

“Just scratching the surface”: Mental health promotion for Punjabi seniors (Forums)

Final Report

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“Just scratching the surface”: Mental health promotion for Punjabi seniors (Forums) ~ Executive Summary

This report summarizes findings from two forums, held in Abbotsford and Surrey, British Columbia in April and May 2011. Their purpose was to explore the extent to which community services targeted at Punjabi seniors at these two locations address the social determinants of mental health, identified by Keleher and Armstrong (2005):

- ◆ social inclusion
- ◆ freedom from violence and discrimination
- ◆ and access to economic resources

At each of the community forums, older Punjabi men and women shared their experiences and identified the barriers to accessing such mental health supports that they and many other seniors in their community faced.

Service providers met in separate groups to discuss the nature and scope of the services they provide and their perceptions of the benefits to their older Punjabi clients.

Key findings:

Punjabi older adults are **hard to reach** and a relatively **vulnerable population** in terms of their mental health needs.

Social inclusion is an important determinant of mental health and wellness in this population, in terms of the need to feel respected and valued, to have supportive relationships, to participate in the community and to have access to basic human entitlements.

Family plays an essential role in Punjabi older adults’ mental health and wellbeing, both *positively* in terms of providing support and sense of belonging, and *negatively* in terms of the stress that dependency on other family members engenders, unmet expectations, tension between generations that can lead to depression, conflict, violence or elder abuse, or substance abuse, and lack of knowledge and awareness among and within family members to assist elders with their mental health needs. Successful mental health promotion and intervention programs inclusive of Punjabi older adults need to find meaningful ways of involving families and younger generations.

Reaching out to Punjabi seniors by service providers and community groups is required in order to address the seniors’ mental health needs. Knowledge of programs and services available to this population needs to be increased, as well as awareness of mental health issues.

Access to mental health supports by this population can be improved by offering supportive and inclusive services that reflect language and health literacy **barriers**, providing

transportation, child-minding for grandmothers with childcare responsibilities and employing culturally-sensitive approaches to raising awareness of programs and mental health issues.

There are **differences between the two municipalities** in the way mental health supports for Punjabi seniors are structured and delivered. In Surrey, service providers come predominantly from the settlement sector and the same cultural background, while in Abbotsford, mental health supports are provided mainly by mainstream community programs. It would be beneficial to further explore pros and cons of the two approaches.

Service providers need additional **supports** in terms of training and resources (such as long term funding to promote continuity of mental health supports). This team will further explore the sustainability and capacity-building potential of promising practices and the development of mental health promotion competencies amongst community service providers.

“Just scratching the surface”: Mental health promotion for Punjabi seniors (Forums) ~ Final Report

ICARE

The ICARE (Immigrant Older Adults—Care Accessibility Research Empowerment) team was founded in 2009 with an infrastructure team grant from the Women’s Health Research Institute of BC by co-PIs Dr. Sharon Koehn (Centre for Healthy Aging at Providence Health Care) and Dr. Karen Kobayashi (University of Victoria). With this funding we developed dense networks and consulted with diverse stakeholders, such as interdisciplinary academics, clinicians, multicultural settlement and community service sector staff, policy makers and older adults (Spence, Koehn & Kobayashi, 2009).

Two working groups were developed in response to the identified priority areas: (1) community mental health, and (2) chronic disease self-management. The community mental health team partnered with the Canadian Mental Health Association-South Fraser to apply for the BC Government, Community Action Initiative funding that supported this work.

Background and Purpose of the Forums

In late 2010, Community Action Initiative funding enabled cross-cultural collaboration of several community partners focused on community capacity building to explore if and how the social and economic determinants of mental health for Punjabi-speaking seniors were addressed by community programs in the South Fraser region of B.C. The partners organized two “Punjabi Seniors Wellness Forums”, one held in Abbotsford, B.C. on April 6th, 2011 and the other in Surrey, B.C. on May 10th, 2011. This report summarizes findings from the two forums.

Purpose of the forums

- Identify sources of marginalization specific to Punjabi seniors as well as those that may cross-cut other ethnocultural groups, e.g. age, gender, disability, etc.
- Identify promising practices and community assets for mental health promotion focusing on those that serve a protective function against the negative impacts of marginalization.
- Identify challenges to the efficacy or sustainability of these community supports.
- Identify how community capacity can be increased and supported.

Rationale

The proportion of seniors in Canada is expected to reach almost 24% by the year 2031 (BC Ministry of Health Services, 2004). Already, 51% of all seniors in Metro Vancouver are immigrants and 31% are visible minorities (Turcotte & Schellenberg, 2007). Of the latter, 24% are South Asian, the majority of whom are Punjabi speakers (Statistics Canada, 2006). In 2006, visible minority populations in the South Fraser cities, of Surrey and Abbotsford were 52.1% and 26.2%, respectively (Fraser Health Authority [FHA] 2011a, b). In 2010, 32% of the population of Surrey were South Asian and 18% said that Punjabi is the language they most often speak at

home (FHA 2011a). Similarly, in Abbotsford, South Asians represented one fifth of the population and Punjabi is the most common language spoken at home, other than English (FHA 2011b).

The risk of mental illness is higher among immigrants who migrate to Canada after age 65 (Hansson *et al.*, 2009). In community consultations with Punjabi seniors conducted by the ICARE team (Spence & Koehn, 2010), depression was discussed as a substantial but hidden problem among immigrant Punjabi seniors. Social determinants that can challenge the mental health of older immigrants include factors that arise from the immigration process (i.e. resettlement stress, poverty, racism, and family separation), being a sponsored immigrant and hence dependent on sponsors for ten years, a drop in social status and a shift in roles, and childcare obligations, from which intergenerational tensions and barriers in access to services and supports can arise (Koehn, 2009; Koehn, Spencer & Hwang, 2010; Spence, Koehn & Kobayashi, 2009, Spence & Koehn, 2010).

The promotion and maintenance of seniors' mental health contributes positively to their quality of life, physical health and effective utilization of health care services (Parent *et al.*, 2002). Yet participants in the ICARE consultations with Punjabi seniors in Surrey told us that they have less access to community services and transportation than their counterparts in Vancouver. These consultations also revealed that many Punjabi seniors are unaware of most services, often do not know how to operate telephones or televisions to get the information they need, and families do not always offer help. Many, especially women, struggle with low literacy in their own language (Koehn, 2009). ICARE multicultural settlement partners who provide services to Punjabi seniors in the region also report that they do not have the capacity – either in terms of resources or knowledge – to provide or maintain all of the necessary supports (Spence, Koehn & Kobayashi, 2009). Finally, there is no evidence to illustrate which types of community supports most effectively promote mental health and well-being for Punjabi seniors.

In light of these issues, the ICARE mental health team, led by Sharon Koehn (Providence Health Care) and Satwinder Bains (University of the Fraser Valley), partnered with representatives from the Canadian Mental Health Association – South Fraser Region, B.C. Healthy Communities and Fraser Health Authority to form the “Punjabi Seniors Wellness Coalition.” With a Community Action Initiative convening grant, the coalition organized two “Punjabi Seniors Wellness Forums,” one in Abbotsford, the other in Surrey. The forums brought together Punjabi seniors and representatives from local organizations that we identified as potentially delivering mental health promotion services to this population. The aim of this group was to further explore challenges as well as promising practices in mental health promotion for Punjabi seniors and their families in B.C.'s South Fraser region. The findings from this explorative inquiry will inform mental health promotion practice and policy as well as further research efforts that seek to identify effective ways to build on community strengths and promote the mental health and wellness of Punjabi older adults in these communities and ultimately throughout BC and Canada.

Service Provider Workshop:

Training Component:

*Integral Capacity Building Framework
(adopted by B.C. Healthy Communities)*

Relating personal experiences and associations to four quadrants (I, WE, IT, ITS)

Presentation of fundamental relationships to mental health in each quadrant

Presentation of the relationships pertaining to service providers' supports of mental wellness

Questions:

Given the work you have all done on the survey and what we have just discussed with respect to community capacity and the determinants of mental health, can you tell us if and how your programs and services currently address these determinants?

Is there something that you, your agency or another agency does already that is successful? (i.e. What are the 'promising practices' already out there?)

What really supports or inspires you to do the work you do with newcomer seniors?

Forum Processes

A total of over sixty participants attended the two forums. Seniors were recruited by our local Punjabi-speaking forum organizers from *gurdwaras* (Sikh temples), through advertisements in a local free Punjabi-language newspaper, a poster in a Laundromat, staff at local immigrant serving community agencies, and word of mouth. Our goal was to invite 20 seniors, balanced by gender, to each forum. In total, 24 older women and 22 older men attended the two forums. Some seniors at the Abbotsford forum also came from the small neighbouring community of Mission, whereas all senior participants in the Surrey forum lived in that jurisdiction. Seniors received a small honorarium which was appreciated but it was clearly not the incentive for attending since 6 additional seniors (two men and four women) accompanied their friends to the Abbotsford forum stating that they didn't care about the money; they just wanted the opportunity to attend and participate.

Service provider participants were carefully selected to represent local services that our team identified as addressing at least one of the social determinants of mental health for Punjabi older adults and their families (see Appendices A and B). These determinants are identified by the VicHealth Framework and are described in the next section. A total of 28 service providers attended the two forums; 14 in each location. Two service providers in the Abbotsford forum came from Mission.

As part of their registration, service providers were asked to complete a questionnaire capturing the demographics of clients their program/organization serves, what types of service they offer, and what specific determinants of mental health they address. Their responses are summarized in Appendices C and D. This exercise was beneficial in preparing them for the forum discussions. Survey results also provided a preliminary summary of what is offered in the community and what determinants of mental health are

Seniors' focus group questions:

1. What can you tell us about the programs you attend, if any?
2. We'd like to understand what's most important to people about the programs they attend, so we're going to ask you about different kinds of benefits that they may offer. Please can you tell us if and how the program you attend has made any difference in each of these areas for you?
 - Making new friends (see them elsewhere?)
 - Learning about what goes on in your city?
 - Learning how to take care of your health?
 - Talking about safety in your community?
 - Finding resources you need?
 - Doing things on your own (getting around, making decisions)?
 - What have you enjoyed the most and the least when attending these programs?
3. There are others that don't or cannot attend these programs: Why do you think that is? What can we do about that?

primarily addressed. However, these results alone proved to be incomplete. Rather than describe the various components of their services, some simply selected the category, settlement services as a catch-all descriptor. Some participants from each location did not complete the surveys. The in-depth discussions with service providers that the forum encouraged were therefore essential for exploring service provider's perspectives more fully and identifying in greater depth what services they offer, how these promote the mental health of their senior Punjabi clients and what their successes and challenges are.

In Abbotsford, the day began with a talk by a local government mental health provider, Jasmeet Randhawa, who presented in Punjabi on mental health issues and the services available through the local health authority to address them. The talk was well-received and succeeded in personalizing the health authority's mental health services for the older Punjabi participants. Jasmeet's counterpart in Surrey was not available for our Surrey forum, therefore well-known community figure and coalition member, Jas Cheema, from the Fraser Health Authority, delivered the talk at that event.

Following a *chai* break, participants were divided into three groups: Service providers, older Punjabi men, and older Punjabi women. Service providers gathered in a workshop that included a training component on the B.C. Healthy Communities *Integral Capacity Building Framework* (described below). They were then further divided into two discussion groups of less than ten apiece, allowing for a rich discussion and inclusion of all participants (see panel, p. 3).

Punjabi men and women met separately in two rooms so as to ensure that power imbalances along gender lines previously witnessed by team members in mixed groups did not result in the silencing of the women. The older participants questioned this division, but differences in their discussions were noted and supported the advisability of this decision. Their discussions took the form of focus groups (see questions in text box, this page). Both groups were led by

experienced facilitators in Punjabi and 2-3 bilingual (Punjabi & English) note takers were assigned to each group.

Discussions in all three groups took 90 minutes and were recorded in detail by volunteer note-takers. Group facilitators were responsible for preparing a poster at the end of the sessions, summarizing key themes that arose in their group. After lunch, all three groups reconvened and facilitators presented their posters in both Punjabi and English to all forum participants. Participants contributed to lively discussions in which several, particularly seniors, were eager to confirm and expand on the summaries of their discussions. This step affirmed the trustworthiness and reliability of the facilitators' interpretations.

At the conclusion of the forums, participants were asked to fill out an evaluation form. We used a pictographic format with simplified wording and fewer questions for seniors to reflect the fact that many older adults, particularly in this community, may have relatively low levels of literacy in their own language. We received positive feedback from all participants. Both service providers and seniors felt that they had opportunities to speak and to be heard. Service providers wrote that they gained new knowledge and contacts that will be useful in their future work with Punjabi seniors and their families. Seniors were interested in upcoming similar events and strongly urged that they be invited for continued participation in community forums.

Ethics approval for this project was obtained from the University of the Fraser Valley. Consent to use and present on the aggregated results of our discussions for research purposes was secured from seniors and service providers upon registration. In order to ensure that consent from older Punjabis was truly informed, our project information and consent form was bilingual in Punjabi/English. As well, local Punjabi-speaking forum organizers explained the consent process in person to all potential senior participants prior to the forums, answering any questions that arose. Service providers consented in English.

Conceptual Frameworks

The *VicHealth 2005 Framework for the Promotion of Mental Health and Wellbeing* (Keleher & Armstrong, 2005, see Appendix E) provided a valuable starting point from which to explore community supports that promote the positive mental health and well-being or strengthen protective factors that prevent or delay the onset of mental illness and/or substance abuse for the culturally diverse seniors' population of the South Fraser region. The framework identifies three overarching social and economic determinants of mental health: (1) **social inclusion**: e.g. social and community connections, stable and supportive environments, a variety of social and physical activities, access to networks and supportive relationships, a valued social position; (2) **freedom from violence and discrimination**: e.g., valuing diversity, physical security, opportunities for self-determination and control of one's life; and (3) **access to economic resources and participation**: e.g., access to work and meaningful engagement, access to education, access to adequate housing, access to money.

This approach aligns with the ***Integral Capacity Building Framework*** (Wilber, 2005) adopted by *B.C. Healthy Communities* to successfully lead collaborative community conversations and processes since 2006. An integral approach is comprehensive, inclusive, and balanced. In community development and asset mapping, care is taken to acknowledge all factors that influence health, the arts and culture and systemic development, and all of the ways that it can be fostered. It pays attention to the whole person in the whole community: to individuals (both interior and exterior experiences), to the systems and structures within which we carry out our activities, and to the culture of our day-to-day lives.

This framework was incorporated into the service provider workshops as a training component. The purpose of the training was to further sensitize service providers to specific components of mental health promotion and help them to think about the services in terms of social and economic determinants of mental health. The four quadrants of integral capacity building are outlined and combined with the VicHealth 2005 social and economic determinants of mental health in Appendix F.

In the service provider discussions, it became apparent that these dimensions are seen as interlinked and all equally important in promoting mental health in this population. Some of the services functioned more as referring agencies, fostering access to other community or health services. Others argued that by helping in one area (for example promoting physical wellness through exercise), other dimensions were also addressed (such as building supportive relationships with other participants). As family plays a vital role in personal decisions, including physical and mental health, it may be difficult to separate internal and external as well as individual and community dimensions of capacity building in this culture. Similarly, mind and body are traditionally not seen as separate. Several service providers commented on what they felt was a discrepancy between this approach and their cultural beliefs. This reflects in part an incomplete understanding of the Integral Model due to the brevity of our training session. While the quadrants are distinguished conceptually and diagrammatically, they are seen as arising as a whole, regardless of culture. The Punjabi service providers' unease with the diagrammatic representation of the quadrants is nonetheless indicative of their discomfort with the Western tendency to separate mind and body and individuals from the family or community. Considering their work with Punjabi seniors through the lens of the combined Integral and VicHealth frameworks nonetheless helped service providers to recognize the relevance of their work with older adults to the promotion of their mental health.

Analysis

Subsequent to the workshop, all of the notes taken for each group at both locations were transcribed, as were the posters developed to summarize the discussions. These were then imported into the data management program, Atlas.ti 5.2.0[®]. Both inductive and deductive coding strategies were employed simultaneously. We wanted to let the collective wisdom of our participants speak for itself; however, we were also curious as to whether and how the participants' conversations reflected the 'VicHealth Framework' utilized in this research.

Inductive codes were applied to sort and categorize the transcribed text. Multiple codes can be assigned to the same text segment. Atlas.ti allows the analyst to search for codes that occur alongside each other in the document (co-occurring codes). This is helpful in determining dimensions of emerging themes, subcategories and associations between them. Some codes may serve as main, overarching categories while at the same time constituting a subcategory of another code, depending on which lens is used to view the data. For example, “Family” may be seen as a main category, clustering several other codes such as “Barriers – family”; “Stressors – family”; or “Childcare responsibilities” as dimensions of family. On the other hand “Family” can be also viewed as a subcategory of social inclusion.

Main themes can be described as headings that the analyst arrived at while summarizing groups of codes with the highest number of quotations, their co-occurring codes and associations between them. In addition to using text coded in the analytical software, notes and poster summaries were reviewed to ascertain that the main themes indeed reflected the discussion and to look for differences between groups and sites.

Forum findings were further discussed with coalition members who are professionals with extensive research, community and mental health promotion experience with Punjabi older adults. Some are also Punjabi community members. Bains and Cheema facilitated the focus group discussions in Punjabi with older adults at both the Surrey and Abbotsford forums. Service provider workshops were led by Addison, Goudriaan and Koehn in Abbotsford and Jarvis and Koehn in Surrey. This group was therefore well-situated to verify and elaborate on emergent themes.

Findings from the Forums

Inductive Themes

We identified two main inductive themes: Family and Reaching Out.

Family

Commentary related to the role of family in Punjabi seniors’ settlement experience and mental health was captured in a number of inductive codes: Family; Barriers-social networks; Childcare responsibilities; and Stressors-family. It became apparent that “Family” was a major, reoccurring theme in the discussions, with a total of 55 quotations. Notions of family overlapped with other major themes, appearing in all of the following codes: Awareness of programs; Barriers; Building knowledge/awareness; Childcare responsibilities; Coping strategies; Cultural context; F-Access to economic resources; F-Freedom from discrimination and violence; F-Social inclusion; Lack of control; Navigating systems; Needs; Programs attended; Programs offered; Promising practices; Quadrants interlinked; Reach; Settlement experiences; Social isolation/loneliness; Stressors – family; Stressors – social networks; Stressors – systemic; and Work obligations.

Punjabi seniors depended on their families for support in numerous aspects of their lives and settlement experience. This was especially pronounced in the Abbotsford group, where the majority of the participants were more recently arrived immigrants—still within the ten year period of dependency on their sponsors and hence living with adult children—when compared to the Surrey participants, who had lived in Canada relatively longer and worked after immigrating as well. Seniors relied on their adult children for housing, financial support and banking, transportation to medical appointments and community programs. Family members were consulted when making personal decisions. Seniors expected their families to provide guidance and assist them in adapting to the new environment after immigration, such as learning basic skills (banking, etc.) and navigating the healthcare, legal and other systems.

On the other hand, family ties and intergenerational relationships caused tension, adversely impacting the older adults' mental health. Punjabi seniors reported unmet expectations, noting that their children were busy with their lives and unable to guide them. A male participant maintained that

Sponsors of the seniors don't have time to tell them the ways of a new community. No one takes the time to teach or help them understand things they don't understand (especially when they are new from India). Children need to guide their parents after they immigrate here on resources [programs and services available] – but [they are] busy with their lives so [there is] no guidance.

Similarly, mental health issues were not recognized by family members and without guidance, the older adult could be left without adequate assistance. Service providers noted that

Seniors have their own issues but the family members don't acknowledge it. It isn't stubbornness – it is an actual mental health issue (dementia, etc.). Families [are] in denial [or] ignore dementia. Families need to be educated. There is a lot of stigma, guilt and shame around mental health in the community. For example – grandmother [staying] at home, waiting for family to come and spending lots of time sleeping. [This is] not recognized as depression.

In the new country, roles are reversed (especially for men) both within the community and in their own families. A drop in social status experienced in Canada (e.g. when a government employee works as a security guard or janitor, or a village councillor has to work in the fields here) is felt keenly when more established immigrants shame or bully them by drawing attention to this fact. In contrast to their experience in India, where they owned their homes and were independent, here they have to rely on their children and consult them before making any decisions. Language barriers, different lifestyles and cultural values even within the home cause tension and intergenerational conflict. Service providers maintained that tension in families can result in elder abuse and violence. As in many cultures, such negative behaviours are ignored or accepted in the interests of 'saving face' and protecting the 'honour' of the family; the incidence of abuse is therefore thought to be grossly under-reported. Finally, we heard that culturally, the senior generation was expected to provide assistance with childcare and the seniors anticipated that they would do so. Some commented on a sense of obligation

to their children for sponsoring their immigration to Canada (see also Koehn, 1993). For older women, in particular, taking care of grandchildren provided an important role in their families. However, childcare responsibilities could have a negative impact on their wellbeing. For example, this responsibility was noted frequently as an obstacle to attending community programs.

Given the significant influence of family on the Punjabi seniors' overall wellbeing and mental health, it is not surprising that service providers emphasized the need to include family members in programs and services. Some of the programs available for seniors recognized this need by offering to include other family members in client intake sessions. Child-minding services for program participants enabled grandmothers to participate in activities that would have otherwise been inaccessible to them. Service providers recognized issues around lack of understanding between generations, once the grandchildren are a little older. Working with younger generations was seen as an important factor for improving the older adults' mental health and wellbeing. One of the service providers in the Surrey workshop maintained that they

. . . need to talk to younger generations because they are the ones who will create change. Get them to understand what they [the grandparents] are going through. There is a generational gap because of lack of role modeling, such as hugging elderly grandparents. There need to be groups for children to educate them about being affectionate.

Often separated from their grandparents and older generations by immigration for much of their lives, many second-generation Punjabi-Canadians have not witnessed first-hand how families need to care for their elders with affection and respect.

Reaching out

Several inductive codes captured the forum participants' experiences in accessing services and managing their mental health needs. Barriers in mental health promotion in this population were repeatedly mentioned in the forum. Subcategories of barriers (Barriers – individual; Barriers – language; Barriers – social networks; Barriers – systemic; Barriers – transportation) were clustered under an overarching code “Barriers”, generating a total of 126 quotations. Clearly, both seniors and service providers felt that there is much more work to be done in order to fully address the mental health needs of this population.

Rather than focusing on barriers, however, we wanted to identify promising practices that could underpin our goal of building on community assets. Other codes that might reveal how barriers may be overcome were therefore explored. Our combination of the following codes thus informed the emerging theme entitled, “Reaching out”: Awareness of programs; Barriers; Building rapport; Needs; Promising practices; Reach; Willingness to attend.

Throughout the consultations with all three groups (Punjabi older men, Punjabi older women and service providers) it became apparent that seniors were very interested in using services offered to them in their area. Often, however, they were not aware of what programs were available. In addition, they faced a variety of barriers to accessing these programs.

Reaching out is essential for service providers in order to promote psychological and emotional wellbeing and address the mental health needs of Punjabi seniors. In Abbotsford, service providers estimated that some of the services reach as few as 5% of Punjabi seniors who need them. Surrey service providers guessed that they only reach anywhere between 15% to over 25% of potential clients. Some areas of mental health promotion were seen as even more problematic. For example, substance abuse, violence and elder abuse that often result in mental health issues are associated with shame and stigma and are therefore commonly undiagnosed and unresolved. One of the Surrey service providers noted that

Outreach is important in identifying needs. We are not able to reach certain groups, such as women staying at home ... There are a lot of needs in new immigrants that we have to address. With all the services and programs available now we are just 'scratching on the surface.'

Raising awareness of programs and services was identified as an important component of reaching out to the Punjabi community. Seniors repeatedly expressed their interest in programs and services by saying,

"[We] always attend if we come across [programs or events]"; "[We attend] where invited – always go when we come to know"; "[We] would attend if there was more information provided."

Similarly, an English-speaking senior who has taken a leadership role in the community emphasized the need to reach out:

When we had our wellness forum for seniors, we had Punjabi-speaking health professionals as speakers, but we didn't have many coming to the first one, even though we advertised everywhere. So for the second one, we went out to so many places where the seniors were and we phoned them up to encourage them to come. In the end, we had so many we had to turn many people away due to fire regulations. People really want this information, but you have to reach out to them first.

Multiple strategies need to be utilized to raise awareness of programs and services and to reach out to Punjabi seniors and their families. Workshop participants recommended disseminating information through *gurdwaras*, multicultural media (especially Punjabi radio and television programs), newsletters and notices in appropriate languages at diverse locations (including approaching potential clients in parks or private homes). Successful outreach entails not only improving the awareness of programs and services but also acknowledging and alleviating barriers that prevent access and meaningful participation. Offering programs at convenient locations and times (such as evening hours and weekends) and providing transportation, childminding and free of charge services and programs are examples of promising and more inclusive practices.

Creating a supportive environment, where program participants are able to access culturally sensitive information in their own language, feel respected and understood and where they

have opportunities to gradually build trusting relationships with service providers is essential in maintaining program participation. Examples of programs that seniors were interested in included sightseeing trips to learn more about the community and Lower Mainland; community events that foster cultural exchange; learning to navigate systems (language, healthcare system, law and police); exercise programs; opportunities to socialize; and programs that foster cohesion and understanding between family members across generations.

Reaching out and addressing mental health issues in the Punjabi community also requires changes on the systems level. For example, sponsorship regulations and discrimination in the employment market render older immigrants dependent on their families or struggling with lack of resources. This has an adverse impact on older adults' mental health and overall wellbeing (also see Koehn, Spencer & Hwang, 2010).

Service providers struggle to offer meaningful continuing support due to funding issues. In both groups, several service providers offering innovative programs were concerned that their funding would be curtailed within the next few months, and the programs, although well attended and showing positive results would be discontinued. Not only are the programs reaching a very small proportion of those in need, lack of long-term funding may result in the loss of clients currently being supported. Building trust is essential in addressing the needs of Punjabi seniors, and this takes considerable time. This is especially true for mental health issues that tend to go unrecognized and are more often stigmatized by some members of the community. The long-term trusting relationships that service providers need to build with their clients in order to support them are not possible without continuity of funding. As a service providers in Surrey explained,

It takes a long time to develop trust with clients and they attach to you as an individual ... they feel that very personal attachment, so they expect you to know and they rely on you and you alone. But here I am – I don't know if I still have my job in June, because the funding for the program is never long-term ... And if there is no funding for a while, then you get the program going again later, maybe some of them will come back, but often many of your clients have lost the only connection to services they had and you won't get them back again – they're lost to you.

Deductive Themes

Three deductive codes were used to identify how the discussions of service providers and seniors related to the three broad domains identified as determinants of mental health by the 'VicHealth Framework' (Keleher & Armstrong 2005): *i.e.* Social inclusion; freedom from discrimination and violence; and access to economic resources. Social inclusion emerged as the most prevalent theme.

Social Inclusion

The VicHealth Framework conceptualizes social inclusion in terms of social ties, participation in community life and access to basic human entitlements or more broadly in terms of social

cohesion, connectedness, social networks and social, economic and human capital. In a socially inclusive community or society, individuals are integrated into the community feeling valued, living with dignity with their basic needs met and their differences respected.

The code “F-Social inclusion” was applied to all commentaries of programs fostering supportive relationships, involvement in community and group activities and civic engagement. Needs and preferences in terms of social supports, social integration, cultural exchange and involvement in the community were included. This code was also used to capture instances where new skills were learnt, improving the individual’s opportunities for integration (language skills, computer skills, navigating systems). The following co-occurring codes were reviewed to further inform “Social inclusion” as an emerging theme: Awareness of programs; Barriers; Building knowledge/awareness; Childcare responsibilities; Family; Navigating systems; Needs; Promising practices; and Willingness to attend.

Punjabi seniors repeatedly expressed their need to integrate and to be valued and respected. Older women spoke of their low self-esteem, the need to be recognized and to celebrate their achievements, to “*get respect from events, groups.*” The need to be respected and to be accepted as full members of the community and society seemed to be even more pronounced for men, who emphasised cross-cultural social interaction “*between Punjabis and mainstream people*” and the seniors’ need to “*find ways to integrate.*” One of the senior men complained, “*We have lost our respect after moving here.*” In the Surrey men’s group, participants expressed their concerns about being “shamed” by newer immigrants, who have not yet learned or accepted the social etiquette of their new country and who may not understand or fully grasp the concepts of integration. In the notes from the seniors’ groups, the facilitator states that:

[They] don’t feel like they are listened to sometimes. All they seem to want is to be loved and cared about. [They] would like attention and want to feel important again as seniors. [They would like to] go to places where they are understood.

The social aspect of programs and services offered was important both from the older adults’ and service providers’ perspectives. Social outings, social time (*Chai* and Chat time), social meals and celebrations, cultural exchange and integration programs, groups for mothers and grandmothers as well as leadership or educational classes are examples of programs offered to foster social inclusion. In addition, service providers noted how other group programs, such as exercise classes, could also foster friendships and combat social isolation. Seniors spoke of their need to share knowledge and to be mentors and spoke highly of existing mentorship and leadership programs. In addition to programs offered by multicultural organizations and community services, *gurdwaras* play an important, if less formalized, role in providing opportunities for meaningful social interaction and for building supportive social networks. However, these settings bring together Punjabi seniors with members of their own community, rather than promoting cultural exchange.

Although there are some programs that focus on cultural exchange and integrating Punjabi seniors in the larger community, many gaps and barriers exist. In Surrey, service providers noted the difficulties that Punjabi seniors face in navigating systems (police; healthcare; legal,

etc.): *“Systems here are very different and it is not easy to translate to them how they all work and how they can use them.”* Seniors expressed their interest in learning how to take care of their health and bemoaned the lack of information provided to them by healthcare professionals. Programs aiming at facilitating integration of Punjabi with other seniors had been hampered by discrimination and racism in the broader community. A service provider in Surrey who had tried to introduce a group of Punjabi older adults to a “mainstream” seniors centre found that *“[t]hey weren’t welcome; there wasn’t even a willingness to provide a corner for them to sit in. Also, the programs weren’t appropriate – they just play bingo and not one of our seniors knew how.”* Similarly, in Abbotsford, service providers felt that more inclusive community services need to be created to combat discrimination.

Systemic barriers further hinder social inclusion of Punjabi older immigrants. Many do not qualify for pension or benefits after years of living in Canada. One of the service providers describes a common dilemma and a stressor for older immigrants: *“To receive a pension, they must be here 10 years and they cannot have things back home if they become citizens. The more they go back, the more time they have to be here for to receive benefits. They decide not to become citizens to keep their properties back home. They worry about their legal rights. If there is a divorce or separation (of their children) they always want to hold onto it.”*

A minority (n=3) of seniors involved in our forums struggled, like younger immigrants, to have their former education and work experience recognized in Canada. They perceived that that ageism in society as a whole further contributed to their inability to find suitable work in Canada. It is difficult to document the number of seniors in this position. However, a study commissioned by the Progressive Intercultural Community Services Society (PICS) found that, while most (35%) of a sample of 63 South Asian seniors in the Abbotsford/Mission area, had elementary or less education, 6% had some post-secondary education and 8% had Master’s degrees (Basran & Karpoff 2007). Research on the mental health consequences of the disenfranchisement of this small but growing group of educated/highly skilled immigrant seniors is needed.

Attention to the need for social inclusion of Punjabi seniors is therefore critical. There are some programs and services available to Punjabi seniors in the South Fraser region that build supportive relationships and integration skills and foster cultural exchange and positive social interaction. Promising practices include cross-cultural programs and events, programs where seniors develop English language skills and learn more about police, healthcare and legal systems, and trips and outings that give older adults an opportunity to explore and learn more about their community and region. In Abbotsford, forum participants felt that all local community services should be more inclusive. They emphasised the need for programs in different languages; Punjabi-speaking staff at the front desk; reaching out to the community; and providing transportation and child-minding. Although social inclusion as a determinant of mental health is addressed to some extent, forum participants and the expert panel clearly agree that only a very small proportion of Punjabi seniors are reached and much work needs to be done to overcome the above mentioned barriers and to create fully inclusive communities both in Abbotsford and in Surrey municipalities.

Discussion

Social and Economic Determinants of Mental Health

Three main themes emerged from discussions at the two forums. The main deductive theme, “Social inclusion” brings together the other two inductive themes – “Family” and “Reaching Out”. It is also recognized as a priority theme in Keleher and Armstrong’s (2005) Framework for the Promotion of Mental Health and Wellbeing, one of the conceptual frameworks that guided our discussions. Their work is based on the following definition of mental health:

Mental health is the embodiment of social, emotional and spiritual wellbeing. Mental Health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just (VicHealth 2005b, p.7, as cited in Keleher & Armstrong 2005, p.13).

In order to promote mental health of all its members, society has to be socially inclusive, valuing all people, respecting their differences, meeting their basic needs and fostering dignified lifestyles for all.

Reaching out is essential for successful mental health promotion strategies in this population. Both older women and men repeatedly mentioned their willingness to participate in activities and programs. However, there were multiple barriers that prevented them from accessing services and participating in programs. These included lack of awareness of programs; stigma and lack of recognition of mental health issues in the Punjabi community; lack of time due to childcare or work obligations; transportation barriers; and language barriers. Service providers noted systemic barriers, such as lack of continuity of funding. This negatively impacts their ability to build trust and relationships with clients, so vital for mental health promotion in this population. According to service providers, some groups are even harder to reach, such as older adults who are victims of domestic violence/abuse or substance abuse. Awareness of programs can be improved through announcements at the temples and using multiple sources, such as ethnic media (radio, TV shows, etc.), Punjabi newsletters, or phone calls from friends. In order to facilitate program participation, family members need to be included. Other important incentives for program participation were a central location that is easy to get to or help with transportation; child-minding services for the caregivers; and flexible timing of the programs.

The significant role of **Family** in promoting mental wellness among Punjabi older adults arose repeatedly in all groups. Seniors talked about the support and help of their families in the settlement experience. They depended on their families in many aspects of their lives, including housing and financial support, navigating healthcare, legal and other systems, and transportation. This dependency on family also had negative consequences on older adults’ overall well-being. Both female and male participants felt that their roles with their adult children were now reversed as compared to pre-migration, and they felt a lack of control in their lives as a result. The lack of understanding between generations was a great concern, leaving the older adult feeling disrespected, lonely and isolated at times. Participants reported that their adult children were busy with their own lives and were not able to assist the older

adult in integrating into the new community. For older women, looking after grandchildren was a frequently mentioned barrier limiting their ability to attend programs. Older adults also expressed the need for programs that “strengthen family relationships.” Similarly, service providers agreed that in order to reach older adults and to promote mental wellness among Punjabi seniors, family members and younger generations need to be included. Some of the programs acknowledge the significant role of family by inviting other family members to client intake sessions. This can be very beneficial and create a supportive environment for the older adult. However, there is a note of caution: this approach may also be counterproductive. With other family members present, the older adult may not express their views or talk about his or her problems as freely, especially if they are associated with stigma (such as substance abuse) or they are victims of abuse or violence within the family. Literature on health care and interpretation services warns against the use of family members as interpreters for patients, noting the multiple problems that arise in such circumstances, such as questionable confidentiality or impartiality of the family interpreter, lack of privacy for the patient, likelihood of withholding information, embarrassment or changes in family relationships (Sasso, 2004). Building a comprehensive relationship with the client so as to place his/her needs into context will help alleviate some of these issues.

Findings from our forums demonstrate that **Social inclusion** is a very important topic for Punjabi seniors and settlement sector professionals. There are some programs and services currently available to Punjabi seniors in the South Fraser region that build supportive relationships and integration skills and foster cultural exchange and positive social interaction. Promising practices include cross-cultural programs and events, programs where seniors develop English language skills and learn more about police, healthcare and legal systems, trips and outings that give older adults an opportunity to explore and learn more about their community and region. In Abbotsford, participants emphasised the need to create more inclusive community services by offering programs in different languages; employing bi-lingual Punjabi-speaking staff at the front desk; reaching out to the community; and providing transportation and child-minding. Although social inclusion as a determinant of mental health is addressed to some extent, forum participants and the expert panel clearly agree that only a very small proportion of Punjabi seniors are reached and much work needs to be done to overcome barriers and to create fully inclusive communities both in Abbotsford and in Surrey municipalities.

Differences between Municipalities

The expert panel discussed differences between the two municipalities in addressing mental health needs of Punjabi older adults. Bains and Cheema facilitated seniors groups in both of the forum locations and similarly, Koehn led service provider consultations both in Abbotsford and in Surrey. Therefore, the panel was able to compare similarities and differences in findings from the two locations, in terms of the population and approach to mental health promotion.

In Abbotsford, the majority of the participants were fairly new immigrants living with their families, with a majority of the men and women not having work experience in Canada.

Services that were directly targeted at Punjabi seniors were provided almost exclusively by non-Punjabi speaking staff from a single community agency (Abbotsford Community Services). These service providers reported that while they sometimes partnered with the *gurdwara*, which provided space for some of their programs, misunderstandings often arose and staff found it inconvenient to offer programs there. Similarly, few links have been established between the neighbouring communities of Abbotsford and Mission. The role of family and the need to be respected were most heavily emphasized in this group.

By contrast, Surrey seniors were predominantly living independently from their adult children. Most had lived in Canada longer than ten years and some of them had worked here as well. Programs and services in Surrey were well-targeted towards this specific population, rather than ‘immigrant seniors’ in general, as in Abbotsford. Programs were provided by the immigrant settlement/multicultural sector and led by staff from the Punjabi community. Accordingly, seniors in the Surrey group talked about systemic barriers limiting their access to work, their financial struggles due to high medical expenses and low pensions and the need to integrate and be respected. These longer –term immigrants also commented on how the lack of understanding of Canadian etiquette by some more recently arrived older immigrants brought ‘shame’ on the community whereas some said that some members of the community were ‘bullied’ by others based on their social class. Such comments draw attention to the internal heterogeneity of the Punjabi community, even within this older age group.

It should be noted that our senior samples were small and the differences between them in terms of the length of the time in the country may well be an artefact of a sampling bias. Among the 63 South Asian seniors in the Abbotsford/Mission area recruited by snowball sampling for the PICS study, the majority (92%)—as in our sample—were Punjabi Sikhs (Basran & Karpoff 2007). Distinct from our Abbotsford/Mission seniors sample, however, they found that most (79%) of those canvassed had been in Canada for more than 10 years. The differences between our Abbotsford/Mission and Surrey senior samples nonetheless illustrate the importance of taking the length of time since immigration into account relative to the types of programs needed to promote mental health: each group encounters different types of stressors. Service provider participants were, by contrast, fully representative of the agencies serving the two communities.

Conclusions

Our findings demonstrate that Punjabi older adults are a hard to reach and a vulnerable population in terms of their mental health needs. Numerous issues arise with regards to their settlement experience, family dynamics, lack of resources and social exclusion. Mental health problems, such as depression or substance abuse are frequently undiagnosed and untreated. Similarly, victims of family violence, abuse and neglect do not receive the help they need due to lack of awareness and the stigma and shame associated with such issues in the community, dependency on family members and barriers in access to primary and support services.

It is apparent from the discussions that service providers in this sector would greatly benefit from additional supports in order to fully promote mental health and wellness to their older Punjabi clients. The necessary supports include training, for example on family violence, elder abuse and neglect issues as well as culturally responsive approaches to mental health promotion in diverse populations (e.g. learning more about the culture and history of the community, building closer ties to community leaders, etc.). Additional resources are required in terms of longer-term sustainable funding that would allow for continuous mental health supports.

Findings from our consultations also lead to areas for future research. For example, we need to explore the implications of the holistic view of health and family that resists dualistic notions of mind/body, or self/family/community held by many South Asians for mental health promotion efforts. In Canada, these typically reflect the cultural underpinnings of the dominant Western culture in which services for mental and physical health are typically distinct and health promotion efforts are usually focused on changing individual behaviours. Additionally, it would be beneficial to explore the pros and cons of providing services that promote the mental health of Punjabi older adults through inclusive “mainstream” services (as in Abbotsford) versus services offered from within the settlement sector and hence situated within the broader needs of new Punjabi immigrants (as in Surrey). An evaluation of ‘promising practices’ for mental health promotion is required that takes into the account the determinants of mental health per the VicHealth Framework and the four quadrants of the Integral Framework. This would provide at least some evidence needed to inform policy, practice guidelines, and training efforts specific to mental health promotion for older immigrant populations. Research is also needed to explore mental health relative to the employment experiences of older immigrants with post-secondary education or specialized skills. This would require an intersectionality approach that takes the mutually compounding effects of age, education, family relations, cultural integration, visible minority status, gender and immigration history and status into account.

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Appendices

Appendix A: Forum participants - ABBOTSFORD

Senior participants are not listed here in the interests of protecting their privacy

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Appendix C: Summary of Participating Organizations - Abbotsford Forum

Organization	Contact	Services Provided	Nature of Services Provided *			
			Social Inclusion	Freedom from Discrimination and Violence	Access to economic resources	Other**
Abbotsford Community Services 2420 Montrose Avenue, Abbotsford, BC V2S 3S9 Tel.: 604-859-7681			-	-	-	-
Abbotsford Addictions Centre	Devinder Dherari-Sidhu Tel.: 604-850-5106	Provides free alcohol and drug counselling services to individuals, couples, families and youth, including multicultural counselling. Prevention focuses on youth prevention and education in secondary and middle schools.	Social inclusion Community involvement	Self-determination and control of one's life Promoting wellness Violence prevention and awareness Valuing diversity	Community resources Affordable, safe housing Education and professional development Employment opportunities Health services	Therapeutic
ELSA – English Language Services	Corinne Vooy Tel.: 604-859-7681 ext. 216	Provides English language training for newcomers to Canada	Community involvement Civic	Self-determination and control of one's life	Community resources Education and professional	Settlement services Language

Organization	Contact	Services Provided	Nature of Services Provided *			
			Social Inclusion	Freedom from Discrimination and Violence	Access to economic resources	Other**
			engagement	Promoting wellness Valuing diversity	development Employment opportunities Health services Other services	services
Host Program	Andrea Dykshoorn Tel.: 604-217-3055	Provides Conversation Circles that give newcomers the opportunity to connect with community members as well as practice their English skills.	Social inclusion		Community services	Language services
Immigrant Settlement Program	Geeta Bhardwaj Tel.: 604-859-7681 ext. 248	Provides orientation, information, adjustment support, service linking service bridging and service support to immigrant families	NA	NA	NA	NA
Meals on Wheels Lunch with the Bunch Senior Immigrant Project	Nancy Deba Tel.: 604-870-3764	Promotes emotional and physical well-being to enable seniors to remain independent through meals, social outings and community speakers	Social inclusion Community involvement	Promoting wellness Violence prevention and awareness	Economic resources Community resources Health services	

Organization	Contact	Services Provided	Nature of Services Provided *			
			Social Inclusion	Freedom from Discrimination and Violence	Access to economic resources	Other**
Multicultural Victim Assistance Program	Sandeep Jawanda Tel.: 604-864-4720	Provides justice related information and support to victims of physical and sexual abuse, family violence and elder abuse. Services are also provided in Punjabi and Hindi.	Social inclusion	Self-determination and control of one's life Promoting wellness Violence prevention and awareness Valuing diversity	Economic resources Community resources Affordable, safe housing Education and professional development Employment opportunities Health services Other services	Settlement services Language services
Fraser Valley Child Development Centre	Amarjit Pabbi 102 – 32885 Ventura Avenue Abbotsford, BC V2S 6A3 Tel: 604-852-2686	Provides programs such as IDP, occupational therapy, physiotherapy, speech therapy, mental health, family services	Community involvement	Promoting wellness	Community resources Health services Other services (funding)	Language services
Gladwin Language Centre	210 – 2580 Cedar Park Pl	Provides Canadian Language Benchmarks ESL instruction	Social inclusion	Self-determination	Economic resources	Settlement services

Organization	Contact	Services Provided	Nature of Services Provided *			
			Social Inclusion	Freedom from Discrimination and Violence	Access to economic resources	Other**
ELSA, Host Program	Abbotsford, BC V2T 3S5 Tel.: 604-854-8160	to new immigrants as well as information about Canada. Provided new immigrants with friendship community partners to help them make connections to the community.	Community involvement Civic engagement	and control of one's life Promoting wellness Violence prevention and awareness Valuing diversity	Community resources Affordable, safe housing Education and professional development Employment opportunities Health services referrals Other services	Language services
Ministry of Children and Family Development	2335 Mc Callum Rd Abbotsford, BC, V2S 3N7 Tel: 604-870-5880	Serving children with mental health issues and working with their families	NA	NA	NA	NA
Mission Community Services Society Immigrant Seniors Demonstration Program	Kusum Soni 33179 2 nd Avenue Mission, BC Tel.: 604-826-3634	Serves immigrant seniors who are 55 and over, permanent residents of Canada or refugees and persons in the process of becoming residents.	Social inclusion Community involvement	Self-determination and control of one's life Promoting wellness	Economic resources Community resources Affordable, safe housing	Settlement services Language services

Organization	Contact	Services Provided	Nature of Services Provided *			
			Social Inclusion	Freedom from Discrimination and Violence	Access to economic resources	Other**
				Valuing diversity	Education and professional development Employment opportunities Health services referrals	

* Three categories based on the VicHealth social and economic determinants of mental health (Keleher & Armstrong, 2005), corresponding with the service provider survey completed upon registration (n=10; N=14)

** Another category was added at the request of service providers during our consultations prior to the Forums; this includes settlement services, language services

Also applies to Appendix D

Appendix D: Summary of Participating Organizations - Surrey Forum

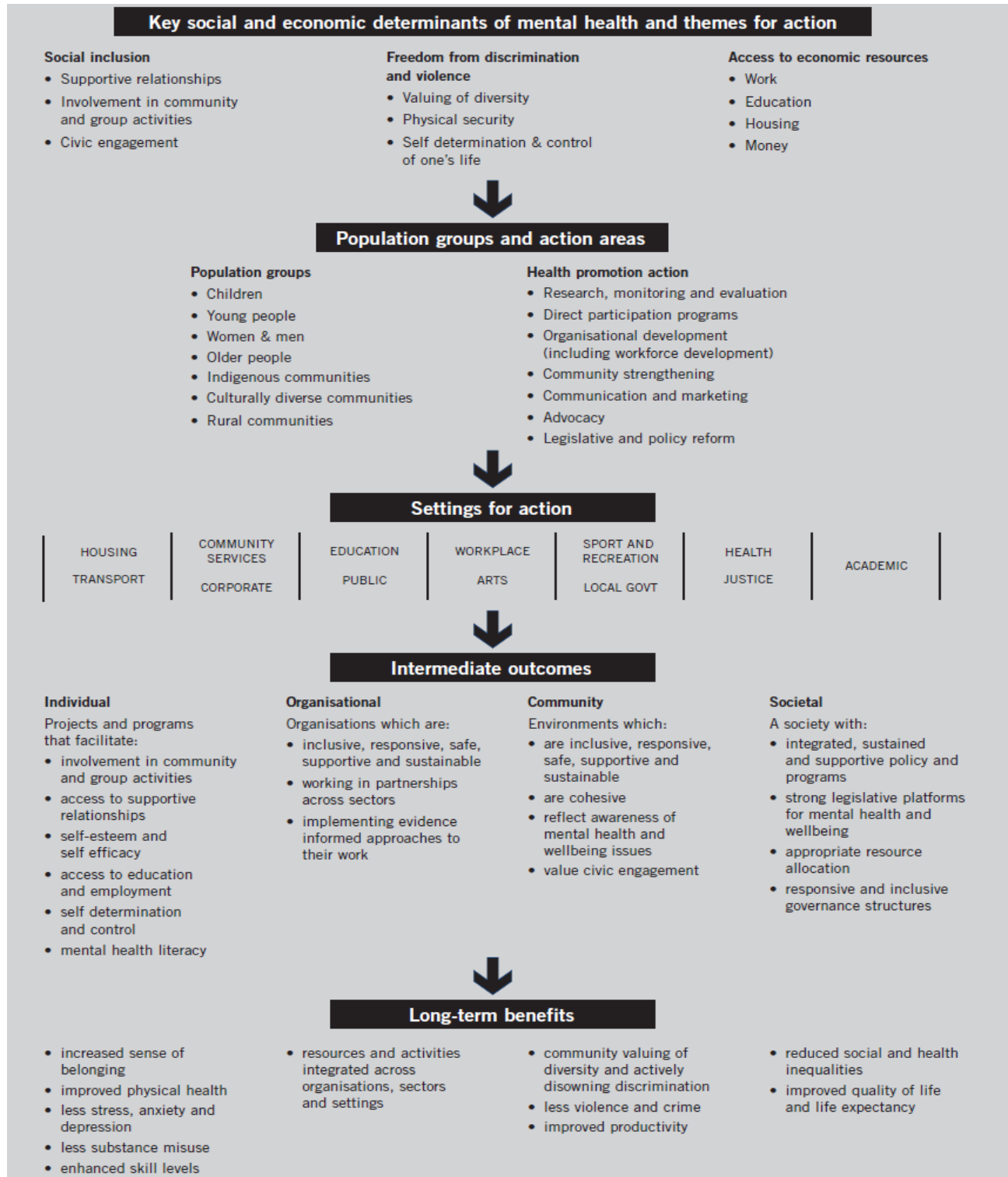
Organization	Contact	Services Provided	Nature of Services Provided *			
			Social Inclusion	Freedom from Discrimination and Violence	Access to economic resources	Other**
BC Centre for Elder Advocacy and Support Seniors Advocacy and Information Line (SAIL) Victim Services Program Legal Advocacy Program Seniors Reaching Out to Seniors Program Elder Law Clinic	Grace Balbutin 304 – 411 Dunsmuir St Vancouver, BC V6B 1X4 Tel.: 604-688-1927 ext. 222	Provides education and information about abuse and neglect. Provides assistance and support to older adults that are, or may be, abused and those whose rights have been violated. Provides programs that educate, support and advocate on behalf of older adults	-	Violence prevention and awareness	Economic resources Community resources Affordable, safe housing Education Other services	-
Community Living BC	Tariq Mehboob 110 – 7525 King George Blvd. Surrey, BC Tel.: 604-501-8327	Crown agency that provides funding to support adults with developmental disabilities	Social inclusion Community involvement Civic	Self-determination and control of one’s life Promoting wellness	Community resources Education and professional development Employment	

Organization	Contact	Services Provided	Nature of Services Provided *			
			Social Inclusion	Freedom from Discrimination and Violence	Access to economic resources	Other**
			engagement		opportunities Health services	
DIVERSEcity Community Resources Society South Asian Seniors Program	Shabina Jahan- Chaudhary Archana Sharma 1107 – 7330 137 th Street, Surrey, BC V3W 1A3 Tel.: 604-597-0205 ext. 1523	Helps South Asian seniors to adjust to their surroundings and connect with the community	Social inclusion Community involvement Civic engagement	Self- determination and control of one’s life Promoting wellness Violence prevention and awareness Valuing diversity	Economic resources Community resources Affordable, safe housing Education and professional development Employment opportunities Health services Other services	Settlement services Language services Therapeutic
Moksha Counselling & Consulting Services	Polly Sidher Tel.: 604-715-2521	Private agency that provides case-by-case support and offers presentations and workshops to newcomers and seniors within the community	Social inclusion Community involvement	Promoting wellness Valuing diversity	Community resources Health Services	Settlement services Therapeutic
Progressive	Waqar Ahmad	Provides settlement services	-	-	-	Settlement

Organization	Contact	Services Provided	Nature of Services Provided *			
			Social Inclusion	Freedom from Discrimination and Violence	Access to economic resources	Other**
Intercultural Community Services Society	109 – 12414 82 nd Avenue, Surrey, BC V3W 3E9 Tel.: 604-596-7525	to help newcomers to Canada adjust to their new life.				services
South Asian Mental Health Action & Awareness	Polly Sidher Tel.: 604-715-2521	Provides action and awareness for mental health issues within the South Asian community (non-profit organization in development)	Social inclusion Community involvement Civic engagement	Self-determination and control of one's life Promoting wellness Valuing diversity	Community resources Health services	-
South Fraser Women's Services Legal Information and Advocacy Program South Asian Legal Education	Mandy Sidhu 214 – 7565 132 nd Street Surrey, BC V3W 1K5 Tel: 778-565-3638 ext. 503	Provides resources, programs and support to improve the lives of women and their families (legal program, trauma counselling)	Community involvement	Self-determination and control of one's life Violence prevention and awareness	Economic resources Community resources Affordable, safe housing Education and professional development Other services (funding)	Settlement services Language services

Organization	Contact	Services Provided	Nature of Services Provided *			
			Social Inclusion	Freedom from Discrimination and Violence	Access to economic resources	Other**
Vancouver & Lower Mainland Multicultural Family Support Services Multicultural Outreach and Stopping the Violence Community Based Victim Services Children's Programs Volunteer Programs	306 – 4980 Kingsway, Burnaby BC V5H 4K7 Tel.: 604-436-1025	Aims to empower immigrant, refugee and visible minority women and their families who experience family violence. Help develop coping skills, assist them in self-exploration and support them while they go through different stages of rebuilding their lives.	Social inclusion Community involvement	Self-determination and control of one's life Promoting wellness Violence prevention and awareness Valuing diversity	Economic resources Community resources Affordable, safe housing Education and professional development Employment opportunities Health services referrals Other services	Settlement services Language services Therapeutic

Appendix E: Vic Health 2005 Framework



(Keleher & Armstrong, 2005, p. 6)

Appendix F: Integral Capacity Building Framework & Social Determinants of Mental Health



Courtesy: Deirdre Goudriaan, BC Healthy Communities (see www.bchealthycommunities.ca)