

# MENTORING INTERNATIONALLY TRAINED PSYCHOLOGISTS



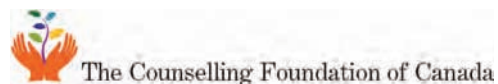
## *Manual & Discussion Guide*



*Produced for The Bridge Training Program for Internationally Trained  
Psychologists and Allied Mental Health Professionals*



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*Tanya and Eva have worked together with a strong advisory committee and hardworking staff team to develop the Bridge Training Program for Internationally Trained Psychologists and Allied Mental Health Professionals.*

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| Rexdale Women's Centre | St. Joseph's Women's Health Centre | TAPE Educational Services

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# THE MENTORING EXPERIENCE

Walking with Internationally Trained Mental Health Professionals  
at the Mennonite New Life Centre



*First mentoring group for internationally trained psychologists at the Mennonite New Life Centre (L to R): Norma Jimenez, Leticia Esquivel, Martha Rodas, Eva Saphir (Mentor), Luz Betancourt (circa 2008).*

**T**his manual and discussion guide is rooted in the experience of the Mennonite New Life Centre. It is the story of walking with newcomers through pain and resilience, supporting them along the journey to hope and wholeness in a context where culturally and linguistically appropriate mental health services are few and far between. It is the story of partnering with internationally trained professionals to offer these services within the context of a community-based settlement agency, where newcomers bring not just discrete settlement, language and employment needs, but whole lives and stories as well. It is the story of learning to better support internationally trained professionals in their own career development, that they might bring new eyes, new ideas and new gifts to the mental health profession in Ontario. We share this story to encourage creativity, innovation and partnership in and among settlement and mental health agencies, and to better meet the mental health needs of the increasingly diverse population in the Greater Toronto Area. Settlement agencies seeking to develop mental health programming may be particularly interested in Chapter 4.

Founded in 1983, the Mennonite New Life Centre is a multi-cultural settlement agency that supports newcomers from diverse cultural and religious backgrounds to participate and contribute in all aspects of Canadian life: social, economic, cultural and political. Newcomers receive settlement services,

language instruction, employment mentoring and supportive counselling. They also participate in a variety of group programs designed to build support networks and encourage active participation in civic life, programs that range from parenting support groups and leadership development workshops to citizenship classes. Our mission is to facilitate newcomer settlement and integration through holistic, person-centred services and community engagement.

Founded in response to the needs of refugees fleeing Central American in the 1980s, the Mennonite New Life Centre has always been deeply concerned with the emotional health and well-being of newcomers to Canada. In addition to addressing the social determinants of mental health, the New Life Centre has offered counselling and emotional support to refugees and other newcomers struggling with the traumas of the past as well as the stresses of a challenging and often uncertain present. In addition to early initiatives focused around bereavement counselling, art therapy, and anger management, the Mennonite New Life Centre has developed an innovative Community Mental Health Program, mobilizing the knowledge and skills of internationally trained mental health professionals to offer individual counselling and group work in Spanish to refugees and immigrants from Latin America.

Our Community Mental Health Program mobilizes and empowers internationally trained mental health



*Internationally trained psychologists and settlement workers from the Mennonite New Life Centre and the Learning Enrichment Foundation attend a training on cross cultural mental health at the Canadian Mental Health Association (2009).*







*Mental health interns Esbel Dorantes and Blanca Cruz (back row), and members of the children's art therapy group, pose in front of their art display (2009).*

professionals to meet the emotional health needs of Spanish speaking newcomers in Toronto. Through this unique program, internationally trained clinicians offer individual counselling and group programs to settlement clients presenting with mental health needs. Tailored group programs have allowed us to develop new models of mutual support, strengths-based empowerment work, and collective advocacy to address the root causes of emotional distress. Meanwhile, the internationally trained clinicians themselves receive support, professional development and clinical supervision via a biweekly mentoring group meeting with an experienced therapist. Professional mentoring supports internationally trained professionals in transferring their skills and experience to a new professional context.

Our experience has taught us much about developing responsible systems for screening, interviewing and orienting internationally trained professionals, for explaining our work and documenting informed consent, for developing and signing off on counselling reports in support of refugee claims and other sensitive legal processes, for encouraging and supporting interdisciplinary collaboration between settlement workers and mental health counsellors. Much of this organizational learning is shared in Chapter 4, to support other settlement agencies interested in developing mental health programming based on this model.

**Tanya Chute Molina, MSW, RSW**  
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More than this, however, our experience has taught us to believe in the power of a dream, and in the enormous gifts and generosity of internationally trained mental health professionals. In three short years, our Community Mental Health team has grown from two, to four, to ten internationally trained mental health professionals. We have been witness to the great hunger among internationally trained professionals to exercise their skills and to respond to mental health needs in their community.

As we have learned more about the employment barriers faced by internationally trained professionals, we have begun to seek out new strategies to support them in their career development, first through paid internships and then through partnership with other settlement, mental health and educational institutions to develop a formalized Bridge Training Program. At the time of writing, the Mennonite New Life Centre has three paid internship positions for internationally trained mental health professionals. We are also home to the project staff and classroom activities for the Bridge Training Program for Internationally Trained Psychologists and Allied Mental Health Professionals.

As we look to the future, we look forward to deepening our partnership with internationally trained mental health professionals and the broader mental health sector in promoting resilience, mental health and well-being for diverse communities in Ontario.



*Orientation session for the first cohort of students in the Bridge Training Program for Internationally Trained Psychologists and Allied Mental Health Professionals (August 2010).*



# Mentoring in Context

## The Future of Mental Health and Addictions Services in Ontario



*Internationally trained professionals are needed to strengthen and diversify the mental health and addictions workforce.*

Internationally trained professionals have a critical role to play in helping the mental health and addictions sector respond to the service and labour market challenges of the future. Mentoring internationally trained professionals is about opening new doors for service recipients and service providers. It is also about mutual learning, and mutual transformation, whereby mentors and mentees learn together to make the mental health and addictions sector ever more responsive to the population of Ontario.

In July 2009, the province of Ontario released a discussion paper entitled *Every Door is the Right Door*, outlining a framework for a 10 year Mental Health and Addictions Strategy. At present, many people fail to find the help they need due to the complexity of the system, as well as the strong focus on diagnosis and treatment of serious mental illness. A central theme of the discussion paper is enhancing accessibility, whereby people can use a much wider variety of “doors” to access mental health and addictions services. It outlines a vision for a culturally competent mental health system that reaches out to the whole population, gives priority to prevention and early intervention, and works in a coordinated and integrated manner with other services and government ministries.

The discussion paper notes a number of labour market challenges that need to be addressed in order to achieve

this vision. It states: “shortages of skilled mental health and addiction workers are common across Ontario and contribute to wait lists, job stress and burnout. With the ageing of the health workforce, the problem will only become worse” (Every Door, 2009, p. 40). The discussion paper notes that the workforce is already hard pressed to meet growing needs and that strengthening the mental health and addictions workforce is critical to the success of the new strategy. Workers are needed not only for traditional mental health jobs, but for a new system of integrated care, where mental health expertise will become a key inter-professional competency across a variety of service systems, in order to ensure that “every door is the right door” to access mental health supports.

In particular, the paper notes a labour market need for workers who can offer culturally competent care. Unfortunately, the Ontario mental health labour force has not kept pace with the diversity of the community, creating service access barriers and limiting system effectiveness. Research shows that mental health services are most effective when provided in the client’s first language (Sadavoy et al, 2004; Hoen & Hayward, 2005). A newcomer guide to mental health services, published by Community Resource Connections of Toronto, encourages immigrants and refugees to seek help from someone who understands their culture and language, while acknowledging that few such services currently exist.



Internationally trained professionals have an important role to play in achieving the vision outlined in the *Every Door* paper. Those who come from countries with greater experience in inter-professional collaboration may bring new ideas and models for integrated care. International practitioners also bring critically important skills and perspectives to multicultural mental health practice: from language and cultural understanding, to lived experience of the challenges of migration and adaptation. These assets enhance their ability to empathize and connect with a diverse population.

In the context of growing mental health needs, internationally trained professionals also represent an important human resource to grow and strengthen the mental health and addictions workforce. For instance, 2006 census data show 4,935 foreign trained mental health professionals living in Ontario who had immigrated in 1996 or later. Of these, only 235 had worked in psychology or counselling positions

since immigrating to Canada. Unfortunately, many internationally trained professionals experience difficulty reintegrating into their field of expertise, both because of language and knowledge gaps related to professional practice in Ontario, and because of the challenges of understanding and meeting regulatory requirements. In particular, internationally trained psychologists who have been practicing with a bachelors or masters degree in their country of origin often get stuck when they learn that they need a PhD to practice as a psychologist in Ontario. Mentors can play a key role in helping to open doors to other professional roles within the mental health sector, or supporting mentees on the long journey to credential recognition. Critical skills are lost when internationally trained professionals lose hope of practicing in Canada. By helping mentees maintain hope, mentors contribute not only to the development of individual careers, but also to the growth and development of the mental health sector.

## References:

Community Resource Connections of Toronto. (n.d.). *Navigating mental health services in Toronto: A guide for newcomer communities*. Downloaded March 2008 from <http://www.crct.org>

Hoen, B. and Hayward, K. (2005). *CHC Mental Health Services for Newcomers: A Guide Reflecting the Experience of Toronto Community Health Centres*. Downloaded March 2008 from <http://www.accessalliance.ca/>

Ministry of Health and Long Term Care. (2009). *Every door is the right door: Towards a 10-year mental health and addictions strategy*. Downloaded September 22 2009 from [www.health.gov.on.ca](http://www.health.gov.on.ca)

Sadavoy, J., Meier, R., Ong, A.Y.M. (2004). *Barriers to access to mental health services for ethnic seniors*. Canadian Journal of Psychiatry 49:192-199.

Statistics Canada. 2009. *2006 Census of Population (master file)*. Using York University Research Data Centre (distributor). Released January 2009.





# INTRODUCTION



*Mental Health interns Marisabel Tovar Abu-Jaber and Leticia Esquivel mentor fellow newcomers, supporting them to become leaders for change in their communities.*

This manual is more a personal essay than a technical document. Although the term “essay” has many definitions, I choose this one: according to the Encarta Dictionary of English, “essay” is an attempt to accomplish something, a test or a trial.

The topic at hand is how a group of people worked together to meet two needs: mental health needs in immigrant communities, and professional development needs among internationally trained mental health professionals. Since 2007, I have participated in a project that helps internationally trained professionals gain Canadian experience, while providing fellow immigrants and refugees with language and culturally specific mental health services that are not readily available in the community at large. As a member of the Latin American community, I see it as taking care of our own.

The story may go something like this: “Once upon a time there was a need. Some people saw this need and invented a possibility to start meeting it. With fits and starts, trials and errors, it took a shape and as it developed, they noticed other needs. It was like

opening a door into a room that has several other doors to open, and each door leads to another room with other doors. Some people might have gotten frustrated believing that this task was never going to finish, but the people in this story got excited because they saw one opportunity after another to grow, learn and have an impact. It was not a job, it was a passion.”

My role in this story, and my passion, has been mentoring internationally trained mental health counsellors as they exercise their knowledge, skills, and insight in a new professional context. In this role, I have had the opportunity to participate in the Advisory Committee for a new Bridge Training Program for Internationally Trained Psychologists and Allied Mental Health Professionals. This program offers academic bridging, occupation-specific language training, supervised work experience, and professional mentoring to internationally trained mental health professionals. Bridge training mentors and internship supervisors are the primary audience of this manual. Its content, however, may also be of interest to others concerned by the two needs that inspired this project:





mental health needs in immigrant communities, and professional development needs among internationally trained mental health professionals.

Through this manual, I hope to pass on my passion and encourage others to invest in the potential of internationally trained professionals. I also hope to pass on my experience for others to use in their own way. This work is only a suggestion, based on experience in the particular context of the Latin American community. Whoever uses it may adapt it and make their own mentoring work as different and unique as it needs to be.

I tend to differentiate the word “mentor” from the word “supervisor”. From my cynical observations of my cultures (both Canadian and Latino), I have concluded, generally, that a supervisor is considered to occupy a higher level of authority, experience and pay. From a position of superiority, they generally focus on what is wrong and attempt to impose what is right and convenient for them. OK, maybe not everyone is like that; possibly I am exaggerating a little.

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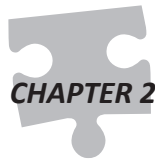
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The word “mentor” suggests an alliance from the perspective of peers. It is essential to keep in mind that bridge training participants, like other foreign trained mental health practitioners, are already experienced professionals. They know their subject matter and, like the rest of us, will always benefit from further “professional development”.

*Mentoring is professional development.* The purpose of a mentor is to improve the profession that we have in common by encouraging the development of the practitioner. Taking into account that there are no prescribed solutions in our field and that so-called “best practices” are only suggestions, the purpose of a mentor must be to encourage creative thinking.

What I hope to accomplish is to start a process and see what happens. My intention is not to give you etched-in-stone rules and procedures, but instead to share scratched-in-jello possibilities based on what worked with us. Feel free to write your own ideas in the manual and record issues that come up in your groups. Please write to us and contribute these ideas so that we can keep updating and evolving.





## CHAPTER 2

# GROUP MENTORING

## Approach, Structure and Philosophy



*The Community Mental Health team gathers for a mentoring meeting with Eva Saphir at the Mennonite New Life Centre (circa 2008).*

**M**y experience has been in mentoring internationally trained mental health professionals volunteering and working at the Mennonite New Life Centre. It is important to stress that this has been primarily a group mentoring experience. Group mentoring is qualitatively different than individual mentoring, in that it allows for mutual learning and support.

In my experience, group mentoring is particularly suited to the needs and strengths of internationally trained professionals. The employment barriers faced by internationally trained professionals strike a blow to their professional confidence and sense of self. Bringing these professionals together in a group mentoring experience gives back some needed recognition of the clinical knowledge and skills that each participant brings to the table. Furthermore, the mentoring group reduces the isolation experienced by internationally trained professionals, giving them the opportunity to find themselves once more among peers, to recognize that the employment barriers they are facing are more about the system than about themselves as individuals, and to give and receive support.

To adapt a phrase from Shakespeare, “The group’s the thing”. That which benefits the group ultimately benefits the clients. It is essential to remember that this experience is not about a job for our volunteers and bridge training participants; it is the link to their identity and passion. Imagine a person who has lost someone dear and after a time of grief and adjustment to the loss, finds that someone again. That which was once lost, and then found again, becomes more meaningful, more conscious, more valued. The passion is reignited with more fire, like a rebirth.

This is the excitement with which internationally trained professionals enter volunteer opportunities at the Mennonite New Life Centre. One of them expressed it this way: “I feel alive again after a long time”. Another talked about reconnecting with her sense of self: “On the street, at work, I’m someone else. At the New Life Centre, I’m Norma.”

This fire must be kept stoked. That is perhaps the most important, though least tangible, job of the mentor.

It has been my experience that before people attach to a project or idea, they attach to the people in the project. In a language-specific group such as the Community Mental Health team at the Mennonite New Life Centre, people bond quickly and then more deeply with time. With Spanish speaking people, the language is a strong bond. In language-heterogeneous groups, like the clinical seminars for bridge training participants, the bond is the profession that was lost, the immigration experience, etc. In these and other cases, the initial bond may be with the mentor, who then facilitates group development.



## The Mentoring Meeting

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The mentoring meeting, as it has evolved at the Mennonite New Life Centre, is a meeting of internationally trained professionals with an experienced mentor, who facilitates discussion of clinical challenges and guides learning about professional practice in Canada. Guest speakers may join the group for discussion of particular topics, such as referrals to Children's Aid, or counselling reports in support of refugee claims. Both participants and guests are subject to a confidentiality contract in order to protect client information and to encourage participants to share freely. Mentoring is not and cannot be about evaluating; it is about supporting participants to learn and grow from the challenges they face in their practice.

In the spirit of mutual learning, the mentoring meeting agenda is established at the beginning of the meeting by all present. The mentor leads the meeting and requests input for discussion. The general order is as follows:

- Greeting and hugs to group members (cultural ritual)
- Introductions and welcome to any guests who may be present
- Agency/program announcements
- Call for agenda items: cases to discuss, other issues and concerns
- Guest speaker presentation and discussion (if any)
- Case discussions
- Issues and concerns
- In-service education by group members and/or mentor on topics of interest, as time permits.

Each member of the group brings unique experiences. What one member does not know, someone else in the group has usually done, and so they feed each other. During case consultation sessions there has to be time for input from members. This validates and enables them. The mentor brings specialized knowledge and experience of the practice environment in Ontario, but all members of the group have clinical experience and wisdom to offer.

As should be clear from the meeting agenda described above, the mentoring process is directed by the participants, who raise cases and concerns for discussion. It is important that the mentor trust the group and feels comfortable allowing participants to identify their own learning needs. It is also important for the mentor to be open to individual consultations if participants are not comfortable sharing a particular case scenario or personal challenge with the group as a whole. In my experience, most group members develop the trust to share challenges and concerns with the group. Some approach me for individual consultation after the mentoring meeting, or follow up by phone or email at another mutually arranged time.

One can see by the extensive agenda that there is a good case to be made for weekly two-hour mentoring meetings with internationally trained professionals engaged in an ongoing practice experience. Besides the business and education issues, there is also, intermittently, a need for humour and bonding.



## Professional & Personal Support

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At the Mennonite New Life Centre, as in many of the agencies where bridge training participants will complete their internships, both mental health professionals and clients are immigrants. It is possible that some—both professionals and clients—have come as refugee claimants and are suffering the anxiety and uncertainty of a hearing at the Immigration and Refugee Board. It is necessary and important for mentors to keep in mind that professionals going through the bridge training program may be as vulnerable as the clients they are serving, and they may indeed be going through the same experiences, sometimes at the same time. This means, for example, that a professional who has lived through the trauma of war may be counselling a client who is seeking refugee status because of war violence. It may even be that both the professional and the client are dealing with the same anxieties of preparing for a hearing or waiting for a decision.

Mentors need to be very sensitive to any aspect of the experience of the internationally trained professional that would necessitate individual attention and support. This does not mean being intrusive with questions, but rather being alert to emotional clues. If the mentored group is cohesive, friendships will be made between the professional participants. If the mentor is perceived as non-judgmental, trustworthy and loyal to the group, then important information will be shared.

The job of promoting the profile and success of the program belongs to the administrators. The work of promoting the confidence and success of the participants belongs to the mentors. If the Bridge Training Program is viable, these two roles will work smoothly with each other because they will share the same philosophy.





## Mentoring: A Working Philosophy

A mentor needs to be consistent, optimistic and have a comprehensive life philosophy that explains their approach to clinical work and to the mentoring process. The rules must generally make sense and be consistent. If there are exceptions, then the rules must be clarified to include that possibility. Initially, fewer rules give the opportunity for the group to develop organically through natural consequences and learning opportunities. Imposing rules without the input and consensus of the people affected is disempowering.

My own mentoring philosophy rests on two pillars. The first is: "Try it; see what happens." No one knows enough about life to accurately predict outcomes for people's behaviour. Scientists are constantly experimenting to deepen their understanding of nature. They work in a laboratory. Life is the laboratory in our case and both mentors and mentees must feel free to experiment within the limits of ethical professionalism.

The second pillar of my mentoring philosophy is rooted in the popular adage: "Practice what you preach." Over the years, I have observed that I cannot help anyone evolve to a level of maturity beyond my own.

### Here are some additional building blocks that I bring to my mentoring structure:

#### Separate thoughts and facts

It may take years of training for yogis to empty their minds of thoughts. I haven't practiced long enough to accomplish that feat. My mind has thoughts all the time: it observes, it judges, it has fantasy conversations with people, it reviews past events, it plans for the future. Only at times is the brain in the present.

Clients often come to therapy believing that this is pathological. "I can't sleep because my thoughts are racing all the time," says a client. The thoughts preventing sleep may be: "I should be acting on my thoughts. I should not be having these thoughts. There is something wrong with me."

Often, what is keeping people awake is not so much a concrete preoccupation as a judgment about what is happening in their life. For example, a woman may believe that if she has had intercourse before marriage, she has dirtied herself. She then may act as though she is unworthy and isolate herself. If pregnant, she may think that she must stop studying, get married, give up on her dreams. The thought and judgment may come from social or religious conventions.

*Think of other examples where beliefs (thoughts) and judgments (thoughts) are confused with facts. For example: "If I fail this test, my life will be in ruins", "If my son drops out of school now, he will get into drugs and crime and his life is ruined for ever."*

Thoughts do not create problems. *Judgments* about thoughts and the consequent *actions* create problems. Just as a good counsellor works with clients to help them become aware of their thoughts and judgments, so mentors must continually be aware of their thoughts and assumptions, so as not to act upon harmful judgments and cause problems. For example:

- The mentor may offend mentoring group participants by making stereotypical assumptions about their beliefs or behaviour based on their country of origin.
- The mentor may try to impose their own cultural norms, political opinions or religious beliefs on members of the mentoring group.
- The mentor may make negative judgments about participants' clinical knowledge or expertise based on unconscious influence of racist views in the media and social environment.

It is important for mentors to be aware of differences within cultures, as well as across cultures. We can often have mistaken assumptions about people who come from our own culture, and more harshly impose our own norms and beliefs.

The role of the mentor is not to impose norms, but to support internationally trained professionals in bringing their unique gifts and perspective to mental health practice, within the ethical and legal parameters of the profession.



## Words limit expression: Ask questions to clarify meaning

Be suspicious of words because they are often used to hide information. Politicians and advertisers do it all the time.

Therapists cannot understand their clients' meaning until they know the person.

How can we know people if we rely only on words? It takes time, experience and practice—and even then, it is only a guess. So we question everything.

It helps to have some common experiences, and it helps to make guesses, just so long as we verify these guesses with the person concerned. Someone once told me to never assume. Don't believe it. It can't be done. The important thing about assumptions is not to avoid having them, but to become aware of what our assumptions are and then to question them.

A mentor must help participants take the time to get to know their clients. Working in a multicultural context may be a new experience that requires asking more questions in order to avoid mistaken assumptions. Mentors must also take time to get to know mentoring group participants. Only then can they make an educated guess about the real concerns and fears that may underlie a case consultation, or recognize the need for affirmation and encouragement to build professional confidence.

## Understanding context: Challenges in cross cultural communication

Words are not neutral; they come with the meanings and expectations bestowed by experiences. Sometimes these meanings and expectations depend on context. Consider the word "love" as used in the following contexts:

1. An abused woman: "I can't leave him, I *love* him."
2. A parent hitting a child: "I am doing this because I *love* you"
3. A teen: "I *love* this song"

For internationally trained professionals, it takes time to understand such nuances in English. Misunderstandings may arise with clients or with peers. Mentors can help internationally trained professionals be aware of multiple meanings, ask clarifying questions, and be proactive about revisiting conversations when a misunderstanding or conflict becomes apparent.

Mentors can also be aware of the potential for miscommunication that occurs when second language speakers use a turn of phrase that works in their mother tongue, but means something else or sounds impolite in English. Assume good intentions, ask questions, and use these incidents as a teaching moment to share new words or phrases that will help internationally trained professionals communicate more successfully with clients and colleagues.

## Challenges and expectations

M. Scott Peck's book, "The Road Less Travelled", made quite an impression on me. This is what I took away from the very first page: Life is a struggle - but as soon as you accept this very premise, life ceases to be such a struggle. Letting go of the expectation that life will be easy makes it easier to embrace and to overcome the challenges we face.

In my mentoring work, I ask internationally trained professionals to erase the word "difficult" from their vocabulary. I ask them to substitute the word "challenge" instead. I notice that people tend to use the word "difficult" when they are discouraged and believe that they cannot succeed. Difficult comes with a STOP sign. "Challenge" generally implies that something can be done and that one can get better with practice. Olympic athletes speak of challenges; mountain climbers face challenges; children keep at the challenge of walking until they can do it.

Embracing life as a challenge is about letting go of rigid preferences and expectations. Life doesn't always meet our expectations. That makes sense to me, but there is a



glitch: The human brain is made to have preferences and expectations. How do these two apparently contradictory truths go together? What are the implications?

The main one is: Life is a challenge.

Some corollaries:

- As new challenges arise, the expectations we developed for ourselves earliest in life are the hardest ones to give up, so old problems keep popping up as the gap between expectations and reality widens.
- Even bigger problems arise if we have rigid expectations for *other* people to meet, especially if we have created these expectations without their consultation and agreement.

People have different life experiences, which have shaped different expectations. We tend to believe, sometimes quite unconsciously, that what has worked for us will work for everyone else. As a mentor, I must be able to accept challenges to my assumptions and test and affirm different approaches to clinical cases. I must also be able to support and advocate on behalf of the professionals that I mentor, even when their approach is different from my own.

### The three F's: Flee, Fight, Flow

There seem to be three major options for meeting challenges. These may change from second to second and depend on personal choice and circumstances. When presented with a problem one can FLEE, FIGHT OR FLOW. No one option fits every situation and a decision is best made after considering all possible consequences or outcomes.

In mentoring, for example, there may be times when a mentee may have a definite idea about an approach to a client that is different from the usual practice of the mentor. Your first instinct may be to fight the idea, but upon further reflection you might decide to flow. It can be useful to keep in mind that there are many different approaches to therapy, and different studies supporting the benefit of various therapies. There are also studies which suggest that a client's rapport with the therapist is more important in recovery than the therapy itself.

Other mentoring scenarios may present similar challenges. Consider a potential comment from a mentee who admits that they have no experience working with gay men and that they have never, in fact, known one. Do you avoid the question (flee)? Do you lecture on human rights (fight)? Do you thank the mentee for having the courage to bring up a sensitive subject (flow)? Do you ask what specific concerns there are (flee, flow)? Do you bring the group into the discussion and ask them to share their experiences (combination)? Do you offer to bring a speaker from the community (combination)?

Each of the options—flee, fight, and flow—can be used in productive and non-productive ways. Consider your typical approach—your leadership style. Which option are you most comfortable with? What are the kinds of situations where you need to challenge yourself to take a different approach? Self reflection can help you prepare for difficult conversations and learn from your experiences.

## Conclusion

For internationally trained professionals, much is new in Canada. Cases, contexts and resources may have been very different in the country of origin. In Ontario, for example, a professional who writes a letter to an organization on behalf of a client expects a response. This may be surprising to an internationally trained professional from a country with much more limited access to people in power, where communication with those in leadership positions must be brokered. Manners of thinking and problem solving need to change as cultural context changes.

*In short, the approach to problem resolution must include broadening the scope of possibilities for mentees, so that they too can help their clients see a new breadth of possibilities. As a mentor, help your mentees brainstorm solutions – even ideas that might seem unlikely. This encourages the practice of considering possibilities before censoring.*



# MENTORING ISSUES

## *Social Issues, Counselling Issues, Therapeutic Issues*



Bridge Training participant Maryna Svitashcheva poses a question to the keynote speaker at the Opportunities Fair for Internationally Trained Psychologists (October 2010).

As a mentor, some of my most important discussions with internationally trained professionals have been about the social context of mental health practice in Ontario. We've talked about social realities and social values: prejudice, harassment, anti-oppression, and feminism. We've also talked about counselling issues as they relate to social norms: challenging issues like child abuse, domestic violence, and suicide. All of these are issues that are understood in different ways both within and across cultures.

For the mentor, it is important not to make assumptions about the viewpoint or the values of internationally trained professionals based on their cultural background. At the same time, because we work in a values-based profession, it is critical to be able to engage in honest conversation about the values that guide our work, and how personal values interact with organizational values.

I see my role as orienting internationally trained professionals to the social context in which they will practice. It is not about asking them to adopt another cultural norm, but rather about familiarizing them with the dominant values of the workplace. Information is power. Participants must know the rules of play to decide whether and how to play. Legal norms must be followed. Other norms may be embraced, adapted or contested.

There is also the matter of understanding the difference between, say, the medical model of hospital practice, and the wellness model that might govern a community health centre, and choosing the practice context most congruent with one's personal and professional values.

The discussion points that follow are not all there is to know. They are a starting point for further discussion. For mentees, the learning curve is steep. They must adapt to new social contexts and new ways of dealing with known clinical concepts. Adapting does not mean giving up one's culture, traditions or beliefs, but it does mean making choices about what fits and how, and also what doesn't fit and may therefore require modification.

*The mentoring process is not about asking mentees to choose one approach over another, but to offer the information needed to navigate new concepts, norms and vocabulary, so that the newcomer professional learns two social languages and can choose when and how to move from one to the other as necessary.*





## Social Issues

Our job is to open the eyes of mentees to our world of mental health in Ontario. I hope that we will not tell the mentees what this world is “really like,” but rather invite them into a learning process.

A mentor has a diverse *range* of experience in Canada. Mentees also have a depth or breadth of experience *in their country*. My assumption is that the concepts below may need to be discussed because of their importance to the mental health world in Ontario. Other cultures may not have these concepts or apply them to the mental health field in the same way.

*These concepts are also understood in different ways here in Ontario. I suggest some basic definitions and considerations as a starting point for discussion in mentoring groups. Feel free to add other issues. Consider that these ideas and understanding are written in jello. The hope is to generate discussion.*

### Prejudice

Everyone knows the word “prejudice,” so we often assume a common understanding of what this means. However, this word, as other words, is just air until it is used in a context.

I define prejudice as a learned judgment that is based in fear and/or ignorance. From the perspective of Cognitive Therapy our issues have to do with our prejudices treated as facts. In general, “prejudice” is considered a “bad” word, but it is merely a description of a universal human behaviour. All of us have prejudices. We need to be aware of our prejudices in order to make useful choices about what we do with them.

How a prejudice comes about is not as important as how it is used. Instead of using the words “Bad” or “Good”, I have found it more useful to describe feelings, thoughts or actions as “Useful” or “Not Useful”. My logic is that “Bad” and “Good” are labels that do not allow much flexibility or change. The prejudice is not necessarily the danger—after all, it is only a thought. The danger is in the ACTION(s) that may arise from that prejudice.

Prejudices are useful when revealed in a safe environment so that thoughts, feelings and actions can be modified as necessary.

*Help your group identify and discuss some prejudices and corrective ideas and actions that can be considered.*

### Harassment

This is where we move from thoughts to actions. I define harassment as harmful behavior by one or more people against one or more others because of prejudice. Harassment arises from a misuse of power to create an imbalance.

This behaviour can last for as long as the people involved are in the same environment. It is a specific and individually targeted behavior, linked to but separate from systemic discrimination and oppression. Harassment can be difficult to identify and prove. In harassment, the overpowered group or individual lacks support from peers, who fear retribution. It may feel like a dwarf fighting a giant dragon with a slingshot. Harassment begins in the school playground with children playing the role of bully, bullied and bystanders, and continues into the workplace, where adults assume the same roles.

Many immigrants or refugees have experiences of harassment in the political or domestic context of their countries, where authorities endorse these actions and/or do not carry out their duties to protect. Harassment also happens in Canada, often in more subtle ways.

*As mentors, we need to give internationally trained professionals the tools to recognize harassment in the workplace, and to take appropriate recourse. Reflecting on sample human resource policies may be a helpful way to facilitate discussion of acceptable and unacceptable behaviours at work.*



## Oppression and Anti-Oppression

These are tricky words that can cause strong reactions from anyone accused of “oppression”, as well as from anyone who experiences it.

Here is a classic case of multiple meanings. To a refugee professional, oppression may be a life and death matter of political persecution. Moving into a Canadian workplace, it may be difficult to understand the broad use of this term to describe a range of discriminatory or exclusionary behaviours tied to race, gender, class, ability, or sexual orientation, among other social identities.

I define oppression as the harmful application of power by one group in order to suppress, hold back, stifle and diminish the perceived threat of another group. In other words, oppression is the systemic imbalance of power, fueled by fear and a false sense of superiority. Oppression, and the struggle against oppression, is old and persistent in human history.

“Anti-oppression”, “anti-racism”, “anti-discrimination”, and other similar terms are used to describe approaches to human service work that gives priority to challenging oppression at the individual, organizational and societal level. It may mean supporting a client to overcome the scars of internalized racism, or considering issues of access and equity in the design and delivery of mental health programs. It may mean critically evaluating structures of power within an organization and diversifying the faces around a board table. It may also mean advocating on public policy issues in order to address systemic inequities at a societal level.

Discussions of oppression and anti-oppression can be controversial. As is the case with racist stereotypes, the word “oppressor” can also be used to label one person with the faults of a whole group. Thus, white people may be labeled as oppressors for their practice of slavery in the past, as well as for unfair and discriminatory practices in the present. The individual white person may agree that past and present injustices are real, but take offense at being identified as an oppressor.

In order to avoid misunderstanding, it can be helpful to talk about the relative “power” and “privilege” of different groups in society, and the struggle of disempowered and underprivileged groups for justice and equality. It can also be helpful to acknowledge that identity is multi-dimensional: an individual may experience privilege in one dimension of their identity, while also experiencing oppression. On the other hand, oppressions may also overlap, as in the case of a refugee woman living in a shelter, or an aboriginal survivor of the residential schools, who is now living on the street. In both cases, the individual is doubly marginalized due to poverty and racism, leading us to talk about intersecting oppressions. The implication is that real change requires us to link struggles against marginalization and oppression in all its forms.

Some work environments are intentional and effective in promoting anti-oppression, while others only pay lip service.

*Mentors can alert mentees to the importance of reading about an organization's philosophy or approach before applying for a job or going to an interview. This may provide a guide for considering whether organizational values match one's personal values, although ultimately it is how values show themselves in action that is most important.*

## Feminism

In Canada, women were not legally recognized as persons with the right to vote until 1928. Gender inequality continues to mark the lives of many women accessing mental health services, in many and varied forms ranging from stress resulting from unequal sharing of child and elder care responsibilities, to trauma arising from workplace harassment or domestic violence.

Feminism, as a theoretical approach and a social movement, is a response to an imbalance of power that relegates women to a disadvantaged position, either by design or incidental to other priorities. Feminism is often misunderstood – both in Canada and around the world – in that some people tend to think of it as anti-male, anti-marriage or anti-family. For this reason, it merits discussion with mentees.



In my view, the real intent of feminism is to redress the imbalance by empowering women and redesigning their role in society. Feminist activists have campaigned for women's rights to hold property or exercise the vote, while also promoting reproductive rights. They have opposed domestic violence, sexual harassment, and sexual assault. In economics, they have advocated for workplace rights, including equal pay and opportunities for careers and to start businesses. In this sense, feminism is not an "anti" word. Rather, it should be seen a "pro" word which emphasizes *awareness* of inequity and *action* to promote justice.

Feminist therapy recognizes that many of the problems that arise in the counselling process have their roots in social inequality. Rather than further blaming the victim, therapy recognizes these social forces and seeks to empower the client.

*Mentees will benefit from discussion and clarity in this area because questions related to feminist practice are common in job interviews, particularly in agencies specifically focused on violence against women.*

## Conclusion

Harassment and oppression are behaviours that arise from prejudice and result in inequity. Inequity gives birth to resistance, and to the struggle for change. It is through this struggle that gains are made for social justice: child protection laws, women's suffrage, the right to unionize, to give just a few examples.

That which is apparent in society at large may in fact start at the individual and family level. One may consider two phases of individual development (at least in North American society) that are particular opportunities to assert one's identity and question conventions: "the terrible twos" and adolescence. Unfortunately, social institutions, often represented by parents and schools, may suppress emerging creativity and curiosity by instilling fear and punishment. This serves to silence dissent and maintain power imbalances. Over the long term, however, it may stimulate protest and rebellion.

*The role of the mentor is to take a new approach to education, encouraging critical thinking and dissenting opinions so that internationally trained professionals can ask the questions that lead to professional and social transformation.*



## Counselling Issues

Counselling issues are social issues that emerge in individual, family or couple contexts. What exists in society at large also exists at the individual and interpersonal level. Fear and loss of significance underlie most counselling issues. They may lead to nonproductive behaviours through which clients seek to achieve the illusion of safety and redress power imbalances by disempowering another.

When discussing highly emotional topics, it is essential to keep in mind that some of the mentees in a mentorship group may have themselves experienced domestic abuse, suicidal ideation, immigration trauma, closeted sexuality, and so forth. It is important for mentors to monitor their biases and measure their speech so that mentees do not experience further rejection and trauma.

### Here are some specific topics for mentors to consider in the process of orienting the internationally trained mental health professional:

#### Child protection

Society has highlighted and prioritized our concern for children's well being through laws meant to protect children. Agencies have been created to ensure that protection. Child protection workers are undoubtedly committed to the welfare and safety of children. However, due to the pervasive social inequities discussed earlier in this paper, and because of errors, omissions and the stress of limited resources, child protection agencies have historically had a troubled relationship with marginalized communities. To give just one example, the relationship between child protection agencies and the aboriginal community has been particularly problematic. During the 1960s and beyond, the child welfare system removed disproportionate numbers of aboriginal children from their homes and communities, placing them in foster care with white families who had no understanding or respect for their culture.

It is helpful to acknowledge that the child protection system is not perfect. At the same time, internationally trained professionals need to know that they have a legal obligation to report suspected child abuse to a mandated child protection agency: Children's Aid Society, Catholic Children's Aid Society, Jewish Family & Child, Native Child & Family Services. When in doubt, they should report and let the child protection workers design the steps to follow. Children at risk are not only children who get verbally, physically and sexually abused, but, very importantly, children who are neglected and/or witness abuse.

Mental health workers may have many concerns about reporting suspected child abuse:

- Fear of endangering the therapeutic relationship.
- Desire to avoid the negative impacts of intervention: Clients may ask for another chance, or beg the counsellor not to report because of fear that the child will be taken away. The client may also speak of possible repercussions, threats, dangers, humiliation, and so forth.
- Distrust of the system, which could be linked to the worker's own traumatic experiences with abusive people in positions of authority in their own countries.

This list is not exhaustive, and any discussion of child protection needs to include cases that have gone wrong.

Sharing a client consent form with mentees (appendix 1) is a way that mentors can address concerns about confidentiality and therapeutic alliance. The consent form explains the role of the counsellor and informs the client of the counsellor's commitment to confidentiality as well as exceptions to confidentiality, including the counsellor's duty to report suspected child abuse. By signing the form, clients indicate their understanding of the information and acceptance of its terms. Many agencies will have their own forms and procedures for this.

*I recommend inviting a child protection worker or supervisor to speak to the mentoring group. Internationally trained professionals need to understand the working context of child protection in Canada. The stated ideal of the law may be different from the reality due to several factors including inadequate funding and a lack of other resources needed to implement adequate protection. There should be no doubt in mentees' minds that a child's safety is always more important than the therapeutic alliance with the parent(s).*





## Children and Parenting

It is the parent's responsibility to educate the child by passing on the necessary tools to orient the child and ensure she has the skills to function in life. This is not just about the parent's culture and wishes for the child. Life exists in the greater world, too. Authoritarian parents do not provide such tools, nor do negligent parents. Neither train the child to make responsible decisions or resolve unwanted consequences. A parent, like a teacher, a therapist and a mentor, needs to teach her child how to think.

Thinking and making decisions are transferable skills. Strict authoritarian rules do not help to develop this sort of skill. This is a new concept in many cultures, one which many well-intentioned parents find difficult to understand. Newcomer parents who seek to pass on their cultural values by imposing rules often provoke rebellion and ultimately fail to prepare their children to find their own way between two cultures.

This is why it is important to talk with internationally trained mental health professionals about parenting. By encouraging mentees to think, mentors help them and their clients explore new models of parenting. Models grounded in respect and empowerment prepare children to better negotiate their changing social environment.

Parenting must be practiced for the benefit of the child, not for the convenience of the parent. A parent who hits or yells at a child to enforce certain behaviours does not teach the desired behaviours. Rather, she passes on the violent behavior she is modelling. A small child is totally dependent on her parents and through this relationship learns about life, about others in her life and about herself in the social context. Parents or adults responsible for the child must empower, not overpower.

It's not always easy to take this approach. Parents may not feel they are accorded the respect they want from their children—or at least not in the ways they want. Children are programmed for personal survival. Their first behaviours are geared to get what they need to

fulfill this natural mandate. In the beginning, they do this without the ability to communicate in the parent's language. So, not unlike many of us when we feel misunderstood, they yell. Sometimes this behaviour continues beyond the early years, unless parents teach and model to them how to communicate in a more useful way.

Three basic tenets of parenting:

- Kids are not there for your convenience.
- They don't yell to bother, they yell to express a need.
- It is your job to give them useful tools to understand life and make choices.

It takes a while to learn this from life. It is more effective to provide parenting classes so that parents can learn together and support each other.

Finally, it is useful to keep in mind that children are marvelous observers. They watch everything. They are also lousy interpreters of what they see because they do not have the experience to make sense of it. Lack of information leads to poor decision making. This leads us to the next topic.

## Sex and Drugs

It has been my experience that mental health workers know very little about drugs. In fact, most people don't know much about drugs. Fewer people know much about sex, despite the fact that references to sex and drugs are pervasive topics in pop culture. References to sex in many other cultures are shameful and references to drugs are not even part of public awareness except as illegal substances.

Young people constantly see and hear not-so-veiled references to sex and drugs without being given any real information. What they learn from friends is "everybody is doing it, it is available everywhere, people look happy doing it, it's what socializing is all about." A common conclusion can be that if it looks like fun and "everybody is doing it," then it must be something worth trying.

We want our children to get an education, so we talk to them about education, where to get it, and what the



benefits are—better jobs, more money, social respect. We help them to make responsible choices. We use the opposite strategy regarding sex and drugs. We don't want them to engage in sex and drugs, so we don't talk about the behaviour except for forbidding it. Fairy tales and religious books tell stories about forbidden things that the hero or heroine tests, sometimes with positive results. Exploring the unknown is a part of human experience, especially for adolescents. Withholding information and forbidding exploration makes for an enticing unknown.

*Mentees may benefit from a discussion of this mythology. Are there stories in their culture about forbidden fruit? Curiosity is a human condition that facilitates learning and growth. With sex and drugs, it is more beneficial for children to explore these topics with responsible sources rather than with peers who may pass on misinformation.*

*I have found it helpful to invite sex educators and addiction workers to mentoring sessions to address taboos and to prepare mentees to talk with parents and youth about sex and drugs. The topics will invariably come up in therapy.*

## Sexual Orientation

If talking about sex is taboo for many people in most cultures, imagine the isolation of a child who hears sexual information from peers, but for whom almost none refers to her or his own feelings and sense of identity. A boy attracted to boys hears other boys talking only about girls. A parallel experience happens with girls attracted to other girls who only hear talk about boys among their peers. When their sexual attraction is nothing like what everybody else is talking about, children often wonder if they are not from another planet. Furthermore, some of what these isolated children hear in the playground only confirms their mistaken idea that they are freaks who must hide their true selves behind a public mask.

If you are heterosexual and have not experienced the isolation of living as a lesbian, gay, bisexual, transgender or queer individual in a hetero-normative world, I invite you to imagine going through life with a secret that nobody knows, and that must be kept from anyone who might suspect. Imagine living with the fear of being found out, of losing the respect of loved ones, of being looked at differently at work, of being attacked on the street just for being who you are (or are thought to be).

Talk about this with your mentees. It may be that some of them have never met or spoken with an openly non-heterosexual person. Many more may be unsure how to approach issues of sexual orientation in the counselling context.

In my years of practice, I have never counselled an LGBTQ client who has not had some trauma associated with public perception of their sexual “preference”. It can be much worse with immigrants and refugees from cultures that do not admit even the possibility of non-hetero-normative forms of sexual practice.

*Often the deepest trauma is that which is experienced in childhood and adolescence. Share the research on trauma. Examine the effects of trauma on a child's brain and how this affects their ability to concentrate, learn and trust others.*

*Talk with mentees about the word “preference” with respect to sexuality. The term preference implies a choice, and LGBTQ individuals often face blame for making the “wrong” or “deviant” choice. Sexuality is a human condition and sexual orientation, as it is understood now, is distributed along a continuum. While much remains to be done to overcome homophobia, individuals at all points along this continuum of sexual orientation can live full and satisfying lives.*

*It is essential that mentors invite openly LGBTQ individuals to speak to their groups, teach the current vocabulary and answer questions.*



## Domestic Violence

As with child abuse, domestic abuse is about someone wielding power over another person in the household. Although the term domestic abuse is most often used to describe male violence against a female partner, many other forms of abuse happen within the family context. Abuse may take place in same sex relationships. Heterosexual men also experience abuse from their wives or female partners, but often withhold that information for fear of ridicule. Many young people living on the street have gone there to escape from abuse. Older people are abused by their adult children, a fact that is now garnering greater public attention than in the past.

For some internationally trained professionals, the language of safety plans, shelters and custody battles may be very new. Behaviours that are unacceptable here may be ignored or viewed differently in their country. The consequences of leaving a marriage may be very different in that cultural context.

*It is important to take time in mentoring sessions to talk about abuse, ask and answer questions, offer information and connect people to resources. It is your role to walk with mentees along their journey to new understandings.*

When the victim of abuse is an adult, the laws of protection do not apply. The adult has to be the one who reports the behaviour. In domestic violence cases where children are also the target of abuse, or are indirectly affected by the abuse directed at a parent, it becomes a child protection issue that requires intervention. Such intervention may benefit the abused parent as well as the children.

Given that most victims of domestic violence are women, it is important to review with empathy the reasons that women stay in an abusive partnership.

NOBODY likes to be abused. Women stay because they are more afraid of leaving than they are of staying. They may be threatened by their abuser in order to create more fear, a greater imbalance of power and less likelihood of their escape. The treatment, of course, is patience and validation, information about resources and, where possible, pointing out the myths and lies underlying the abuser's threats.

At the same time, it is important to acknowledge that the immediate situation for a woman who reports violence may be bleak. For many women, the economic consequences of reporting violence in her intimate relationship is a serious disincentive. This was brought home to me when a woman I knew finally reported her abusive husband. He was taken away by the police, put in jail and ordered to stay away from his wife. However, because he was no longer living at home, the welfare system clawed back his welfare payments. The rent, however, stayed the same so the wife could no longer afford to keep their apartment for herself and her two children. In Ontario, sometimes it can take more than a year to resolve an abuse case, and the family situation stays in limbo for that time.

### *In your mentoring sessions:*

- *Talk about abuse*
- *Talk about why people stay in abusive relationships*
- *Create a list of encouraging and discouraging consequences of reporting abuse*
- *Round out your discussions by inviting a police officer, shelter worker or lawyer to talk about their experience of domestic violence issues in their work. Consider the intersection of domestic violence and immigration issues: additional power imbalances are created in cases where women are being sponsored by their partner to stay in Canada. Talk about the practical realities of spousal, elder and youth abuse.*



## Suicide

There is always a media flurry when a movie or rock star commits suicide. To some, the suicide may appear to be a noble act and the dead person may be revered as a hero. Such myths feed teen suicide—along with teenagers' lack of hope of future opportunities. Suicide is tied inversely to hope, and disproportionately impacts those who face the greatest barriers and oppression. Thus, aboriginal young people in the north of Canada have the highest suicide rate in this country.

Suicide is also the most frightening situation for a mental health practitioner. Reporting the possibility of suicide to the police may not produce desired results. Family members who could take the client to hospital may not be available in the moment of crisis. Organizational protocols may be lacking or insufficient. Despite confidentiality contracts that say we need to report self harm, there are often no places to report it in an emergency, especially if a supervisor is not on site.

This topic cannot be ignored in the mentoring of internationally trained mental health workers because it is where there is often the least support for the practitioner, resulting in the greatest guilt and trauma. Survivor guilt, the anger of those who feel that suicide was an act of revenge against them, the grief and sense of betrayal—these and any other feelings or thoughts connected with a suicide or attempt need to be recognized not only among family and friends, but for the therapist also. Furthermore, therapists themselves may have considered suicide in moments of trauma or loss.

A person who feels supported and empowered to solve problems, and who has information about resources, is unlikely to commit suicide. Having said this, almost everyone has thought about suicide at some time. It is most often a passing thought associated with wanting to flee from the problem at hand. The story that comes to mind is “Sleeping Beauty”, where the heroine appears to die but actually sleeps until the problem is worked out miraculously by someone else, so she can wake up to “happiness ever after”.

Suicide is generally not a sudden impulse, but since no rule of human behaviour is accurate at all times, it is absolutely necessary to take seriously any conversation about self harm. Threats of metaphysical and religious punishment as a consequence of suicide are not helpful. Listening to and acknowledging the suffering behind the thought or intent is helpful. It is essential

to create awareness that no one can stop suicide by someone who is determined to take their own life. Awareness of and use of a no-suicide contract is an important tool to teach.

There are many suggestions about caring for someone who is suicidal. The most important is non-judgmental listening and reflecting.

*Mentors may consider inviting a guest speaker from the suicide hotline to present to the mentoring group. A discussion on individual and cultural points of view about suicide is an opportunity to provide support for the mentee as well as for future clients.*

## Post-Traumatic Stress Disorder (PTSD)

There is no end to information in the literature about PTSD. In my view, PTSD goes beyond the official definition in the DSM and is more common than we might think among newcomers, including internationally trained professionals. Many immigrants and refugees have experienced trauma, having felt or feared the loss of identity, security, loved ones, or life itself. Indeed, these terrors may have persisted over a lifetime.

Arrival in Canada does not guarantee an end to the trauma. The hoped-for security is often no more than an illusion. The obstacles and challenges may be greater than expected: financial crises, language and employment barriers, misunderstanding and discrimination. Refugee claimants face the additional stress of their refugee hearing, not knowing for months or even years whether they will be allowed to stay in Canada.

PTSD never ends. It recedes with time and treatment, but resurfaces under renewed stress and related stimuli. You may imagine a bookcase neatly stacked up with books. The books are a lifetime of memories and events that have been understood, catalogued and shelved. Then there is a tremor or even an earthquake. Some books, the ones closer to the edge, the books with the memories of the trauma, fall first. They have to be dusted and re-filed again, along with the accompanying emotions re-generated by the memories that have resurfaced.

One outstanding example of this occurred during the SARS crisis, when hospitals and residences for the elderly were closed to visitors and hospital staff were required to wear gloves, masks and gowns for protection against infection. Many of the older residents of a Jewish hospital began to show strong





signs of agitation, paranoia, insomnia and delusions. The professional attire, along with the restrictions on visitors, created a scenario reminding some residents of their concentration camp experiences. This was more than half a century after the events of the Holocaust! All memories remain in the body.

*Talk about migration-related trauma and PTSD with your mentees. Work with them to list any pre-migration traumas that led to flight, as well as traumatic experiences faced after arrival in Canada. As they share cases for discussion, help them to consider the effects of trauma on their newcomer clients and to develop appropriate interventions. Trauma survivors need to establish a sense of safety, to grieve their losses, to give meaning to their experience, and to find purpose for the future.*

*For refugee claimants, the first step to safety may be preparing for their refugee hearing. Counsellors can help by providing a psychological report to support the refugee claim. Consider inviting an immigration lawyer to talk to the group about the kinds of information to include in a report for the Immigration and Refugee Board.*

## Immigration Issues

Here are some considerations for newcomers:

- If they knew the language fluently
  - If they had acceptable housing
  - If they had jobs adequate to their level of education
  - If there were enough childcare spaces so both parents could work or study
  - If they could get their refugee claim heard or bring family members more quickly
  - If they knew their rights as residents
  - ....add some other ifs...
- ....then there would much less need for counselling.

A substantial body of research on the “healthy immigrant effect” shows that newcomers are generally better educated and healthier than the general population upon arrival. After five years, they are less healthy and also poorer. The immigration process and associated employment barriers are the primary liability for the health and welfare of immigrants to Canada.

*In your mentoring meetings, discuss the detrimental effects of immigration on both counsellors and clients. Invite mentees to identify their own coping strategies and their own moments of beginning to feel better about life in Canada. Talk about what it means to work with clients who are experiencing similar challenges, and how to bring together self care and client care. You, as a mentor, have the experts in your group.*

*Invite mentees to reflect on the social determinants of mental health and the role of mental health professionals in working for social change.*



# The Therapeutic Process

Internationally trained professionals also need a space to talk about issues related to the therapeutic process. Here I discuss some of the important issues raised by internationally trained counsellors on the Community Mental Health Team at the Mennonite New Life Centre.

## Confidentiality

Confidentiality is a sensitive issue. Share the sample confidentiality/consent form from the appendix, or consider policy and processes in different workplaces. It is important to make clear that the *team* is the unit of care. The team includes anyone in the agency that is directly involved with the client. Teams can include physicians, social workers, case managers, settlement workers, and others. Any information that is shared should be relative to the type and degree of involvement of the team member.

Confidentiality is also important for group work. Internationally trained professionals should be proactive about letting group participants know that no information about the group should be discussed in public, even with another group member. In multicultural Toronto, no one can ever know whether the person sitting next to you on the subway speaks the language that you are speaking.

With language-specific group programs, there is a strong possibility that a therapist and client could meet outside the group setting at some community project or other social event. I suggest to internationally trained professionals that they leave it up to the client to initiate any greeting when they first meet. In that way, it is the client's choice whether to acknowledge the therapist. It is up to the therapist to direct the conversation away from information related to therapy.

A therapist will clarify to a client that no information will be shared with anyone without the specific written permission of the client, with the exception of a child at risk and other exceptions in the confidentiality agreement. Confidentiality applies to speaking with lawyers, other agencies and family members.

## Transferences

At the Mennonite New Life Centre, we organized a focus group to obtain feedback from the internationally trained professionals about their mentoring experience. One of the issues for discussion was the possibility of transference, or the unconscious redirection of feelings from one person to another. For

these counsellors, the issue was quite clear. The issue is not whether there is transference—there is—but rather how safe counsellors feel sharing and discussing this. For internationally trained professionals who are already in a vulnerable position by virtue of their immigration experience and who are struggling to understand new rules of professional practice, the mentor's compassion is essential. Transference is not a professional weakness; it is the human result of empathy. As with prejudice, it cannot be erased. It must be acknowledged and managed for the benefit of the mentee and, eventually, the client.

## Resistance

From a psychoanalytic perspective, the client's unwillingness or inability to approach a subject matter or complete a task is termed "resistance". For me, this has the connotation that the client is not willing to go where the therapist wants to go. It may be interpreted that the client is weak or unable to recognize the wisdom of the therapist. This concept blames the client for what may well be a relationship issue. For an immigrant client, identifying yet another deficiency is counterproductive. The same could be said for the internationally trained professional in the mentoring process.

The aim of the bridge program, like the aim of counselling, is to empower. Resistance may be reframed in several ways that may be more empowering, such as:

- Now is not the right time to introduce this topic.
- There has not been enough time to learn to trust each other.
- The task was not understood. It can be explained another way.
- The task/question is too complicated. It can be broken down into smaller steps.
- The mentor—or counsellor, as the case may be—can choose to leave the issue until the mentee or client brings it up again.
- Or, the mentor and counsellor/counsellor and client may choose to realign the goals of the process.
- If the mentor and mentee, therapist and client, are on the same page, there is no need for resistance.



## Termination

Termination of therapy may be a concern in agencies where there are large numbers of clients and long waiting lists. It may be a concern, for different reasons, for counsellors who do not wish to rush the counselling process and may feel that more work is needed. It is a concern, as well, for clients who have already experienced loss and rejection. Many newcomer clients will be in this category.

If the goal of therapy is to empower, then there is no reason to fear that a client will become dependent and require interminable therapy.

Where the agency offers some flexibility, I suggest the following options for approaching questions regarding termination:

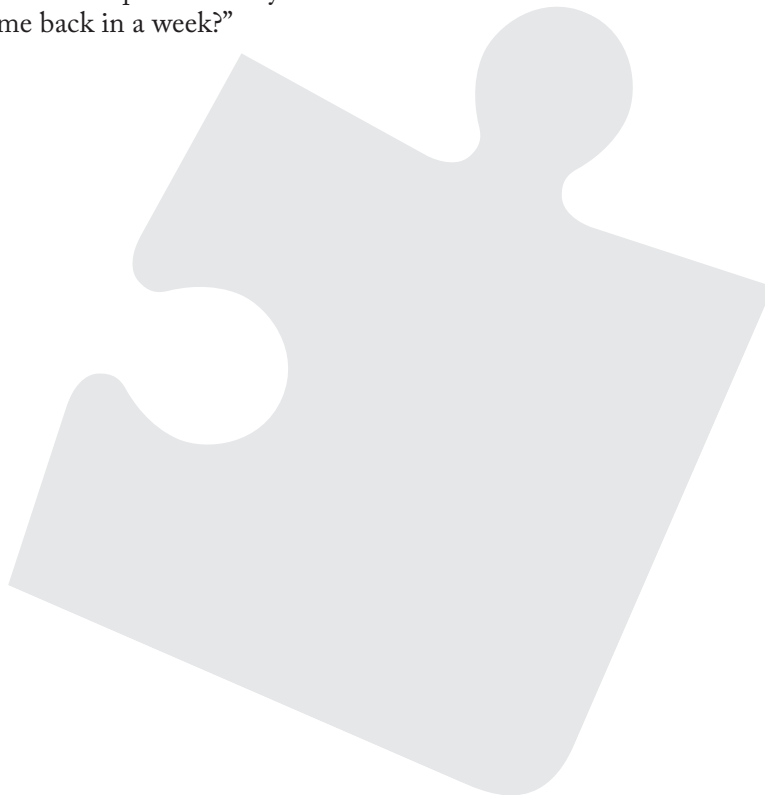
- It is always useful to empower the client to leave counselling, and to leave satisfied. One way that has worked for me is to ask at the end of every session: "Have you felt comfortable with me? Do you want to make another appointment or do you want to call me when you want to make another appointment?"
- Assuming that the client wants to make another appointment, then the next question is: "When is it convenient for you to come back?"
- Sometimes the client wants an opinion: "Do you think that I should come back in a week?"

One answer: "That would be your decision. Do you want more information or do you want some time to think over our session?" In cases of violence or other crisis, the counsellor may give a "sooner rather than later" suggestion.

Eventually the client may opt for biweekly sessions. After a while, the choice may be every three weeks, or a month, with the reassurance that if there is a need, they can call for an earlier appointment.

There need not be a formal termination to therapy. When it becomes apparent that the client is empowered and confident in resolving problems, then the invitation is: "Call me when you want to check something out, and we'll make an appointment".

I've never had to drag a client kicking and screaming out of my office because I decided that the therapy was over. It was always his or her decision. Once clients are empowered to live productive lives they do not have time to go to appointments.



# MENTAL HEALTH WORK IN SETTLEMENT AGENCIES



*The Mennonite New Life Centre is a community based settlement agency that reaches out to newcomers with practical and emotional support, in order to facilitate full participation and integration in Canada.*

The migration and settlement journey is both a practical and an emotional journey, and so newcomers bring both practical and emotional needs to their interaction with settlement workers. Settlement organizations are already engaged in addressing many of the social determinants of mental health. They also have the potential to play a critical role in mental health intervention, supporting newcomers to overcome different kinds of stress and trauma, while building resilience, strength and well-being at the individual and community level.

Citizenship and Immigration Canada, the major funder of settlement services, is showing growing awareness of the intersection between settlement and mental health issues, but it does not currently fund mental health services. Settlement agency staff are often aware of mental health needs, but lack the expertise or mandate to engage in counselling. Training initiatives such as the OCASI/Hong Fook *Journeys to Mental Health Project* have helped to raise awareness and understanding of mental health challenges in newcomer communities by offering workshops to settlement workers across the province, but mental health referrals remain a formidable challenge for workers seeking professional counselling or other supports for immigrant clients. Affordable mental health services in the client's first language are usually few and far between. Even in Toronto, the very few language-specific counselling programs that do exist tend to have extremely long wait times.

This is the situation that inspired the Mennonite New Life Centre to partner with a team of internationally trained professionals to offer counselling and mental health group work to Spanish-speaking newcomers from Latin America. There was a clear fit between an unmet need, an untapped resource and an organizational commitment to holistic programs and services. We believe that this model could be used effectively to promote mental health in other newcomer communities.

The model is simple, with all the advantages of being situated in the non-stigmatizing environment of a settlement agency. Refugees and other vulnerable newcomers come in search of practical supports. Settlement workers, their first point of contact, identify emotional needs in their clients and make the referral to a volunteer clinician, who describes her role and obtains informed consent before initiating the counselling process. The clinician discusses complex cases with a clinical supervisor, who offers suggestions and information about community resources, sometimes recommending specialist referrals when the needs appear to go beyond the expertise of the volunteer clinician.

In this section of the manual, we share what we have learned in working with internationally trained professionals to build a community mental health program, in the hopes that this information might be a source of encouragement and practical assistance to other settlement organizations in taking up the challenge of responding to unmet mental health needs in immigrant and refugee communities. An organization might choose to build a volunteer-driven program, such as the Community Mental Health Program at the Mennonite New Life Centre, or they might begin by offering an internship to one or more participants of the Bridge Training Program. Over time, they might decide to seek funding to strengthen their mental health work.





## Service Quality and Professional Liability

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Due to the sensitive nature of mental health services, agency leaders and boards of directors may have questions about how to ensure service quality and malpractice insurance when working with internationally trained volunteers. At the Mennonite New Life Centre, we took a number of practical steps to address these serious and legitimate concerns.

First, the agency hired a clinical supervisor/mentor. The job included interviewing prospective volunteers to ensure that they brought an adequate level of professional knowledge and experience to their counselling role, and offering clinical supervision to the team. The primary vehicle of clinical supervision is our biweekly mentoring meeting, which usually lasts about 3 hours. The supervisor/mentor's approach to these meetings is described in detail in Chapters 2 and 3 of this Manual.

In addition to the biweekly meetings, the Mentor has the following roles:

- Orient new counsellors. As part of this role, she has compiled a resource manual of mental health articles and fact sheets in Spanish. The manual is both a resource for counsellors and a source of easy-to-read handouts for clients in their own language. The book is continuously growing, as group members add their own recommended readings.
- Make herself available by phone or email for consultations with counsellors.
- Review, edit and sometimes translate counselling

reports and letters that are directed externally. These documents are also signed off on by the Executive Director.

- Help develop administrative procedures, clinical practices, record keeping, and so forth.
- Meet regularly with the Executive Director and Settlement Manager

Second, to address liability concerns, we took two measures. The first was to request a police record check of all volunteers. The second was to support volunteers in securing professional liability insurance. The Mennonite New Life Centre recommends all volunteers for general membership in the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists (OACCPP). Once they have become members, volunteers can access professional liability insurance through the Association. The Mennonite New Life Centre pays both membership and insurance costs as part of its support and recognition of volunteers.

*Support is available to address service quality and professional liability concerns for settlement agencies offering internships to Bridge Training Program participants. First, bridge training students receive clinical supervision from an experienced therapist through a weekly clinical seminar. Secondly, all bridge training participants come to their internships with OACCPP membership and professional liability insurance already in place.*

## Support and Recognition

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When working with volunteers or interns, support and recognition are key. Too often, internationally trained professionals have been told that their training and experience mean nothing in Canada. They need genuine affirmation to rebuild their confidence in the knowledge and skills they have to offer.

Recognition takes many forms. The message should be one of trust in the knowledge and clinical skills of the internationally trained professionals, and appreciation for invaluable services rendered to the community. The mentor must continually send this message and back it up by offering practical support to help mentees in meeting the clinical challenges they face. Agency staff

must also send this message of recognition, and back it up by offering appropriate work space and logistical support.

For counsellors, working in a comfortable and private space makes all the difference. At the Mennonite New Life Centre, early counselling work took place wherever space could be made available—in the office of a staff member who was away for the day, or in an unused meeting room. It was a real turning point for our program when we were finally able to set aside a dedicated office for the mental health program. Clients felt more comfortable and counsellors knew that their work was valued by the organization.



At the Mennonite New Life Centre, we began with a team of volunteers, each of whom offered an average of 4–5 hours/week. We established a supportive foundation that consisted of a regular mentoring meeting, and an agency go-to person who could help with administrative and logistical concerns. We also offered mentees a small honorarium of \$100/month. Over time, we added new elements to this foundation:

- Recommendation for membership in OACCPP. Payment of membership fees and professional liability insurance.
- Opportunities to attend professional development workshops, with registration fees paid by the organization.
- Paid internships.

*Successful pilot projects can lead to funding opportunities. As our community mental health team progressed, it became clear that clients were satisfied and felt helped by the program. It was also clear that the internationally trained counsellors had the necessary expertise to walk with clients along their very difficult roads, but needed additional support—including financial support—to pursue their own career development in Canada. The Centre launched a fundraising campaign to build the financial basis to offer our first paid internships for internationally trained mental health professionals. We later accessed funding to offer additional internships through the Investing in Neighbourhoods Fund of Toronto Employment and Social Services and the Counselling Foundation of Canada.*

## Interdisciplinary Collaboration

For mental health programming to succeed in a settlement agency, there needs to be strong interdisciplinary collaboration. In particular, there needs to be mutual appreciation of what mental health counsellors and settlement workers have to offer, how their work complements one another's, and what each group needs for successful collaboration. For this to happen, there must be strong communication at both leadership and front line levels.

At the Mennonite New Life Centre, it is the commitment to ongoing communication that has allowed us to learn and grow over time. At the leadership level, the program has worked and still works because:

- There is frequent communication between the ED, the Settlement Manager and the Clinical Mentor.
- There is an atmosphere of trust, respect and affection, together with an assumption of goodwill.
- There is a genuine commitment to clients, and a commitment to making the community mental health program work for the benefit of clients.
- There is curiosity to see how things could work, and a willingness to learn together from our experience.

Good communication and collaboration at the leadership level have translated into good communication and collaboration on the front line. It has been important to bring settlement workers and mental health counsellors together in staff meetings in order to develop mutual understanding of each other's roles and needs. Settlement workers have learned what kind of information is helpful to include in the intake and referral form that is passed on to the mental health counsellor. They have also learned to better identify and distinguish between mental health “emergencies,” “urgent cases” and “regular cases.” For their part, mental health counsellors have come to understand the expertise of the settlement worker, and to consult or refer clients back to the settlement worker when immigration, employment or other such matters arise in the counselling session.

In general, front line collaboration takes the following shape:

- Intake and assessment is always conducted by a settlement worker, who then refers clients with emotional needs to the mental health team. This allows for a consistent approach to client intake, assessment of both settlement and mental health



needs, and proper documentation of all clients in the ICAM's reporting database. Given the high level of demand for services, it also allows for an initial screening with regards to the urgency of the case, and facilitates matching the client to a counsellor with the appropriate clinical interests and experience.

- Settlement workers assist clients with immigration, employment, income support, housing and other settlement matters.
- Mental health counsellors offer clinical counselling and group work, assisting clients with emotional struggles.
- Mental health counsellors may consult with settlement workers, and vice-versa, on information referring to common cases without requiring specific permission from the client.
- The confidentiality and consent form, discussed at the first counselling session, and signed by the client, specifically mentions that no information will be shared outside the treatment team without written permission.

At the Mennonite New Life Centre, front line collaboration has been strengthened by hiring a settlement worker with mental health expertise to act as a liaison between the settlement and mental health teams. This staff member also acts as in-house coordinator for the mental health program, managing intake distribution, scheduling appointments, solving problems in situ and coordinating group programs.

*We recommend that all settlement agencies working to develop mental health programming identify a staff member with some basic understanding of mental health issues to support program development and logistics. Even when clinical supervision is offered externally, as is the case with the bridge training program, there is a need for in house involvement in setting up agency-appropriate processes for referrals and interdisciplinary collaboration, scheduling and case documentation. Be prepared to spend time on process development to minimize frustration and conflict. Be prepared also to learn from experience—it may take some experimentation to figure out the system that works for your organization.*

## Scheduling and Logistics

The work flow of the mental health counsellor is different from that of the settlement worker, often requiring weekly or bi-weekly appointments over a sustained period of time. Where there is a high demand for counselling services, this requires protecting appointment time for ongoing clients rather than scheduling appointments on a first-come first-served basis. At the Mennonite New Life Centre, we have developed the following approach: Settlement workers submit intake and referral forms to the mental health coordinator, who adds them to the waiting list. As counsellors have space to take on new clients, they contact the mental health coordinator to request a new client. The counsellor herself calls the client to schedule a first appointment and works with the client to determine the required frequency of counselling sessions. Counsellors manage their own appointment calendars. The mental health coordinator manages the waiting list, approaches counsellors to take on urgent cases, and tracks the time it takes from the initial appointment with a settlement worker to a first appointment with a mental health counsellor.

Developing a scheduling system requires attention to a series of considerations, from counsellor practice scope and preference to management of wait times and 'no shows'. Every organization will need to develop the system that works in its particular setting. We share our approach here as a guide to developing your own process:

### Practice scope and preference

Mental health professionals, internationally trained or otherwise, work best within their practice scope and preference. Although our volunteers and interns had significant experience and could handle a wide range of therapeutic issues, it became clear that each team member had specific skills in particular areas. Some preferred to work with children and/or adolescents; others with adults. Some enjoyed working with couples

and addressing intra-familial conflict. Others did not feel comfortable working on issues of domestic violence.

A list of preferences enabled the mental health coordinator to assign waiting list cases to the most appropriate counsellor, or to speak in advance with counsellors when a case seemed likely to take them beyond their comfort zone.



## Client load

In their excitement about finally practicing in their chosen field and passion, many of our volunteers filled their four hours of volunteer work with four client appointments. This became problematic because it gave no time for case documentation and report writing. Furthermore, it left no time to respond to new cases identified by settlement workers as requiring immediate attention. In order to allow time for case documentation and unforeseeable emergencies, we recommend scheduling no more than three fifty minute appointments during a half day (four hours), or six appointments during a full day (eight hours).

## Emergencies and urgent cases

In the early days of our community mental health program, some volunteer counsellors reported feeling stressed by frequent requests by settlement workers to make time for a client “emergency” or “urgent case.” Responding to emergencies would often take them beyond the time they were able to give to the Centre, while still giving the time they needed to other commitments.

*In order to manage scheduling pressures and avoid undue stress on mental health counsellors, it is important to define “Emergency” and “Urgent.” “Emergencies”, in our vocabulary, are cases, such as those involving recent violence, that demand medical verification or investigation, or that involve an immediate suicide risk, and where the individual involved needs to go to the nearest emergency department. When faced with an “Emergency,” settlement workers can request immediate assistance from a mental health counsellor and/or the Settlement Manager. Such cases are extremely rare, but merit careful thought. Consider looking at suicide protocols from other agencies, if you don’t have one already.*

“Urgent” cases involve an emotional outburst, or high degree of distress, where the settlement worker is not comfortable sending the client home without an initial contact with the mental health counsellor. These are cases that can wait for the counsellor to have a free moment to do a quick assessment, calm the client, and set up a future appointment. I have also done crisis intervention training with settlement workers in order to increase their comfort level in responding to such cases when a counsellor is not available, and the Mennonite New Life Centre’s Executive Director also makes herself available for telephone consultation on urgent cases.

## Client no show

A ‘No Show’ is a missed appointment with no prior notice. Clients may miss an appointment for many reasons. They may have a personal emergency or they may simply forget. They may feel better and no longer see the need for counselling, or they may be embarrassed about talking with a counsellor. It is important for settlement workers to assess the client’s comfort with the idea of counselling, and not to pressure a client who is not ready and committed to the counselling process. It is also important to follow up with clients who have missed an appointment, to assess the need and interest in further counselling.

At the same time, it is important to have a policy on “no shows”, in order to clarify when it is time to move on and offer the counselling opportunity to someone on the waiting list. At the Mennonite New Life Centre, a written memo is given to the client and explained at the outset of the counselling relationship. The memo explains that a No Show is a missed appointment with no prior notice. Two No Shows will return the case to the waiting list. Notices of this policy are also posted in the counselling room.

## Waiting list management and group programs

Given current gaps in mental health services, agencies developing mental health programming may well face the challenge of managing wait lists. At the Mennonite New Life Centre, we found ourselves facing a community need that was greater than the available resources. The mental health team discussed the challenge of our growing wait list, and the idea that emerged was to create psycho-educational groups on various themes to offer to clients on the waiting list. The mental health counsellors then ran a number of very successful groups, with some evolving into ongoing programs. Some examples of psycho-educational groups offered by the Centre include: an empowerment and leadership development group for women, a life skills and resettlement stress group, and a parenting support group. Most groups run on a weekly basis for a period of six to eight weeks. The Centre also has an ongoing Anger Management Program and Senior Support Group, as well as a popular theatre program for newcomer youth.





## Documentation and Record Keeping

Just as work flow and scheduling are different for settlement work as compared to mental health work, so are documentation and record keeping. In addition to an intake form, it is important to have templates for: a) confidentiality and consent, b) assessment, and c) counselling reports for immigration purposes. Sample forms are included in the appendix.

### Intake

We use a standard intake form for settlement and mental health clients. The intake form is filled out by the settlement worker during the first meeting with the client. It includes demographic information, and a short summary of the presenting problem. The intake form is submitted to the mental health coordinator, who uses it to assign the case to the most appropriate counsellor. The counsellor reviews the intake form in preparation for the first counselling session with the client.

### Confidentiality and consent

It is important that the client understand the parameters of the counselling relationship. The form that we use specifies that counsellors have international training and experience in psychology but are not currently registered with any professional college in Canada. It also outlines our commitment to confidentiality, clarifying that information will be shared within the treatment team, but not beyond unless required by law (as in the case of suspected child abuse). This form is discussed in the first counselling session and signed by the client, or by the parent or guardian in the case of a minor. Where information needs to be shared with an immigration lawyer or other outside professional, the client is asked to sign a form specifying her or his consent to share this information.

Current legislation also requires that a privacy statement be posted in the counselling room.

### Assessment and case documentation

At the Mennonite New Life Centre, the mental health team helped to develop assessment and case documentation forms, including an electronic version designed to facilitate the sharing of information when a counsellor leaves the team and refers a client to a new counsellor.

When they take on a new case, consider providing counsellors with a file folder including the intake form and all blank forms that may be necessary for the development of the case. This eliminates the need to interrupt sessions to look for copies. Besides the confidentiality and consent form, the documents below are suggestions for the file.

- Intake form
- Consent to exchange information
- Assessment form
- Progress reports
- Record of referrals
- Supervision discussion
- External consults
- Reports for external sources

There are a variety of ways to organize this information. For example, the dated progress report form may have a specific area to include referrals made on that date; or the referrals may be listed on a separate page dedicated to referrals. Similarly, supervision notes may be recorded on a progress report and titled “supervision notes” or included on a separate page specific to supervision notes.

At the Mennonite New Life Centre right now we are working with our IT technician to develop ways to track client data and statistics in our database. Tracking statistics can be helpful to identifying program needs and presenting a solid case in funding applications. Tracking basic client data can also facilitate continuity of care when a client is transferred from one counsellor to another. When considering online information systems, it is important to give careful thought to confidentiality issues, as well as the time involved in entering data. As a general rule, I recommend not to ask for more information than is strictly necessary, and not to share that information more broadly than is strictly necessary, even within the team.



## Reports for immigration lawyers and other professionals

Many times, clients will approach a counsellor looking for a report to support a refugee claim or humanitarian and compassionate application. Other times, Children's Aid may request a report from the attending counsellor. It would be a mistake to assume that internationally trained professionals know how to write such reports, since the information requirements are closely tied to Canadian systems and laws. At the Mennonite New Life Centre, we have developed templates and organized workshops with immigration lawyers and CAS staff. We also provide significant editing support: The clinical mentor/supervisor reviews, edits, translates (as necessary) and signs off on all reports for external professionals. Final sign off is done by our ED.

*If you wish to work with internationally trained professionals to offer counselling reports, be prepared for a significant time investment by agency supervisors. With refugee hearings and CAS investigations, the stakes are high and you want to produce a high quality report that will genuinely help your client. Be clear with clients and lawyers that you can't produce a report overnight. We tell lawyers that we require up to eight weeks to prepare a report. This leaves time for development of the counselling relationship, writing the report, editing the report, and securing agency sign off.*

## Internships and Group Projects

Much of the preceding discussion focuses on individual client counselling. Individual work is an important modality of mental health intervention, but it is not the only or the most important modality. Group programs give the organization the opportunity to serve multiple clients at the same time. They give clients the chance to realize they are not alone, and to offer one another mutual support. They also give the internationally trained professional new scope for creativity, and an opportunity to develop a model or even a manual that can be shared as part of their professional portfolio.

At the Mennonite New Life Centre, we have used paid internships to invite internationally trained professionals to develop group programs. While volunteers were more limited in their time commitment, paid interns had the time to develop, implement and evaluate a group project.

Our first two interns, Marisabel Tovar and Leticia Esquivel, developed a strengths-based empowerment series of six workshops. The group was designed as a leadership development process and a seed group for future empowerment group facilitators. Marisabel and Leticia then developed a manual to share their model with peer leaders, as well as with other organizations interested in their empowerment model. This manual has twice been presented at the OCASI Professional Development Conference.



**Recommended reading:**  
Tovar, M. and Esquivel, L., “Facilitator’s Manual: Mental Health and Social Change”. Mennonite New Life Centre of Toronto, 2009.

Subsequent interns have developed a variety of group projects that have matched professional interests and expertise with client and community needs. Over the last three years, interns have developed the following group programs:

1. A life skills group to help newcomers develop strategies for coping with the stresses of their migration and settlement journeys, and to integrate into Canadian society.
2. A parenting support group focused on developing parental and child resilience.
3. A children’s expressive arts group that used visual arts to explore themes of identity, dreams and conflict resolution.
4. A women’s support group, in partnership with CMHA

Another intern is currently in the process of designing a workshop series on “Employment and Mental Health: Discovering Strengths, Setting Goals, Nurturing Hope.” Other group initiatives include the development of an online survey to identify mental

health needs among immigrant men, and a blog for immigrant youth.

*Group projects have offered interns a place to apply their clinical interests and strengths in the development of new programming initiatives. For organizations hosting a bridge training internship, we recommend offering interns the opportunity to work on a group project that both utilizes their professional strengths and meets client needs. If you are able to host two interns, collaborative creation yields an even richer program development experience.*

*A good internship-based pilot project can help you build the funding case for a more sustained mental health program and demonstrate organizational capacity. It may even be possible to hire your intern to continue the work! At the Mennonite New Life Centre, program development and new funding allowed us to hire two former interns as permanent staff. Their understanding of and commitment to the organization and to the mental health program have made them invaluable in furthering program development.*

*Internationally trained professionals have much to offer to your agency and to the mental health field. We wish you well as you embark on a journey of mutual learning!*



# THE FIELD OF MENTAL HEALTH



*Joyce Rowlands addresses bridge training participants at the Opportunities Fair for Internationally Trained Psychologists (2010). Joyce is the Registrar for the Transitional Council of the College of Registered Psychotherapists and Registered Mental Health Therapists.*

## Words, Meaning and Professional Identity

Throughout this manual, I have suggested that words only partially convey concepts, since they are subject to interpretation by the listener. The speaker may ascribe one meaning to her message, rooted in her own experience and point of view. The listener, coming from a different experience and perspective, may understand what she hears in a different way from what the speaker intended to communicate.

This is particularly true for communication between a mentor and internationally trained professionals who come from different cultures and different professional contexts. These diverse contexts shape different understandings of what it means to be a psychologist or a mental health professional. Licensing requirements and professional roles vary from one country to another. Barriers to licensing may also make it necessary for internationally trained psychologists to consider different roles within the mental health system in Ontario. It's not just a matter of finding a new word to describe their work. It's about an often-emotional shift of professional identity.

As a mentor, you will need to be able to offer information to support the internationally trained professional to find her place in the field of mental health in Canada. As a practitioner in this country, you already have a good idea of who the players are, but the mentees don't. Trying to explain this can be a challenge.

This chapter offers some ideas, based on the writer's experience and viewpoint, for mapping out the mental health field, offering the information and landmarks needed for internationally trained professionals to adapt to their new environment in a way that is satisfying to them—and meets the minimum requirements of professional survival. In my view, these minimum requirements are as follows:

- You don't harm yourself
- You don't harm others
- You don't harm the environment

In other words, internationally trained professionals need to be able to find a meaningful role for themselves, while respecting professional ethics and legislative requirements.





## Mapping the Mental Health Field

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Let's start with definitions of two terms that are commonly used to attempt to explain the work performed by professionals in our field: psychology and mental health. The Bridge Training Program assumes university level study of psychology and professional experience in clinical counselling and/or community mental health.

- Psychology, according to Funk & Wagnall's Standard Desk Dictionary, is "the systematic investigation of mental phenomena, especially those associated with consciousness, behaviour, and the problems of adjustment to the environment."
- Mental Health, as defined by the World Health Organization, is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". <http://www.who.int/mediacentre/factsheets/fs220/en/>

Psychology work, then, investigates, describes and explains human behaviours, and their possible origins and effects on the individual, family and social group.

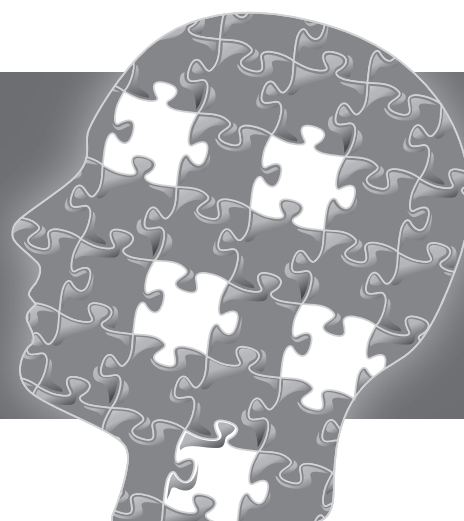
Mental Health work helps the individual manage thoughts, feelings, and actions to live more fruitfully and contribute more effectively to the community. Mental Health work, then, must facilitate adaptation to society and effective use of social resources.

You can easily see that the two terms are not mutually exclusive and refer to overlapping areas of professional practice. The terms confuse many people, including professionals from countries that do not clearly differentiate one from the other.

It is important to be able to offer mentees a map of regulated and non-regulated mental health professions in Ontario, together with some historical context and perspective on professional regulation. Regulatory bodies, of course, see their primary role as protecting the public. However, given that different countries make different decisions about regulation and public safety, it may also be helpful to talk about professional recognition in relation to context-specific struggles for recognition, power and status. I suggest the following handout as a starting point for discussion.



# MENTAL HEALTH IN ONTARIO



## Regulated Mental Health Professions

Psychiatry, psychology and social work are all regulated professions in Ontario. Regulatory bodies or “colleges” have established strict requirements for practicing these professions in Ontario. According to Ontario law, you must be licensed or registered by the relevant regulatory college in order to practice as a psychiatrist, psychologist or social worker.

### Psychiatrists

The people who first investigated human consciousness and behaviour, and made it of public interest were physicians. As medical practitioners, their interest was primarily in disease and cure. The specialized study of mental illness and its treatment was named psychiatry.

In Ontario, psychiatry is a regulated profession. Psychiatrists are specialized medical doctors, trained in accredited medical schools and regulated by the College of Physicians and Surgeons of Ontario. Psychiatrists are authorized to diagnose and to treat mental illness. Only Psychiatrists and Medical Doctors can prescribe medications for the treatment of mental illness.

### Psychologists

After the emergence of psychiatry, a new wave of thinkers studied human behaviour in depth, designed ways to test and measure many aspects of behaviour, and investigated other influences on human behavior, beyond the scope of the medical model. These people called themselves psychologists and established schools of psychology to disseminate a new body of knowledge not taught in medical schools. Because they were competing with medical doctors for professional recognition, they designed the requirements to be comparable to that of a doctor. You need a doctoral-level graduate degree to become a licensed psychologist in Ontario.

In Ontario, psychology is a regulated profession. Psychologists must provide evidence of a recognized doctoral degree or PhD and the required supervised practice hours to be licensed by the College of Psychologists of Ontario. Individuals with a Masters degree in clinical psychology and the required supervised practiced hours may be licensed as a Psychological Associate. Psychologists and Psychological Associates are authorized to diagnose psychological disorders and use a variety of non-medical approaches to support the maintenance and enhancement of emotional and social functioning.



## Clinical Social Workers

The third wave of workers saw that there was a need to address the social determinants of mental health. They recognized that people who lack adequate food, housing, educational opportunities, and employment cannot live fruitfully or enjoy mental health and well-being. This wave of workers promoted the creation of social services and programs and called themselves social workers. Initially they focused on practical help and community organization, but later they expanded their training and practice to include clinical counselling to meet the emotional needs of historically under-served and disadvantaged people. Like psychologists, social workers fought their own battle for recognition via professional regulation.

Social work is a regulated profession in Ontario. Social workers are trained in faculties or schools of social work, departments connected to an accredited university, and regulated by the Ontario College of Social Workers and Social Service Workers (OCSWSSW). Social workers are authorized to assess, treat and evaluate individual, interpersonal and social problems. They are important players in social service delivery. Many mental health-related jobs in hospitals, community health clinics and Children's Aid Societies require a social work degree, with most clinical positions requiring an MSW. Social service workers, who are trained at the community college level, are also regulated by the OCSWSSW.

## Career Maps

The Ontario Government has partnered with a number of regulatory bodies to create career maps for internationally trained professionals. Career maps explain in detail the process for registration with the relevant regulatory body for a particular profession. You can find career maps for physicians,

psychologists and social workers at: [www.ontarioimmigration.ca/en/working/OI\\_HOW\\_WORK\\_CAREER\\_MAPS.html](http://www.ontarioimmigration.ca/en/working/OI_HOW_WORK_CAREER_MAPS.html)

Access Centres for the Internationally Trained can provide further information and support.

### **Internationally trained medical graduates and psychologists may contact:**

Health Force Ontario  
Access Centre for Internationally  
Educated Health Professionals  
Tel: 416-862-2200 or 1-800-596-4046  
Email: [accesscentre@healthforceontario.ca](mailto:accesscentre@healthforceontario.ca)

### **Internationally trained social workers should contact:**

Global Experience Ontario (GEO)  
Access and Resource Centre  
for the Internationally Trained  
Tel: 416-327-9694 or 1-866-670-4094  
E-mail: [geo@ontario.ca](mailto:geo@ontario.ca)



## Non-Regulated Mental Health Professions

There are other players in the mental health field – including psychotherapists, counsellors and case managers – whose practices currently fall outside of the scope of any of the existing regulatory bodies or Colleges. Although many of these practitioners hold undergraduate or graduate degrees in a range of disciplines, they do not currently qualify for membership to any of the existing regulatory bodies or Colleges in Ontario.

While they do not qualify for professional licensing, psychotherapists, counsellors and case managers all

provide valuable support to individuals experiencing mental health challenges. Psychotherapists mostly work in private practice, counsellors work in both private practice and community service organizations, and case managers mostly work in community service organizations and public institutions.

As an internationally trained professional, you may want to explore such roles for yourself, learn about the relevant training institutes and professional associations, and seek to understand new legislation which aims to regulate psychotherapy and mental health therapy.





# The new College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario

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Mental health is a constantly evolving field of work. A wide range of approaches and treatments have emerged over time, together with relevant training programs and professional associations. Psychotherapy has long resisted definition and regulation, because there is no single approach to practice, nor is there a clearly defined curriculum to train practitioners.

Despite all this, the Psychotherapy Act of 2007 has now mandated the formation of a new College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario. At the time of writing (fall, 2010), the Transitional Council is in the process of consulting with stakeholders and deciding on the requirements for membership in the new College. Once membership requirements are defined and registration begins, practitioners will be required to register with the College in order to use the protected title of “psychotherapist” or “registered mental health therapist.” In addition, only College members will be

able to practice the controlled act of psychotherapy, defined as the treatment “by means of psychotherapy technique ... of an individual’s serious disorder that may seriously impair his or her judgment, insight, behaviour, communication or social functioning.”

Existing training programs and professional associations are important stakeholders in this process, advocating to make the registration process fair and accessible to current practitioners. The Bridge Training Program also presented a position paper to the Registrar of the new College in August 2010, advocating for fair assessment of the knowledge and skills of internationally trained professionals. The Transitional Council has committed to the development of a Prior Learning Assessment tool to be used in making decisions regarding grandparenting of current practitioners and applications for membership from internationally trained practitioners.



## Training programs

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The Association of Psychotherapy Training Institutes (APTI) brings together a wide range of reputable counselling and psychotherapy training programs. Each of its members has its own approach and curriculum. Some of these programs require prior university training, while others do not. Recently, this group has been working to define core competencies for the practice of psychotherapy, and to influence

the membership requirements of the new College of Registered Psychotherapists and Registered Mental Health Therapists.

Two APTI member organizations sit on the Advisory Committee for the Bridge Training Program: Adler Graduate Professional School and TAPE Educational Services.

**For more information about APTI, contact Linda Page at [ljpage@adler.ca](mailto:ljpage@adler.ca)**







## Associations

Professional associations are groupings of practitioners who work from a common approach or with a particular population. Professional associations are different from professional colleges. College membership is required for all members of regulated professions. Association membership—for members of regulated and unregulated professions—is always voluntary.

Professional associations keep their members up to date on professional development and work opportunities. Some have a larger role in setting practice standards and in certifying members who meet certain requirements. These certifications are useful for credentialing purposes but do not carry the same weight as mandated requirements for licensure or registration. Licensure or registration is needed for the practice of any of the controlled acts. Psychotherapy, for example, will become a controlled act sometime in 2012 when the Psychotherapy Act (2007) is proclaimed and actually becomes law.

Associations also watch out for the interests of their members and advocate on their behalf. Some professional associations who have already established standards for certified membership have been advocating for the grandparenting — or automatic acceptance — of these certified members when they apply for registration with the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario.

The Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists (OACCPP) is one such professional association. OACCPP represents a range of mental health service providers in the areas of consulting, counselling, psycho-educational assessment and psychotherapy. Membership categories include Certified Members, General Members, Affiliate Members, and Associate Members. Members have access to professional liability insurance, professional development conferences and publications, and benefit from collective representation in public, professional and legislative issues. Certified members may be listed in OACCPP's Certified Profiles of Mental Health Providers and participate in the Client Referral Service.

The Bridge Training Program has been developed in consultation and collaboration with OACCPP. The Bridge Training Program supports participants to apply for general membership in OACCPP, pay membership fees and secure professional liability insurance. This professional liability insurance covers Bridge Training participants during their internship, while also allowing them to take on private practice clients should they so choose. Bridge Training participants interested in applying for certification and taking the certification exam may make a written request to the OACCPP membership committee, asking for detailed feedback with regards to whether they require additional course work or supervised hours in order to meet certification requirements.

### **For more information about OACCPP, please contact:**

Judy Nikkel  
OACCPP  
586 Eglington Ave E, Suite 410  
Toronto, ON M4P 1P2

Toronto: 416-298-7333  
Toll Free: 1-888-622-2779  
Fax: 416-298-9593  
E-mail: [director@oaccpp.ca](mailto:director@oaccpp.ca)



Professional bodies build recognition and status by staking out their territory, drawing boundary lines to define who is included and who is excluded from the profession. If we imagine the mental health field as a vast expanse of diverse clinical practices, our map outlines a series of regulated provinces – psychiatry, psychology and social work – that have clearly defined borders, as well as a large unregulated territory occupied by psychotherapists and others, where professional boundaries are only now being sketched out. Your job as mentor is to help internationally trained professionals find their way on this map.

### You may find it helpful to engage mentees in discussions about:

#### Language and identity

What do mental health professionals do? Here are some of the terms that are used to describe what we do...

Psychotherapy, Counselling, Coaching, Psychoanalysis, Mental Health Counselling, Case Management, Consulting, Crisis Intervention.

*Brainstorm other terms with mentees. As a group, identify differences and similarities among the different roles. Which roles do mentees most identify with? Why? What other skills are part of their professional tool kit? How might these skills help them find work in the mental health field? What does it mean for them to forge a new professional identity? Acknowledge that employment in non-regulated roles usually comes with less status and lower salaries.*

#### Private practice and regulation

Talk with mentees about the opportunities and challenges of private practice. Currently, anyone can practice therapy, counselling, coaching or advising. This can be a way for internationally trained professionals to create their own employment and continue a clinical counselling role. For those considering private practice, belonging to an association such as OACCPP can help them with access to liability insurance and learning about how to run a business.

Challenges of running a private practice business include:

- Finding and paying for appropriate office space
- Finding clients who have the resources to pay for counselling, since insurance will not cover the services of non-regulated professionals
- Learning to run a small business in Canada

*Talk with mentees about private practice as an option. Connect those interested in exploring this possibility with private practitioners who can share their experience and offer advice.*

#### Training and networking

For any professional, internationally trained or not, continuing education and professional development is a way to stay current, explore new areas of specialization, build your professional network, and find out about new career opportunities. Sharing information with mentees about relevant workshops and courses can be another way of helping them find their way onto the mental health map. Share information from your own contacts and networks, and connect trainees with training institutions and professional associations related to their area of interest and specialization.

See next page for a list of members of the Alliance of Psychotherapy Training Institutes.

To explore relevant professional associations, you may find it interesting to browse the lists of national and provincial professional organizations from the Canadian Information Centre for International Credentials:

[www.cicdi.ca/en/profess.aspx?sortcode=2.19.21.21](http://www.cicdi.ca/en/profess.aspx?sortcode=2.19.21.21)



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# Alliance of Psychotherapy Training Institutions ([www.apti.ca](http://www.apti.ca))

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List of members and representatives, as of 17 September 2010

**Adler Graduate Professional School**

Linda Page  
[ljpage@adler.ca](mailto:ljpage@adler.ca)

**Advanced Training Program in Psychoanalytic Psychotherapy**

Judy Dales  
[j.dales@sympatico.ca](mailto:j.dales@sympatico.ca)

**Canadian Association for Pastoral Practice and Education (Ontario)**

Marvin Shank  
[Marvin.Shank@sjhc.london.on.ca](mailto:Marvin.Shank@sjhc.london.on.ca)

**Canadian Association for Sandplay Therapy**

Maria Iosue  
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**Centre for Training in Psychotherapy**

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**Canadian Professional Counsellors Association**

Alice Hunnensen  
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**Gestalt Institute of Toronto**

Fran Khanna  
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**Hincks-Dellcrest Centre/Gail Appel Institute**

Jim Duvall  
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**Institute for the Advancement of Self Psychology**

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**Institute for Studies in Psychotherapy and Emotional Bodywork**

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**Meaning-Centered Counselling Institute Inc.**

Lilian Wong  
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**New Realities**

Orit Morse  
[newrealities@rogers.com](mailto:newrealities@rogers.com)

**Ontario Association of Jungian Analysts**

Helen Brammer-Savlov  
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**Ontario Counsellor Education Association**

David Smith  
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**Ontario Psychotherapy and Counselling Program**

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**Ottawa Institute for Object Relations Therapy**

Gus Meier  
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**Southern Ontario Society for Bioenergetic Analysis**

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**The Living Institute**

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**Toronto Advanced Professional Education (TAPE)**

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**Toronto Centre for Psychodrama and Sociometry**

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**Observer: Canadian Association for Psychodynamic Therapy**

Susan Wood  
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## Bill 171 - Schedule R - Psychotherapy Act

(excerpt from Ontario Government site [www.ontla.on.ca](http://www.ontla.on.ca))

“The Schedule enacts a new health profession act with respect to the regulation of psychotherapy and makes complementary amendments to the Regulated Health Professions Act, 1991 (RHPA) and a number of other Acts.

The College is established as the **College of Psychotherapists and Registered Mental Health Therapists of Ontario** and the new profession the College will govern is psychotherapy.

The scope of practice of psychotherapy is the assessment and treatment of cognitive, emotional or behavioural disturbances by psychotherapeutic means, delivered through a therapeutic relationship based on verbal or non-verbal communication.

In the course of engaging in the practice of psychotherapy, a member is authorized, subject to any terms, limitations or conditions on the member’s certificate of registration, to treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual’s serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual’s judgment, insight, behaviour, communication or social functioning.

The College Council will be composed of at least six and no more than nine persons who are members who are elected in accordance with the by-laws, and

at least five and no more than eight persons appointed by the Lieutenant Governor in Council. The Council shall have a President and a Vice-President who must be elected annually by Council from among Council members.

The Schedule restricts the use of the titles “psychotherapist” and “registered mental health therapist” to members of the College. No person other than a member may hold themselves out as qualified to practise as a psychotherapist or registered mental health therapist in Ontario. Anyone who contravenes these restrictions is guilty of an offence and on conviction is liable to a maximum fine of \$25,000 for a first offence and a maximum of \$50,000 for a second or subsequent offence.

The short title of the new health profession Act is the Psychotherapy Act, 2007.

*Mentors should be able to explain and clarify this act, address initial concerns of the participants and refer them to the Transitional Council website for further information: <http://cprmbto.on.ca/pages/Home>*

*It is important to clarify that the Transitional Council is still in the process of defining the both the process and criteria for membership in the College of Psychotherapists and Registered Mental Health Therapists of Ontario.*





## Conclusion:

The complexity of the human psyche continues to inspire intellectual curiosity and clinical innovation. New professions and professional titles continue to emerge, each with new ways of understanding human behaviour, and new approaches to supporting clients on the road to well-being and fruitful living. Many professionals work in specialized areas, which may overlap or complement each other.

In many countries, the title of “psychologist” carries a great deal of social status and this defines a person in society. Losing the right to use that title has a significant impact on the professional identity and self-esteem of many internationally trained professionals. It is therefore important, as a mentor, to put psychology in the context of the many practices and labels in Canada. It is also important to let mentees know that their knowledge and training is not wasted nor the importance of their work minimized in the group. It is the mental health system in Canada that, up to now, has not been able to fully use their resources. This is a reflection on the inefficiency and limitations of the system, not on their work or worth to society as internationally trained professionals.

*In sum, there are many ways to work in mental health, under a variety of professional titles. Encourage mentees discouraged by the barriers to professional recognition as a “psychologist” to focus on their skill set. That skill set has not changed and can be applied in a variety of different ways. Some may choose to work towards licensing; others, to explore non-regulated roles within the mental health and addictions field. Both choices represent valid and significant contributions to the mental health field.*





## FINAL ESSAY

As I worked on creating this manual, it became clear to me that the job of mentoring is not restricted to the supervision of mentees. Words limit understanding here too. If the purpose of mentoring, as defined for this project, is to help people find ways to work together to meet the mental health needs of immigrant communities and the professional development needs of internationally trained mental health professionals, then there is also a need for a variety of actors and mentors:

- **Immigrant communities and allies** – to advocate for programs and services that are more accessible and responsive to the needs of a diverse population
- **Government and other funders** – to provide resources and support
- **Dreamers and innovators** – to generate ideas and design new programs
- **Internationally trained professionals** – to implement new programs, and bring new perspectives and approaches to existing services
- **Canadian experienced professionals** – to encourage and guide the immigrant professionals to understand the mental health context in Ontario.
- **Mental health service providers** – to offer placements and practical orientations for internationally trained professionals, opening doors for future employment.

The mental health field is a field ideally suited to mentorship. The mentoring approach described in this manual also applies to the practice of therapy, where it is the therapist who recognizes and values the client's strengths, while offering support and encouragement to their growth and development.

Internationally trained professionals bring tremendous skills and experience to the field – assets that are essential to building a more accessible, diverse and responsive mental health and addictions sector, where every door becomes the right door to access service. Canadian professionals and mental health agencies will benefit from mentoring internationally trained professionals, and learning from them about how to better respond to the mental health needs of under-served communities. Settlement agencies can provide a natural setting for innovative education and early intervention programs, opening new doors for immigrants and refugees to access mental health supports. To achieve maximum effectiveness, they need the support of funders and the partnership of mainstream mental health service providers. It requires broadening the scope of possibilities to consider new ways to move forward. It is a challenge, but our experience has shown that it can be done.



# THANKS

In addition to thanking future dreamers and those who will help them along the road, there are specific people we'd like to thank for offering their time and wisdom to mentor us (in no particular order):

- Consuelo Llanos, Francisco Corroy and Leticia Esquivel: for reading the emerging work and encouraging us to continue.
- Adriana Salazar: for designing and carrying out the focus group with our team of internationally trained psychologists and counsellors at the Mennonite New Life Centre.
- The volunteer counsellors, past and present: for giving selflessly of their time, energy and wisdom to clients who would have had no other options for healing; and for giving caring and support to each other and to me.
- To the Mennonite New Life Centre staff and especially Mario Bianchi: for their patience, cooperation and welcoming of our ideas and work.
- To the Bridge Training Advisory Committee and staff, for supporting us in extending our mentoring work to a wider and more diverse group of internationally trained mental health professionals
- To Linda Page, Beatrice Traub-Werner and Carlyn Zwarenstein: for the thorough and time-consuming work of editing and suggestions made to improve the readability of this manual.

As co-authors, we also need to thank each other, for neither of us alone could have done this work. Tanya thanks Eva for believing in our work with internationally trained psychologists, and for giving her time and her heart to building a real community of support around the mental health team. Eva thanks Tanya for letting me work with her, for adding the “Right Stuff” to my ideas, for contributing her invaluable perspectives and for going outside the box to make all this happen.

Let's go forward....

*Eva and Tanya*

## BRIDGE TRAINING PROJECT PARTNERS

### Across Boundaries

Canadian Centre for  
Victims of Torture

Canadian Mental  
Health Association

### Culture Link

Hong Fook Mental  
Health Association

Ontario Association of  
Consultants, Counsellors,  
Psychometrists and  
Psychotherapists

Rexdale Women's Centre

St. Joseph's Women's  
Health Centre

TAPE Educational Services



# APPENDIX

## Appendix 1 ~ Sample Forms

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- A. Confidentiality and Consent (Adult)
- B. Confidentiality and Consent (Child)
- C. Assessment Form
- D. Memo to Client Regarding Counseling Reports
- E. Memo to Legal Counsel Regarding  
Counseling Reports
- F. Request for Counselling Report

## Appendix 2 ~ Sample Reports

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- A. Sample Report for Refugee Claim
- B. Sample Report for Appeal of Refugee Decision

## Appendix 3 ~ Focus Group Report

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- A. Focus Group Report





## A. Confidentiality and Consent (Adult)

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Date: \_\_\_\_\_

I, the undersigned, agree to receive counselling from \_\_\_\_\_ at the Mennonite New Life Centre. I understand that this service is provided without cost by volunteer professionals who support clients of the Mennonite New Life Centre. These volunteers have academic training and work experience as psychologists in their home countries but are not licensed psychologists in Canada. They are members of the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists (OACCPP).

\_\_\_\_\_  
Signature

I also confirm that I have received explanation on the limits of confidentiality as follows:

Confidentiality will be maintained except:

1. When a child is at risk.
2. When a person is at risk resulting from the actions disclosed by the client during a session.
3. When the client expresses an intention to harm her/himself.
4. When the federal or provincial government subpoenas the counselor's files.
5. When the counsellor needs to access professional consultations or supervisions.

I also understand and agree that the decisions and actions that I make in the course of therapy are my own responsibility and that I am under no obligation to act on the counselor's suggestions or perceptions.

I agree that my counselor is not legally liable for my actions.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Client name



## B. Confidentiality and Consent (Child)

---

Date: \_\_\_\_\_

I, the undersigned, agree for my child \_\_\_\_\_ to receive counselling from \_\_\_\_\_ at the Mennonite New Life Centre. I understand that this service is provided without cost by volunteer professionals who support clients of the Mennonite New Life Centre. These volunteers have academic training and work experience as psychologists in their home countries but are not licensed psychologists in Canada. They are members of the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists (OACCPP).

\_\_\_\_\_  
Signature

I also confirm that I have received explanation on the limits of confidentiality as follows:

Confidentiality will be maintained except:

1. When a child is at risk.
2. When a person is at risk resulting from the actions disclosed by the client during a session.
3. When the client expresses an intention to harm her/himself.
4. When the federal or provincial government subpoenas the counselor's files.
5. When the counsellor needs to access professional consultations or supervisions.

I also understand and agree that the decisions and actions made by myself or my child during the course of therapy are our own responsibility and that we are under no obligation to act on the counselor's suggestions or perceptions.

I agree that my counselor is not legally liable for my actions.

\_\_\_\_\_  
Signature: Parent or legal guardian

\_\_\_\_\_  
Print name



## C. Assessment Form

Date: \_\_\_\_\_ Counselor: \_\_\_\_\_

### IDENTIFYING DATA:

Name \_\_\_\_\_  
 Sex \_\_\_\_\_ Languages \_\_\_\_\_ Tel \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Address \_\_\_\_\_  
 Country of Origin \_\_\_\_\_ Date of entrance \_\_\_\_\_  
 Legal Status \_\_\_\_\_  
 Main Source of Income: \_\_\_\_\_  
 Referred by \_\_\_\_\_

**PRESENTING PROBLEM:** *(Use the client's own words if possible) (duration, stressors associated, solution attend)*

### RELEVANT HISTORY:

	Current	Childhood	Adolescence
Physical Abuse			
Sexual Abuse			
Emotional Abuse			
Suicide Ideation			
Any Plan			
Previous Suicide Attempts			
War Experience			
Other			

### CURRENT SYMPTOMS CHECKLIST:

Sleep disturbance	Appetite
Weight (loss or gain)	Level of Energy
Concentration	Anxiety
Phobia	Panic attacks
Obsessive/Compulsion	Current Physical Complaints



## HEALTH HISTORY

**Previous Personal Mental Health Diagnosis:** (when, by whom, treatment)

**Medication** (if any), **Hospitalizations** (specify dates and treatment)

**Substance Use** ( Age of first use):

\_\_\_\_\_ Drugs \_\_\_\_\_ Alcohol \_\_\_\_\_ Other (describe): \_\_\_\_\_

**Family Relevant Mental Health History**

## FAMILY HISTORY

Family Composition in childhood

Significant Childhood family experience:

\_\_\_\_\_ Outstanding home environment \_\_\_\_\_ Normal home environment

\_\_\_\_\_ Chaotic home environment \_\_\_\_\_ Witnessed physical/verbal/sex abuse towards others

Age of leaving Home: \_\_\_\_\_

Circumstances:





Positive childhood circumstances: (school success, awards, helpful people)

Current Immediate Family

Persons currently living in the household

Relationship satisfaction

Contact with family of origin:

Significant issues:

**SOCIAL INTERACTION**

\_\_\_ Normal

\_\_\_ Supporting Network

\_\_\_ Isolation, alienation, shyness

\_\_\_ Participate in Community/recreational/spiritual activities



## **INTELLECTUAL, ACADEMIC FUNCTIONING**

Education (Highest level Achieved):

Learning problems:

Authority conflicts:

## **EMPLOYMENT AND FINANCIAL SITUATION**

Employment and satisfaction:

Current financial situation:

## **MILITARY AND LEGAL HISTORY**

\_\_\_\_ Served in Military

Incident:

Present or past legal trouble:

## **MENTAL STATUS**

### **Appearance /Behavior**

Hygiene, grooming, self-care:

Facial expression, eye contact:

Orientation, time, space:

Aggressive, oppositional, distrustful, self injuries acts, impulsive:

Extreme worrier:

Tearful:

Agitated, restless:

Still:

Slow Moving:

Other:

### **Thought/Perception**

Speak fast, slow, slurred, dissociation, tangential, distract, focused:

Hallucination (visual, Auditory, Tactile):

Delusion:

Other:



**Mood/Affect (expressed/observed E/O)**

Appropriate:

Elevated:

Hostility, irritability, guilty:

Depressive, hopelessness, worthlessness :

Mood swings:

Other:

**Judgment/Insight**

Decision making ability/problem solving, immature:

Ability to understand the reality:

Other:

**DIAGNOSIS IMPRESSION:**

--

**CLIENT'S GOALS FOR TREATMENT**

--



## PROGRESS REPORT

---

Date:

Contact Type: (Check One)

Telephone: ---- In Person: ----- Other (specify):-----

**Main Topic:**

**Content (quotes, paraphrase etc):**

**Tasks for Next Session:**

Next Appointment: \_\_\_\_\_





## D. Memo to Client Regarding Counseling Reports

---

### Counseling Reports

The counselors at the Mennonite New Life Centre work as volunteers. Their first priority is to support newcomers with emotional needs through counseling. In some cases, they may be able to provide a counseling report – for example, to support a refugee claim or humanitarian application. If you need a report, please remember the following:

- **Your counselor needs time to prepare a report.** Please inform your counselor two months in advance that you need a counseling report. You will need to attend several counseling sessions before your counselor has enough information to write a report. You also need to allow time for the report to be reviewed and signed by your counselor's supervisors.
- **Your counselor needs information about your case.** Please give your counselor a copy of your PIF. Your counselor will also need the full name and contact information for your lawyer. Ask your lawyer whether there are particular questions or issues that should be addressed in the counseling report and give this information to your counselor.
- **You will not be charged for the counseling report.** However, if you are receiving Legal Aid, we will talk to your lawyer to find out whether Legal Aid can help cover the cost of preparing the report.



## E. Memo to Legal Counsel Regarding Counseling Reports

---

The Mennonite New Life Centre, through our Community Mental Health Program, offers counselling services to Spanish speaking newcomers, regardless of immigration status. Counselling is offered by internationally trained psychologists, with clinical supervision from a certified member of the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists.

The Mennonite New Life Centre will provide counselling reports in support of refugee claims, PRRAs and H and C applications. In order to provide a high quality report, we ask that you notify us two months in advance, provide us with a copy of the PIF narrative, and advise us of any particular questions or issues that should be addressed in the report. This will allow us sufficient time to establish a meaningful therapeutic relationship, write a well founded report, and ensure sign off by supervisors. All reports are signed by Executive Director Tanya Chute Molina, MSW, RSW.

The Mennonite New Life Centre seeks to provide the same level of service to all clients, regardless of financial circumstances. For this reason, we do not charge clients for counselling reports. However, if the client is covered by Legal Aid, we ask that you provide payment for the counselling report. It is our understanding that Legal Aid will reimburse \$150 or more for a psychological report.

All requests for counselling reports should be faxed to 416-699-2207, and accompanied by the client's signed consent to share information. Please advise us at the time of the request whether the client is covered by Legal Aid.

Sincerely,

Tanya Chute Molina, Executive Director  
Mennonite New Life Centre



Client name:  
Legal Counsel  
Name:  
Address:  
Phone:  
Fax:

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Report covered by Legal Aid:    Yes    No

Send invoice to: \_\_\_\_\_

- the client's signed consent to share information
- a copy of the PIF narrative

Please fax requests to: \_\_\_\_\_



## A. Sample Report for Refugee Claim

---

Name:

Date of birth:

Country of Origin:

Immigration Status: Refugee Claimant

Arrival Date:

This report has been written by [REDACTED], counsellor at the [REDACTED], a community agency providing settlement and emotional support services to immigrants and refugees. The counsellor and this report are supervised by [REDACTED], MA, and DTATI, certified by the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists.

### **Presenting Problem:**

[REDACTED] is a [REDACTED] year old married [REDACTED] who has been receiving counselling at this Centre's Special Support Services since [REDACTED]. The referral was made by the settlement worker, [REDACTED], who identified that the client was undergoing severe emotional crises.

During the initial interview, the client could barely speak because he was crying continuously. He described feelings of guilt and memories that have seriously affected his life. He appeared very anxious with pressured speech, physical agitation and stated feelings of claustrophobia in the centre's office. He spoke of having constant fears for his life.

### **History of the Problem:**

In [REDACTED], during political elections in [REDACTED], the client witnessed electoral fraud and reported it to the authorities. Subsequently, he received death threats and, after moving to various places in the city, he was found and arrested by police. While in jail, he was tortured. After he was able to escape, he entered the United States in [REDACTED], leaving his family behind. Shortly after this, his wife was beaten and raped and had to flee to the [REDACTED] with their children.

The client states, that in [REDACTED], his father was attacked and died of his injuries and a cousin named after him was murdered.

In [REDACTED], their refugee petition in the [REDACTED] was rejected and they decided to migrate to Canada because they were convinced that returning to [REDACTED] was still a grave danger for them.

All these events have traumatized [REDACTED] and he lives with ever present hyper-vigilance; insomnia due to horrible nightmares of his persecution, kidnapping and beatings; guilt about his wife's rape, as well as the death of his father and nephew; claustrophobia related to his confinement during the kidnapping and constant terror due to the uncertain future for himself and his family. These symptoms are consistent with a description of Post Traumatic Stress.

### **Mental Status:**

The client presents as very anxious and cries often during the sessions. He has difficulty concentrating and questions have to be repeated because he is not able to focus on the words. He emphasizes constant fear about being returned to [REDACTED], where he is certain that he will be murdered. He is also expresses fear that his wife and children will be killed with him. These fears, fed by the ongoing flashbacks to his torture and visualizations about their death, are factors that destabilize his mental health and ability to deal with present life. As a consequence his family feels vulnerable and more frightened.



**Work done:**

The client has attended ■ sessions of cognitive based therapy geared to reducing his anxiety levels and moments of panic. He has been taught various relaxation techniques to increase his stress tolerance and to reorient him to improving his level of adaptation to his current present. Although ■ has attended all scheduled sessions and follows through with his relaxation and other contracted tasks, progress has been slow because of the suspense of the upcoming refugee hearing and his being unable to find the safety necessary to stabilize his life. Nevertheless, some improvement has been noted in the symptoms of claustrophobia. Whereas he was not able to enter an elevator before because of the physical hyper-reaction to the place of torture, he is now able to use an elevator when accompanied by a family member.

**Conclusions:**

■ presents with credible symptoms which as a group are described in the literature as Post Traumatic Stress. His life experience, as detailed in the PIF, the peril of his and his family's life, his guilt about the murder of loved ones by his persecutors, his own sense of responsibility for the suffering that he believes that he has caused occupy his daily thoughts. He is unable to concentrate and function to create hope, has destabilized himself cognitively and emotionally and has left his wife vulnerable to further emotional anguish at the loss of someone who has previously taken the role of protector.

It is very feasible that, if returned to ■, ■ would decompensate severely in view of what he considers a serious and present threat to his life and that of his wife. He is certain that his persecutors are still active and have, furthermore, murdered his father and nephew. Those nightmares, flashbacks, moments of panic, lack of cognitive clarity and other symptoms which destabilize his life in Canada, would paralyze him and his family in ■. It is reasonable for him to believe that if he was traced before when he moved, then this would continue upon his return.

The ■ authority that he once trusted has betrayed him by producing the thugs that now want him dead. He has no one to turn to there, he sees no way of surviving.

Acceptance into Canada would offer a sheltered stage in which to create a new life after many years of emotional earthquakes.

Sincerely,





## B. Sample Report for Appeal of Refugee Decision

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██████████  
DOB: ██████████

### Introduction

For the record, I am a Psychotherapist certified with the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists.

██████████ was referred by ██████████, immigration attorney. The interview was done in Spanish.

### Presenting problem

██████████ is a ██████ year old ██████████ from ██████████. She has been in Canada since ██████████ and has been living in a shelter. Her refugee claim was rejected. ██████████ does not fully understand why her credibility was questioned and is very anxious that she not be returned to her country where she is very afraid for her safety and livelihood.

### History of the problem

██████████ is one of ██████ children raised by her mother and of the same father. Her father, who still lives with the mother, is an alcoholic womanizer who frequently beat the mother with rubber or electrical cords. The children were, of course, constant witness to this violence. The family was very poor and the town had no school, so the children walked several miles to another school. ██████████ finished classes to grade 6 because that is as far as the school went and the next school was too far to go. Her childhood was overwhelmed with violence and hardship.

At age ██████ she started to work in various jobs in banana, plantain and coconut trades. These jobs required heavy physical work for minimal pay. During this time, a close family member was murdered. ██████████ is the mother of six children. ██████████ had different women and was a very violent man who allegedly killed his own brother during a fight and spent time in jail. He would come and go into her home as he pleased over many years and in between his women. He was always violent and on at least three occasions caused her severe physical harm. When ██████████ finally got the courage to go to the police they did nothing to help, even though they ostensibly knew of his history. ██████████ came to Canada believing that she could flee this violence.

At one point, ██████████ rented an apartment in a house in which the landlord had no apparent heat. She protested to no avail. When she threatened to withhold part of the rent until the heat was provided, the landlord called the police and ██████████ was arrested and found to be illegally in Canada.

### Mental Status

██████████ arrived a few minutes early for the appointment and greeted the therapist in a friendly smiling manner. After she sat in the office, she broke down in tears and said “I don’t want to talk about it any more”. The emotion was very credible for the quivering of the lips and the contortion of the face, indicating that she was trying not to cry. This happened several times during the interview, which was obviously very stressful and painful.

██████████ spoke with a strong rural accent and dialect which was somewhat difficult to understand and would be more so to anyone who did not speak Spanish. Nevertheless, she was willing to repeat anything that she was asked to repeat and did so without rancor.



She was oriented and after she was able to relax, she smiled often. When she was asked what gave her pleasure in life, she laughed with child-like pleasure at the thought of something before she stated it. Her mood is sad and her affect is anxious, but she can be distracted. Her memory for details was poor at times, especially when she spoke about an upsetting event. It is apparent that she has a minimum of education and lacks understanding of abstract ideas, such as differentiating roles between lawyers, counsellors, social workers, etc. She simply does what someone tells her to do. To this end she has attended job search courses, computer classes, resume writing workshops, etc.

Her attitude is hopeful and present oriented. She lives on a day to day basis. It has only been since the immigration problem that she has been forced to consider a distasteful future consequence. It never occurred to her before, that standing up for a right to have heat in her residence would result in a threat to her stability in Canada.

She attends church regularly. She does not remember the name, but she smiles as she describes that they sing and clap hands.

### Analysis

██████████ has experienced trauma since childhood. Witnessing severe violence against a mother is considered, in Canada, to be serious enough for reporting to the Child Protection agencies. A definition for Post Traumatic Stress (PTSD) (1) considers that it is a result of "...witnessing or being involved in a horrifyingly frightening event such that you feel that your life or the life of those around you are in danger." Regardless of the cultural norms of a society, a child will always be traumatized at seeing violence against a parent. ██████████ suffered this since early childhood.

Furthermore, it is now known that physical changes take place in the brain of someone suffering from PTSD, that these changes are more drastic in children and that they affect memory of children as well as adults. (1, 2) In addition, the chemical changes affect not only the ability to understand words but may render a person unable to express her/himself clearly verbally. The right words do not seem available.

In view of the above information, it is reasonable to conclude that her husband ██████████ abused her many more times than the three times mentioned in the PIF, but that ██████████ was not able to coordinate this information in a context apart from the three memories that stand out for their brutality. In fact she admitted during the assessment questioning which was done gently and supportively, that he was always drunk and violent.

On the IRB rejection paper that the claims on the two PIFs do not coincide, it is useful to note that they do not conflict. Given ██████████ intellectual concreteness, it is very likely that she gave the information requested by the person attending to her at the time and said no more than she believed was required. In addition, her memories are affected by her ability to interpret and understand the importance of them (abstract thinking required) and also by the effect of the traumas on her brain. (2) The IRB paper also disbelieves her claim that she did not know the refugee application process. It is quite credible that she would not have information about the refugee system, since it is not a usual topic of conversation in most social circles.

The issue of her accent and idiom makes her claim (that she was not understood and that she did not understand what was explained to her) credible. Understanding decreases with increased anxiety such as that which would be present during the discussion of the PIF.

Any other events, such as the murder of her sister, burning of her house, loss of her land, poverty, living without heat, incarceration, etc, are exacerbations of an already damaged system. Her fear of further violence upon a return to ██████████ is also believable because she has lost her sense of being able to survive there. She knows that she will not get help to live there and that is a terrifying sentence,



a risk to her life and a risk of further violence to a woman obviously unable to determine protective decisions for herself without professional help.

### **Conclusion**

██████████ is a █████ year old woman from ██████████ of very concrete intellectual capabilities and many experiences of trauma since childhood. She came to Canada to escape abuses and losses. It is not only believable that she had no information about the refugee system but also that she had no idea about how to ask the questions to find answers. Current research shows that trauma in general affects memory and understanding and this is especially critical in the case of child development. ██████████ needs life skill help and emotional support to remedy a lifetime of damage and she cannot obtain this in ██████████. She has connected with appropriate resources in ██████████. There is no question about her credibility.

Sincerely,

References accessed on ██████████

- 1). [http://www.ehow.com/about\\_5503313\\_effects-ptsdrelated-memory-loss.html](http://www.ehow.com/about_5503313_effects-ptsdrelated-memory-loss.html)
- 2). <http://ajp.psychiatryonline.org/cgi/content/abstract/150/7/1015?eaf>



## Appendix III: A. Focus Group Report

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This focus group aimed to document learning and best practices arising from the experience of the community mental health team at the Mennonite New Life Centre, and their group mentoring experience with author Eva Saphir.

Using participatory research methodology, we designed both a focus group discussion guide and a questionnaire for past volunteers and interns. Both the focus group and the questionnaire focused on two main areas of inquiry: the professional and the personal. On the professional side, participants were asked to reflect on: useful information and tools learned through the supervision meetings, additional content that would be helpful, learnings about the Canadian mental health system and work environment, and outstanding needs for furthering their professional development. On the personal side, participants were asked to reflect on how the mentoring process helped them negotiate the changes and transitions in personal and professional identity that often accompany the migration experience, their experience of counselling people experiencing similar settlement and integration challenges to themselves, and their learning from working alongside peers from a range of countries.

To encourage response, Eva herself sent out the invitation to past and present members of the mentoring group to participate in the research process. To encourage full freedom of expression, another staff member facilitated the focus group. In total, six internationally trained counsellors participated in the focus group while four more submitted questionnaire responses. With the participants's permission, focus group proceedings were taped, transcribed and shared with Eva as a starting point for reflection in developing a manual and discussion guide for mentoring internationally trained mental health professionals.

### **Process**

The focus group facilitator explained the process.

A general information questionnaire was completed by each group member less one person. The first part of the work was done individually where each member received 4 Yellow papers, each with a different question to be answered on that paper.

The second part of the session involved small group work. The group was divided into two sub groups, each of which was given 4 Blue papers with additional questions. Each group had different questions to answer and summarize in writing.

In each case the themes were discussed with the whole group at the end of the exercises. There were six participants in the group.

Four questionnaires were received by email.

Eva was presented with

1. A transcript of the tape without identifying names
2. Six sets of 4 Yellow papers with written answers but no names
3. Two sets of five Blue question papers with written summaries of discussion on the topic.
4. Individual answers from the four emailed questionnaires, without identifying information.

All communication was in Spanish. The information below was culled and translated by Eva. Special gratitude to Marisabel Abu-Jaber, Carlos Charris, Leticia Esquivel and Monica Patarroyo, for their help to Focus Group facilitator Adriana Salazar and myself in this project.



## Focus group composition

### SELECTED QUESTIONS AND COMPILATION OF ANSWERS

#### Demographics (from the general information form)

1 male  
8 females  
One page missing  
4 responses by email  
5 responses from the focus group

#### Age

25-30 ..... 2  
30-35 ..... 2  
45-49 ..... 1  
50-60 ..... 2  
2 declined

#### Education

Psychology degree ..... 6  
Masters in clinical psychology ..... 2  
Doctorate ..... 1

#### Experience in Country of Origin

4 mo., 1, 4, 9, 14, 10, 15, 15, 20

#### Time in Canada

1-2 yrs ..... 4  
2.5-3 yrs ..... 3  
4.5-5 Yrs ..... 2

#### Time in the Group

Not specified ..... 1  
< 1 yr ..... 3  
1-<2yrs ..... 3  
2-3 yrs ..... 2

#### Studied in Canada.....3

Certificate in Home Child Care  
Certificates at George Brown and Ryerson  
Certificate as a Life Skill Coach

#### Comfort with English

Difficulty with any English communication ..... 1  
Can engage in simple English conversations .... 3  
Can work in English ..... 2  
Could present in a Conference in English ..... 3

#### Immigration Status

Temporary foreign worker ..... 1  
Permanent resident ..... 4  
Citizen ..... 1  
Convention Refugee ..... 2  
Refugee Claimant ..... 1

#### Income Source

Permanent work ..... 1  
Social Assistance ..... 4  
Training, apprenticeship ..... 1  
Employment in the field ..... 2  
Savings ..... 1





### **What concrete information or tools have you received during the case supervisions?**

1. What to do as a counselor in Canada
2. Requirements to qualify for the profession
3. Technical aspects of how clients can access services
4. How to write reports for lawyers or other institutions
5. How to refer a client to a general hospital
6. How to manage cases of child abuse, children's rights and issues of adolescents and how they interact with parents.
7. Resources for addictions
8. Various schools of thought and approaches to treatment
9. More technical information about the management of some cases
10. Validation and encouragement
11. Personal and professional enrichment

More generally, participants stated that they:

12. Value the knowledge and experience of the supervisor
13. Appreciate the day to day coordination work of mental health program by Leticia
14. Learn from the contributions, knowledge and experience of peers: discussions between counsellors show new options that can be used for other cases

### **What other information would you have liked to get from the supervision?**

1. Help group members to connect with work possibilities
2. Create a space in which the different group members can share different solutions and theoretical approaches that they have used. Discuss more scientifically the different approaches, and identify which approaches are being used when discussing a case.
3. Create a record to save approaches to different cases discussed in supervision in order to save the good ideas and different theoretical approaches so that future counselors could have access to them.
4. Understand how others in the group practiced their profession in their countries.
5. Have more specialists or experts in the field come and teach.
6. Learn about mental health education and prevention programs

Focus group participants also offered ideas for strengthening the structure of the community mental health program at the New Life Centre:

7. Distinguish between mentoring and supervision and dedicate adequate time and resources to each of these roles. Consider assigning these two roles to separate people.
8. Limit the volunteer placements to 6 months or a year in order to avoid agency dependency on long periods of volunteering.

### **How has the process of the mentoring group helped you understand the Canadian Mental Health System?**

1. It has presented us with realistic rather than idealistic approaches to interventions.
2. I've learned that finding a psychiatrist is not simple and there are waiting lists for services that have no cost. That the waiting lists are sometimes 6-9 months long. That if someone wants psychological help, it is quicker if you pay.
3. It has helped learn about the limitations of the system and ways to negotiate the system.
4. The process gave me information about alternative/natural treatments.
5. I came into the group assuming a rose garden of mental health and social services in Canada. I learned that this rose garden doesn't exist. For example, an immigrant client may not have services available because of his or her language.
6. I understood that our experience as immigrants is actually an advantage for the mental health system here because we can communicate and understand many aspects of our client's struggles.



**In order to continue with my professional development, this program should offer:**

1. Economic and/or professional support
2. Access to professional courses/workshops/training programs in psychology
3. Access to a library with information on interventions, procedures, legal issues, forensics, etc.
4. More information about community resources, community services, and mental health legislation.
5. More information about prevention and social reintegration strategies
6. Work with interdisciplinary teams and not just focus on client internal cases
7. More sharing of the experience and knowledge of the group members
8. More opportunities to improve the language
9. Coordination and interface with other institutions.
10. Research

**What was your motive for volunteering in this program?**

1. Wanting to use my abilities again to help the community
2. Wanting to feel useful and productive again
3. The need to be again what I always wanted to be
4. To teach my brother and sister immigrants that in this new context it is still possible to continue with the life history that we had before we came.
5. Canadian experience
6. Wanting to continue my work in the field of mental health
7. To continue working with my Latin-American community
8. I liked the ED's attitude during the first interview
9. To do volunteer work and learn more about the system
10. To increase the possibility to practice my profession
11. To keep myself informed in the area of mental health
12. To learn the theoretical psychological practices used in Canada
13. To increase my network of contacts
14. I wanted to establish a mental health program

**What qualities/fortes should an immigrant psychologist have, in order to be able to work professionally in Canada?**

1. Passion for the work and experience and education in the field.
2. Interest in learning
3. Respect for others
4. Creativity and self assurance
5. Problem solving skills
6. Awareness of the Canadian context, mental health system and referral resources
7. Self awareness and understanding of their own process
8. Capacity to put themselves in the client's shoes without losing track of their own process
9. To be open to give and receive at a personal and professional level
10. To have awareness and manage their own prejudice
11. To be respectful of all differences, i.e.: sexual preferences, religion, etc
12. To be flexible and aware of the changes needed in order to adapt to the culture and workplace here
13. Desire to improve general language and technical language skills
14. To be in their own therapeutic process
15. To have access to and be receptive to supervision
16. Have the qualities of warmth, understanding, patience sense of humour and the immigration experience that could be used to understand and help the client.
17. Manage frustration and have patience.



**How has it been for you to help a person who is facing a situation that is equal or similar to the one that you experienced?**

1. It was important to keep in mind that we have different roles and stay concentrated on the client's needs.
2. We can validate the client by being able to put ourselves in his position. We can also share ideas from our own experience that might be useful for a client to consider as options.
3. Solidarity and empathy are important in order to motivate a client to persevere.
4. It was difficult for me to face cases where I knew that a refugee claimant was lying in his case and receiving government benefits that I did not have access to, but I found a way to deal with my feelings with the help of a peer in the group.
5. If I faced problems that I ethically could not deal with, I would arrange for the client to see someone else in the team because the client needs to be protected from re-victimization.
6. For myself and my clients, I feel it is important to create goals to work towards, and to redefine failures as opportunities and motivators.

**What has been your experience of working with peers from other cultures? What have you learned from them? How have you resolved conflicts?**

1. It has been an enriching experience, both personal and professionally.
2. It has been enjoyable to hear points of views and experiences that are different from mine.
3. Eva helps validate and support the work done by each member in the group
4. Every day one learns from the experiences of the others.
5. When conflicts arise, I am direct and state the problem, but also take part in finding a solution.
6. I learned that in group processes, one needs to be patient and wait for things to happen.
7. The group will always be heterogeneous and one has to learn to wait for a consensus.

