Bertolote acknowledged that the selective focus on PTSD in emergency mental health has been a problem, as has been the vertical organization of trauma services, the tendency to "parachute in" foreign trainers and clinicians, as well as attempting to make a distinction between "mental health" and "psychosocial" services. Another problem is a lack of baseline data on the impact of emergencies on mental health, although some assumptions can be made based on world surveys and disaster studies. Highly recommended responses at national and sub-national levels include developing community-based mental-health services, integrating these services into primary health care, and training personnel in all sectors to identify mental-health issues and make appropriate referrals.

Bertolote emphasized that, without achieving cultural understanding beforehand, emergency responses will only exacerbate the impact of the disaster. Mental distress and mental illnesses are expressed differently in different cultures, but there are some common response patterns. For example, many cultures devote a period of 30 days to mourning. Furthermore, in all disasters there are special groups that are known to require attention. Children are always affected by adults' reactions in emergencies, although children's reactions to mental distress are often misinterpreted and condemned as "bad" behaviours. Similarly, the responses of the elderly, who are an important community resource, may be misconstrued as their functional limitations and physical challenges are sometimes misinterpreted as mental distress or disability. Bertolote concluded by saying that different emergency responses are required at various levels to address the full range of possible mental distress, from common experiences to more serious mental disorders, and from the acute phase to a long-term, post-emergency phase.

Dr. Daya Somasundaram, Department of Psychiatry, University of Jaffna, Sri Lanka, presented on *Community-Level Interventions in the Aftermath of Disasters.* He made the point that most mental distress does not emerge as a mental illness *per se*. Because mental distress does not arise as a medical problem, it, therefore, should not be treated in a medical setting, but rather in the community. He described the effects of the December 2004 tsunami at several levels of society in Northern Sri Lanka. At the individual and family levels, distressing experiences included loss of cohesiveness and unity; deaths, which created "vacuums;" family separations; disturbances in family dynamics; and family role change due to deaths of females. At the community level, experiences included widespread destruction of "organic roots" and breaks in the biological connections to the home; loss of support systems, networks, traditions, structures, and institutions; and loss of communality. He also described "collective trauma," which was characterized by an increased sense of dependency; deterioration in morals and values; poor leadership; adoption of superficial and short-term goals; prevalent mistrust and suspicion; and social deterioration exemplified by general resignation, loss of work ethic, and increasing alcoholism.

As for appropriate responses, Somasundaram suggested that the goal should be psychosocial well-being as defined by the World Health Organization, that is, health as "a state of complete physical, mental, (familial), social and (spiritual) well-being, and not merely an absence of disease or infirmity." He recommended several effective therapeutic interventions for disaster survivors, including psychoeducation, crisis intervention, psychotherapy, behavioural-cognitive methods, pharmacotherapy, relaxation techniques (Western principles and traditional practices), breathing exercises, progressive

(deep) muscular relaxation, meditation, Tai Chi, massage, and group therapy (small groups with similar problems and support groups for caretakers).

He suggested that family therapy could work to promote unity, cohesiveness, and sharing of burdens and responsibilities; increase mutual understanding, communications, and interactions; fulfill roles and the need for respect; and create positive family dynamics and extended family support. He also stressed the utility of expressive methods, such as art, drama, and storytelling; writing poems and novels, as well as therapeutic play and rehabilitation, which promote individual and social healing, recovery, and reintegration. He emphasized the primacy of respecting the local population's wishes and needs as well as their active participation in useful tasks such as vocational training, agrotherapy, non-partisan cultural healing, and symbolic expression in media, monuments, and public mourning ceremonies. Linked with these family and community-based interventions should be a referral system for mental-health care and treatment.

Somasundaram also stressed community-based approaches to raising awareness of mental-health issues through pamphlets and news articles, public lectures for small and large target groups, and popular dramas and documentaries. As part of community-based efforts, he further suggested training grass-roots community workers and primary health-care providers in mental-health promotion through the use of manuals and "training of trainers" programs. Finally, he highlighted the significance of indigenous coping strategies, including rituals and ceremonies such as funerals and festivals, and described the important role of traditional healers. According to Somasundaram, traditional methods are based on disaster survivors' cultural and religious beliefs, and are, therefore, less stigmatized, more culturally acceptable, and popular.

Patience Onyut, is a psychologist at the University of Konstanz Refugee Outpatient Clinic working with the University of Colombo, Sri Lanka, and she is associated with Vivo (Victim's Voice), which treats patients and victims of violence and disaster who do not get better on their own. She presented her applied research with the Basic Education Sector Program (BESP), which entailed an epidemiological survey among children in Northern and Northeastern Sri Lanka. The program involved training teachers, screening 348 fifth-grade children in five districts in these areas (including 18 randomly chosen schools), and eliciting independent parent ratings of children's mental health.[27] Results show that the potentially traumatic experiences of Tamil children include war experiences (77 per cent), witnessing an unexpected or violent death, threats with a weapon, witnessing of torture, harassment by armed personnel, and sexual abuse. There was high concurrence between expert and teacher, and expert and parent assessments, and a 10 per cent co-morbidity of other psychiatric disturbances, specifically anxiety and attention-deficit disorders. Consequences of PTSD for the children in this study included more somatic symptoms, high suicidality, impaired school performance, and impairment of memory for place.

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[27] Teachers are trained in diagnosis of Post-traumatic Stress Disorder (PTSD) using the Child Version of the UCLA PTSD index for DSM-IV. Parents' ratings are obtained using the Parent Version of the UCLA PTSD Index for DSM-IV). Instruments used in the project also include the Composite International Diagnostic Interview PTSD-Section), M.I.N.I. Kid version (Mini International Neuropsychiatric Interview for Children and Adolescents, Sheehan 2002), Rey-Osterrieth Complex Figure Test, and Memory for Places Test.

Onyut also described a second epidemiological study in Sri Lanka in January 2005, in which 71 children aged 7 to 15 in two camps in the most tsunami-affected Tamil areas (Manadkadu and Point Pedro) were interviewed by teachers using the same UCLA instruments. This survey showed a 43 per cent prevalence of PTSD three weeks after the tsunami. Predictors of PTSD include war experiences, domestic violence, and the severity of the tsunami itself, with a cumulative effect, as demonstrated in other studies.

Most relevant to culturally-appropriate distress relief practices, Onyut described the successful use of the Cascade Model in which over 120 master counselors are overseeing many more counselors in Tamil schools, as well as 1000 "befrienders" in all Tamil districts. The counselors provide Narrative Exposure Therapy that has been shown to be effective for children using techniques such as drawing lifelines and other representations, acting, and body awareness. Training of counselors includes basic concepts, literacy, supervised group work, diagnostic interviewing, and fieldwork, thereby producing a workforce of autonomous local therapists capable of working with minimal supervision. Emergency psychology care also includes crisis management and trauma coaching.

Jack Saul, PhD, Director of the International Trauma Studies Program, New York, spoke on *Facilitating Community Resilience following War and Terrorism*. Saul described his 10 years of work with torture survivors in various refugee communities, including those from Liberia and Chile. Saul described the Metro Area Support for Survivors of Torture (MASST) which consists of the Solace and Safe Horizon Program for Survivors of Torture and Refugee Trauma, the Cross Cultural Counseling Center/International Institute of New Jersey, the Human Rights Clinic/Doctors of the World, and the International Trauma Studies Program.[28] Saul defined resilience for Workshop participants as "the capacity to rebound from adversity, strengthened and more resourceful. It is an active process of endurance, self-righting, and growth in response to crisis and challenge."

The principles of the community-resilience approach include the process of invitation; attaining authority, permission, and commitment from the community; the engagement of the entire community, including representation of individuals and subsystems from each cultural and ethnic group, all economic, cultural, and status strata, as well as the natural support and ancillary or helping system; identification of scripts, themes, and patterns across generations and community history; helping the community to map out its resources to address the challenge they face as a community; turning goals into realistic tasks, and those tasks into practical projects; encouraging community links (natural "change agents") to become leaders in their community; and, finally, attributing success to the community. In this approach to community mental health, the focus is on strengths, resources, and survivorship in the social environment and the need to avoid stigmatization. Communities are understood to harbour a spectrum of opportunities for healing, and people in the community are the greatest resources in the healing process. The role of the care provider is to offer structure and support, to promote positive connections and social process, to build new connections between constituencies, and to recognize and enhance existing resources for recovery. According to Saul, community-resilience themes after massive trauma include building community and enhancing social connectedness as a foundation for recovery, collectively telling the story of the community's experience and response, reestablishing the rhythms and routines of life, engaging in

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[28] More information on these programs can be accessed at www.itspnyc.org and www.communityresilience.org/nyc.

collective healing rituals, and arriving at a positive vision of the future with renewed hope. Saul described his work with Liberian refugee community in Staten Island, New York, as an example.

Raymond Chung, Executive Director of Hong Fook Mental Health Association, Toronto, presented the Association's model of culturally-appropriate care. Hong Fook is a community-based, mental-health organization which advocates "equal access" to achieve "mental health for all." Hong Fook has a notable history offering culturally-appropriate mental-health services in Toronto. The Association began in the early 1980s as an agency to help refugees and immigrants from war-torn Vietnam, and later Cambodia. It adopted a Consultation Liaison Model by training bilingual/bi-cultural mental-health workers to work with mainstream treatment facilities. Workshops on culturally competent practices were also offered to service providers, and public education series were organized in the communities as well. Today, Hong Fook has 47 staff members working with newcomers from Cambodia, China, Hong Kong, Korea, Taiwan, and Vietnam. The guiding principles focus on empowerment, self help, mutual support and capacity building. The service approach has evolved into a *continuum of services* covering consultation/liaison, intensive case management support to those living with serious mental illness, head-lease supportive housing with case management, consumers self help initiatives, family members mutual support groups, prevention and promotion strategies and volunteer development.

Chung outlined several principles and assumptions used in working with distressed individuals and communities: migration is understood to be a stressful experience; migration and mental health are linked in the framework of social determinants of health; stigma attached to mental illness is a barrier to be overcome before any form of treatment or supportive strategies can be effective; and each individual and each diaspora or ethnoracial community is unique, yet continually changing. Service providers, Chung stated, have to "walk alongside the individuals and grow with the communities" to discover the strengths within each. Furthermore, he noted both that prevention is better than treatment and that there are many alternative treatments to consider.

Hong Fook believes in the rich resources of the community. In 2001, an integrative 'research into practice' project was developed to explore the mental health status of refugee/immigrant women from six Asian communities, which developed the 'Peer to Peer' model and trained over 250 Peer Leaders to act as Mental-Health Ambassadors in their own communities as a support to their peers and other newcomers. Through this evidence-based program development, Hong Fook learned that each community has its own healing forms and strategies. Many in these communities, it was recognized, would not be open to conventional forms of 'medical' treatment for mental distress due to the stigma associated with it. The study also found that engaging indigenous leaders in the community can be more effective than many other approaches.

IMPLICATIONS FOR CANADIAN HEALTH RESEARCH, POLICY, AND SERVICE DELIVERY

Dr. Clare Pain, Mount Sinai Hospital, Toronto, was asked to summarize the key themes from the foregoing workshop presentations. Her observations pointed to a model of culturally-appropriate distress relief that emphasizes the quality of relationships, specifically respectful, collaborative relationships,

among health-care practitioners, service providers, policy makers, and communities. She recognized, however, that education and training for emergency preparedness has to start at the top, even with a growing focus on community-level interventions. Pain observed that the most effective distress relief depends upon pre-existing relationships and knowledge. All too often, a disaster or crisis occurs, chaos ensues, and the question only then arises, what interventions are appropriate? She noted that the wish to help confers strength, but also does possible harm. To avoid doing harm, it is important not to rush in to the situation, but to *listen* to requests first, then identify needs. She acknowledged that there are known vulnerable groups: children, elderly, and psychiatric patients in particular. Most people caught in crisis, however, are ordinary people, not patients (though some may not be able to function well for some time following a crisis).

Pain also suggested that a theme of the morning presentations was the notion of the collective experience of distress, which is not necessarily caused by a single traumatic "event," but rather ongoing and extraordinary disruptions to normal life. Therefore, a reorientation in thinking is needed: going beyond the contemporary focus on PTSD, an individual disorder, to an analysis of collective trauma and ways to promote community healing. This new orientation might be thought of as a "bio-psychosocial-cultural orientation." Pain cautioned that in adopting a broader approach to mental health in emergency situations, we must not ignore those who do suffer from disorders such as PTSD, and who cannot ask for help. In her closing comments, she remarked on our abilities to empathize and understand in a larger social context. Although we cannot really know others' experiences of mental distress, we can share them to some extent, for example, through the arts. With respect to conveying and shaping shared experiences, the mass media also have a significant role to play, but they should report, not create, problems.

Perspectives from the Front Lines in Toronto: Workshop Participants' Experiences

In the ensuing discussion by workshop participants, several specific challenges of providing distress relief were highlighted. Most service providers, who had first hand experience dealing with the tsunami-affected Tamil population in Toronto, observed that the tsunami disaster had brought to the surface many long-standing problems and stresses associated with migration and settlement in Canada that had accumulated through the years. A few noted that disaster-aid efforts also brought out feelings of anger and disappointment because of the inadequacies of the political response and the seeming inability of the Canadian government to follow through on promises made to deliver aid to affected areas. Another source of frustration was misinformation about the government's intentions to fast-track affected family members through the immigration process. More positively, service providers noted that the community-based supportive programs that they were able to offer, particularly those in group settings that offered time and space for sharing emotional responses among clients and community members, appeared to be effective in alleviating mental distress for many people.

At an organizational level, workshop participants noted that the tsunami disaster response revealed a number of problems, such as jurisdictional barriers; the need for prior networking among agencies, professionals, and community workers; and the lack of response from mainstream institutions where mental-health services are normally delivered. As well, they observed that many institutions were unprepared to deal with disaster response and uncertain about how to proceed to deal with intercultural

communication. For example, in Toronto's schools, which were central gathering points for disaster-affected families and communities, people generally were not found to be receptive to available counseling literature about ways of dealing with psychosocial trauma. Furthermore, the political "hype" surrounding the tsunami disaster relief that motivated some institutional and government responses created skepticism in the end, because in immediately planning for "worst case" scenarios, some institutions and agencies requested or allocated resources for needs that did not materialize. Raising expectations thus hurt community members and may inhibit effective institutional responses in the future.

Workshop participants noted that we might not expect to share culturally-influenced, affective experiences of disaster as easily as we can share objective knowledge. Moreover, because the effects of a disaster, such as trauma and grief, may be long-lasting, mental-health-care providers and institutions should support community organizations and community mental-health-care workers and provide health promotion on an ongoing basis. In sum, participants reiterated the importance of working with community organizations, securing commitments from mainstream institutions, and recognizing that linkages among families and the homeland may remain strong.

JOINT RECOMMENDATIONS FOR CULTURALLY-COMPETENT DISTRESS RELIEF

Workshop participants developed recommendations for the provision of culturally-appropriate policy, service provision, and research on aspects of distress relief through initial small group discussion. This was followed by reports to and subsequent input from, the full group of workshop participants. The resulting recommendations were analyzed and summarized according to ten key principles and are presented below. The first eight principles were identified in the article authored by Van Ommeren, Saxena and Saraceno appearing in the *Bulletin of the World Health Organization* (January 2005), "Mental and Social Health During and After Acute Emergencies: Emerging Consensus?" These principles are as follows: 1) contingency planning, 2) assessment, 3) long-term perspective, 4) collaboration, 5) integration into primary health care, 6) access to service for all, 7) thorough training and supervision, and 8) monitoring indicators. Workshop organizers suggested adding two additional principles - 9) relations with other cultural communities and larger society, and 10) transnational ties - to better acknowledge the unique experience of diaspora communities. A brief statement about the principles under discussion, paraphrased from the article cited, precedes the list of specific recommendations offered by workshop participants below. Specific recommendations by workshop participants have been grouped into several categories and included:

Contingency Planning and Assessment

Before an emergency, national-level *contingency planning* should include establishing the infrastructure for interagency coordination, designing mental-health response plans, and training general health-care personnel in basic mental-health care and psychological first aid. *Assessment* should cover the sociocultural context (setting, culture, history, perceptions of illness, ways of coping), available services, resources, and needs. More specific recommendations included:

- Identify different, relevant agencies and their scope of practice in advance in order to increase communication and facilitate linkages among them. This will permit more efficient and rapid response during a disaster.
- Increase interaction between agencies and the various levels of government (federal, provincial, and municipal). There is a particular need for both horizontal and vertical information flow and collaboration in order to avoid jurisdictional conflicts.
- Determine who does what, and use this information to determine respective areas of responsibility during disaster response. Partner organizations may or may not have a specific mandate with regards to disaster relief; what is critical is the sharing of information and pooling of resources among them.
- Develop clear lines of communication flow so that everyone is informed regarding relevant planning, expertise, resources, and initiatives.
- Consult with and learn from the experiences of other initiatives, organizations, and communities.
- Ensure increased cultural and linguistic sensitivity and competence around planning and assessment by involving community partners. This will be helpful in identifying and working with various sub-groups (including political interest groups) within existing ethnocultural communities, as well as in fostering learning from possible past experiences in dealing with trauma and disasters.
- Focus on the needs identified by the community itself when developing a contingency plan, as well as on what is realistically feasible in the current environment.
- Undertake all distress-relief initiatives in true partnership with community leaders. To be most effective, such partnerships should also include representatives from various organizations currently serving the community.
- Ensure that focus of action remains with the community. Tasks need to be focused around empowering the communities and building their capacity to deal with disasters.
- Ensure ongoing review of contingency planning.
- Assessments of individuals should be made in terms of disability and their ability or inability to perform daily functions.
- Assessments should also include consideration of the health-seeking behaviors of various communities, and the impact of these variances in the type of service delivery.

Long-Term Perspective and Collaboration

Affected populations are helped most by a focus on the *medium- and long-term development of mental-health services*, although the needs are highest during or immediately after acute emergencies. Strong *collaboration* among agencies avoids waste and duplication. Continuous involvement of government, universities and community agencies is essential for sustainability. More specifically, Workshop participants agreed that it was necessary to:

- Ensure that the solutions that are developed are both long-term and sustainable.

- Ensure that the services that are developed are built directly into existing structures in order to address the problem of sustainability, increase the efficiency of the services, and better utilize existing resources.
- Always keep in mind that trauma can trigger serious mental illnesses, particularly in vulnerable populations.
- Ensure that these services directly respond to existing and/or anticipated needs (for example, post-traumatic stress, alcohol abuse).
- Ensure that policies and legislation (such as legislation d policies pertaining to refugees) are responsive to community needs, particularly during acute emergencies.
- Be aware of the 'social disconnectedness' often experienced by communities and their members, and seek to counter this during times of need.
- Engage in both community capacity-building and institutional capacity-building (that is, in hospitals, centres, institutions, governments) Facilitate greater collaboration among mental-health organizations in this area, under the umbrella of 'public health.'
- Ensure true collaboration among service providers, health professionals, policy makers, community members, and researchers. These partnerships should be meaningful and provide benefits to all; they should not exist for the purpose of convenience.
- Keep in mind that collaboration is important for building and strengthening existing social capital, but that some communities may be hesitant to collaborate due to past experiences. Elicit the support of other communities in order to reach out to these communities.
- Collaborate with the affected community or communities in order to assess their needs, as well as their readiness for seeking help or assistance through existing services. Community collaboration can occur through community forums, strategic networks and linkages, and information-exchange forums.
- Keep in mind that there are different types of partnerships (research, service provision, policy development) at different levels (local, intergovernmental, international). Each has an important role to play.
- Ensure that there is clarity with regards to respective roles and responsibilities. Also outline respective expectations and contributions.
- Always ensure that there are individuals specifically charged with the responsibility of coordinating collaborations.

Integration into Primary Healthcare and Access to Service for All

To ensure access to non-stigmatizing services for the largest number of people, mental-health services should be made available within the *primary health-care* sector. Setting up separate, vertical mental-health-care services is discouraged. At the same time, *outreach* is crucial to ensure treatment of *vulnerable* groups within general health and social services. More specifically, participants suggested the need to:

- Shift away from the compartmentalized provision of care to a more decentralized process that would see mental-health care integrated into primary health-care service delivery. The

more compartmentalized health-care providers are, the less able they are to serve efficiently. This has important implications for existing funding criteria.

- Move distress-relief services from a 'general practitioner'-centred model to a multidisciplinary model involving multiple sectors (for example, schools, drop-in centers).
- Find ways to strengthen existing systems and organizations that provide distress relief (such as the Settlement Workers in the Schools program supported by Citizenship and Immigration Canada) in order to both increase efficiency and better facilitate the decentralization process.
- Provide training and practice for health professions (primary care and mental health) and other service providers around gender and cultural sensitivity. This is critical to the planning of more effective responses to the needs of an increasingly diverse multicultural society.
- Increase the cultural competency of organizations and institutions to better respond to the multicultural needs of our communities.
- Facilitate acceptance and incorporation of community-identified and community-directed traditional healing approaches. This would require a significant change in policy surrounding the recognition of credentials, particularly to permit the recognition of traditional healers.
- Focus services on a health promotion/prevention of illness perspective rather than placing the emphasis on a treatment/reactive approach.
- Utilize a community-based approach when addressing mental-health issues related to acute emergencies. This approach would be able to reach the larger population and address the collective trauma at the social level rather than only at an individual level.
- Provide communities with culturally-appropriate avenues for dealing with the trauma or disaster. Examples include the dissemination of pamphlets by the Local Distress Relief Network during the Tsunami Vigil held in Toronto, and the delivery of personal letters written by Toronto women to affected women in devastated parts of Sri Lanka.

Training, Supervision, and Monitoring

Training and supervision should be carried out by mental-health specialists, or under their guidance, for a substantial period of time in order to ensure lasting effects of both training and care. *Monitoring* indicators should be determined before starting activities, and should include resources (including available and pre-existing), processes and outcomes. Workshop participants recommended the need to:

- Base all programmatic and training initiatives on prior community needs assessments.
- Identify both immediate needs and long-term needs before you start to train. Incorporate the immediate and long-term needs of communities directly into the training materials.
- Ensure that there is a collective decision-making body of experts and key stakeholders to develop guidelines and procedures in the area of training and supervision.
- Involve organizations both within and outside of the relevant community or communities.

- Identify and compile a list of existing strengths and resources within the relevant communities themselves in order to utilize existing expertise.
- Provide training to researchers, policy makers, and service providers in professional cultural competency. The former includes the latter.
- Provide training to community members to create a greater awareness of the mental-health impacts of acute emergencies, as well as of effective coping strategies.
- Use a cascade model of training, wherein key leaders are trained and then train others.
- Ensure 'core readiness' by compiling, in advance, a list of relevant specialists and experts.
- Develop and maintain effective communication mechanisms that help to facilitate information flow and collaboration.
- Evaluate participation of all key stakeholders according to the group model.
- Develop indicators of training success.
- Develop measures to determine programmatic success.

Relationships with the Larger Society, Other Cultural Communities, and Transnational Ties

These additional topics were discussed in recognition of special situation of diaspora communities.

- Work toward better partnerships and collaboration to reduce competition for resources among cultural communities.
- Keep in mind that various forms of mass media can be helpful in communicating and connecting various communities. Caution, however, needs to be employed to ensure that representations are accurate and that the communities' best interests remain paramount.
- Encourage greater awareness of the fact that some newcomers are vulnerable due to prior trauma experience. This is often the case with refugees; however, may immigrants share similar migration and settlement experiences.
- While increasing involvement of foreign-trained health professionals in culturally-competent health-service delivery might be a solution, keep in mind that these professionals are migrating from countries where there is also a great need for their services.
- Recognize that attitudes about the homeland can differ among the members of a given community and may depend on many factors, including length of stay and sense of belonging in the new society (Canada).
- Pursue and support effective collaboration with institutions in the homeland, as many communities are linked to their counterparts. For example, culturally-competent program manuals regarding disaster and/or distress relief or alternative therapies developed in the homeland may provide very helpful insights in Canada.

In conclusion, workshop participants offered the following recommendations as part of emerging strategic research priorities:

- Ensure that the given community is directly and meaningfully involved in any research, service, and policy-making initiatives that concern them.

- Increase cultural competence in research (for example, develop culturally-appropriate assessment tools).
- Undertake social-intervention research in the area of cultural competence and mental health.
- Conduct more evaluation-based research of relevant initiatives.
- Ensure that research initiatives are responsive to community needs. Specific topics identified include, in particular, the cultural competency of professionals, process mechanisms related to service provision to ethno-cultural communities, and family violence within refugee communities.
- Provide appropriate funding streams to support academic/community partnerships. Develop and disseminate effective policies and guidelines regarding academic/community partnerships, outlining the respective roles, rights, and responsibilities.
- Ground any research conducted in this area on the principle of community development.
- Undertake more research into specific issues within both local diaspora communities and within homeland communities to provide comparative data; for example, research on mental illnesses such as PTSD in Canada and the country of origin (for example, Sri Lanka) may be useful.
- Ensure that research findings are translated into concrete products and services that can be used to address existing community needs.
- Reconsider limited definitions of "mental health" and immigration and settlement, which are not comprehensive enough to encompass the full range of experiences of various communities. This has implications for service provision and funding formulas.

CONCLUSION AND KEY MESSAGES

In summary, to best provide mental-health care in public-health policy and practice, ensuring culturally-appropriate distress relief to diaspora communities in acute and post-emergency situations:

- Involve broad, representative community leadership in planning and implementation;

- Engage wide support from government and mainstream institutions;

- Sustain working relationships with communities;

- Rely on existing cultural expertise; and

- Use evidence-based practices

APPENDIX A: WORKSHOP SPEAKERS AND PARTICIPANTS

Guest Speakers

- Jose Bertolote, Director, Department of Mental Health and Substance Abuse, World Health Organization, Geneva
- Raymond Chung, Executive Director, Hong Fook Mental Health Association, Toronto
- Patience Lamaro Onyut, PhD, Victim's Voice (VIVO) and Universitat Konstanz, Germany
- Clare Pain, Psychiatrist and Clinical Director, Psychological Trauma Assessment Clinic, Mount Sinai Hospital; Assistant Professor, Department of Psychiatry, University of Toronto
- Jack Saul, International Trauma Center, New York University, New York
- Daya Somasundaram, Professor, Department of Psychiatry, University of Jaffna, Sri Lanka

Workshop Participants

- Branka Agic, Offices of International Health and Diversity Programs, Centre for Addiction and Mental Health, Toronto
- Lisa Andermann, Assistant Professor, Department of Psychiatry, University of Toronto; Psychiatrist, Mount Sinai Hospital, Toronto
- Morton Beiser, FRCPC, Professor, Department of Psychiatry, University of Toronto; Senior Scientist, Centre of Excellence for Research on Immigration and Settlement, Toronto
- Joseph Chandrakanthan, Associate Professor and Consultant in Clinical Ethics, Centre for Clinical Ethics and University of Toronto Joint Centre for Bioethics
- Sudha Coomaraswamy, Community Development, St. Joseph's Health Centre, Toronto
- Peter Dorfman, Provincial Coordinator, Settlement Workers in Schools, Citizenship and Immigration Canada
- Kenneth Fung, Director, Asian Health Initiative, Toronto Western Hospital
- Dave Hutton, Centre for Emergency Preparedness and Response, Public Health Agency of Canada
- David Jeyasingh, Tamil Project Manager, Providence Health Care Centre, Toronto
- Pushpa Kanagaratnam, PhD, Counselor, Violence Against Women Programme, Family Service Association, Toronto
- Ted Lo, Psychiatrist, Culture, Community and Health Studies, Department of Psychiatry, University of Toronto; General Psychiatry Program, Centre for Addiction and Mental Health
- Martha Ocampo, Executive Director, Across Boundaries Ethnoracial Community Mental Health Centre, Toronto
- Nalini Pandalangat, Program Coordinator, Community Support Research Unit, Centre for Addiction and Mental Health, Toronto
- Dr. Rasiah Paramsothy, Psychiatrist, Toronto
- Cristella Pathmanathan, Canadian Mental Health Association, Toronto
- Jothi Ramesh, Counselor, Sherbourne Health Centre, Toronto
- Arun Ravindran, Clinical Director, Mood and Anxiety Program, Centre for Addiction and Mental Health
- Lakshmi Ravindran, Resident, Department of Psychiatry, University of Toronto
- Joanna Anneke Rummens, Assistant Professor, Culture, Community and Health Studies, Department of Psychiatry, University of Toronto; Health Systems Research Scientist, Community Health Systems Resource Group, Hospital for Sick Children, Toronto
- Laura Simich, Assistant Professor, Department of Psychiatry, University of Toronto; Scientist, Culture Community and Health Studies Program, Centre for Addiction and Mental Health
- Abimanyu Singam, Research Coordinator, Tamil Mental Health Study, University of Toronto
- Barbara Switzer, Coordinator, Community Crisis Support, Toronto Public Health

APPENDIX B – WORKSHOP AGENDA

Mental Health in Public-Health Policy and Practice: Providing Culturally-Appropriate Services in Acute and Post-Emergency Situations 26 May 2005

Overall Objectives

1. To achieve consensus on key research questions and policy issues
2. To make recommendations for strategic research initiatives
3. To produce guidelines/recommendations for clinical/community mental-health services

Process

- Background reading materials sent to participants in advance
- Brief orienting/informational presentations followed by reflective comments with opportunities for open discussion and participant interaction
- Afternoon working groups, group discussion, and joint syntheses
- Final group discussion to reach consensus on recommendations and guidelines
- Write-up to circulate to participants for comments after workshop
- Compilation into report format for dissemination and translation

Workshop Schedule

I – Morning: Orientation, Information Exchange, and Reflection

8:30-9:00 Arrival and light breakfast
9:00-9:15 Welcome; Review of day's objectives (project team)
9:15-9:45 Participant introductions – name, organization, relevant experience/interest

9:45-10:15 Local Context and Responses

Tamil Mental Health Project - Dr. Laura Simich
Scientist, Culture, Community and Health Studies, Centre for Addiction and Mental Health; Assistant Professor, Psychiatry, University of Toronto

Local Distress Relief Network - Dr. Joanna Anneke Rummens
Health Systems Research Scientist, Community Health Systems Resource Group, Hospital for Sick Children, Toronto; Assistant Professor, Culture, Community and Health Studies, Department of Psychiatry, University of Toronto

Tamil Emergency Medical Services – Thammi Ramanan
Masters Candidate, Department of Public Health Sciences, University of Toronto

10:15-10:45 Service Providers' Perspectives (open discussion)

10:45-11:00 Break

11:00-12:30 Models and Lessons: From International to Local Levels

Brief presentations, with opportunities for participant questions and comments

- Dr. José Bertolote, Coordinator, Management of Mental and Brain Disorders, Department of Mental Health and Substance Dependence, World Health Organization, Geneva, Switzerland
- Dr. Daya Somasundarum, Professor of Psychiatry, University of Jaffna, Sri Lanka
- Dr. Lamaro Patience Onyut, Vivo Mbarara, Uganda, and Cupramontana, Italy, Mbarara University of Science and Technology and University of Konstanz, Germany
- Dr. Jack Saul, Director, International Trauma Studies Program, New York University, New York
- Mr. Raymond Chung, Hong Fook Mental Health Association, Toronto

Reflective Summary - Implications

- Dr. Clare Pain MD, MSc., FRCPC, Staff Psychiatrist and Clinical Director, Psychological Trauma Assessment Clinic, Mount Sinai Hospital; Assistant Professor, Psychiatry, University of Toronto

12:30-1:30 Lunch

II – Afternoon: Development of Research, Policy and Service Delivery Recommendations

Focus: Provision of culturally-appropriate distress relief to diaspora communities in acute and post-emergency situations

Specific Tasks:

- To jointly identify key 1) research, 2) policy, and 3) service issues; includes identification of respective challenges and examples of successful culturally-appropriate practices;
- To develop concrete recommendations using the 10 principles regarding mental-health service provision in disaster situations distilled from workshop background readings.

1:30-2:15 Small Discussion Groups
Breakout into five groups, each taking responsibility for two principles; recording of key research, policy, and service issues/challenges and recommendations

2:15- 3:00 Reports, Participant Input and Joint Synthesis
Recorder's reports to the entire group, with opportunity for further input from other workshop participants

3:00-3:15 Task Oriented Discussion re: Meeting of Workshop Objectives
Development of consensus on guidelines/recommendations and best ways to disseminate the workshop proceedings

3:15-3:30 Closing Remarks

CERIS

The Joint Centre of Excellence for Research on Immigration and Settlement - Toronto (CERIS) is one of five Canadian Metropolis centres dedicated to ensuring that scientific expertise contributes to the improvement of migration and diversity policy.

CERIS is a collaboration of Ryerson University, York University, and the University of Toronto, as well as the Ontario Council of Agencies Serving Immigrants, the United Way of Greater Toronto, and the Community Social Planning Council of Toronto.

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Status of Women Canada
Statistics Canada
Human Resources and Skills Development Canada
Atlantic Canada Opportunities Agency
Royal Canadian Mounted Police
Public Safety and Emergency Preparedness Canada
Department of Justice Canada
Public Service Human Resources Management Agency of Canada

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http://ceris.metropolis.net

The Metropolis Project

Launched in 1996, the Metropolis Project strives to improve policies for managing migration and diversity by focusing scholarly attention on critical issues. All project initiatives involve policymakers, researchers, and members of non-governmental organizations.

Metropolis Project goals are to:

- Enhance academic research capacity;
- Focus academic research on critical policy issues and policy options;
- Develop ways to facilitate the use of research in decision-making.

The Canadian and international components of the Metropolis Project encourage and facilitate communication between interested stakeholders at the annual national and international conferences and at topical workshops, seminars, and roundtables organized by project members.

For more information about the Metropolis Project
visit the Metropolis web sites at:
http://canada.metropolis.net
http://international.metropolis.net