

LATIN AMERICAN COMMUNITY-BASED MENTAL HEALTH INITIATIVE: STAKEHOLDER MATRIX TOOL

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This article presents a matrix tool that facilitates a systemic view, both for planning and evaluation purposes, of the roles and interactions between key stakeholders in community-based mental health programs. The tool emerged from a community mental health initiative centered on natural caregivers, that commenced in 1995 in Edmonton, Alberta, Canada, and involved the Latin American community, social agencies, and health institutions. The article describes the Latin American Community-based Mental Health Initiative and exemplifies the use of the stakeholder matrix tool. The purpose of the tool is to assist community-based initiatives to explicitly examine, on an ongoing basis, roles, interactions, and areas of tension between its stakeholders. The lack of this examination undermines the possibility for community-based initiatives to overcome the many challenges they face. The stakeholder matrix tool offers a relatively straightforward structure from where to initiate this process, be it from a planning and/or evaluation perspective. © 2002 Wiley Periodicals, Inc.

Community mental health programs involve, by their very nature, a series of distinct players, both individual and institutional. Often a key component, the interaction and areas of tension between stakeholders, are overlooked when planning and evaluating these programs. This article presents a matrix tool that facilitates a systemic view, both

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DESCRIPTION OF THE LATIN AMERICAN COMMUNITY-BASED MENTAL HEALTH INITIATIVE

A series of suicides and suicide attempts by members of the Salvadoran community in Edmonton during 1995 prompted the start of a Latin American Community-based Mental Health Initiative (LACMHI). These incidents had the effect of mobilizing interest in suicide prevention and on ways of dealing with the issue in this immigrant community. Two Edmonton agencies, The Mennonite Centre for Newcomers and The Support Network, became involved and worked with members of the entire Latin American community to strategize options for effectively responding to these concerns. Together with a series of immediate interventions, these agencies (with funding from Health Canada and The Muttart Foundation, and staff support from the Royal Alexandra Hospital) facilitated a process "for building more in-depth community participation and dialogue." (Mennonite Centre for Newcomers, 1996) A first step culminated in the organization of a 10-hour Suicide Prevention Workshop for 26 individuals of the Latin American community in Edmonton. A series of recommendations came out of this workshop, which outlined future steps.

A second workshop of similar characteristics was held 3 months later. Before this second workshop a broader consultation and information gathering process in the form of a survey was carried ahead. Eighty-one Salvadorans living in Edmonton were sampled with the purpose of identifying community and agency "recommendations regarding a multi-cultural model that would enable an immigrant community to adequately access formalized mental health crisis services . . . (and to) identify ways of strengthening natural supports including natural caregivers, existing within the community so that the community is better able to self-support around mental health issues" (Mennonite Centre for Newcomers & Support Network, 1996). A Latin American Community-based Consulting Committee was formed as a way for the Latin American community to take ownership of the survey process and to establish a body that would continue educating and serving the community in issues related to mental health in the future.

From this phase of the project the following basic recommendations originated: take steps to increase community awareness of existing services; natural caregivers should be encouraged, supported and trained; efforts should be made to recruit bilingual (Spanish-English) volunteers for the distress line; additional suicide prevention workshops for community members. These recommendations led to the obtaining of partial funding from Health Canada for a 3-month follow-up project to recruit and train 11 individuals from the Latin American community. The training, of 60 hours, was on suicide prevention, crisis intervention, bereavement/loss support skills, posttraumatic debriefing, and listening skills. The intention was that this group of 11 continue in a role of natural caregivers. As well, of this group of 11, five individuals were selected to receive further training to form a Spanish speaking "Liaison

Team” to enable the Mobile Mental Health Crisis Team to provide on-call para-professional support in Spanish.

This model was later replicated with other immigrant communities in Edmonton. In the years that followed, further funding from Health Canada was secured for what became known as the “Community-based Immigrant Mental Health Project,” involving five immigrant/refugee communities. The goal was to address the lack of readily accessible and culturally relevant services in mental health, with the rationale that immigrants and refugees experience difficulties in accessing and using the formal mental health system because of linguistic and cultural barriers. The intent was to provide accessible and appropriate mental health services through a network of support and services available to immigrant and refugee families. A further goal was to strengthen community capacities to undertake mental health promotion in the five immigrant/refugee communities involved, through the training of natural caregivers and supporting collective initiatives to respond to specific mental health issues. As stated by Health Canada (Joubert, 2000), “ultimately, the project will demonstrate an authentic process of community–institution partnership, which will have long-term implications in the development of inter and multi-sectoral collaboration in health.” The stakeholder matrix tool introduced in this article is a product of the initial stages of this process of the community–institution partnership, and is thus exemplified here through the LACMHI, and not through its more recent and broader development. The purpose, to enable this type of partnership to assess the initiative from a systemic viewpoint, is nonetheless applicable, with adjustments, to the broader project.

RATIONALE FOR THE LATIN AMERICAN COMMUNITY-BASED MENTAL HEALTH INITIATIVE

An initiative of the type described above assumes that social support and community participation are determinants of health (Patrick & Wickizer, 1995; Wallston, Alagna, DeVellis, & DeVellis, 1983; Wilkinson, 1996). This appears to be particularly pertinent to mental health (Corin, 1995). Isolation is a key determinant in mental illness and a particular risk that immigrants face. Although the initiative under study appeared to have been mostly triggered by suicides of community members (acute episodes), it opened the door to explore broader mental health concerns. Consequently, the role of natural caregivers within the community did not relate only to suicide. The expectation was that these caregivers were a “natural” source of contact for Latin Americans in Edmonton at whatever level of emotional or mental health distress. These caregivers would, if possible, help community members at a primary prevention level. If other interventions were required, they would facilitate the accessibility to secondary and tertiary mental health care of community members. Their role was conceived along the lines of what some authors have called “natural helpers . . . lay people to whom others naturally turn for advice, support, and tangible aid” (Eng, 1993; Israel, 1982, 1985), with elements of what Jane Jacobs (1993/1961) has called “brokers in public community life.”

The creation of the Spanish-speaking liaison team to provide on-call para-professional support to the Mobile Mental Health Crisis Team, addressed the “crisis phase” of mental health. It integrated Latin American mental health workers with a mainstream Canadian crisis intervention agency. This was an important and concrete initiative that had been recommended by the community. Therapeutically speaking, these mental health workers had the cultural and linguistic capability of observing

what is “unobservable” to mainstream mental health workers. Several studies have stated similar notions (Budman, Lipson, & Meleis, 1992; Minas, Stuart, & Klimidis, 1994; Musser-Granski & Carrillo, 1997).¹ They, however, became one of the first visible sources of tension. In health in general, and in mental health in particular, crisis interventions, because of their urgency and tangible nature, have a tendency to “steal the show” in health initiatives. Institutionalized care and emergency interventions are the “flashy” sides of mental health (and health care in general). Despite their appropriateness, there seems to be a natural tendency both from the community members’ and institution’s perspectives, to perceive them as meeting broader mental health needs. This became an initial risk and source of tension for the project. If institutionalized care took over, the mental health initiative could have become alienated from broader community participation, defeating in the end the overall goal of the project. The stakeholder matrix tool was created, in part, as way of preventing this type of situation.

From a therapeutic perspective, the basic component of the LACMHI was the natural caregiver. The natural caregiver was defined as an active member of the community who had also received training to enhance their normal capabilities, and who had access to resource information. Natural caregivers would play different roles according to their particular circumstances. Some would remain latent within the community, able to involve themselves at the level they considered appropriate when there was a mental health need within their immediate community. Others would have a more active role because of their jobs or their other volunteer activities. As well, a small group, as already mentioned, took on the task of on-call workers with the Mobile Crisis Team, in addition to their general role as natural caregivers. Finally, some natural caregivers would have at times active participation in the Community Consultation Committee and/or other groups that would occasionally be formed to work on particular issues. The common element, at whatever level of participation was that their role would be mostly of primary prevention, both in its health promotion and illness prevention aspects and as a source of appropriate referral and follow-up (primary prevention also includes follow-up after secondary or tertiary prevention interventions). The expectation of this model of intervention was to enable emotional/mental health to be addressed jointly at societal, familial, and individual levels. An added benefit (which can be of particular relevance for some immigrant groups) was its potential to minimize the taboo around emotional/mental health.

DEVELOPMENT OF THE STAKEHOLDER MATRIX TOOL

The need to develop a tool to assist in the planning and evaluation of the initiative became apparent early on. Many issues and questions related to the feasibility of the project were raised, which required discussions among the various stakeholders. The following were some of the main questions that arose. How representative was the Latin American Consulting Committee of the Latin American community? How participatory was it? Was the commitment of the Consulting Committee members wavering, becoming more passive vis-à-vis institutional players? What was the source of conflict

¹ “. . . with bilingual clients in a therapeutic session, interpreters are called upon to do much more than translate words. They must communicate subtle meanings, idiomatic expressions, sayings, implied meanings, affect, tone of voice, facial expressions, and other non-verbals” (Egli, 1991).

between the Spanish-speaking liaison team and Mobile Mental Health Crisis Team? Was the agenda progressively being taken over by the social agencies or by some of the institutional players? Why was there some resistance from professional mental health staff? Three premises were considered essential for dealing with these types of questions: that the answers be sought in a collective manner; that they be framed in a nonaccusatory way; that a relatively simple tool be used to facilitate the analyses.

The matrix presented in this article fits the above criteria. Although at first glance it may appear complicated, it does not involve a complex process. It requires the input of key stakeholders, and it enables the exploration of the questions from a systemic view, consequently minimizing the possibility of “scapegoating” any of the players.

The sources of information used to develop the matrix were the following: interviews and group discussions with project stakeholders, and project background documentation (Bigras, Chagnon, & Eastace, 1996; Healthy Community Development Network, 1997; Mennonite Centre for Newcomers, 1996; Mennonite Centre for Newcomers & The Support Network, 1996; The Support Network & Mennonite Centre for Newcomers, 1997; Walter, 1995). Five interviews were held with family members of suicide attempters of the Latin American community; one focus group with five natural caregivers, two interviews with the main facilitator of the project, one interview with the coordinator of the mobile crisis team, and one interview with director of The Mennonite Centre for Newcomers. Five discussion meetings were held with project stakeholders during the elaboration of the matrix. The first meeting essentially worked on clarifying the purposes of the tool. Following a naturalist inquiry approach (Lincoln & Guba, 1985), the subsequent meetings entailed group discussions that helped to verify information, generate ideas, analyze data, receive feedback and negotiate outcomes with stakeholders at different stages of its development.

IMPLEMENTATION OF THE STAKEHOLDER MATRIX TOOL

The use of the matrix tool involves several steps. First, stakeholders need to be identified² and grouped in meaningful categories. Second, the roles of each category of players should be specified. Third, the interactions determined, and, finally, tension areas examined.

Table 1 identifies components of the matrix as a general case. Stakeholders are headers of rows and columns. Roles are located at the intersection of the same stakeholders. Interactions are specified as column for a stakeholder in interaction with row of a different stakeholder. Tension areas are identified within the same cell, but in italics.

Table 2 illustrates the first step where the LACMHI identified five categories of stakeholders, specifying who the players were in each category. First, the immigrant community itself; second, the community consultation group formed by community members; third the natural caregivers, who given the nature of the initiative had a central role; fourth, social agencies collaborating with the project; and last, institutional players, for the most part members of the formal health care system. This categorization came about by understanding the distinct nature of each group. Most of the stakeholder categories are self-explanatory. However, the Institutional Player

²In a process similar to that proposed by Patton (1997) for utilization-focused evaluations.

Table 1. Stakeholder Matrix: General Case

	<i>Stakeholder 1</i>	<i>Stakeholder 2</i>	<i>Stakeholder 3</i>	<i>Stakeholder 4</i>	<i>Stakeholder 5</i>
S1	ROLE	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>
S2	Interactions/ <i>tension areas</i>	ROLE	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>
S3	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>	ROLE	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>
S4	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>	ROLE	Interactions/ <i>tension areas</i>
S5	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>	Interactions/ <i>tension areas</i>	ROLE

Matrix should be read as follows: columns in interaction with rows (for example, stakeholder 1 in interaction with stakeholder 2).

merits some clarification. Under this term the matrix table includes health care institutions and health professionals that deliver direct service (hospitals, health centers, general practitioners, psychiatrists, psychologists, etc.) as well as governmental or para-governmental entities like Health Canada, Alberta Health, Alberta Mental Health, and Regional Health Authorities. Under Institutional Players the matrix also includes governmental and nongovernmental agencies that are not exclusively involved in health issues, but that may provide funding or have other influences on health initiatives.

Table 2 spells out specific information of what took place in interactions between stakeholders. Linked to this categorization was the clarification of distinct roles played by each stakeholder. The use of the matrix imposed the need to make explicit these roles from the very beginning (with the understanding that roles may evolve and change over time). In some cases the role may not be initially clear, as is evident with the category Community.

The analysis of the interactions imposed a dynamic understanding of these roles, by focusing specific observations of how one stakeholder interacts with another. The interactions can have both an ideal component, i.e., how the stakeholders as a whole conceive the interactions should be, and an empirical component, where evidence is interpreted about how these interactions actually occurred. Table 3 illustrates this process of interpreting evidence, which lead to the final step, i.e., the identification of tension areas. Tension areas are essentially indicants of role conflicts between players, of deviance from original roles, or of overly passivity or aggressiveness by some stakeholders.

DISCUSSION

The LACMHI can be identified with ideas put forward by researchers studying social networks and social support in community mental health. Gottlieb (1981a, p. 17) states, among several themes foreshadowing the role of informal helping networks in health maintenance, the “importance of a diversity of informal helping resources that are ubiquitous in the community and that ought to be drawn into any comprehensive plan to meet the mental health needs of citizens.” He proposes the mobilization of informal resources focusing “on improving the supportive quality of network con-

Table 2. LACMHI Stakeholder Matrix: Stakeholder Identification and Actions

Players	Community	Community Consultation Group	Natural Caregivers	Social Agencies	Institutional Players
C	Latin American community in Edmonton	Represented Community concerns on mental health issues.	Active members of Latin American Community; have done primary prevention work within community; have worked as liaison workers at Mobile Crisis Team.	Mennonite Centre and Support Network strategized with Latin American community on how to deal with suicide issue.	Health Canada and Muttart Foundation provided funding; Royal Alexandra Hospital provided staff support; Mobile Crisis Team—Support Network included Liaison Workers in their team.
CCG	Was represented to some degree through the Latin American Consulting Committee.	Latin American community-based consulting committee	Some Natural Caregivers participated in the Latin American Consulting Committee; Natural Caregivers was informed of Latin American Consulting Committee's recommendations.	Helped organize Salvadoran Consulting Committee and Latin American Consulting Committee.	No direct interaction.
NGC	Used Natural Caregivers within Community.	Provided information to Natural Caregivers on Community needs and perceptions.	Workshop participants; group of 11; liaison workers	Provided organizational support for Workshops; resource support for Group of 11; training for Liaison Workers.	Provided support to workshops; Trained Liaison Workers; Incorporated Liaison workers in Mobile Crisis Team.
SA	Community strategized with Mennonite Centre and Support Network on how to deal with suicide and broader mental health issues.	Worked with Mennonite Centre and Support Network providing information on Community needs and recommendations.	Received training from Mennonite Centre and Support Network (through Workshops); received support from Mennonite Centre and support network.	Mennonite Centre for Newcomers; Support Network	Worked with social agencies for workshops. Provided funding for project.
IP	Used Mobile Crisis Team (35 calls since having Liaison Workers); Sought counseling.	Provided recommendations that led to inclusion of Liaison Workers in Mobile Crisis Team.	Received training from Mobile Crisis Team (Support Network); receive training support from Royal Alexandra Hospital; some Natural Caregivers work with Mobile Crisis Team as Liaison Workers.	Mennonite Centre and Support Network worked with Mobile Crisis Team and Royal Alexandra Hospital to organize workshops and training of Liaison Workers.	Mobile Crisis Team; Muttart Foundation; Health Canada; Royal Alexandra Hospital

Matrix should be read as follows: columns in interaction with rows (for example, community in interaction with community consultation group or social agencies in interaction with natural caregivers).
 Codes: C = Community; CCG = Community consultation group; NCG = Natural caregivers; SA = Social agencies; IP = Institutional players.
 Italics = Tension areas.

Table 3. LACMHI Stakeholder Matrix: Roles, Interactions, Tension Areas

Players	Community Consultation Group	Natural Caregivers	Social Agencies	Institutional Players
C	<p>Represents Community members; works with Community issues and concerns; advocates for Community.</p> <p><i>Isolates itself from Community, becomes a small alienated body. Dies due to lack of community participation.</i></p> <p>Represents and Advocates Immigrant Community</p>	<p>Work within Community; listens to Community concerns. Responds to Community needs. Link Community members with other resources.</p> <p><i>NGC's professionalize themselves; community has difficulty accessing NCG.</i></p>	<p>Strategize with Community on how to deal with mental health issues.</p> <p><i>Social Agencies impose the agenda; nothing is done without Social Agencies involvement.</i></p>	<p>Provide funding for Community initiatives; listen to community concerns and suggestions and changes accordingly.</p> <p><i>Disregard Community issues and recommendations: Impose own model as exclusive mental health model.</i></p>
CCG	<p>Raises issues to Community Consultation Group; promotes participation in Community Consultation Group.</p> <p><i>Ignores the existence of Community Consultation Group; doesn't raise issues to Community Consultation Group.</i></p>	<p>Are involved in the Community Consultation Group; listen to Community Consultation Group recommendations and take ideas to Community Consultation Group.</p> <p><i>Do not acknowledge role of Community Consultation Group; isolate from Community Group issues.</i></p>	<p>Provide initial organizational support to Community Consultation Group and some minimal ongoing resource support.</p> <p><i>Drive Community Consultation Group; Community Consultation Group becomes dependent on Social Agencies.</i></p>	<p>Aware of the existence of Community Consultation Group; listen to Community Consultation Group recommendations.</p> <p><i>Disregard legitimacy of Community Consultation Group; impose own hegemonic model over Community Consultation Group's initiatives.</i></p>
NCG	<p>Makes good use of Natural Caregivers; fosters the development of more Natural Caregivers.</p> <p><i>Doesn't use Natural Caregivers; doesn't consider Natural Caregivers as a Community resource; isolates Natural Caregivers from Community.</i></p>	<p>Promotes Natural Caregivers and provides them with support, ideas. Seeks funding for training.</p> <p>Therapeutic role within Community. Broker role.</p>	<p>Provide training support; resource support; contacts and information.</p> <p><i>Take over Natural Caregivers' initiatives; professionalize Natural Caregivers; denies them necessary support.</i></p>	<p>Provide technical training and support; provide resource information.</p> <p><i>Do not recognize unique knowledge of Natural Caregivers; professionalize Natural Caregivers.</i></p>
SA	<p>Community approaches Social Agencies to work together on mental health issues.</p> <p><i>Community leaves issues in hands of Social Agencies and remains passive.</i></p>	<p>Works in partnership with Social Agencies to foster community-based mental health approach.</p> <p><i>Leaves leadership exclusively to Social Agencies; does not influence Social Agencies.</i></p>	<p>Initial organizational facilitator role. Provide some resource support. Help with institutional linkages.</p>	<p>Work as partners with Social Agencies to support community mental health initiatives.</p> <p><i>Override Social Agencies; make Social Agencies financially dependent on Institutional Players.</i></p>
IP	<p>Community members access appropriate care with Institutional Players; community influences Institutional Players.</p> <p><i>Community remains passive in relation to Institutional Players' policies; type of care and accessibility.</i></p>	<p>Knowledge of Institutional Players' types of care and refer community members to appropriate care; some also work within health care institutions.</p> <p><i>Rely on Institutional Players care model not valuing own potential; are absorbed by Institutional Players.</i></p>	<p>Work with Institutional Players to organize training; Influence Institutional Players policies; lobbies them for funding.</p> <p><i>Remains passive to Institutional Players hegemonic care model; total dependency on Institutional Players funding.</i></p>	<p>Provides crisis intervention. Provides secondary and tertiary prevention interventions.</p>

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 Codes: C = Community; CCG = Community consultation group; NCG = Natural caregivers; SA = Social agencies; IP = Institutional players.
 Italics = Tension areas.

tacts.” The LACMHI parallels his suggestion of “focused strategies of teaching helping skills . . . to categories of people who are known to be approached frequently as informal helping agents . . .” (Gottlieb, 1981b, p. 211) It also goes further, along the lines of what other authors (Froland, Pancoast, Chapman, & Kimboko, 1981) identify as fostering a linkage between formal and informal support systems.

Ultimately, the LACMHI links social support and social networks, consistent with what Israel (1985) categorizes as “programs enhancing entire networks through natural helpers.” This social network model is favorably argued by D’Augelli (1983) as having the potential to provide “a framework to help the isolated and to enrich the development of those embedded in social networks.” For this to be so, the monitoring of a program of these characteristics requires that it be assessed from a systemic point of view. Questions about the impact of the project on natural helpers in terms of both their skills and the way they relate to their networks, or about changes in the professional service system (Mitchell & Hurley, 1981, p. 292), for example, can only be answered from that vantage point.

Further, monitoring of these programs need to be consistent with the main philosophy, that is of the involvement of stakeholders. For this to be feasible, a relatively simple process of planning and evaluation should be established to realistically foster this involvement. The stakeholder matrix tool presented here has the potential to help in this endeavour because of its relative simplicity and several of its characteristics: It is a relatively clear-cut tool, involving straight steps and a plain structure for analysis. It overtly addresses tensions and potential sources of conflict in community programs that by their very nature involve various stakeholders of very different characteristics. It can help to normalize the existence or potential for existence, of conflict. It enables a simplified systemic view. It provides a systemic structure for stakeholder discussion, consequently minimizing the possibility for scapegoating of any particular group. It enables a dynamic examination of the process.

Table 3 illustrates the use of the matrix for the LACMHI. It shows five stakeholder categories: Latin American community in Edmonton, community consultation group, natural caregivers/liaison workers, social agencies, institutional players, that resulted from the following process. A specific *community* (Salvadoran) that was part of a larger related cultural community (Latin American) suffered acute mental illness incidents. Community members together with some *social agencies* agreed on the need to act. Through workshops and a broader consultation process, needs and recommendations were identified. The recommendation that took the most concrete form was the one related to crisis response and to accessibility to formal care (health care institutions, *institutional players*). There was a group (in a sense intermediating between community and agencies/institutions) put in place for *natural caregivers* to interact, and a broader *community group* (Latin American Community-based Consulting Committee) to advise “its community and the relevant agencies on mental health issues concerning the Latinos” (Support Network & Mennonite Centre for Newcomers, 1997).

Because there is a tendency to avoid the explicit examination of conflict or of potential conflict in planning and evaluating community programs, a tool of this type enabled its observation within a framework where it was normalized. The notion is that interactions between players will eventually create areas of tension, which constitute ongoing challenges to the initiative.³ Tension areas simultaneously provide infor-

³Hoping that tensions will not occur and/or trying to ignore them, ultimately makes things worse.

mation about the vitality of the process, and about possible breakdown points. To exemplify, the following were a series of possible tension areas faced by the LACMHI: tension between formal care and informal care; tension between acute care and prevention/promotion; tension between institutionalization and community participation; tension between agency leadership and community leadership (or “lack of” from either player); tension between “specialized” professionals and “natural” caregivers; tension between natural caregivers with institutional roles and those without institutional roles.

Although tension areas may seem to be the negative side of the interactions, they are actually a key source of information of the initiative’s dynamics because they signal areas of conflict, of lack of vitality, etc. They provide light on possible necessary adjustments to the program. Ultimately, the examination and discussion of these tension areas by representatives of the different stakeholders holds the most promise for ensuring the initiative’s ongoing renewal and success. An interesting use of this matrix tool is the possibility of anticipation. If this type of analysis is done during the planning stages, there can be stakeholder speculation concerning future potential areas of tension, enabling useful foresight.

Using this matrix tool, the examination of the LACMHI brought to the forefront several challenges that the initiative of this type faced. One has been mentioned previously: the “narrowing” of mental health issues to the crisis phase (and, therefore, mostly dealing with acute mental health problems). This also relates to the tendency for institutionalized care to take over as the central player. Added to a tendency of some community-based activities to lose participants and the dynamism of the earlier mobilized period, there was a risk of losing the essential nature of this type of initiative (i.e., that it be community driven).

The versatility of stakeholder matrix derives from the fact that it can be implemented at any stage of an initiative or program. As well, it can be used both for planning purposes and evaluation purposes (mainly, although not exclusively, formative evaluation). Community-based programs need to explicitly examine, on an ongoing basis, the roles and interactions of its different players and identify tension areas. The lack of this examination undermines the possibility for community-based initiatives to overcome the many challenges they face. Central to this examination is that it be done with the involvement of the different stakeholders as part of a common exercise. The stakeholder matrix tool offers a relatively straightforward structure from where to initiate this process, be it from a planning and/or evaluation perspective.

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