

WOMEN AND POST TRAUMATIC STRESS DISORDER: MOVING RESEARCH TO POLICY

**A Report Conducted under the Auspices of Immigrant,
Refugee, and Visible Minority Women of Saskatchewan,
Provincial**



Project #61

The Prairie Women's Health Centre of Excellence

56 The Promenade
Winnipeg, Manitoba R3B 3H9
Phone: (204) 982-6630
Fax: (204) 982-6637
E-mail: pwhce@uwinnipeg.ca
Website: www.pwhce.ca

PWHCE Regina Site

CB 109, College Building
University of Regina Extension
College & Scarth
Regina, Saskatchewan S4S 0A2
Phone: (306) 585-5727
Fax: (306) 585-5852
e-mail: pwhce@uregina.ca

PWHCE Saskatoon Site

University of Saskatchewan
107 Wiggins Road
Saskatoon, Saskatchewan S7N 5E5
Phone: (306) 966-8658
Fax: (306) 966-7920
e-mail: pwhce@usask.ca

Francisca Isi Omorodion

President
Immigrant Refugee and Visible Minority
Women of Saskatchewan
2248 Lorne Street
Regina, Saskatchewan S4P 2M7
Phone: (306) 359-6523
Fax: (306) 522-9959
e-mail: irvm@accesscomm.ca
Website: www.irvm.org

Professor Judy White

Faculty of Social Work
University of Regina
1121 College Drive
Saskatoon, Saskatchewan
S7N 0W3
Phone: (306) 664-7375
e-mail: judy.white@uregina.ca

This report was funded by the Prairie Women's Health Centre of Excellence (PWHCE). The PWHCE is financially supported by the Centres of Excellence for Women's Health Program, Women's Health Bureau, Health Canada. The views expressed herein do not necessarily represent the views of the PWHCE or the official policy of Health Canada.

This document may be reproduced in whole or in part without permission, however please cite the authors and PWHCE when using information from this document.

This is Project #61 of the Prairie Women's Health Centre of Excellence.

WOMEN AND POST TRAUMATIC STRESS DISORDER: MOVING RESEARCH TO POLICY

Francisca Isi Omorodion
and
Judy White

Participatory Action Team

Francisca Isi Omorodion, President
Immigrant, Refugee, and Visible Minority Women of Saskatchewan

Judy White
Immigrant Women of Saskatchewan, Saskatoon Chapter;
Faculty of Social Work, University of Regina

Tara Maharaj, Vice President
Immigrant, Refugee, and Visible Minority Women of Saskatchewan

Erica Cancino, Project Officer III
Immigrant, Refugee, and Visible Minority Women of Saskatchewan

Rosetta Khalideen, President
Immigrant Women of Saskatchewan, Regina Chapter

Daljit Mall, Vice President
Immigrant Women of Saskatchewan, Moose Jaw Chapter

Contributing Organizations

Immigrant Women of Saskatchewan Saskatoon Chapter,
Multicultural Council of Saskatchewan (Moose Jaw, Regina, Saskatoon, and
Yorkton),
Nigerian Cultural Association,
Open Door Society,
Registered Psychiatric Nurses Association of Saskatchewan,
Saskatchewan Action Committee on the Status of Women,
Saskatchewan Human Rights Commission,
Saskatchewan Intercultural Association,
Saskatoon District Health-Adult Community Services,
STOPS (Saskatchewan Toward Offering Partnership Solutions) to Violence,
Yorkton Regional Health Centre,
YWCA Saskatoon.

TABLE OF CONTENTS

ABSTRACT	i
ACKNOWLEDGEMENTS	ii
EXECUTIVE SUMMARY	iii
INTRODUCTION	1
1.1 Objectives	2
1.2 Research Questions	2
1.3 Research Methods	3
2.0 LITERATURE REVIEW	4
2.1 Health Service Utilization	4
2.2 Conceptualizing Quality of Care	5
3.0 FINDINGS	7
3.1 Empowering Clients	7
3.2 Violence and Family Breakdown	8
3.3 Building Awareness	9
3.4 Normalizing Traumatic Response	9
3.5 Health Provider-Client Relationships	10
3.6 Attitudes Toward the Use of Medication	12
3.7 Language Barriers in Health Care	13
3.8 Labour Force Participation and Health Status	14
3.9 Training Front-Line Workers	16
4.0 COMMUNICATION METHODS	17
5.0 POLICY ISSUES AND ACTIONS	20
1. Multidisciplinary Coordinating Team	20
2. Improved Public Understanding	21
3. Curriculum for ESL and Other Students	22
4. Training for Service Providers	22
5. Service Delivery	24
6. Physician Care	26
7. Recognition of Foreign Credentials	27
8. ESL Training	28
9. Violence and Family Breakdown	29
SUMMARY OF IRVMWS ACTIONS	31
SUMMARY OF RECOMMENDATIONS TO GOVERNMENT AND OTHER AGENCIES	33
REFERENCES	36

ABSTRACT

The Prairie Women's Health Centre of Excellence funded a previous project on *Post Traumatic Stress Disorder: The Lived Experiences of Immigrant, Refugee, and Visible Minority Women of Saskatchewan* that promulgated a number of recommendations on improving the mental health of immigrant, refugee, and racialized women in Saskatchewan (Immigrant, Refugee, Visible Minority, Women in Saskatchewan, 2000). The present study, *Women and Post Traumatic Stress Disorder: Moving Research to Policy*, focuses on working with immigrant, refugee, and racialized women of Saskatchewan, health providers, and policy-makers to explore policies that would contribute to alleviating the obstacles to accessing health services. More specifically, the study addresses the following objectives:

- To endorse or establish (whichever is suitable) a policy position/statement based on the recommendations of the initial PTSD research;
- To develop a strategy for disseminating and communicating the policy recommendations;
- To gather information and make recommendations for the development of communication materials (e.g. brochures) that expand the reach of research findings; and
- To foster development of networks among decision-makers, service providers and PTSD survivors within communities in order to enhance the consultative model for health care delivery.

The long-term goal of the study is to improve the well being of survivors of PTSD. Based on focus group discussions, the study recommends policies for improving people's knowledge and awareness of PTSD, and for eliminating barriers hindering accessibility to health care services, particularly for PTSD survivors.

ACKNOWLEDGEMENTS

Immigrant, Refugee, and Visible Minority Women of Saskatchewan Inc. and the principal investigators, Francisca Isi Omorodion and Judy White, would like to express our appreciation and gratitude to the staff of Prairie Women's Health Centre of Excellence, particularly Margaret Haworth-Brockman and Joanne Havelock, for the encouragement, financial support and editing of this report.

We would also like to express sincere appreciation to: Immigrant Refugee and Visible Minority Women of Saskatchewan - Provincial, and the Chapters of Immigrant Women of Saskatchewan who were involved in the first and second PTSD projects; the Multicultural Council of Moose Jaw; and, participants from other non-governmental organizations and private organizations for their willingness to participate in this project.

Finally, we would like to thank the staff for arranging the focus groups and for transcribing the tapes.

Francisca Isi Omorodion
Judy White

EXECUTIVE SUMMARY

Global tragedies continue to have devastating impact on the populace, particularly women and children. One of the consequences is that immigrant, refugee, and racialized women of Saskatchewan have experienced a number of traumatic events. Yet, women presenting symptoms of Post Traumatic Stress Disorder (PTSD) encounter mental health service providers with little or no experience working with immigrant, refugee and racialized clients. Many immigrant, refugee and racialized women fail to access the health care system for varying reasons, including language barriers and cultural differences between health providers and clients that create structural and systemic problems.

PURPOSE OF THE RESEARCH

The initial project “*PTSD: The Lived Experiences of Immigrant, Refugee, and Visible Minority Women in Saskatchewan*,” proposed a number of recommendations as ways of providing quality care to immigrant, refugee, and racialized women with PTSD symptoms. The ultimate objective of this current study, *Women and PTSD: Moving Research to Policy* was to develop policy statements and a communication strategy to improve and increase accessibility to services for immigrant, refugee, and racialized women in Saskatchewan who present symptoms of PTSD.

METHOD

Focus groups were held in Moose Jaw, Regina, Saskatoon, and Yorkton. A total of 36 individuals participated in these groups. The participants were representative of the sample of the PTSD study completed in 2000. The groups included representatives of health departments and multicultural organizations, health professionals and immigrant, refugee and racialized women.

ISSUES IDENTIFIED

Participants identified several key issues that impacted on the lives of immigrant, refugee and racialized women who were at risk of suffering, or who reported symptoms of PTSD. These included the need to improve accessibility and utilization of mental health services, the need to empower clients, the need to address the issue of the links between racism and mental health, the need to normalize traumatic responses, the need to enhance the relationship between health providers and service users. The study also identified a need to enhance awareness of use/misuse of medication (both on the part of medical profession, and on the part of users), and the issue of language as a barrier in health care.

CONCLUSIONS

The study described a number of policies and actions that will guide the work of Immigrant, Refugee and Visible Minority Women of Saskatchewan (IRVMWS) during the next several years. The following actions are those in which IRVMWS will play a lead role. IRVMWS is also committed to collaboration with other organizations to provide advice and guidance on developing proposals and effective mechanisms for carrying out the recommendations to governments and other agencies.

IRVMWS recognizes the importance of considering the influence of PTSD in counseling and support services for newcomers, and will ensure that its programs and services address the needs of women with PTSD. The organization will strive to ensure that all front line workers and volunteers participate in training to assist them with identifying and working with individuals with symptoms of PTSD.

IRVMWS will serve as a catalyst to set up a multidisciplinary coordinating team on PTSD, and will serve as interim chair while developing terms of reference.

IRVMWS will take the lead in promoting culturally specific policies and programs to recognize the importance of past traumatic experiences to the integration of immigrant, refugee and racialized women. This leadership will involve collaborating with other agencies that serve immigrant, refugee and racialized populations:

IRVMWS will work with ESL educators to integrate training and awareness of PTSD and trauma into all ESL curricula and programs. IRVMWS will do this through workshops and presentations to ESL educators.

IRVMWS will produce pamphlets in different languages to be accessed by immigrant, refugee and racialized women.

RECOMMENDATIONS TO GOVERNMENTS AND OTHER AGENCIES

The responsibility of ensuring full integration of immigrants, refugee, and racialized individuals and groups lies with all levels of governments — municipal, provincial and federal. The following are the recommendations for action by governments and other agencies for the policy issues identified through the research.

1. Multidisciplinary Coordinating Team

- 1.1 That governments and agencies participate in a Multidisciplinary Coordinating Team on PTSD.
- 1.2 That funding agencies and organizations include a statement of support for the Multidisciplinary Coordinating Team within their funding strategy.

- 1.3 That the Multidisciplinary Coordinating Team on PTSD will develop a broad-based media campaign to raise the awareness and knowledge of PTSD, following the suggestions found in this report.
- 1.4 That the Multidisciplinary Coordinating Team on PTSD develop a strategy to provide ongoing specialized training related to Post Traumatic Stress Disorder to a broad range of service providers, following the suggestions found in this report.

2. Improved Public Understanding

- 2.1 That Saskatchewan Health include a statement of commitment to informing the public about PTSD within their health promotion strategy.
- 2.2 That Saskatchewan Health collaborate with the Multidisciplinary Coordinating Team to enhance awareness of PTSD through information, education and communication.
- 2.3 That all levels of government enact and implement policies, programs and statutes that would specifically recognize PTSD as an important factor mitigating against the full integration of immigrant, refugee, and racialized women.

3. Curriculum for ESL and Other Students

- 3.1 That material on PTSD be developed and included in the ESL curriculum.
- 3.2 That the Saskatchewan Department of Learning collaborate with the Multidisciplinary Coordinating Team to develop curriculum material on PTSD for students in K-12 schools, public libraries, SIAST and universities.
- 3.3 That policies to collaborate with the Multidisciplinary Coordinating Team to develop curriculum focusing on PTSD be established and implemented by: the Saskatchewan Department of Learning; the University of Saskatchewan Colleges of Nursing and Medicine; the Faculties of Psychology at the University of Saskatchewan and the University of Regina; and, the Saskatchewan Institute of Applied Science and Technology Nursing Education Program.

4. Training for Service Providers

- 4.1 That training on how to deal effectively with the growing cultural diversity in Canadian society be provided to all health care professionals and other social services providers including police, immigration officers, resettlement officers, ESL instructors and educators.
- 4.2 In particular professionals and service providers should be made aware of the traumatic experiences of newcomers, immigrant, refugee, and racialized women. Professionals and service providers must receive appropriate training to enable them to appreciate the different manifestations of traumatic experiences in the day-to-day activities of survivors and their families.

- 4.3 Governments and service delivery organizations need to develop culturally and individually specific responses to clients presenting symptoms of trauma.

5. Service Delivery

- 5.1 That all levels of government make counseling newcomers an integral part of their resettlement programs, and attempts be made to identify PTSD in the process of counseling.
- 5.2 That Saskatchewan Health and other health authorities institute policies addressing more appropriate and accessible intake and service delivery for persons with PTSD.
- 5.3 That options be created for delivery of services related to PTSD, including mental health services, in locations other than in traditional or mainstream centers.
- 5.4 That government establish and fund women's health clinics within multi-purpose centres.
- 5.5 That health care providers and other first line workers, ESL instructors, resettlement officers, schools, immigration officers, police and other professionals collaborate in identifying the symptoms of PTSD, its effects and the likelihood of recurrence following similar traumatic situations.
- 5.6 Service provider organizations are encouraged to use resource material on PTSD in a variety of situations, including therapy groups, shelter programs, immigration programs and employment training programs.

6. Physician Care

- 6.1 That steps be taken to enhance physician billing methods so that they support the provision of good quality care and not quantitative health care.
- 6.2 That the Government of Saskatchewan provide additional incentives to physicians dealing with immigrant, refugee and racialized groups and other less privileged persons or groups as a way to encourage physicians to spend quality time with such clients.

7. Recognition of Foreign Credentials

- 7.1 That all levels of government recognize the foreign qualifications of immigrant, refugee and racialized individuals, and that this recognition occur as part of the resettlement process.
- 7.2 That governments and educational institutions continue to work towards the full implementation of Prior Learning Assessment, as quickly as possible.
- 7.3 That governments work towards improving the proportion and contribution of immigrant, refugee and racialized people to all departments, including the health sector.

7.4 That governments and health care organizations develop strategies for upgrading and training immigrant, refugee and racialized individuals who have worked for many years in health care.

8. ESL Training

8.1 That the costs of providing English as a Second Language (ESL) for newcomers be the responsibility of all levels of government.

8.2 That additional funds be allocated to second-language classes such as ESL.

8.3 That ESL training be provided to all Canadian residents (including immigrants, Canadian born individuals whose parents are immigrants, racialized groups and Aboriginal people) not only refugees, who lack the language skills necessary to become functional in the society.

8.4 That the ESL program become more flexible in terms of maximum hours of learning.

8.5 That all levels of government be encouraged to work with employers to provide tax rebates to motivate the introduction of language instruction in the workplace, including ESL or French language instruction.

9. Violence and Family Breakdown

9.1 That governments and agencies develop more culturally sensitive programs to support immigrant, refugee and racialized women and their families who are victims of family violence.

9.2 That the federal government examine its immigration policy and its implementation to ensure that there are mechanisms other than deportation for immigrant and refugee women whose sponsorship arrangements break down, and that this policy be well communicated to immigrant and refugee women.

9.3 That alternatives to deportation be established for immigrants and refugees charged or convicted with family violence.

9.4 That Citizenship and Immigration Canada and other levels of government establish follow-up mechanisms to ensure the protection of immigrant, refugee, and racialized women who are survivors of violence.

1.0 INTRODUCTION

Global tragedies continue to have devastating impact on the populace, particularly women and children. However governments, international agencies, and non-governmental organizations seem to focus on short-term solutions. These short-term solutions aim at providing immediate needs such as shelter, food, water, and residences in more stable societies through granting of refugee or other residency status. Often, victims of tragedies and traumatic experiences cope individually with the severe social, cultural and health consequences arising. The general assumption is that provision of shelter and “a better life” brings an end to any trauma or negative impact of such trauma. The failure to address the serious long-term health consequences of such traumatic experiences during the life span of individuals is a huge omission.

Immigrant, refugee, and racialized women of Saskatchewan have experienced a number of traumatic events. Yet, women presenting symptoms of Post Traumatic Stress Disorder (PTSD) encounter mental health service providers with little or no experience working with immigrant, refugee and racialized clients. Many of these same women fail to access the health care system for varying reasons, including language barriers and cultural differences between health providers and clients that create structural and systemic problems. The initial project *PTSD: The Lived Experiences of Immigrant, Refugee, and Visible Minority Women in Saskatchewan*¹, proposed a number of recommendations as ways of providing quality care to immigrant, refugee, and racialized women with PTSD symptoms. This current project, *Women and Post Traumatic Stress Disorder: Moving Research to Policy* focuses on building on these recommendations.

Based on the World Health Organization’s definition of health that encompasses a holistic approach to health care², we need to strategize to evolve ways and models by which immigrant, refugee, and racialized women will access appropriate quality health care. Achieving this goal should also be compatible with Government of Saskatchewan health policy that emphasizes both the health of individuals and their communities in the goals of the *Action Plan for Saskatchewan Health Care*.

¹ Immigrant, Refugee and Visible Minority Women of Saskatchewan (2002) “PTSD: The Lived Experiences of Immigrant, Refugee, and Visible Minority Women in Saskatchewan”. Prairie Women’s Health Centre of Excellence, Winnipeg & Regina.

² World Health Organization (2003),”About WHO”. Retrieved March 14, 2003, from: <http://www.who.int/about/en>

1.1 Objectives

The ultimate objective of this project, *PTSD: Moving Research to Policy*, was to develop policy statements and a communication strategy to improve and increase accessibility to services for immigrant, refugee, and racialized women in Saskatchewan who present symptoms of PTSD. More specifically, the following are the project objectives.

1. To conduct focus group discussions to endorse or establish (whichever is suitable) a policy position/statement, building on the recommendations of the research in *PTSD: The Lived Experiences of Immigrant, Refugee, and Visible Minority Women in Saskatchewan*.
2. To develop a strategy for disseminating and communicating the policy recommendations.
3. To gather and make recommendations for the development of communication materials (e.g. brochures) that expand the reach of the research findings.
4. To foster development of networks among decision-makers, service providers, and PTSD sufferers within communities to enhance the consultative model for health care delivery.

The full achievement of all of these objectives will take time. Within the funding time frame of the project, a number of these objectives were addressed and are discussed in this report. Section 3 of this report contains a description of the methods and results of Objective 1, that is the focus group discussions and the recommendations coming out of those discussions. Steps towards meeting Objective 2, disseminating and communicating the policy recommendations, are found in the communications methods recommended in Section 4, and in the recommended actions in Section 5. Section 4 also contains recommendations to meet Objective 3, the development of communication materials that expand the reach of the research findings. The suggested communications methods, and the discussion of policy issues in Section 5 include actions that will provide the foundation for Objective 4, fostering the development of networks among decision-makers, service providers, and PTSD sufferers.

1.2 Research Questions

The following research questions framed the focus group discussions.

1. What policies and procedures may be recommended/developed for action by the different levels of the health care system/or outside to ensure that the needs of immigrant, refugee, racialized women who suffer from PTSD are better served?
2. What mechanisms are required (existing or to be established) to ensure that above policies are implemented/acted upon and who should be involved in this process?
3. What kind of resource materials need to be developed (type, content, language), to meet the learning needs of service providers and immigrant, refugee, and racialized women with respect to PTSD?
4. Who will develop the resource materials, with what resources and where or how the materials be disseminated?

1.3 Research Methods

The first step was to map out the logistics in conducting the focus group discussions. This involved identifying, liaising and obtaining confirmation of members of Immigrant, Refugee and Visible Minority Women of Saskatchewan who would be responsible to organize and facilitate the focus group sessions in Saskatoon, Regina, Moose Jaw, and Yorkton. Tentative dates for the focus group sessions were established. The project drew out a timeline including the identification of individuals responsible for facilitating/moderating the focus group sessions. The lead researcher for the earlier PTSD research, Judy White, was actively engaged in this current project on developing policy statements.

In each community, the Participatory Action Research team drew out a list of possible participants that included: health care organizations; health care providers (professionals such as physicians and psychiatric nurses, social workers); immigrant service organizations; policy makers and other members of the communities interested in women's health issues, particularly PTSD. We sent a letter of invitation confirming the dates, time and venues for the focus group sessions to the possible participants. The venues for the focus group sessions allowed privacy and concentration on issues discussed with little or no external variables influencing the discussions. Some participants in the initial project participated in the current project.

We held five focus group sessions in total, using a discussion guide to facilitate the discussions. The focus group discussion guide assisted the PAR team to generate data that provided a holistic approach to proposing policy and mechanisms for bringing about significant changes.

The focus group sessions had 8 participants on the average. The number of participants in each focus group was as follows: Regina (14) from two sessions, Saskatoon (6), Yorkton (6), and Moose Jaw (10). The participants were representative of the sample of the PTSD study completed in 2000. The groups included representatives of health departments and multicultural organizations, health professionals and immigrant, refugee and racialized women.

Prior to commencing the sessions, consent forms were given to participants and signed by them. In one of the sessions, we obtained verbal consent for ethical purposes. The facilitator or moderator of the focus group discussions informed all participants of their right to withdraw from the discussion at anytime, as participation was voluntary. Similarly, we sought and obtained the consent of participants to tape the discussions at the beginning of each session.

Each session lasted an average of two hours. The facilitators attempted to involve all participants by occasionally directing the inquiry to passive participants. This approach ensured that the discussions captured the opinion of all participants.

2.0 LITERATURE REVIEW

The initial project, *PTSD: The Lived Experiences of Immigrant, Refugee, and Visible Minority Women in Saskatchewan*, showed that immigrant, refugee and racialized women continued to live with the serious health consequences of past traumatic experiences. The women reported that they did not receive adequate health care from their perspective, but at the same time were under-utilizing health care services – pointing to a mismatch of needs and services. The initial project provided an overview of the literature on PTSD. This current project addresses two additional issues, health service utilization and quality of care.

2.1 Health Service Utilization

Williams (2001) reported that for over 30 years there have been comments about “the under-utilization of mental health services by racial minority patients”³. Williams further notes that minority people use other resources to address their needs, such as social support networks, spiritual and emotional counseling and other complementary approaches.

Jenkins et al., (1996) studied Vietnamese immigrants in America and found a positive relationship between under-utilization of preventive care and access to health care, influenced by class, race and gender.⁴ Research by Bates in Puerto Rico and New England showed the influence of cultural values, standards and beliefs on the ways in which health professionals respond to chronic pain and illness, the relationships between providers and patients, and the patients’ responses to chronic pain and illness.⁵ In Canada, studies have also shown that race and ethnicity play significant roles on the health seeking behavior and the treatment received by Canadians (Baltzan, 1999; Gorey et al., 1998; Singh et al., 1999).⁶

³ Williams, C. (2001) “Confronting the Racism in Research on Race and Mental Health Services,” *Canadian Social Work Review*, 18(2): page 231.

⁴ Jenkins CNH, Le T, McPhee SJ, Stewart S and Ha NT (1996) “Health care access and preventive care among Vietnamese immigrants: Do traditional beliefs and practices pose barriers?” *Social Science and Medicine*, 43(7): 1049-1056

⁵ Bates MS, Rankin-Hill L and Sanchez-Ayendez M (1997) “The Effects of the Cultural Context of Health Care on Treatment of and Response to Chronic Pain and Illness.” *Social Science and Medicine*, 45(9): 1433-1448.

⁶ Baltzan, MA (1999) “Access to health care, socioeconomic status, and health” [Letter; comment], *Annals of Internal Medicine*, March 2; 130(5): 452-453. Gorey KM, Holowaty EJ, Laukkanen E, Fehringer G and Richter NL (1998) “Association between socioeconomic status and cancer incidence in Toronto, Ontario: Possible confounding of cancer mortality by incidence and survival,” *Cancer Prevention and Control*, October, 1998 2(5): 236-241. Singh N, Gupta M, Fell D and Gangbar E (1999) “Impact of inequity of inpatient waiting times for advanced cardiovascular services in community hospitals across the greater Toronto area,” *The Canadian Journal of Cardiology*, July; 15(7): 777-782.

2.2 Conceptualizing Quality of Care

This second stage of the project, *PTSD: Moving Research to Policy*, aims to improve the well-being of PTSD survivors/sufferers. One means of doing this is to improve the quality of care for services received, by enhancing public knowledge and awareness of PTSD and eliminating the barriers to accessing available health care services.

Because the women in the initial project reported dissatisfaction with the quality of health care services that they had received, it is useful to define what good quality of care would be. Conceptualizing quality of care has taken numerous perspectives, often based on the context and aspect of health care received.

The American Medical Association (AMA) (1984) defined quality of care as “care, which consistently contributes to the improvement or maintenance of quality and/or duration of life.” In 1986 the American Medical Association further defined quality of care in terms of these eight elements:

- ◆ To produce optimal improvement in the patient’s health.
- ◆ To emphasize the promotion of health and prevention of disease.
- ◆ To provide health care services in a timely manner.
- ◆ To achieve the patient’s informed consent, cooperation and participation in the care process and decisions concerning it.
- ◆ Provision of health care to be based on accepted principles of medical sciences.
- ◆ Provision of health care services with sensitivity and concern for the patient’s welfare.
- ◆ To make efficient use of technology.
- ◆ To be sufficiently documented to allow continuity of care and peer evaluation.⁷

Other scholars, like Donabedian (1980), question quality of care being seen as a “single attribute, a class of functionally related attributes, or a heterogeneous assortment.” Rather, Donabedian sees the degree of quality of care as “the extent to which the care provided is expected to achieve the most favorable balance of risks and benefits”, and that attributes such as accessibility, continuity, and coordination while influencing quality, remain mutually exclusive. He asserts, “Balance of benefits or harms is essential in the definition of quality of care.”⁸

While these two conceptualizations of quality of care tend to equate quality to efficiency, Rutstein et al. (1976) sought to differentiate quality and efficiency. Rutstein notes “quality is the

⁷ Steffen GE (1988) “Quality Medical Care: A Definition,” JAMA, The Journal of the American Medical Association, 260(1): page 56.

⁸ Donabedian A (1980) The Definition of Quality and Approaches to Its Assessment. Ann Arbor, Michigan, Health Administration Press, cited in Steffen GE (1988) “Quality Medical care: A Definition,” JAMA, The Journal of the American Medical Association, 260(1): 56-62, page 57.

effect of care on the health of the individual ---- and must be differentiated from the efficiency of medical care.”⁹

More recently, Bruce (1990) examined the quality of care with focus on family planning. Bruce identified “three vantage points from which to view quality, namely the structure, the service, and the outcome particularly with respect to individual knowledge, behavior, and satisfaction with services”.¹⁰ He noted that six elements are essential to quality of care, with interpersonal relations being very important, as they remain fundamental to return visits and continuity in accessing care.

Campbell et al. (2000), focused on the clients’ perspectives, centering on access and effectiveness, as well as the notions of equity and efficiency. Effectiveness is defined as referring to both the effectiveness of clinical care and effectiveness of inter-personal care.¹¹

In the current PTSD project, we adopt the definition of quality of care from the clients’ perspectives, as given by Campbell. We focus on listening to and working with the study participants to propose policy statements to improve the quality of care and well-being of immigrant, refugee, and visible minority women in Saskatchewan.

⁹ Rutstein DD, Berenberg W, Chambers TC, et al. (1976) “Measuring the Quality of Medical Care,” New England Journal of Medicine, 294: page 582.

¹⁰ Bruce J (1990) “Fundamental Elements of the Quality of Care: A Single Framework,” Studies in Family Planning, 21(2): page 61.

¹¹ Campbell SM, Roland MO, and Buetow SA (2000) “Defining Quality of Care,” Social Science and Medicine, 51(11): 161-165

3.0 FINDINGS

The participants put forward the following suggestions as ways of controlling all aspects of their health including the accessibility and utilization of mental health services by immigrant, refugee, and racialized women in Saskatchewan.

3.1 Empowering Clients

Empowering immigrant, refugee and racialized women involves providing them the necessary tools such as language, knowledge and awareness, education, and improved entry into the labour force. Hence, empowerment allows individuals to be aware of their human rights as entrenched in the Canadian Constitution under the Charter of Rights and Freedoms. Our fundamental rights and freedom give us right to information on our health, and the ability to change our physician and to see a physician of our choice.

The project notes that many immigrant, refugee, and racialized women are not aware of their constitutional rights, and therefore have experienced all forms of total disregard of their person and their rights. Participants recounted their experiences in accessing and utilizing health care services in Saskatchewan. For them the experiences tend to have some commonalities, which include disrespect and lack of sensitivity by health providers, as well as failure to reach out to immigrant, refugee, and visible minority communities and their members. One participant gave an account of her case history.

“I visited my family doctor with symptoms of pain. All laboratory tests failed to show anything in particular. Then the family physician referred me to a specialist. The specialist ordered for a number of tests. He found nothing unusual; yet, I remained in severe pain. I and no one else only understood the intensity of my pain. But no one seemed to neither believe me nor understand my agony.

All the physicians I saw concluded that the pain is in my head. Finally, the physician sent me to a psychiatrist, who concluded that my pains were signs of depression, and at the end signs of mental health. The outcome was to place me on anti-depressant medication and labeled mentally ill.

I told the physician of my sister with thyroid, and that might need investigation. What triggered my imagination is that there was some sort of disagreement on the medication or line of treatment to follow by the physicians. If the physicians cannot arrive at a more appropriate medication to prevent, and control my thyroid, how would I continue to have faith in them?

The striking issue here is that I was and continued to be seen as an insignificant partner in my health. I was seen as someone who knew nothing. Yet, I have family life histories and experiences to give. No one seemed to listen or put into consideration what I had to contribute to the search for a more effective management of my health.”

Another woman, citing her own experiences, noted the lack of communication amongst health providers. For instance, she noted that though the experience she wanted to share is not on PTSD, it speaks to a common issue that cuts across the management of immigrants, refugee and visible minority clients' health problems.

"I was pregnant and had a gynecologist. I was in severe pains so I went to the hospital emergency. I was given medication and sent home. But, I continued to express to the hospital staff that I was still very bad. My pains were really bad and burning sensation in my vagina was hurting. Well, I was sent home with drugs.

On reaching home, I could barely sleep. The next day I went back and was re-admitted. I received no special care but remained in pains. I requested to see my gynecologist. No one bothered to listen to me. Rather than send for my gynecologist, I saw a totally strange doctor who had no up to date information on the management of my pregnancy.

On the third day, I was taken to the theatre and my pregnancy terminated. On discharge, I was asked to see the doctor who saw me in the hospital.

Well, I went to see my gynecologist again. The nurses went ahead to weigh me and carry out other procedures as if I was still pregnant. I reminded them that I lost the baby. On seeing my doctor, I told him that I had requested that they call him to see me in the hospital, but was denied the simple request. My doctor was never informed of my experience nor was he told of the termination of my pregnancy.

I felt disrespected and violated."

A common feature in the above cases and experiences of other immigrant, refugee, and racialized women is disrespect from health providers, which they argued, "is an infringement into our rights." Such disrespect includes the behavior of health providers that point to the client as uninformed and ignorant. Therefore, the client has no contribution to make towards the management of her health.

3.2 Violence and Family Breakdown

Participants in the focus group sessions argued that violence in personal relationships also triggers the recurrence of PTSD. However, immigrant, refugee and racialized women find that the support systems for victims and survivors of violence against women are not culturally sensitive.

Women survivors of violence can be taken away from their families to shelters, but their emotional needs and social support are often neglected. Language barriers lead to problems with communication. Counselors recommending family counseling for families experiencing violence have failed to follow up causing the women not to have faith or trust in the system. Physicians

may rely more on the words of family members such the spouse who is more likely to be the perpetrator of violence. The survivor of violence remains powerless as the man she loved becomes the violator and the system meant to protect and assist her in healing is insensitive. The fear of further trauma causes many of the women to remain in violent relationships rather than seek help.

Women are concerned that the present immigration policy could lead to deportation of immigrant offenders if a complaint is made about family violence. Their communities may stigmatize and ostracize women if they involve the legal system. This spill over effect further jeopardizes the well being of the women and leaves them more traumatized.

Women also fear what will happen to themselves and their children if there is a family breakdown, especially if their spouse was the person who sponsored them to immigrate to Canada. Spouses have been known to threaten to withdraw their sponsorship if their partner wants to seek help about family violence. And women are uncertain what will happen to themselves and their children if the sponsoring spouse is deported. There was a sense that a policy protecting these women was already in place but its implementation remains problematic.

The general consensus was that there is an urgent need to determine and establish a more effective process and programs to deal with violence against women in a multicultural society like Canada, particularly Saskatchewan.

3.3 Building Awareness

The issue of awareness pertains to both the health care workers and members of the immigrant, refugee, and visible minority community. Immigrant, refugee and racialized women who participated in the focus group discussions argued that the general lack of awareness on this health malady calls for innovative actions to build and improve such awareness. Communication methods suggested by participants can be found in Section 4.

3.4 Normalizing Traumatic Response

Participants felt that as part of the process to create greater awareness of PTSD and more effective treatment for this condition, there is a need to normalize the experience of PTSD and avoid labeling victims of trauma as mentally ill.

PTSD should be recognized as a normal response to a stressful situation. Programs aimed at normalizing post traumatic stress symptoms need to convey the message that trauma is “a normal reaction to dislocation, to disasters, to traumatic situations.” Normalizing trauma includes an acknowledgement that most immigrant, refugee and racialized women have lived experiences of traumatic events. That is, immigrant, refugee and racialized women are not “crazy” but have symptoms of PTSD. They often come from countries where there is a stigma attached to trauma and mental health issues and so they are reluctant to attend the clinic. They are also reluctant to

talk about these issues. Therefore, the federal and provincial governments need to integrate discussions about trauma into settlement and integration programs.

Several participants discussed difficulties with respect to the terminology used to describe what is happening to immigrant, refugee and racialized women who experience trauma. They discussed how immigrant, refugee, and racialized women were usually uncomfortable with the term “mentally ill” and that a description such as “severely traumatized” seemed to work better for some. There was also some discussion about the eagerness among service providers to label clients. There needs to be further discussion about the appropriate use of language.

Another focus group participant suggested that sometimes if women *were* suffering from particular mental illnesses, workers would not necessarily identify the traumatic experiences they experienced because the response to the trauma was seen as part of their mental illness. Again, participants emphasized the importance of normalizing trauma and the need to address this trauma directly in the same way that they would address trauma among other clients.

According to the service provider participants, normalizing trauma means working with clients at community based organizations, establishing trust, building rapport, and identifying support networks. Referrals to mental health clinics came only after the clients developed some comfort with discussing the issues. This was particularly important when English was not the first language of the clients.

Otherwise, health providers’ diagnosis of immigrant, refugee, and racialized women as psychiatric cases remain. This perpetuates the stereotyping, stigma and taboos surrounding mental health in most of the cultures/communities of immigrant, refugee, and racialized women. Such labeling hinders immigrant, refugee, and racialized women from communicating their experiences and symptoms to or visiting a physician. This reaction flows from the cultural taboos that surround issues of mental health, which these newcomers and members of immigrant, refugee, and visible minority communities bring with them from their country of origin.

3.5 Health Provider-Client Relationships

A number of barriers such as language, time spent with clients and cultural differences were identified as weakening provider-client relationships. Often, immigrant, refugee, and racialized women have poor English language skills and have difficulty communicating their problems or symptoms. Such language difficulty requires more time for the client to present the symptoms. However, participants note “health workers tend to spend a few minutes with clients, due to the need to see more patients. Participants reiterated that presently in Saskatchewan, the number and time spent seeing clients determine the earnings of physicians. The emphasis is on quantity rather than quality.”

The participants called on the provincial government to provide additional incentives to physicians dealing with immigrant, refugee and racialized groups and other less privileged persons/groups as a way to encourage physicians to spend quality time with such clients.

This approach would give both the client and the health provider satisfaction with the care received and/or given.

Another common experience reported is “the practice by physicians to write prescription before a client finishes presenting her symptoms.” The participants see this behavior as disrespectful, assuming that they “lack any clue about their health issues and symptoms.”

Other health practices contribute to the feeling of not being respected. According to immigrant, refugee, and racialized women in the studied communities, health providers tended “to talk down on them by emphasizing health practices like the importance of washing your hands after using bathroom as if they are so ignorant of personal hygiene.”

The participants also emphasize the link between an informed client and quality of care. However, health providers often fail to inform immigrant, refugee and racialized women of their health condition because of poor attitudes towards their ways of life.

Immigrant, refugee, and racialized women remain in the dark concerning what the doctors are investigating, their findings and conclusions. No matter the questions raised, “you often do not get the appropriate response except that ‘We at this point do not know what is wrong’.” The participants note, “Such closure and keeping the client in the dark more than worsen the client’s condition. This is a form of total disregard for the client as a person, who has a right to be informed.” However, the referral of clients to different physicians and hospitals, and the suspense tend to worsen the health of the client.

The common view is the urgency in sensitizing health providers on the issue of cultural diversity and respect for all irrespective of their race, class, gender, ethnicity, and language barriers. The issue of PTSD is similar to other women’s health problems in Saskatchewan. Participants argue that immigrant, refugee, and racialized women need to have their issues and concerns taken to the physicians during professional week.

Some participants from women’s organizations described how they dealt with accessibility issues. Some women suggested that they developed good working relationships with certain mental health workers, and were able to make direct referrals (with the consent of women) to these workers. In several of these situations, the mental health worker attended the organization’s office and met with individual women. Focus group participants suggested that if they had made the referral, given the information regarding location of the mental health centre to the woman and left it at that stage, they felt certain that “not a single woman would ever have gone down to the clinic”.

“And so I think somehow having that link so that you bring them into a comfortable environment. ...The community organizations are probably where they feel most comfortable to talk but I am not capable of knowing how to respond to it [issues of trauma, depression etc] rather than to refer it to someone else...so to have that link. That would be the most important thing.”

Related to the problems of communicating with health care professionals is the lack of immigrant, refugee and racialized women as workers in the health care sector. As such, immigrant, refugee and racialized women face health workers whom they do not identify with and who tend to be insensitive to their issues. This makes health clinics strange places that are uncomfortable and surrounded with uncertainty, particularly with the difficulty in communicating with the health care providers.

The participants recommended that all levels of government recognize the foreign qualifications of immigrant, refugee and racialized individuals as a way to improving the proportion and contribution of immigrant, refugee and racialized people in all departments including the health sector.

Such recognition of foreign credentials needs to occur during the resettlement processes of newcomers. The introduction of Prior Learning and Assessment Recognition (PLAR) in some educational institutions working with newcomers empowers newcomers/refugees by easing the tension of seeking jobs. In the future, the recognition of foreign credentials and skills would encourage newcomers/refugees to settle in Saskatchewan rather than continue to seek alternative places in other provinces where they feel integration and accommodation of newcomers in terms of employment are more liberal.

Closely connected to the recognition of foreign credentials is the potential for upgrading and training immigrant, refugee and racialized individuals who have worked for many years in health care in Saskatchewan. This also would contribute to reducing the shortage of health care workers such as psychiatric nurses.

3.6 Attitudes Toward the Use of Medication

While a number of participants raised objections to the reliance on medication by health providers, some health providers argued that there is a place for medication in the treatment of PTSD. The consensus reached was that future health promotion policy, education and awareness programs include the importance of enhancing immigrant, refugee and racialized women's attitude to medication as well as building their knowledge and awareness in the area of mental health.

3.7 Language Barriers in Health Care

Language is fundamental to effective communication and integration into the mainstream society. It is also seen as a key component in the healing process of PTSD sufferers and those who may be at risk for PTSD.

Language barriers infringe on the communication between health care workers and PTSD survivors. The participants reported that the English as a Second Language (ESL) program fails to provide many immigrant, refugee, and racialized women the needed linguistic skill to interact with other members of the society, including health workers, and to perform everyday activities.

Participants had specific comments on ESL training.

"ESL focuses on basic language such as 'Hello, how are you today?' Such language is inadequate in individuals' daily activities including interaction between immigrant, refugee, and racialized women with health providers."

"ESL content fails to equip newcomers in expressing their health problems. We continue to have communication problems with our physicians. This makes it difficult to present the symptoms. The physicians in turn do not have the time to spend on one patient. This leaves the immigrant, refugee, and racialized women frustrated and unwilling to re-visit the physician."

"ESL teachers are first line workers and they need to be equipped in assisting newcomers, particularly those presenting signs of PTSD. PTSD can affect their learning and concentration due to the traumatic experiences."

The participants felt the provincial government should act to recruit and train ESL teachers to recognize the symptoms of PTSD, particularly as they are front line workers. In addition, such ESL teachers should work with other social services providers in identifying and assisting immigrant, refugee and racialized women in overcoming the symptoms and serious consequences of PTSD.

Invariably, participants argued that there is a need for more money to train and improve the ESL classes and content. The expected outcome is to allow the integration of newcomers, immigrants, refugee and racialized women. Language acquisition would not only improve health but also other issues such as social relationships.

The flexibility in ESL classes was also an issue. Presently, ESL is available only to newcomers to Canada or refugees. The provincial government of Saskatchewan needs to extend ESL classes to all persons resident in the province wanting to improve their communication and mastery of the language. Otherwise, we will continue to have individuals who are experiencing language barriers, and this would continue to negate their lived experiences, particularly for those individuals with PTSD. The participants stated that addressing this issue is a matter of urgency.

Furthermore, the present ESL policy restricts individuals to a maximum of three years of ESL classes or lessons. With respect to the implementation of this policy, eligibility is determined according to the language skills of the newcomer. This means that newcomers may qualify for between approximately 600 and 1200 hours, based on their location in the province, and their language skills at the time of assessment. This period of time for instruction provides only very basic language skills to the majority of ESL learners

Participants argued that ESL learners, such as immigrant, refugee and racialized women, do not always have equal footing in terms of time needed to learn English. Individuals differ in terms of learning ability and therefore, there are some who would need more hours of instruction. Similarly, there are women who may be experiencing marital and cultural problems, as well as health issues related to traumatic events. These experiences may affect their rate of learning.

Very few immigrant, refugee and racialized women are currently ESL instructors. The participants noted that having more immigrant, refugee and racialized women as ESL instructors may reduce the difficulty in learning English. These women would be role models to newcomers by showing that acquisition of English is possible and easy through self-determination. Consequently, there is need to train and recruit more immigrant and racialized women as ESL instructors.

There was also a consensus among participants that ESL classes should be subject to program evaluation.

The participants generally proposed the extension of ESL to the workplace. According to the participants, this extension would increase the participation of immigrant, refugee and racialized women in ESL classes. There will be no loss of work time and income. ESL in the workplace would benefit both the employees and the employers. It would enhance the working environment, and invariably empower the workers as a means of improving their status.

More importantly, government and employers would be sharing the cost of ESL classes. This would provide the financial resources to extend hours beyond the present policy of a maximum of 3 years of ESL instruction and assist those who need the extra instruction.

Incorporating ESL in workplaces would further guarantee participation in ESL classes and act as an incentive to newcomers to learn English.

3.8 Labour Force Participation and Health Status

The ability to have gainful employment is an important variable related to the empowerment of immigrant, refugee and racialized women.

Most immigrant, refugee, and racialized women identified working as a priority to their everyday life. As such, most of them reported that they worked in their country of origin.

Therefore, coming to Canada, particularly Saskatchewan, and finding no job due to devaluation of their foreign credentials and lack of Canadian experience has a negative impact on the women's personality and attitude to life in general. Individuals begin to have low self-esteem and this further embeds them in the traumatic experiences they had before their relocation to Canada. It also affects their social interaction within their community and Canadian society. Consequently, some of the immigrant, refugee, and racialized women become introverts, by avoiding public situations and withdrawing from close friends and relatives. They do not receive

the personal support and interaction that would help them attain or maintain a healthy balanced life.

The participants argued that the racism they face has a huge impact on their health status. The women reiterated that racism hinders their ability to pursue their careers after migrating to Canada. Prior education, training and work experiences are irrelevant to obtaining jobs. Invariably, the participants noted that they have no other choice than to take up jobs not commensurate to their training.

Even women educated and trained in Canada end up working under someone with lower education, skills and experience. The majority of immigrant, refugee and racialized women remain underpaid as they work on jobs they are over-qualified for, and earn less than white Canadian women.

Yet working is essential. Immigrant, refugee, and racialized women often must take on multiple jobs to garner enough income to meet the needs of their family members and themselves. What immigrant, refugee, and racialized women face today is not the “second shift syndrome”, but “multiple role syndrome” as they work most of the day and week; going months and years with no leisure or holiday.

Refugees must pay back their cost of transportation to sponsors including the government. In addition, there is the demand from children and family members resident in Canada. The children often like to acquire material things and participate in extra curricular activities and learning opportunities, such as basketball, soccer, music, and arts, just like everyone else. These demands cost money. Therefore, funds are required to provide the children with that extra prompt needed for survival in the new country, Canada.

In addition, funds are often needed to assist other family members like parents and siblings in their place of origin. While many residents in Canada can offset some of the expenses incurred in taking care of their elderly parents or relatives in their income tax returns, immigrant, refugee and racialized women lack such opportunity. In the end, they pay more money back to the government during tax times, while also jeopardizing their health due to multiple jobs and less time for leisure and resting.

The work pattern of immigrant, refugee, and racialized women makes it difficult for them to focus and participate in ESL classes and acquire language skills. Multiple jobs lead to work overload that further imparts on their health, physically, physiologically and emotionally.

For immigrant, refugee, and racialized women, recognition of foreign credentials is essential. Participants recommended the full integration of Prior Learning Assessment and Recognition in the resettlement and integration plans of government for newcomers to Saskatchewan.

3.9 Training Front-Line Workers

Participants stated that front line workers need training on recognizing and working effectively with people with PTSD.

Participants defined front line workers as those individuals and groups that meet and interact with newcomers in the processes of integrating and accommodating them into Canadian society. This implies all the settlement officers such as those working with Open Door Society, immigration officers, ESL instructors, public health nurses, physicians, social workers, and law enforcement workers. Participants noted the need for respectful treatment of newcomers particularly immigrant, refugee, and racialized women. This means sensitizing front line workers to past traumatic experiences and problems of settlement and readjustment.

The establishment of a network of relationships among these front line workers would go a long way to ameliorating the problems facing immigrant, refugee, and racialized women including the issue of health. Participants reiterated the need for ESL instructors to identify and refer any student not showing progress. This approach would begin to make visible other problems facing these individuals, such as abuse, nutritional deficiency, disability and other urgent issues that require special attention.

Participants recommended that deliberate efforts be made to recruit and include members of the immigrant, refugee, and visible minority communities as front line workers as it creates a connection to the new environment in Saskatchewan. The personal experiences of these front line workers would also help in facilitating positive integration and accommodation processes for newcomers.

Training of these frontline workers has to include the issue of PTSD, as this would get everyone involved in reducing known serious consequences of past traumatic experiences. Traumatic experiences lead to an individual to not be trustful of others. He or she may present symptoms of fear, indecisiveness, and signs of not wanting to work in teams or groups, by keeping to him or her self and not sharing in conversation and activities with others.

Building trust and working closely with immigrant, refugee and racialized women with PTSD would go a long way towards preventing any negative experiences with the health sector, as well as other sectors of the society such as labour or education. This underlines the importance of improving the knowledge and awareness of all dealing with newcomers and IRVM communities on issues such as PTSD.

4.0 COMMUNICATION METHODS

Participants suggested a number of communication methods to improve knowledge and awareness about PTSD.

The actions Immigrant Refugee and Visible Minority of Women of Saskatchewan (IRVMWS) has planned or already undertaken in response to these suggestions are included.

◆ **Improve curricula of health providers-in-training**

In response to this recommendation, IRVMWS hopes to network with educational institutions and professional bodies to influence a review of training curricula for health providers to reflect the health needs and problems of immigrant, refugee and racialized population in Saskatchewan.

◆ **Presentations at meetings of health professionals**

In response to this recommendation, tentative plans have been set up to present at a staff-training day for workers at Saskatoon Adult Community Mental Services. An invitation will be extended to other regions. The intent is to hold at least one session in every health district or region.

◆ **Presentations at meetings of service clubs and other community organizations.**

In response to this recommendation, IRVMW made a presentation at St. Paul's Hospital in Saskatoon in March 2002. This event was attended by a broad cross section of service providers. A presentation was made at the 2002 International Women's Day in Regina to a cross section of immigrant, refugee and racialized women from four community organizations.

A presentation was made to the Board of Saskatoon Open Door Society in January 2003. Similar presentations will be made to new settlers visiting Regina Open Door. A keynote speech focusing on the topic of PTSD was presented at TESL Manitoba's Annual Conference in February 2003.

The Yorkton University Women's Club has expressed interest in organizing a presentation at a weekly meeting. Invitations will be extended to other groups in other communities. IRVMW expects to host at least one session in the following locations: Swift Current, Moose Jaw, and Prince Albert.

◆ **Presentations by immigrant, refugee, and racialized women at agencies and organizations providing service to this population.**

Several immigrant and refugee women shared stories of their experiences of trauma at a conference held in Saskatoon in October 2002. These stories exposed a wide cross section of the public to the issues of trauma experienced by so many immigrant and refugee women.

◆ **Articles in newsletters for health professionals**

IRVMWS has responded to requests for interviews to discuss the findings of the study and to discuss the topic of PTSD. Articles have been published in medical journals, university newsletters, and local newspapers. IRVMWS will continue to respond to requests for articles. The text of a follow-up presentation by one of the researchers will be published in TESL Manitoba's journal.

◆ **Multipurpose women's centres for IRVMW communities**

Participants in one location suggested that community-based multipurpose centres be proposed to the different levels of governments. These centres will provide opportunities for all family members to interact with each other and alleviate fears, and find ways to deal with problems such as those related to abuse or violence that they may face in their respective homes.

These centres would function as a center for the improvement of the health of women as the women will be able to see female physicians, have translators readily available and also promote physical health through an exercise facility in the center.

◆ **Establishing a pool of interpreters and translators**

A pool of interpreters and translators is needed to assist immigrant, refugee, and racialized women to communicate with their physicians and other health providers. The list of such translators and interpreters should be made available to organizations such as Open Door Society, ESL departments or units, Canada Immigration, Saskatchewan Intercultural Association, etc. These interpreters and translators would be drawn from the IRVM communities and be funded by government. The participants noted that this would go a long way to ameliorating the resettlement problems facing newcomers and in the long run reduce the health costs.

◆ **Production and distribution of pamphlets or brochures**

There is a need to produce pamphlets in different common languages such as Spanish, Arabic, Swahili, Pidgin, Russian, French, and display them at clinics, hospitals, and schools. Producing pamphlets on health issues that plague immigrant, refugee and racialized communities (e.g. PTSD) would not only give a sense of belonging but enhance many coming out to discuss these traumatic

experiences, by knowing its not a private issue but also common to others. It would also improve the awareness of health providers and sensitize them to the issue of PTSD.

◆ **Improving the public and private status of women.**

IRVMWS has responded to requests from university students engaged in research related to gender issues and to PTSD. IRVMWS will continue to respond to these requests and will make presentations to schools when requested.

5.0 POLICY ISSUES AND ACTIONS

This section outlines the policy issues arising from this research project and the basic rationale behind the need for action on these issues. Actions planned by IRVMWS and recommendations for action by governments and other agencies are outlined.

The responsibility of ensuring full integration of immigrants, refugee, and racialized individuals/groups lies with all levels of governments- municipal, provincial and federal.

The recommendations in this section relate to all levels of government, health and educational institutions and service delivery organizations. IRVMWS is showing its leadership in addressing PTSD by committing to specific actions.

1. Multidisciplinary Coordinating Team

Rationale

Service providers in all sites where focus groups were conducted expressed a need to have training to enhance their ability to respond adequately to this issue. The participants recommended that a multidisciplinary coordinating team be set up to facilitate this process and that all funding agencies/organizations include a statement of support for this goal within their funding strategy.

IRVMWS Actions

- 1.1 *IRVMWS will serve as a catalyst to set up a Multidisciplinary Coordinating Team on PTSD.*
- 1.2 *IRVMWS will serve as interim chair for the Multidisciplinary Coordinating Team on PTSD while terms of reference for the team are developed.*

Recommendations to Governments and Other Agencies

- 1.1 *That governments and agencies participate in a Multidisciplinary Coordinating Team on PTSD.*
- 1.2 *That funding agencies and organizations include a statement of support for the Multidisciplinary Coordinating Team within their funding strategy.*
- 1.3 *That the Multidisciplinary Coordinating Team on PTSD will develop a broad-based media campaign to raise the awareness and knowledge of PTSD, following the suggestions found in this report.*

- 1.4 *That the Multidisciplinary Coordinating Team on PTSD develop a strategy to provide ongoing specialized training related to Post Traumatic Stress Disorder to a broad range of service providers, following the suggestions found in this report.*

2. Improved Public Understanding

Rationale

Immigrant, refugee, and racialized women who participated in this study reiterated the importance of considering the influence of PTSD when counseling newcomers, particularly those individuals or groups who have experienced traumatic events. Information on PTSD needs to be available not only to health professionals, but also to all professionals working with immigrant, refugee, and racialized communities; to immigrant and refugee women; and to the general public, through broad-based media campaigns or coverage.

IRVMWS Actions

- 2.1 *IRVMWS will play a lead role in the public education strategy to be established by the Multidisciplinary Coordinating Team on PTSD.*
- 2.2 *In the interim (while the Multidisciplinary Coordinating Team on PTSD is being set up), IRVMWS will respond to requests for presentations on the topic of PTSD and extend offers to present at annual meetings, board meetings and other community events.*
- 2.3 *IRVMS will produce pamphlets in different languages for immigrant, refugee and racialized women.*

Recommendations to Governments and Other Agencies

- 2.1 *That Saskatchewan Health include a statement of commitment to informing the public about PTSD within their health promotion strategy.*
- 2.2 *That Saskatchewan Health collaborate with the Multidisciplinary Coordinating Team to enhance awareness of PTSD through information, education and communication.*
- 2.3 *That all levels of government enact and implement policies, programs and statutes that would specifically recognize PTSD as an important factor mitigating against the full integration of immigrant, refugee, and racialized women.*

3. Curriculum for ESL and Other Students

Rationale

Most immigrant, refugee, and racialized women have lived experiences of extreme trauma. These women need information about PTSD. IRVMWS believes that information about trauma and post traumatic stress needs to be integrated into all ESL curricula including Language Instruction for New Canadians (LINC) material.

The curriculum for health care and other service providers will need additional information about PTSD. PTSD information for K-12 schools would be useful for students who may be experiencing PTSD or have the condition present in their family or community.

IRVMWS Actions

3.1 IRVMWS will work with ESL educators to integrate training and awareness of PTSD and trauma into all ESL curricula and programs.

Recommendations to Governments and Other Agencies

3.1 That material on PTSD be developed and included in the ESL curriculum.

3.2 That the Saskatchewan Department of Learning collaborate with the Multidisciplinary Coordinating Team to develop curriculum material on PTSD for students in K-12 schools, public libraries, SIAST and universities.

3.3 That policies to collaborate with the Multidisciplinary Coordinating Team to develop curriculum focusing on PTSD be established and implemented by: the Saskatchewan Department of Learning; the University of Saskatchewan Colleges of Nursing and Medicine; the Faculties of Psychology at the University of Saskatchewan and the University of Regina; and, the Saskatchewan Institute of Applied Science and Technology Nursing Education Program.

4. Training for Service Providers

Rationale

Immigrant, refugee, and racialized women who participated in this study reiterated the importance of considering the influence of PTSD in the counseling and support services for newcomers, particularly those individuals or groups who experience traumatic events. Women also emphasized the need to have services in a safe and welcoming place.

Although the initial project *PTSD: The Lived Experiences of Immigrant, Refugee and Visible Minority Women in Saskatchewan*, noted that a number of health care providers are not very

sensitive to the issue, the policy research and discussions of this second study show that more Canadian health providers are starting to recognize the serious health consequences of past traumatic life experiences. This change may be partly due to the publicity raised by the first study and attention to other similar issues raised in the media. Thus, health care providers are beginning to consider PTSD as a factor in understanding the mental health of immigrant, refugee, and racialized women. However, participants argued the need to recognize the importance of culturally specific strategies to reducing the serious consequences of past traumatic experiences.

Training policies and programs would clarify and promote the education of all first line workers such as ESL instructors, immigration officers, resettlement officers, and health care providers, as well as the public. In addition, it would allow early detection of individuals who are more likely to experience slow integration, through displaying early signs of PTSD including slow learning, experiences of memory loss, unwillingness to socialize, fear and stress.

IRVMWS Actions

- 4.1 *Front line workers and volunteers at IRVMWS will be trained to identify and work with individuals with symptoms of PTSD, so that these survivors can seek early interventions or treatment, as a means of promoting quality of life among immigrant, refugee and racialized women.*
- 4.2 *IRVMWS will work to ensure that all frontline workers including health care providers, ESL instructors, resettlement officers, schools, immigration officers, police and other professionals are trained to identify individuals with symptoms of PTSD and to help them to seek early intervention or treatment.*
- 4.3 *IRVMWS will produce a pamphlet for educators and settlement officers as a tool for identifying PTSD in clients and working with them.*
- 4.4 *IRVMWS will collaborate with educators, service providers and medical practitioners to effect changes in the curricula of health care providers appropriate to the needs of immigrant, refugee, and racialized women*
- 4.5 *IRVMWS will provide workshops and presentations on PTSD to ESL educators.*

Recommendations to Governments and Other Agencies

- 4.1 *That training on how to deal effectively with the growing cultural diversity in Canadian society be provided to all health care professionals and other social services providers including police, immigration officers, resettlement officers, ESL instructors and educators.*
- 4.2 *In particular professionals and service providers should be made aware of the traumatic experiences of newcomers, immigrant, refugee, and racialized women. Professionals and*

service providers must receive appropriate training to enable them to appreciate the different manifestations of traumatic experiences in the day-to-day activities of survivors and their families.

- 4.3 *Governments and service delivery organizations need to develop culturally and individually specific responses to clients presenting symptoms of trauma.*

5. Service Delivery

Rationale

There was a sense among several participants that while individual mental health offices had developed positive relationships with women who have PTSD, this still remained at the level of individual relationships, and was not necessarily a system policy.

Therefore, participants urged that policies be instituted that would recognize the need for more creative and flexible intake and service delivery, including delivery of services in locations other than at mental health offices. The participants suggested that there is a need to establish and fund women's health clinics within multipurpose centers, where women could be more relaxed and network with other women as steps towards improving their health, including mental health.

The effects or symptoms of PTSD can re-emerge or become stronger after similar events reoccur. Traumatic events that can trigger PTSD include the September 11, 2001 attack on America, Columbine School Killings and the École Polytechnic Female Engineering Student Massacre. There is a need for service providers to recognize the potential in these situations.

There may be similarities between the experiences of immigrant, refugee and racialized women and Aboriginal people who have experienced PTSD. While this issue was not addressed in this study, it is an area that merits further study.

IRVMWS Actions

- 5.1 *IRVMWS recognizes the importance of considering the influence of PTSD in counseling and support services for newcomers, and will ensure that its own programs and services address the needs of women with PTSD.*
- 5.2 *IRVMWS will integrate counseling and support services that address PTSD into all programs and activities.*
- 5.3 *IRVMWS will attempt to bridge the gap between community agencies and other more traditional services that provide counseling.*
- 5.4 *IRVMWS will provide on site services as well as make referrals to other agencies.*

- 5.5 *Staff of IRVMWS will accompany women to other agencies when necessary, if requested by the women.*
- 5.6 *IRVMWS will take the lead in promoting culturally specific policies and programs, including counseling and psychological support services, to recognize the importance of past traumatic experiences to the integration of immigrant, refugee and racialized women. This leadership will involve IRVMWS collaborating with other agencies that serve immigrant, refugee and racialized population.*
- 5.7 *IRVMWS will promote the adoption of policies to ensure that culturally specific counseling and psychological support services that address PTSD become an integral part of resettlement and integration programs.*

Recommendations to Governments and Other Agencies

- 5.1 *That all levels of government make counseling newcomers an integral part of their resettlement programs, and attempts be made to identify PTSD in the process of counseling.*
- 5.2 *That Saskatchewan Health and other health authorities institute policies addressing more appropriate and accessible intake and service delivery for persons with PTSD.*
- 5.3 *That options be created for delivery of services related to PTSD, including mental health services, in locations other than in traditional or mainstream centers.*
- 5.4 *That government establish and fund women's health clinics within multi-purpose centres.*
- 5.5 *That health care providers and other first line workers, ESL instructors, resettlement officers, schools, immigration officers, police and other professionals collaborate in identifying the symptoms of PTSD, its effects and the likelihood of recurrence following similar traumatic situations.*
- 5.6 *Service provider organizations are encouraged to use resource material on PTSD in a variety of situations, including therapy groups, shelter programs, immigration programs and employment training programs.*

6. Physician Care

Rationale

Despite Medicare guaranteeing the availability and accessibility of health care to all Canadians irrespective of their social class, gender, ethnicity, and race, members of the immigrant, refugee, and racialized communities continue to face obstacles such as language and cultural barriers to accessing health care services. Such language and cultural barriers hinder relations between clients and physicians or health care providers.

Further factors affecting quality of care include health providers' time spent with clients and the number of patients waiting to see a physician. The number of patients seen by a physician is the unit for calculating the physician's earnings. Yet immigrant, refugee and racialized women often need more time to express and convey the symptoms of illness.

Consequently, inadequate time spent with clients and lack of sensitivity to clients' language and culture, makes clients feel disrespected. This makes immigrant, refugee and racialized women feel they are being "talked down on" by the physicians and other health care professionals. Such feelings keep these women, family members and friends from further visits to the health care professionals. Interpersonal relationships between clients and health providers remain fundamental in clients' perception of quality of care.

Immigrant, refugee and racialized women hold that by recognizing the additional time needed for working effectively with them in payments to physicians, the immigrant, refugee and racialized women are more likely to be listened to and be given the most appropriate and effective care, which will reduce the health costs in the long-run.

IRVMS Actions

- 6.1 *Immigrant, Refugee and Visible Minority Women of Saskatchewan will set up a mechanism to share findings of this study with representatives of the Government of Saskatchewan, to make recommendations for policy change.*
- 6.2 *IRVMS will collaborate with the Government of Saskatchewan to explore ways of monitoring follow-up regarding physician billing methods.*

Recommendations to Governments and Other Agencies

- 6.1 *That steps be taken to enhance physician billing methods so that they support the provision of good quality care and not quantitative health care.*
- 6.2 *That the Government of Saskatchewan provide additional incentives to physicians dealing with immigrant, refugee and racialized groups and other less privileged persons or groups as a way to encourage physicians to spend quality time with such clients.*

7. Recognition of Foreign Credentials

Rationale

The absence of members of immigrant, refugee and racialized groups in health care delivery also hinders immigrant, refugee, and racialized women from relating to and identifying with the services.

All levels of government need to recognize the foreign qualifications of immigrant, refugee and racialized individuals as a way to improving the proportion and contribution of immigrant, refugee and racialized people in all departments, including the health sector. Such recognition of foreign credentials needs to occur during the resettlement processes of newcomers.

The introduction of Prior Learning and Assessment Recognition (PLAR) in some educational institutions working with newcomers empowers newcomers/refugees by easing the tension of seeking jobs. In the future, the recognition of foreign credentials and skills would encourage newcomers and refugees to settle in Saskatchewan rather than continue to seek alternative places in other provinces where they feel integration and accommodation of newcomers in terms of employment are more liberal.

Closely connected to the recognition of foreign credentials is the potential for upgrading and training immigrant, refugee and racialized individuals in Saskatchewan who have worked for many years in health care. This also would contribute to reducing the shortage of health care workers such as psychiatric nurses.

IRVMWS Actions

7.1 IRVMWS will share these recommendations for policy change with governments to increase recognition of foreign credentials and use of PLAR, increase employment of immigrant, refugee and racialized people in all departments including the health sector, and develop strategies for upgrading and training health workers.

Recommendations to Governments and Other Agencies

7.1 That all levels of government recognize the foreign qualifications of immigrant, refugee and racialized individuals, and that this recognition occur as part of the resettlement process.

7.2 That governments and educational institutions continue to work towards the full implementation of Prior Learning Assessment Recognition, as quickly as possible.

7.3 That governments work towards improving the proportion and contribution of immigrant, refugee and racialized people to all departments, including the health sector.

7.4 *That governments and health care organizations develop strategies for upgrading and training immigrant, refugee and racialized individuals who have worked for many years in health care.*

8. ESL Training

Rationale

There is a need to reform the English as a Second Language Training Program to help eliminate barriers in client-health provider relationships.

All levels of governments need to explicitly recognize the valuable contribution of English and French language skills to the full integration of all Canadians and fund training adequately.

The participants expressed the view that the present ESL program targets primarily refugees while neglecting other newcomers such as the immigrants and racialized women who have come to join their families.

Also, the limited hours of ESL classes an individual is qualified to receive fails to take into consideration the fact that every individual learns at a varying rate. As such, some immigrant, refugee, and racialized women may need fewer hours to acquire fluency in English while others may take more hours.

Labour force participation is an important factor in the well-being of immigrant, refugee and racialized women, for income social status and personal fulfillment. Participants recommended that teaching ESL classes in the workplace would improve the relevance of ESL training to employment, and it would make the concepts and language essential for satisfactory work experience readily at the disposal of all newcomers to Canada.

Improved language skills in the workplace would facilitate workers' interaction and build better interpersonal relationships by breaking down language and cultural barriers. At the same time, it would enhance job mobility and career growth, which would contribute to furthering and strengthening the social and economic well-being and health of immigrants, refugees, and racialized people.

IRVMWS Actions

8.1 *IRVMWS will collaborate with government to provide advice on modifications to the funding, scope, and criteria for the ESL program.*

8.2 *IRVMWS will collaborate with government and employers to explore how ESL classes can be expanded to the workplace, and made more employment relevant in order to enhance the employability of immigrant, refugee, and racialized women.*

Recommendations to Governments and Other Agencies

- 8.1 *That the costs of providing English as a Second Language (ESL) for newcomers be the responsibility of all levels of government.*
- 8.2 *That additional funds be allocated to second-language classes such as ESL.*
- 8.3 *That ESL training be provided to all Canadian residents (including immigrants, Canadian born individuals whose parents are immigrants, racialized groups and Aboriginal people) not only refugees, who lack the language skills necessary to become functional in the society.*
- 8.4 *That the ESL program become more flexible in terms of maximum hours of learning.*
- 8.5 *That all levels of government be encouraged to work with employers to provide tax rebates to motivate the introduction of language instruction in the workplace, including ESL or French language instruction.*

9. Violence and Family Breakdown

Rationale

Immigrant, refugee and racialized women find the support systems for victims and survivors of violence against women not culturally sensitive. Language barriers can affect communication. The woman's view of her situation may not be fully valued by professionals. Follow-up on recommendations for counseling may not occur.

Immigrant, refugee and racialized women experiencing violence in their family, or breakdown of their family relationships, were reluctant to seek help because of fear of deportation of themselves or their spouse. Therefore, women remained in unhealthy situations that further impeded their ability to heal from the effects of PTSD. There was a sense that a policy protecting these women was already in place but its implementation remains problematic. Citizenship and Immigration Canada needs to follow up on the protection of immigrant, refugee, and racialized women who are survivors of violence.

IRVMWS Actions

- 9.1 *IRVMWS will collaborate with governments to determine how policies regarding sponsorship breakdown can be more effectively implemented.*
- 9.2 *IRVMWS will collaborate with governments to determine how alternatives to deportation for persons charged with family violence could be developed.*

- 9.3 *IRVMWS will provide advice to governments and other agencies on more culturally sensitive ways to support and follow-up on immigrant, refugee and racialized women who are survivors of violence.*

Recommendations to Governments and Other Agencies

- 9.1 *That governments and agencies develop more culturally sensitive programs to support immigrant, refugee and racialized women and their families who are victims of family violence.*
- 9.2 *That the federal government examine its immigration policy and its implementation to ensure that there are mechanisms other than deportation for immigrant and refugee women whose sponsorship arrangements break down, and that this policy be well communicated to immigrant and refugee women.*
- 9.3 *That alternatives to deportation be established for immigrants and refugees charged or convicted with family violence.*
- 9.4 *That Citizenship and Immigration Canada and other levels of government establish follow-up mechanisms to ensure the protection of immigrant, refugee, and racialized women who are survivors of violence.*

SUMMARY OF IRVMWS ACTIONS

The actions cited in the table will be undertaken by Immigrant, Refugee and Visible Minority Women of Saskatchewan (IRVMWS) to show its commitment and leadership in addressing Post Traumatic Stress Disorder (PTSD) among immigrant, refugee and racialized women.

Policy Issue		Action by IRVMWS	
#		#	
1	Multidisciplinary Coordinating Team	1.1	Serve as a catalyst to set up a Multidisciplinary Coordinating Team (MCT) on PTSD.
		1.2	Serve as interim chair for MCT while terms of reference are being developed.
		1.3	With MCT, develop a strategy to provide ongoing specialized training related to PTSD to a broad range of service providers.
		1.4	With MCT, develop a broad-based media campaign to raise awareness and knowledge of PTSD.
2	Improved Public Understanding	2.1	Play a lead role in the public education strategy to be established by the MCT.
		2.2	In the interim, IRVMWS will respond to requests for presentations on the topic of PTSD & extend offers to present at annual meetings, board meetings and other community events.
		2.3	Produce pamphlets in different languages for immigrant, refugee and racialized women.
3	Curriculum for ESL and Other Students	3.1	Work with English as a Second Language (ESL) educators to integrate training and awareness of PTSD and trauma into all ESL curricula and programs.
4	Training for Service Providers	4.1	Train IRVMWS workers and volunteers to identify & work with individuals with symptoms of PTSD, so that these survivors can seek early intervention or treatment.
		4.2	Work to ensure that all frontline workers including health care providers, ESL instructors, resettlement officers, schools, immigration officers, policy and other professionals are trained to identify individuals with symptoms of PTSD and to help them to seek early intervention or treatment.
		4.3	Produce a pamphlet for educators and settlement officers as a tool to identifying PTSD in clients and working with them.
		4.4	Collaborate with educators, service providers & medical practitioners to effect changes in the curricula of health care providers appropriate to the needs of immigrant, refugee and racialized women.
		4.5	Provide workshops and presentations on PTSD to ESL educators.

TABLE 1 (cont'd):		ACTIONS ON PTSD TO BE TAKEN BY IRVMWS	
Policy Issue		Action by IRVMWS	
#		#	
5	Service Delivery	5.1	Ensure that IRVMWS counseling and support services and programs for newcomers address the needs of women with PTSD.
		5.2	Integrate counseling and support services that address PTSD into all IRVMWS programs and activities.
		5.3	Bridge the gap between community agencies and other more traditional services that provide counseling.
		5.4	Provide on site services and make referrals to other agencies.
		5.5	IRVMWS staff will accompany women to other agencies if necessary.
		5.6	Promote culturally specific policies and programs, including counseling and psychological support services, collaborating with other agencies.
		5.7	Promote the adoption of policies to ensure that culturally specific counseling and psychological support services that address PTSD become an integral part of resettlement & integration programs.
6	Physician Care	6.1	Set up a mechanism to share findings of this study with representatives of the Government of Saskatchewan, to make recommendations for policy change.
		6.2	Collaborate with the Government of Saskatchewan to explore ways to monitor follow-up regarding physician billing methods.
7	Recognition of Foreign Credentials	7.1	Share these recommendations for policy change with governments to increase recognition of foreign credentials and use of PLAR, increase employment of immigrant, refugee and racialized people in all departments including the health sector, and develop strategies for upgrading and training health workers.
8	ESL Training	8.1	Collaborate with government to provide advice on modifications to the funding, scope, and criteria for the ESL program.
		8.2	Collaborate with governments and employers to explore how ESL classes can be expanded to the workplace, and made more employment-relevant in order to enhance the employability of immigrant, refugee & racialized women.
9	Violence and Family Breakdown	9.1	Collaborate with governments to determine how policies regarding sponsorship breakdown can be more effectively implemented.
		9.2	Collaborate with governments to determine how alternatives to deportation for persons charged with family violence could be developed
		9.3	Advise governments and other agencies on more culturally sensitive ways to support and follow-up on immigrant, refugee and racialized women who are survivors of violence.

SUMMARY OF RECOMMENDATIONS TO GOVERNMENT AND OTHER AGENCIES

The following is a summary of the recommendations to governments and other agencies for action on Post Traumatic Stress Disorder (PTSD).

TABLE 2: RECOMMENDATIONS ON PTSD TO GOVERNMENTS AND OTHER AGENCIES			
Policy Issue		Actions Needed	
#		#	
1	Multidisciplinary Coordinating Team	1.1	Governments and agencies participate in a Multidisciplinary Coordinating Team (MCT) on PTSD.
		1.2	Funding agencies and organizations include a statement of support for the MCT within their funding strategy.
		1.3	MCT develop a broad-based media campaign to raise the awareness and knowledge of PTSD.
		1.4	MCT develop strategy to provide ongoing specialized training to a broad range of service providers.
2	Improved Public Understanding	2.1	Saskatchewan Health include a statement of commitment to informing the public about PTSD within their health promotion strategy.
		2.2	Saskatchewan Health collaborate with the MCT to enhance awareness of PTSD through information, education and communication.
		2.3	All levels of government enact and implement policies, programs and statutes that specially recognize PTSD as an important factor mitigating against the full integration of immigrant, refugee, and racialized women.
3	Curriculum for ESL and Other Students	3.1	Develop curriculum material on PTSD and include in the English as a Second Language (ESL) curriculum.
		3.2	Saskatchewan Learning develop materials on PTSD, with the multidisciplinary team, for students in K-12 schools, public libraries, SIAST and universities.
		3.3	Policies to collaborate with the MCT to develop curriculum be established and implemented by: Saskatchewan Learning, U of Saskatchewan Colleges of Nursing and Medicine, Faculties of Psychology at U of Saskatchewan and U of Regina, SIAST Nursing Education Program.

TABLE 2 (cont'd):		RECOMMENDATIONS ON PTSD TO GOVERNMENTS AND OTHER AGENCIES	
Policy Issue		Actions Needed	
#		#	
4	Training for Service Providers	4.1	Training on how to deal with the growing cultural diversity in Canadian society be provided to health care providers and other social service providers including policy, immigration officers, resettlement officers, ESL instructors and educators.
		4.2	Ensure appropriate training to enable health care & social service providers to appreciate the different manifestations of traumatic experiences in the day-to-day activities of survivors and their families.
		4.3	Governments and service delivery organizations develop culturally and individually specific responses to clients presenting symptoms of trauma within government & service delivery organizations.
5	Service Delivery	5.1	All levels of government make counseling newcomers an integral part of their resettlement programs and attempts be made to identify PTSD in the process of counseling.
		5.2	Saskatchewan Health and other health authorities institute policies addressing more appropriate & accessible intake and service delivery for persons with PTSD.
		5.3	Create options for delivery of services related to PTSD, including mental health services in locations other than in traditional or mainstream centres.
		5.4	Government establish and fund women's health clinics within multi-purpose centres.
		5.5	Health care providers, ESL instructors, resettlement officers, schools, immigration officers, police and other professionals collaborate to identify the symptoms of PTSD, its effects and likelihood of recurrence following similar traumatic situations.
		5.6	Service provider organizations use PTSD material in a variety of situations, including therapy groups, shelter programs immigration programs & employment training programs.
6	Physician Care	6.1	Enhance physician billing systems to reflect and support the provision of good quality care and not quantitative health care.
		6.2	Government of Saskatchewan provide additional incentives to physicians dealing with immigrant, refugee and racialized groups and other less privileged persons or groups as a way to encourage physicians to spend quality time with such clients.

TABLE 2 (cont'd):		RECOMMENDATIONS ON PTSD TO GOVERNMENTS AND OTHER AGENCIES	
Policy Issue		Actions Needed	
#		#	
7	Recognition of Foreign Credentials	7.1	All levels of government recognize the foreign qualifications of immigrant, refugee & racialized individuals as part of the resettlement process.
		7.2	Governments and educational institutions continue to work towards the full implementation of Prior Learning Assessment, as quickly as possible.
		7.3	Governments work towards improving the proportion and contribution of immigrant, refugee and racialized people to all departments, including the health sector.
		7.4	Governments and health care organizations develop strategies for upgrading & training immigrant, refugee & racialized women who have worked for many years in health care.
8	ESL Training	8.1	Cost of providing ESL training for newcomers be the responsibility of all levels of government.
		8.2	Allocate additional funds to second-language classes such as ESL.
		8.3	Provide ESL training to all Canadian residents (including immigrants, Canadian born individuals whose parents are immigrants, racialized groups and Aboriginal people) not only refugees, who lack the language skills necessary to become functional in the society.
		8.4	ESL programs become more flexible in terms of maximum hours of learning.
		8.5	All levels of government work with employers to provide tax rebates to motivate the introduction of language instruction in the workplace, including ESL or French language instruction.
9	Violence and Family Breakdown	9.1	Governments and agencies develop more culturally sensitive programs to support immigrant, refugee and racialized women and their families who are victims of family violence.
		9.2	Federal government examine its immigration policy and its implementation to ensure that there are mechanisms other than deportation for immigrant and refugee women whose sponsorship arrangements break down, and that this policy be well communicated to immigrant and refugee women.
		9.3	Establish alternatives to deportation for immigrants and refugees charged or convicted with family violence.
		9.4	Citizenship & Immigration Canada and other levels of government ensure the protection of immigrant, refugee & racialized women who are survivors of violence.

REFERENCES

- Baltzan, MA (1999) "Access to health care, socioeconomic status, and health" [Letter; comment], Annals of Internal Medicine, March 2; 130(5): 452-453.
- Bates MS, Rankin-Hill L and Sanchez-Ayendez M (1997) "The Effects of the Cultural Context of Health Care on Treatment of and Response to Chronic Pain and Illness." Social Science and Medicine, 45(9): 1433-1448.
- Bruce J (1990) "Fundamental Elements of the Quality of Care: A Single Framework," Studies in Family Planning, 21(2): 61-91.
- Campbell SM, Roland MO, and Buetow SA (2000) "Defining Quality of Care," Social Science and Medicine, 51(11): 161-165.
- Donabedian A (1980) The Definition of Quality and Approaches to Its Assessment. Ann Arbor, Michigan, Health Administration Press.
- Gorey KM, Holowaty EJ, Laukkanen E, Fehringer G and Richter NL (1998) "Association between socioeconomic status and cancer incidence in Toronto, Ontario: Possible confounding of cancer mortality by incidence and survival," Cancer Prevention and Control, October, 1998 2(5): 236-241.
- Government of Saskatchewan, "Healthy People. A Healthy Province. The Action Plan for Saskatchewan Health Care". Retrieved March 14, 2003 from: http://www.health.gov.sk.ca/hplan_health_care_plan_skgov.html
- Jenkins CNH, Le T, McPhee SJ, Stewart S and Ha NT (1996) "Health care access and preventive care among Vietnamese immigrants: Do traditional beliefs and practices pose barriers?" Social Science and Medicine, 43(7): 1049-1056.
- Rutstein DD, Berenberg W, Chambers TC, et al. (1976) "Measuring the Quality of Medical Care," New England Journal of Medicine, 294: 582-583.
- Singh N, Gupta M, Fell D and Gangbar E (1999) "Impact of inequity of inpatient waiting times for advanced cardiovascular services in community hospitals across the greater Toronto area," The Canadian Journal of Cardiology, July; 15(7): 777-782.
- Steffen GE (1988) "Quality Medical care: A Definition," JAMA, The Journal of the American Medical Association, 260(1): 56-62.
- Williams, C (2001) "Confronting the Racism in Research on Race and Mental Health Services," Canadian Social Work Review, 18(2): 231-248.
- World Health Organization (2003), "About WHO". Retrieved March 14, 2003, from: <http://www.who.int/about/en>