

**BIRTH OF A PROGRAM: AN EXAMINATION OF THE DEVELOPMENT
OF A CROSS-CULTURAL COUNSELLING PROGRAM**

**A Thesis Submitted to the Department of Graduate Studies
by Duncan Michael Steven Quennell
in Partial Fulfillment of Requirements for:**

Master of Science

**Department of Community Health Sciences
University of Manitoba
Winnipeg, Manitoba.**

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Abstract

The integration of a culturally specific counselling program, the Cross Cultural Counselling Unit (CCCU), into Mount Carmel Clinic, a provincially funded health centre in Winnipeg, Manitoba, is documented. The emergence of the CCCU is viewed as a challenge to the established service system's claims of universal accessibility. The thesis describes how the program became increasingly steered by institutional relations as efforts were made to anchor it within the established health bureaucracy, rather than by the particular needs of the people it was intended to serve.

Along with analysis of public policy statements, six stakeholder groups including government representatives and CCCU clients were interviewed to explicate the contest between different patterns of needs interpretation. Drawing upon sociological theory, cross-cultural health studies, and program statistics, the thesis supports the program user's and originators' contention that newcomers benefit from culturally specific, often long term, mental health services, in contrast to the provincial government's redefinition of the program's mandate to one of a short term feeder service into the mainstream health system.

Rather than a strict focus on the issue of cultural barriers between caregivers and patients, the study juxtaposes the normative basis of government policy and mainstream medical practices with the reality experienced by users of the counselling program. It argues that the Canadian health system is itself culturally specific, and that a superficial understanding of the relationship between culture and health inhibits the transformation of mainstream health services to meet the plurality of needs as expressed and fought for by 'cultural others'.

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A special note of thanks goes to my loving friend Cheryl Rosmus, who provided support and comfort when I needed it most. A special mention must also go to my dear friend October for her friendship and the gift of a cappuccino maker to spark me on to the completion of this thesis.

I dedicate this work to my father, Don Quennell who passed away in October 1981. Among many other lessons, he taught me the valuable and enduring lesson, through his professional life in the labour movement and as a loving parent, of the importance of social responsibility, and to care and have compassion for others.

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Chapter One Introduction

The relationship of socio-cultural considerations to wellbeing is increasingly being recognized at the public policy level of health and social service delivery in Canada (Health and Welfare Canada 1986; Canadian Task Force on Mental Health Issues 1988). Further, there is public recognition of the increasing cultural diversity of Canada, evident by the passage of the Multiculturalism Policy Act of 1988. Despite these formal recognitions, there remains a dearth of culturally sensitive health and social services to complement Canada's cultural diversity (Multiculturalism and Citizenship Canada 1990: 21). The lack of socially and culturally appropriate health and social services suggests that the established service systems are resistant to change.

For the purposes of this study, I use the term established service system to refer to institutions and organizations which a majority of Canadians believe to be part of the social contract of citizenship and that are popularly referred to as 'mainstream'. For example, based on the struggles of various social groups, free access to medical care at the point of delivery has become a major theme in the social constitution of Canada. In contrast, there are ethnic-based services which are treated as marginal to the established 'mainstream medical and social service systems.' I believe that the development of ethno-based service organizations represents a challenge to the dominant liberal ideal of universal and equal access health care services and therefore these organizational units can be seen as competing with the established service system to gain formal acceptance through systemic integration. At the same time, these organizations are in part the product of the same set of social relations which structure and organize the Canadian medical and social service environments in which health needs are defined, understood, negotiated, and addressed.

In recent years there has been a proliferation of 'how to' books and articles aimed at culturally sensitizing the established health and social service systems (Waxler-Morrison et al 1990; Masi et al 1993). In this literature, the conventional approach to addressing newcomer mental health issues is to determine what the barriers are preventing newcomers' access to the established health and social service system (Canadian Task Force 1988;

Masi 1993).

Essentially proponents of this approach seek to resolve the cultural inaccessibility of the health care system through service providers who have acquired the awareness, understanding and skills to interpret the beliefs, values and practices of differing cultural groups, and/or the provision of interpreters to overcome language barriers. From this perspective, the problem of access to appropriate care is primarily seen as a set of individual problems, based on communicative difficulties between provider and consumer. The therapeutic dimension of the encounter encourages the consumer to translate their culturally shaped lived experiences into the interpretive parameters of the service provision. Hence, the focus is limited to the encounter between the service provider and the consumer.

In this thesis, the question of access to culturally appropriate care has been recast to look at the factors inhibiting the transformation of the service system to reflect the plurality of needs in a multicultural society. Rather than accepting the existing system of services as universally accessible, this study examines the underlying normative orientation of the organizational and social processes and practices which influence the design and provision of medical and social services in Canada. It views the problem of access as a consequence of the larger set of social relations which determines the socio-organizational structure and processes within which the interaction between the provider and consumer takes place. As Allan Young puts it, a strict focus on communication within a clinical setting “downplays the importance of forms of communication and interaction that are simultaneously taking place in other sectors and venues, and ignores the ways in which medical meanings and interpretations are being produced, reproduced and contested at different points in this network” (1990: 206).

The Study

The aim of this study is to examine the development of a cross-cultural mental health program within the established medical and social service systems in the province of

Manitoba. The particular program of interest is the Cross-Cultural Counselling Unit¹ (CCCU) at the Mount Carmel Clinic in Winnipeg. The genesis of the counselling program was triggered by the concerns of individuals who had noted that the lack of cultural, social and linguistic understandings by service providers were primary factors inhibiting medical and social service utilization for members of their ethnic communities. Since the established medical and social service system operates on the premise of universal accessibility for all its citizens, the issue of cultural accessibility presents a complicated challenge.

The Theoretical Framework

To elucidate this challenge, the way in which health needs are constructed in public policy and institutional practices must be examined. Fraser, in her article "Women, Welfare and the Politics of Need Interpretation" (1987), writes that the examination of institutional practices requires a theoretical framework to consider the structural and ideological dimensions of public policy. At the structural level, Fraser argues that what is required is an inquiry into the social meanings embedded within social programs; meanings which structure what and how needs are addressed and are themselves seldom scrutinized. Her proposed framework focuses on the relationship between discourse and its consequences for power, control and knowledgeability. Applied to this study, this analytical approach will be used to explore how liberal discourse guides and organizes the Canadian medical and social service environments in which health needs are defined, understood, contested, negotiated, and addressed. Examination of the emergence and promotion of the counselling program will provide an illustration of the interpretive boundary of liberal discursive practices.

At the ideological level, Fraser argues that the typical way issues get framed in

¹ The Cross-Cultural Counselling Unit was named prior to its formal acceptance into the organizational setting of Mount Carmel Clinic. The original title reflects the initial history of the program as a volunteer-based counselling unit initiated by a group of foreign trained health professionals. In this thesis the CCCU is often referred to as a counselling program rather than as a unit per se. Subsequent to this study, the CCCU has been renamed the Cross-Cultural Counselling Program.

public policy statements is through the norms and assumptions which are constitutive of public institutional practices. This administrative approach tends to define needs according to the pretense of a homogeneous population, with the analysis of needs considered primarily in quantitative terms. This approach stands in stark contrast to the actual heterogeneity of society. Fraser points out that as a consequence, the socially patterned interpretation of needs constituted in public policy is necessarily fashioned from institutionally interpreted or constructed identities. Despite such counterfactual practices, these claim-making activities seek to promote the notion of the universality of the policies and practices of public institutions.

Viewed from this position, public policies are claim-making practices which attempt to define, produce and reproduce certain forms or patterns of needs interpretations by privileging certain ways of understanding over others. From this position, it is also apparent that public policies are socially constructed and through their communicative practices create a subjectivity².

The interpretation of needs is at the core of public policy. At the level of program and service development, the normative basis of how needs are defined and understood necessarily constitutes a framework or paradigm which "greatly restricts the alternatives [policy makers] consider and the range of innovations they make" (Simeon 1976: 550). Patton describes the paradoxical nature of the paradigm:

A paradigm is a worldview, a general perspective, a way of breaking down the complexity of the real world. As such, paradigms are deeply embedded in the socialization of adherents and practioners: paradigms tell them what is important, legitimate and reasonable. Paradigms are also normative, telling the practioner what to do without the necessity of long existential or

²According to postmodern theory as described by Fox (1994: 163), "subjectivity is the outcome of power, and the subject is no more than the effect of power, constituted in the discourses of power and knowledge...[I]n spite of this, the undecidability of meaning involved in any discursive practice enables subjectivities to be multivocal rather than fixed, and capable of 'becoming' through resistance to power/knowledge". From this standpoint, public policy can be seen to represent a specific pattern of needs interpretation constituted within discursive practices and manifested in the practices of public institutions. This position suggests that despite the service system's encouragement, through criteria of access, of individuals to communicate social issues according to administrative and other professional discourses, individuals may resist and promote other ways of understanding and addressing the same set of issues. Alternatively, traditional pluralist theorists have argued that public policies can be understood to be the expressed view of government politicians and moreover, to be a democratic form of practical decision-making. However this recognition still leads us to assess the extent to which public policies represents an approach which actively considers the differentiated patterns of needs interpretation which exist in society.

epistemological consideration. But it is this aspect of paradigms that constitute both their strength and their weakness - their strength in that it makes certain action possible, their weakness in that the very reason for action is hidden in the unquestioned assumptions of the paradigm (1978: 203).

In sum, the dominance of paradigm depends upon the ability to define what is to be allowed to be knowledge over other alternatives and the way this process of gaining hegemony has taken place. What is of importance for us here is that, by examining the normative basis of the patterns of need interpretation or the paradigmatic assumptions which guide the development and maintenance of the established service system, we make explicit the social relations of public policy. These relations exemplify how public policy privileges particular patterns of need interpretation and thereby makes certain meanings less significant than others. In this study, my analysis of the normative basis underlying the established service system's interpretation of needs will argue that while public policy asserts the universality of its practices at the same time it fails to identify the health and social needs of more recently arrived social groups.

Against the normative background of the established service system, we will examine how things look 'the other way around'. The examination of the developmental process of the counselling program provides a case study of how the established service system organizes reactively to minimize challenges to its particular pattern of needs interpretation. This analytical approach will demonstrate how certain meanings and interpretations are produced, reproduced and contested within the public sphere. The presentation of the differentiated patterns of needs interpretation are based on interviews with consumers, medical and social service providers and administrators as well as government representatives of the units of the provincial government which deliver mental health, immigration and settlement services.

For the purposes of introduction, the following section briefly describes the cross-cultural counselling program, identifying the objectives and underlying philosophies which, according to the founders of the program, distinguish the program from other forms of assistance specifically aimed at recently arrived newcomers to Canada, as well as from the realm of services currently offered by the established medical and social service

systems. A fuller discussion of the program occurs in Chapters 5 and 6.

The Cross-Cultural Counselling Unit

The CCCU provides counselling to newcomers seeking mental health care from service providers who are cognizant of the newcomers' cultural, social and linguistic backgrounds. The program attempts to deliver mental health services based on a culturally and linguistically responsive model. According to the founders of the program, the program was developed

[t]o fill the gap observed in existing services regarding the access of immigrants and refugees to the mental health system by using qualified professionals (licensed or not) to deliver such services to a specific ethnic community [on a volunteer basis]. By no means does this type of service pretend to create a parallel service to those actually existing (CCCU Procedure and Orientation Manual 1991: 1).

The 'observed gap' refers to the lack of culturally appropriate services within the established mental health service system for newcomers experiencing mental health difficulties, often related to migration experiences or social adaptation in Canada. Community members had noted the lack of cultural, social and linguistic understanding by service providers as a key factor impeding mental health service utilization for members of their communities. Briefly put, the development of the counselling program grew from the belief that a common 'cultural' understanding between the counsellor and client facilitates a focus on issues affecting them, be it depression, anxiety or guilt, within a context which recognizes and appreciates the contribution of customs and beliefs to the illness experience. In the founders' opinion, the current medical and social service systems did not offer culturally appropriate care to the more recently arrived newcomers.

The counselling program began in 1985, as a volunteer project located at Immigrant Access Service, a provincial government settlement service. In 1990, the counselling program was relocated to Mount Carmel Clinic, where a demonstration project was conducted from February 15, 1991 to February 28, 1992. During the demonstration project year, a formal evaluation of the program was conducted between June 1, 1991 and

February 28, 1992, to assist in the development of the program and to act as a reference for future funding initiatives. This thesis is based primarily on the data collected for the evaluation.

Mount Carmel Clinic is a health service organization located in the core area of Winnipeg which offers both medical and social services. The counselling program is currently situated within the Outreach Department of Mount Carmel Clinic. It is supported by an advisory committee representing both professional and community knowledge in mental health and newcomer needs. In addition to these representatives, two members of the Board of Directors of Mount Carmel Clinic sit as members of the advisory committee along with three senior level administrative staff of the Clinic and the co-ordinator and secretary of the CCCU. The committee meets monthly to discuss issues regarding service delivery, program priorities and ongoing funding strategies.

The central objective of the program is to undertake primary intervention with individuals experiencing mental health difficulties related to social adaptation. Clients of the program seek assistance for a range of personal problems. Clients are paired with a counsellor who speaks their native tongue and best matches their cultural and social background.

The CCCU assists individuals not only with reference to their ethnocultural backgrounds, but with reference to their new social contexts. For example, many cases involve family therapy as the mode of treatment, in recognition of the fact that although one person may be identified as the client, the whole family may be affected. The counselling group has developed several self-help groups whose goal is to prevent clients from seeing problems of past experiences or stresses of immigration as individualized problems.

The staff of the CCCU are themselves newcomers to Canada. Based on their own experience of migration and adaptation and combined with an understanding of their client's social and cultural backgrounds established by similar life experiences, the staff of the CCCU believe that they are best able to provide assistance to other newcomers. In interviews for the evaluation, the counsellors pointed to how their own 'lived' experience of migration and adaptational processes provides them with the knowledge and experience of how new situations of normative conflict can be interpreted. They stated that a

counsellors' ability to reflect upon the variability of the two cultures best equips them to provide guidance based on the client's culture's general principles and modes of behavior - the cultural definitions that shape the unique life history and the motivations of the immigrant. They argued that this reflexive ability allows them to draw to the attention of the client the core values of both cultures, which in turn facilitates an effective and efficient therapeutic relationship between the therapist and client.

Clients of the cross-cultural counselling program have come to Canada from areas such as Central and South America, Eastern Europe, Asia, and Africa. During the demonstration project year, the CCCU service expanded to meet the diverse needs of additional cultural and social groups and offered services in at least ten languages serving newcomers from 26 different source countries. The CCCU extended its service delivery to include outreach work, the creation of self-help groups, and the sharing of information and expertise in multicultural mental health issues with other professions and agencies, as well as with ethno-cultural communities and organizations.

Thesis Objective

The objective of this thesis is to describe the development of the cross-cultural counselling program within the larger, complex set of institutional relations that structure and organize the wider health and social service environments. The thesis contends that as efforts were made to anchor the program within the established service system, the program became increasingly steered by institutional relations rather than by the particular needs of the people it was intended to serve. I argue that the normative basis of the existing institutional service environment has constrained the CCCU's ability to fulfill its mandate. Moreover, the history of the CCCU's development indicates the inability of the institutional service system to reflect upon its own cultural and social biases and indeed to appreciate the very reasons why the grass roots movement to establish the program emerged in the first place.

In order to explore these issues, an examination of professional beliefs, values and practices that are dominant within these service environments is particularly apposite. In

order to determine what can be learned from the normative orientation of health and social institutional practices, comparison with other perspectives will be instructive. The logical choice is to compare and contrast the ideological practices³ of institutions and service providers with the social understandings of consumers. The explication of the social understandings which influence both providers and consumers of health and social services highlights the forces and processes which shape current service environments and practices and concludes that these factors prohibit appropriate and accessible health and social service provision to many Canadians.

To better understand these institutional processes and the relevance of the cross-cultural counselling program to newcomers' health needs, the elaboration of the pivotal role that culture plays, not only in terms of agency and the self-understanding of individuals, but also how particular cultural understandings are appropriated, embedded and reflected within the structures and processes of institutions is required. Through a critical examination of the normative orientation of the organizational processes in which the program is situated, it can be seen more fully as evolving from the interaction of possibility and circumstance: precedent and changing realities and political pressure. In this way, the socio-cultural basis of newcomer health needs can be examined not in terms of the cultural incongruity of newcomers, but in contrast to the discursive practices, specifically the norms and assumptions, which underlie those institutional relations which structure and organize the Canadian medical and social service environments where health needs are defined, understood, negotiated, and addressed.

³ Based on the work of Gramsci, I accept the view that all knowledge of social life is socially determined. Furthermore, I follow Allan Young's distinction between ideology, ideological knowledge, and ideological practices: "*Ideology* is a process through which socially significant facts and meanings are produced, valorized, circulated and accumulated. *Ideological knowledge* refers to facts and meanings which have entered into the consciousness of a particular person and now affect that individual's choice of socially significant action. In other words, ideological knowledge mediates between ideology and social behavior. *Ideological practices* are the means by which a) people's facts are materialized, in the sense that they are made to occur and then given a degree of unity and transcendence needed for them to enter people's consciousness; and b) these facts are then appropriated, in the sense that they are collected and selectively distributed among people engaged in the knowledge production process. Ideological practices consist of specific sets of social relations, technologies (including language and conceptual systems), and materials (eg. apparatuses and raw materials). Different material and technologies materialize and appropriate different facts out of the same phenomenological field. In other words, ideological practices mediate between ideological knowledge and the world" (1983: 204).

To accomplish this goal, the social understandings of various stakeholders concerning health issues affecting immigrants and refugees are presented. Six stakeholder or interest groups are identified in this study: 1) program staff of the cross-cultural counselling program; 2) clients of the counselling program; 3) settlement social service workers in agencies who work closely with newcomers following their recent arrival to Canada; 4) mainstream medical and social service providers (social workers, psychologists, psychiatrists, general medical practitioners) who had referred individuals to the counselling program; 5) administrative staff and service providers of Mount Carmel as well as Board representatives, and members of the Advisory Committee of the counselling program; and 6) government representatives of the units of the provincial government which deliver mental health, immigration and settlement services.

Theoretical and Methodological Considerations

The above issues can be seen as part of a larger and broader confrontation between traditional institutional practices and various disadvantaged and disenfranchised groups in society. Within this milieu, new social movements have increasingly begun to articulate differing images of public and private life which challenge dominant notions of self and society. Greater recognition of the situation of disadvantaged people largely began and continues through the lobbying efforts of various groups representing ethnic minorities and aboriginal peoples of this country, women, the aged, and persons with differing abilities. They have sought to have their lives and needs understood through their own voices. They raise critical questions about the ways in which their experiences have been explained and subsequently treated in the public sphere through public policy and institutional practices. Characteristic of all of these struggles is the attempt to make public what had previously been considered private, non-public, and non-political issues.

The recognition of competing meanings and interests concerning existing public policies and practices admits into discussion an examination of discourse and its consequences for what Nancy Fraser (1987) has termed the 'interpretation of needs.' Fraser argues that needs should be understood as irreducibly interpretive. As such the

interpretation of needs is in principle contestable. Thus, the conventional administrative method of defining and addressing social needs, based on a liberalist philosophical tradition, represents only one possible way of institutionalizing social needs. Fraser points to the existence of another possibility, a “dialogic of need interpretation”, whereby the interpretation of needs is developed by public dialogue where individuals and social groups affected by political decisions actively participate in the design and delivery of health resources and services (1987: 119).

The Issue of Power

This dialogic approach is cognizant of the social relations of public dialogue. As Benhabib points out, “public dialogue is not external to but constitutive of power relations.” She argues that there are always certain implicit constraints on modes of public discourse in a society which together can be said to constitute the “meta-politics of institutional dialogue.” These reflect social relations, power structures and socio-cultural grids of communication and interpretation “which limit the parties to the dialogue, which set the agenda for what are considered appropriate or inappropriate matters of institutional debate...[and which] sanctify the speech of some over others as being the language of the public” (1992: 48).

Although it is important here for us to acknowledge that the social position of individuals affects their ability to influence the operation of their society, we should not overlook the power exercised by the politically peripheral and how their efforts do put forth alternative ways of understanding and practices (Ohnuki-Tierney 1990). What is of particular interest in this study is the response of the present established service systems to the emergence of the cross-cultural counselling program. The counselling program can be seen as a challenge to the notion that the established medical and social service systems are universally accessible. The response of the established service systems to the counselling program’s development illustrates ways in which the institutional interpretation of health needs is produced, reproduced and contested at different levels of the public sphere. In this thesis, it is against these contested interpretations that the health needs of newcomers are

examined.

The use of power by various stakeholders is also described to illustrate how macro and micro level interactions influenced the development of the counselling program within the mainstream health and social service systems. Weber's classic conceptualization of power informs us that any discussion or interpretation of power must involve the consideration of the capacity of a person or group(s) to perform or attain their goals despite the desires or interests of others. However as Lukes (1974: 24) points out, the exercise of power is not always overt and the understanding of power must be extended to include other possible considerations.

Lukes provides two additional dimensions by which to view, understand, and measure the use of power. His second dimensional view of power recognizes that power should not be restricted to the study of overt conflict; power is exercised in many other contexts. Certain individuals or group(s), while not wielding apparent control, may be so powerful that they are able to marginalize or silence the interests of others and subsequently exclude these interests from consideration. In some cases the absence of overt conflict may reflect a false or manipulated consensus rather than a genuine agreement among all concerned.

The third dimension of power is its exercise in such a way as to influence, shape and even determine the interests of others. Power has been exercised in this way when a person or group has acted against their own interests, even though they may express satisfaction with the outcome. Lukes suggests that "[w]hat one may have here is latent conflict, which consists in a contradiction between the interests of those exercising power and the real interests of those they exclude" (1974: 24-5).

For example, based on observations of medical encounters between providers and consumers, several researchers (Mishler 1984; Waitzken 1991; Fox 1994) have demonstrated ways in which power is concretized in social interaction. This work reveals how power is maintained through processes of discursive practices which shape meanings and fashion identities for the purposes of diagnosis and treatment. These authors have shown that within these interpersonal processes, based on professional/scientific bodies of knowledge, service providers may interpret social issues affecting individuals as individual

problems and encourage individual behaviors which are consistent with the institutional patterns of needs interpretation and service provision - practices which may be counterfactual with consumers' socially shaped lived experiences and self defined needs.

Power is manifested in the discursive practices of the institution of medicine. These practices actively promote the classification and management of information and the subsequent realm of solutions to be sought and forms of service provision to be considered. In this way, discourse can be seen as providing the determinants of service utilization as discourse shapes organizationally the institutional settings as well as the microlevel processes which occur within these settings. By providing the organizational setting, the geographical location, and determining service provision, discourse and its discursive practices offer a partial set of decision-making paths available for consideration by help seeking health service consumers (Young 1990: 205). The help seeking options available to individuals can of course range beyond the institutional service systems and may be based in alternative interpretive systems of support and assistance.

This discussion suggests that institutional power is a consequence of expertise, a body of knowledge (Fox 1994: 163) which guides and legitimates institutional practices. Here, power is exercised through the ability of the dominant group to provide discursive knowledge from which social policies and practices are constructed and legitimated. From this viewpoint, power may be seen to be constituted in the relationship between discourse and its consequences for control and knowledgeability. As Fox notes, Foucault's linking of power to knowledge means that power is more than the use of unitary and coercive measures. Power is exercised in the microprocesses of interaction. Occurring at the same time, dominant discursive practices may be contested by rival discourses and practices (Fox 1994). The recognition of multiple meanings and ways of understandings suggests that power is not a simple possession but rather it is constituted through a set of social relations in which "diverse and historically situated" actors have skewed opportunities for action (Forester 1985: xiv).

Multiple Players and Perspectives

The theoretical orientation of the thesis is based on the following pragmatic considerations. The emergence of the counselling program occurred within a social environment that consisted of various groups and individuals who came from diverse cultural, social and professional backgrounds and experiences. Based on these differing experiences, the perspectives, motivations and expectations of the various stakeholders regarding the development of the counselling program were to some degree divergent of each other.

Further, the ability of individuals or interest groups to influence and shape the growth of the program was of course dependent upon their situated relationship to the established service systems. For example, potential funders of the program, such as the provincial government, influence decisions through financial expenditures and legislative policies concerning the direction and formulation of particular investments, both economic and social, and what selective needs are consequently addressed (Forester 1982: 39). Furthermore, existing institutional structures and practices provide an organizational setting which privileges existing service practices and provisions and where newly created services or practices must gain acceptance. It is within these environments that competing interests can be seen to exist.

In addition, it must be recognized that each stakeholder group, for example, the group of counsellors, the various representatives of Mount Carmel (i.e. administrative staff, advisory committee and board members), representatives of agencies which had referred individuals to the program, as well as government representatives, should not be seen as a homogeneous groups representing a particular view or understanding concerning the counselling program or its potential for placement within the mainstream health and social service system environments. Perspectives of individuals within each group vary but usually share a common core attributable to the person's situated position within the overall health care system. Consequently, the range of perspectives represented through the views of the respective stakeholder groups described in the study may be seen to have distinct though somewhat overlapping opinions as to the efficacy of the program and the

explicit mode of service provision that the program should offer. Hence, the course of the program is shaped by the personal motivations and interests of various stakeholders who nevertheless represent specific organizational settings, processes, and practices.

Beyond social and professional differences at the individual level, the institutional environment also helps to influence interactions among various stakeholders. As a program which had been developed by a volunteer group of foreign trained professionals which was later imported into the Mount Carmel organizational structure, an established community health centre within the provincially funded health and social service systems, the effects of systemic pressures must be realized as well. I will argue that structural pressures throughout these organizational arrangements served to create tensions which continuously affected the formal work processes of the program.

Chapter Two Research Context, Design and Methods

The Evaluation's Contribution

The research data used in this thesis was collected as part of a formal evaluation of the counselling program which took place from June 1, 1991 to February 28, 1992. Supplemental data was collected subsequent to the completion of the evaluation through attendance at public meetings regarding health care reform issues in Manitoba. The literature review done to assist in performing the evaluation was augmented to provide additional theoretical insights to be discussed in the thesis.

The evaluation of the program described the development, service orientation and objectives of the counselling program and the relevance of the program to newcomers. It compared the counselling program's offering to those provided by settlement services for newcomers and the wider medical and social service environments. Specifically, the evaluation focused on whether the counselling program was addressing an accessibility problem in the mental health service system.

The evaluation used in-depth interviews with various stakeholders concerned with the mental health needs of newcomers, including CCCU clients themselves, as its primary source of data collection. Relevant information on program operation was also gathered: referrals were recorded to provide a map of the clients' help-seeking and utilization patterns; statistics were generated from administrative and clinical records of the counselling program; and additional information collected through attendance at in-service, advisory committee, administrative, and public meetings related to the program. These data sources provide a description of the clientele of the program, the organizational processes of the program, patterns of service consumption, and presenting problems.

The thesis utilizes all of the above data collected from the formal evaluation. Similar to the principal concerns of the formal evaluation, the thesis provides a description of the relevance of the counselling program to immigrants and refugees - the clientele of the service - and to referral agents. The thesis diverges from the evaluation's focus by treating

the formative considerations of the program development. The thesis provides a sketch of the structural and ideological dimensions of public policy in order to support the study's thesis that it is this that provides both definition and the realm of solutions to how health needs are understood and addressed in Canada. The thesis differs from the evaluation with respect to the emphasis placed on the evolution of the counselling program in relation to the explication of the norms and assumptions which guide public policy and practices⁴.

Rationale and Conceptual Approach

The introductory chapter stated the importance of examining the normative orientation of how needs are understood, defined, negotiated and addressed in the public sphere. This discussion was necessary to present a framework by which to counterpose how needs are understood by various interest groups as well as to illustrate how patterns of needs interpretation at the level of public institutions serve to influence and shape how issues affecting newcomers are understood by public policies, and addressed through institutional practices such as medical and social service provision. Based on the recognition of the competing interests, motivations and actions of the stakeholders or interest groups identified in this study, and the need to allow for a discursive examination of these contending positions, the research design is necessarily influenced by the social constructionist paradigm.

The construction of the research design follows many of the principles set forth by Guba and Lincoln (1989) in their recent work, Fourth Generation Evaluation. The central thrust of their approach is that evaluation methodology needs to encompass a broader set of considerations than earlier positivistic approaches. These earlier approaches to evaluation work argued for the need to get to the so-called hard, objective facts and tended to disregard the soft, social, contextual considerations in which the research is situated. Guba and Lincoln's intentions are to move beyond measurement, description, and judgment to a

⁴ For a further discussion of the methods used in the formal evaluation see The Cross-Cultural Counselling Unit: A Culturally Responsive Mental Health Program, Report prepared by Michael Quennell under the supervision of Dr. Sid Frankel and Dr. John O'Neil for Mount Carmel Clinic, Winnipeg, Manitoba. June 4, 1992.

new paradigmatic approach which involves negotiation as a key dynamic among all concerned individuals, or in their words, stakeholders.

To ascend to their 'emergent approach', Guba and Lincoln (: 41) suggest that methodology must recognize six guiding principles which consider "the myriad human, political, social, cultural, and contextual elements that are involved" in any research setting. At the onset, they take the position that evaluation outcomes do not describe "the way things are or really work" but rather are a set of one or more social constructions of how a particular problem or set of issues are understood. Accordingly, they view any methodology which claims to be value free as problematic.

Furthermore, they recognize that the social construction(s) through which people make sense of a particular issue or set of issues is influenced by the belief system of the constructors. As such these social constructions are seen to be "inextricably linked to the particular physical, psychological, social and cultural contexts within which they are formed and to which they refer" (: 8).

Following from these considerations is a key question for all researchers: whose values are to be taken into account and how might different values be accommodated? As society is value pluralistic, research too, must reflect multiple value orientations. In this thesis, I attempt to provide a sketch of the competing understandings, motivations and expectations which exist in the public sphere regarding the mental health needs of newcomers and specifically the cross-cultural counselling program.

Guba and Lincoln recognize that all stakeholding groups do not necessarily occupy the same position vis a vis access to information or the ability to influence others. Based on this recognition, they suggest that stakeholders accept each other as equals regarding the sharing of information among the stakeholder groups and agree to treat information with collective interests in mind.

Guba and Lincoln state that evaluation work must have an action orientation that outlines a course to be followed and that will stimulate all stakeholding groups to be committed throughout the research process. Concomitantly, evaluation work must envelope conventional ethics which include fully informed consent of the respondent and respect of their human dignity, privacy and integrity. They add to the conventionally

accepted list of ethically guided research principles that all stakeholders are to be accorded both full participative involvement as well as full political parity and control. This means “that human participants are accorded the privilege of sharing their constructions and working toward a common, consensual, more fully informed and sophisticated joint construction - they are accorded a full measure of conceptual parity” (1989: 11).

The general principles set forth by Guba and Lincoln are a useful guide by which to understand the social construction of all research based studies. The acknowledgement that problem definition and proposed solutions are produced through interactive, socially based processes has long been understood and appreciated by various researchers. What is novel and at the same time problematic about Guba and Lincoln’s approach to evaluation work is the expectation of a “powerless negotiation” over the sharing of all information, problem definition and realm of solutions to be considered. It is politically naive to assume that all stakeholders will suddenly submit in practice to “political parity and control”. As each stakeholder group has by its very definition its own particular perspective and set of interests concerning the set of issues to be studied, it seems very unlikely that for the purposes of an evaluation study, each groups’ members will suddenly become egalitarians and form a democratic, participatory collectivity for the discussion of the realm of interests to be considered and the production of outcomes or solutions. Apart from this reality, the spirit of these guidelines have been incorporated into this study.

In-depth interviewing is used as the primary source of data collection for several reasons. First, the use of qualitative data is recognized as allowing for the analysis of social action at several different levels of meaning. A qualitative, meaning centered research approach attempts to answer questions of how the life history, culture, and personality of various individuals contributes to their understandings and behaviors. Further, qualitative research allows for the description of the local setting of the research and of broader social processes influencing the social and political context for relationships and patterns of interaction among various individuals and social groups (Marshall and Rossman 1989: 46). Based on these strengths, qualitative research designs have been extensively used across the social sciences disciplines as well as medicine, education, social work, psychology, occupational therapy and management (Poire 1979; Rogers 1982;

Jax 1984; Halworth 1984; Gergen 1985; Morgan and Smircich 1980; Lincoln 1989).

Based on these theoretical considerations, the perspectives of the stakeholders are contrasted with each other and integrated with the relevant literature on mental health issues affecting newcomers and counterposed against the normative claims of public policy statements of both the Manitoba provincial government and the federal government. Similar to the verbal statements, the public policy papers and other relevant literature can be understood as communicative acts which contain values and beliefs about notions of self, health and wellbeing, community and society. By adopting such an approach, interview data, issues discussed in the literature and public policy statements are all seen to represent particular views and understandings. In this way, a dialogue is constructed between real-life situations, experiences and practices to complement analysis of the institutionalized forms of communication evident in public policies and practices.

The relevance of this approach is based on the understanding that scientific claims and ideas influence public (governmental) policies, the social values informing policies, and informal policies and cultural beliefs (Longino 1990: 84). Institutional values and beliefs founded in administrative, medical and scientific texts and derived practices are seen to organize institutional relations and thereby shape professional practices and create organizational contexts which in turn interpret, influence and shape individual social action and personal experience. Applying these considerations to the study of the cross-cultural counselling program and the mental health needs of newcomers helps to illuminate how the theoretical orientation and organizational contexts of mainstream medical and social services often fail to identify social and health issues affecting newcomers.

This approach is contrary to conventional considerations of scientific or medical knowledge and practices which view the consequences of such communicative practices in the more narrow and traditional sense, as solely performances of instrumental action in the absence of value or subjectivity. This approach will describe and socially locate the practices of action emanating from the everyday, social experiences of newcomers and the 'communicative' context of the human service environments. It will also contrast the social experiences of newcomers with the formalized knowledge contained in public policies and practices, concretized in service provision and service provider practices which rely on

particular cultural and psychological claims and ideas to understand newcomer experiences and needs.

The intent is not to abstractly link social structure to social action but rather to illustrate how the particular practices of social institutions provide a social environment in which specific patterns of social action occur. By doing so, it reflects on the structural or institutional affects upon peoples' everyday lives. This approach emphasizes the concept that public institutions structurally stage, shape and contextualize specific patterns of social action (Forester 1985: x). In other words, institutions are seen to shape and provide social environments and contexts which both promote certain types of behavior or social action while constraining or limiting other possible forms and pursuits of social behavior and expression by obscuring some issues and possibilities.

Social Context

As a primary task of this thesis is to examine the situated practices and knowledge of the established service system, it is obligatory to discuss the context in which the research occurred. This has import for the acquisition of the data and its interpretation.

I entered the research setting as the program evaluator of the counselling unit. I was given this opportunity through the recommendation of my thesis advisor and another researcher from the University of Manitoba. These two individuals had been requested by the counselling group and the administration of Mount Carmel Clinic to conduct an evaluation to assess the potential effectiveness of the program and the necessity of its role in relation to the realm of offerings from settlement services and the established and medical and social service systems. Under the supervision of the two researchers, my role as a program evaluator involved several interrelated tasks and considerations including contributing to the research design and methods used to conduct the evaluation, identifying and gaining access to various stakeholder groups, maintaining the protocol of the research design, and the collection and analysis of the data.

The gaining of access to certain stakeholder groups initially involved gaining the trust of the counselling group and the administrative staff of Mount Carmel Clinic through

informing them of the purpose and protocol of the research. In particular, this proved to be a laborious and ongoing process with certain members of the counselling group.

On one level, the evaluation was perceived by some counsellors as yet another unnecessary obstacle provided by the established service system. From my position as an observer and based on informal conversation with the counsellors, I believe that some counsellors perceived the pressure to evaluate the utility of the program primarily as a political issue. In their minds, there was no question of the need for the program or its efficacy in meeting the mental health needs of various newcomer groups. Members from their own particular communities had repeatedly spoken out concerning the inaccessibility of the established medical and social service systems.

In addition, like other migrants, the counselling group was cautious in developing a trusting relationship with and accepting formal demands from representatives of the established service systems. This included the administrative staff of Mount Carmel Clinic as well as other institutions such as the university. The hesitancy on the part of the counsellors was related to their limited experience with the established service system. As recent participants, they were inclined to view the development of the counselling program from a position of being outsiders to the established service systems. From this position and in conjunction with their social experiences in their countries of origin, they tended to interpret actions through a broader critical analysis than did other stakeholders identified in this study. Based on their social and professional backgrounds and circumstances, the counselling group did not have a proclivity for the organizational processes and goals of the established service system.

Moreover, as members of the group who had developed the service, they were disinclined to allow the administration of the Clinic to take over the direction and control of the program. These understandings and motivations concerning the operation of the program necessarily influenced interaction between and among these two stakeholder groups as well as with other stakeholders and myself.

As the counselling program was imported into Mount Carmel Clinic, the competing interests, motivations and actions regarding the operation of the program had to be considered in relation to the management of the research. Tensions periodically emerged

between the administration of Mount Carmel and the counselling group as the result of the organizational union of the two parties. From the position of the board and administrative staff, Mount Carmel had historically designed and delivered the Clinic's programs. The incorporation of a program developed and delivered outside of the direction of Mount Carmel was a change in approach and called for a period of adjustment. This change necessarily involved ongoing accommodation by both parties.

Despite the reluctance of the counselling group to allow outsiders to influence the program, the counsellors realized that they had to make certain accommodations in order to gain the program's acceptance within the established service systems. In part, this led to the relocation of the counselling program to Mount Carmel Clinic. The relocation of the program within the formalized horizontal decision-making structure of Mount Carmel Clinic, itself an established medical and social service organization, began a process of transferring control of the program from the collective decision-making practices of the counsellors to the Clinic administration.

On another level, certain members of the counselling group expected a positive evaluation report without much regard for the responsibility, participation and effort required on their behalf to ensure that the protocol of the research design was followed. Further, some counsellors openly questioned the usefulness of the evaluation as a means of obtaining long-term funding for the program. At differing times these expectations were exhibited by some counsellors through their decision to not actively participate in the collection of data concerning the assessment of clients' participation in the counselling program. In part, the lack of compliance by a few counsellors (in particular those who volunteered their services) may be explained by their commitment to service provision versus the time demands of participation in the evaluation process. For others it appeared to be a form of political resistance.

The counsellors' resistance to the evaluation was displayed at the initial meetings between the counsellors and the researchers. The counsellors argued that their clients would not be willing to participate in the evaluation as a result of their previous experiences with certain institutions both in their former homeland as well as in Canada. The counsellors provided reasons for their opposition to each of the data collection methods

suggested by the researchers. In response to the presentation of a draft proposal of the evaluation, the counsellors commented on the difficulties concerning the researcher's access to the clients of the program including observation of counselling sessions by researchers, interviews with clients and the collection of quantitative data concerning the progress made by clients during their participation in the program. Each reason was ultimately linked to the presumed unwillingness of the client to disclose certain types of information outside of their relationship with their particular counsellor. After initial consultation and ongoing negotiation, they verbally agreed to participate. However, it took several months for many of the counsellors to actively participate in performing the tasks required to conduct the study. I spent a majority of my field work developing their trust and maintaining their participation in the study.

It became apparent after a period of time however that the resistance was also based on the hesitancy of the counsellors themselves to participate in the evaluation of a program which they themselves had developed and hence perceived as their own. Following the first three months of the evaluation, the majority of the counsellors began to fully participate in the tasks required of them to ensure the research protocol was carried out.

It is against this setting that the evaluation took place. The array of differing interests, motivations and actions regarding the development of the program by force of circumstance affected my interaction with all stakeholders. Initially, I had to gain the trust of the counsellors in order to conduct certain aspects of the evaluation. Their acceptance and trust of myself and the protocol of the evaluation was essential to the completion of a successful evaluation of the program. Further, if I was to gain entry into several of the stakeholder groups identified in this study, the counsellors' acceptance and participation was essential. In addition, my relationship with the counsellors had to be balanced with my responsibilities to the administration of Mount Carmel Clinic with whom the contractual agreement regarding the evaluation was secured. Tensions emerged at times which resulted in the display of frustration at times by both parties during the course of the demonstration year.

In short, I became a temporary participant in the program's establishment within the organizational processes of Mount Carmel Clinic. Like all other participants, my own

personal motivations and beliefs concerning the counselling program influenced my interaction with the various stakeholders in this study. The degree of rapport developed between myself and the participants will have affected to some degree the interviewee's responses. Moreover, my role as a researcher not only involved collecting, but also comparing and contrasting the articulation of newcomer mental health needs by various concerned interest groups regarding the counselling program. As with any other study, particularly in the social sciences, my own biases inform my interpretation of the meaning, as well as the significance of, the data.

Data Collection Methods

An understanding of the relationship of the CCCU to other mental health services as well as specific services for newcomers was gained through open-ended interviews with various sets of social actors who have an interest in immigrant and refugee mental health issues. At the policy level, additional insight into the established service system was gained through an examination of public policy documents of the federal government and provincial government of Manitoba.

Prior to beginning the study, six stakeholder groups were identified in order to explore the range of understandings which exist in the public sphere concerning the mental health needs of newcomers. The selection of individuals and organizations for interviews external to the CCCU was informed by counsellors of the program, referral sources to the program and other relevant sources. The stakeholder groups identified and interviewed for this study include: 1) program staff of the cross-cultural counselling program; 2) clients of the counselling program; 3) settlement service social workers in agencies who work closely with newcomers following their recent arrival to Canada; 4) mainstream medical and social service providers (social workers, psychologists, psychiatrists, general medical practitioners) who had referred individuals to the counselling program; 5) administrative staff and service providers of Mount Carmel as well as Board members of the Advisory Committee of the counselling program; and 6) government representatives of the units of the provincial government which deliver mental health, immigration and settlement

services.

The study used an opportunistic sampling strategy, in others words, the researcher attempted to interview as many respondents concerned with the development of the counselling program within the realm of defined and identified stakeholders. This sampling strategy was chosen because of the expectation that some individuals would not consent to be interviewed and the desire to obtain an adequate level of information. The researcher acknowledges the potential for selection bias, however it is felt that this selection process accommodates the autonomy of the consumer to participate while fitting this consideration into a meaningful sampling frame.

To obtain a sample as representative as possible of clients of the CCCU services, a letter of introduction was to be presented to each client upon their initial consultation with a counsellor from the CCCU at the Mount Carmel Clinic. The letter of introduction informed the client of the purpose, content and confidentiality of the research and request consent for an interview. The counsellors of the CCCU contributed to the final draft of said letter.

Interview Schedules

The interview schedules, while specifically developed for each group of respondents and their particular relationship to the program and its clientele, explored common themes and issues. In general, all respondents were questioned regarding their view of the mental health needs of newcomers as compared to native born Canadians and whether the present mental health system meets the needs of newcomers. These inquiries were intended to gauge the respondent's frame of reference and understanding concerning mental health issues affecting newcomers. In addition, specific questions were asked regarding the range and specificity of ethno-specific services that are available for newcomers. See Appendices for all interview schedule listings.

The counsellor interviews explored the social and educational background of the counsellors as well as their view of mental health needs of newcomers and how the counselling program addressed these needs. In addition, these interviews included a discussion of the history and purpose of the program.

The client interview schedule sought to gain from each respondent an understanding of the client's experience and satisfaction with the mainstream health care service system. The interviews tried to uncover how the mainstream health services met the individual's own particular needs as well as those of their community and/or cultural group and whether there were ways in which these services could be improved to better meet their needs. In addition, the interview sought to elicit the client's experience with the cross-cultural counselling program and the ways in which this specific service met their health and/or other social needs.

Additional questions were asked regarding the client's help-seeking patterns for medical and non-medical problems both in their native country as well as in Canada. These questions are based on the recognition that human behavior is significantly influenced by organizational and normative structures in which individuals are first socialized. The internalized norms, values, and traditions of individuals are viewed as critical to the understanding of such crucial contextual variables as the interpretation of needs as well as help-seeking and decision making processes (Wilson 1977; Marshall and Rossman 1989: 70).

Interviews with Mount Carmel staff and committee members included a discussion of the history of the program and its purpose, with a specific focus on the organizational structure of the program, mode of service delivery, and changes made to the program since its relocation to Mount Carmel Clinic.

The next two sets of interviews were aimed at those who refer individuals to the counselling program. Interviews with settlement and other service providers provided an intermediary perspective between the views of newcomers and the overall orientation of the social service and health care systems. Interviews with health and social service providers provided insight into how the cross-cultural counselling program is viewed by such providers and how issues of cultural and linguistic differences between providers and consumers are considered, understood and managed within mainstream institutional environments.

Lastly, interviews with representatives of the units of the provincial government which deliver mental health and immigration and settlement services provided additional

information on how the needs of newcomers are understood and addressed by public policies and practices. Similar to the other interviews, questions were open-ended, with discussions left flexible enough to address issues which emerged during the course of the interview.

The variety of stakeholders interviewed provided a range of perspectives concerning the establishment of a cross-cultural counselling program within the mainstream health and social service systems. Even more importantly, the design of the study allows for the established health and social service perspectives, and the views of settlement and other human service workers working most closely with newcomers, to be compared to the self-reported social context of the newcomers' difficulties.

Moreover, the use of multiple respondents or the triangulation of sources of data strengthens the generalizability of the study. Multiple respondents within and among various interest groups are used as criteria by which to assess the validity and reliability of the research. This methodology of comparing and contrasting the responses of each respondent and among each of the various interest groups allows the the reader to judge the truthfulness of the respondent(s), the applicability of the findings to other settings or groups, and to assess the consistency and neutrality of the findings of the study (Marshall and Rossman 1989: 144-145; Lincoln and Guba, 1985).

Socio-demographic Characteristics of Program Participants

Augmenting the interview data is the provision of clients' referral patterns and discharge information. Several instruments were developed for the study to capture socio-demographic information and help seeking patterns of the counselling program's clients. The socio-demographic information was collected only to provide a description of who the clients of the program were. The help seeking and utilization patterns summary was used to gain a sense of the how the client came to utilize the counselling program as well as to describe what other medical or social services the client had utilized prior to seeking assistance from the counselling program. Socio-demographic information concerning the clients of the CCCU was collected by the counsellors of the program and is supplemented

by the counsellor's own assessment of the client's presenting problems. This data was supplemented with the review of all program documentation (See Appendices for a description of instruments used). The rationale for supplementing the data collected by the counsellors with data from the program documentation was to provide for missing data as well as to augment the profile of the program.

The help seeking and utilization patterns of clients of the counselling program were recorded to assist in the examination of the pathways which clients undertook prior to entering into the counselling program. This information supplements the self reported decision-making processes and patterns by clients and referral agents of the counselling program.

Organizational Dynamics and Public Policy Information

Supplementary organizational detail was obtained through attendance at administrative and public meetings related to the counselling program. In addition, I spent considerable time at the Clinic during the evaluation project, observing the daily processes of the program as well as having conversations with various Clinic staff. In these ways, comparisons were constantly made between the actual as opposed to stated organizational goals. These comparisons provided increased clarity to issues which emerged through the more formalized interviewing processes.

Primary public policy documents were reviewed, and public meetings with government over the counselling program and multicultural health issues were observed. Coupled with the interviews of government representatives, a fuller picture of the state's position and understanding vis a vis these issues was gleaned.

Research Process

The research process began with in-depth interviews of the counsellors of the program and the administration of the Mount Carmel Clinic to acquire an understanding of their approaches to service provision and a description of the clients served. It should be

noted that I attempted to faithfully write down responses manually during the interview. The quotes are presented as recorded, except for the correction of minor grammatical errors.

Seven interviews were conducted with counselling program staff including five paid staff and two volunteer counsellors. The Executive Director, the Administrative Assistant, three program Advisory Committee members and a Board member of the Mount Carmel Clinic were interviewed. These interviews were semi-structured, approximately one hour in length.

Following these discussions, the research proceeded with interviews of the clients of the counselling program. Each counsellor was asked to present a letter of consent to each client upon their initial consultation. The letter of introduction informed the client of the purpose, content and confidentiality of the interview and requested their consent for participation. Every client that provided consent was interviewed. In total, twenty-four clients were interviewed. No record was kept of the actual number of clients who received a letter of consent for consideration, however there were one hundred and nine new clients during the evaluation period.

The interview was semi-structured with the interview lasting from thirty minutes to over an hour in length. The majority of the clients (18) were interviewed without the presence of a counsellor. The client's counsellor assisted as a translator for the balance of the interviews. It should be noted that data collected from counsellor assisted interviews were not used in the presentation of case studies or findings. In brief, to reduce bias, the translator assisted interviews were restricted to enhancing my understanding of issues and concerns raised in the other interviews. In addition to correcting grammatical errors from notes taken during the interviews, portions of most client interviews were paraphrased where the respondent's verbal expression itself was grammatically incorrect.

During this time, settlement service workers who work closely with newcomers following their recent arrival to Canada were also interviewed. Twelve in-depth interviews were conducted with individual health and social service providers representing most of the agencies and organizations which had referred individuals to the counselling program. Interviews were open-ended and lasted between one and two hours.

A fifth perspective was gained from interviews with mainstream social and health care providers (social workers, psychologists, psychiatrists, general medical practitioners) who had referred individuals to the counselling program. Five such interviews were completed.

A sixth perspective was gained through interviews with representatives of the provincial government units which deliver mental health and immigration and settlement services. A total of three interviews were conducted.

Analytical Approach

The interviews were analyzed thematically to provide the social understanding that certain social actors gave to the mental health needs of newcomers and the provision of services and resources. The identification and analysis of themes, ideas, language and patterns of belief of the differing social actors was accomplished through the following methods. Data was reduced and coded as themes. The data was reconsidered throughout the process of the study as ideas emerged. The ongoing process of comparing and contrasting these thematic areas informed me “of what is and what is not yet known” (Marshall and Rossman 1989: 31).

The semi-structured questions of the interview schedules provided the initial framework for the analysis of the qualitative data. The interview schedules for each of the stakeholder groups were constructed to allow for the comparative analysis of specific themes or understandings between and among the various stakeholders interviewed in this study. Competing ideas and understandings were considered as the data was collected, organized and analyzed.

As mentioned above, the interview data were contrasted with each other, with the relevant literature on mental health issues affecting newcomers, and counterposed against the public policy statements of both the Manitoba provincial government and the federal government.

Limitations

In consideration of the program's clientele and because of the researcher's own cultural and linguistic background, several research strategies could not be undertaken. Firstly, as a result of their past social experiences, many of the clients of the program were generally suspicious of formal institutional settings and of outsiders to their social networks. Accordingly, the counselling process could not be observed either in person by the researcher or by videotaping the counselling sessions. Such an intrusion would inhibit service utilization by individuals who would have otherwise used and benefited from the counselling services.

Secondly, as an English speaking native-born Canadian, I was unable to converse with clients in their mother tongue. Due to funding constraints, it was not possible to hire research assistants whose cultural and linguistic background matched the diverse range of cultural and linguistics backgrounds of the clients, or to hire outside translators. As noted above, this limitation resulted in a counsellor from the program acting as a translator for six of the twenty-four interviews conducted with clients. In these interviews the presence of the counsellor may have influenced the respondent's replies, in particular to questions concerning the counselling program.

Despite these limitations, the usefulness of the qualitative data collected through in depth interviews concerning the relevance of the cross-cultural counselling program and other services presently available to meet the mental health needs of newcomers is considerable. First, the qualitative approach reveals how the various perspectives or preferences of individuals and groups are constituted through personal, social and cultural values. One cannot understand the relevance of health service provision to individuals or groups without understanding the framework(s) within which consumers and providers interpret thoughts, feelings and actions (Wilson 1977). Based on this recognition, the health needs of individuals or groups can be identified only when attention is paid to the way in which the core values of a belief system define what constitutes a need within that belief system (Habermas 1981 cited by White 1988: 70). By understanding the ways in which 'health needs' are constituted and understood by various individuals and stakeholder

groups in this study, clarification of the relevance of the counselling program to the clientele of the program, referral agents and other groups is obtained.

Based on these considerations the research design was established to allow for the comparison of understandings of mental health issues affecting immigrants and refugees among various concerned stakeholder or interest groups. As noted above however, the articulation of these understandings must also be viewed within a structural perspective which acknowledges the social, political, and cultural factors affecting the counselling program's emergence.

Chapter Three Providing Dimensions to Public Space

The purpose of this chapter is to elaborate theories concerning socio-cultural processes which are used in my analysis of the program's development. Since this paper will describe the contestation of needs interpretation among and between the various interest groups identified in the study, and attempt to show how these competing interests and motivations in turn influenced the development of the cross-cultural counselling program, first a framework to understand social action from both a system perspective and at the individual level is presented. A systems perspective helps to illustrate how organizational policies, processes and practices influence social interaction at an organizational level. Viewing social action at the level of individual social actors helps to illustrate how social interactions help to reproduce institutional processes and structures.

Having been preceded by a description of the framework, the rest of the chapter then deals with one of the 'cultures' of concern to this study, namely science - more specifically bio-medicine and psychiatry - and liberalism.

Understanding Social Action

Despite the local setting of the program and the specific actors involved, its development must first be viewed within a larger, complex set of institutional relations which provides structure and organizes the local dynamics of the program within the wider health and social service environments. To understand these interrelationships we need an account of how certain institutions serve to mediate between levels of social systems and social action and how a given policy can sustain or alter both systemic relations and social interactions⁵.

Derived from the work of Jurgen Habermas (1971; 1974; 1975; 1979), John Forester (1982; 1985) has proposed a comprehensive framework for the analysis of institutional practices which I will review in detail here. As a communicative model of

⁵ This is not the only approach by which which to understand and evaluate institutions; other criteria may include efficiency, stability and predictability (Benhabib 1992).

social action, it can be applied to the cultural institution of science, of which bio-medicine is a branch. It states that dominant institutions, like science, provide an ideology which influences and legitimates certain political, economic and social realities including health care policies and views. The framework will be elucidated by treating in turn the following concepts and their significance: culture, communicative action, lifeworlds, institutions and their potential for influence.

Culture

In this study, culture is viewed as an overall explanatory framework through which individuals in a society come to understand themselves and the world. By doing so, culture provides a basis not only for how individuals come to understand themselves and others, but it facilitates assumptions for answering questions concerning how the world works and our place within the world (Lock 1988: 3). However, as Gordon (1988: 23) cautions, cultural understandings should be interpreted as “ways of being and feeling” rather than as “understandings or assumptions that people carry around in their heads” and subsequently apply in different circumstances.

Culture is not static, nor is it without any structural constraints (Brittan and Maynard 1984: 20; Anderson et al 1991: 102). Cultural meanings are socially constructed and reconstructed through the processes of human interaction and through the appropriation, promotion and application of culture in differing societies and within particular sets of social relations.

Through the creation and promotion of particular organizational systems, societies promote social understandings (norms, values, and beliefs) and societal learning processes which in turn reproduce social identities and affect social action. For example, the gender-sex system can be seen as a normative structure or as a set of social relations that provide norms and values through which individuals develop an embodied identity, an internalized understanding of being in one’s body and of experiencing the body (Benhabib 1987: 80). Self identity, or the embodied individual, is reproduced through individuals appropriating from “the human community a mode of physically, socially, and symbolically experiencing

its bodied identity” (Benhabib 1986: 405). In this way, culture contributes to the promotion of a social reality which is symbolically organized and lived through experientially. Other social variables and constructs such as class, race, and ethnic origin may also have considerable influence on the reproduction of social identity or personality and thereby influence how individuals come to view themselves and others as well as the social and physical world around them.

It is through the embodiment of social and cultural norms and values that the motives for social action are constituted. In this way, individuals draw upon their culture for guidelines as to how to interpret their environment and the actions of others. An individual learns how to make sense out of his/her environment through the socialization process and patterns provided by the socio-cultural milieu of his/her community and society.

Communicative Action

Individuals socially coordinate activities through communication. In certain spheres of social life reaching consensus requires the conditions of a rationality inherent in communicative action (Habermas 1981: 397). Individuals relate to each other their intentions and concerns in everyday life through speech acts. Social actors come to an understanding through speech acts so as to coordinate their actions and to pursue their particular aims. However, the communicative model of action does not equate action with communication. Language is only a medium of communication through which understanding may be reached (: 101).

Under this framework, social action is distinguished according to how actors coordinate the goal-directed actions of differing participants; the degree of conflict and cooperation among various interest positions; the socially integrating agreement about values and norms of the socio-cultural environment; the level of consensus between these actors and their publics; and their success in reaching understanding through a cooperative process of interpretation. Hence communicative action is but this latter type of interaction that is coordinated through speech acts (but does “*not coincide with them* [Habermas’s

emphasis]" (: 101).

In reaching understanding about themselves, each other and their environment, individuals communicate within their cultural tradition, using and renewing it in the same instance. Through participation with competent reference persons, individuals become socialized through internalization of the value orientations of their social groups and thus acquire "generalized capabilities for action" (Habermas 1984: 208). From this reservoir of implicit knowledge, actions are coordinated via intersubjective recognition of criticizable validity claims. People rely on memberships in social groups while at the same time they reinforce the integration of these groups.

To reiterate: for social actors, in coming to an understanding, communicative action serves four central functions. First, it transmits and renews cultural knowledge; second, it coordinates social action; third, it provides social integration and the establishment of social groups; and fourth, it promotes the formation of personal identities (: 208).

Lifeworlds

These considerations inform this research study in that individuals and collectivities migrating from one socio-cultural system to another are seen as having to adjust not only to language differences but to the various values, norms and meaning structures present in their new homeland. Based on a particular social history and lifeworld⁶, the normative

⁶ I adopt Habermas's definition of lifeworld which is represented as a culturally transmitted and linguistically organized stock of interpretive patterns. Summarized by McCarthy (Habermas 1981: xxiii), "the lifeworld is formed through culture and language. [T]his knowledge base supplies actors with unproblematic background assumptions which they draw in the negotiation of common definitions of situations. Individuals cannot step out of their lifeworlds; nor can they objectify them in a supreme act of reflection. Particular segments of the lifeworld relevant to a given action situations can, of course, be problematized; but this always takes place against an indeterminate and inexhaustible background of other unquestioned presuppositions, a shared global preunderstanding that is prior to any problems or disagreements." As White (1988: 99-100) notes what is distinct about Habermas's notion of lifeworld is his introduction of the concept of the rationalized lifeworld. In the words of Habermas: "To the degree that the institutionalized production of knowledge that is specialized according to...[various] validity claims penetrates to the level of everyday communication and replaces traditional knowledge in the interaction-guiding functions, there is a rationalization of everyday practice which is only accessible from the perspective of action oriented to reaching an understanding....In a rationalized lifeworld the need for achieving understanding is met less and less by a reservoir of traditionally certified interpretations immune from criticism....[T]he need for consensus must be met more and more frequently by risky, rationally motivated, agreement" (Habermas 1981: 340).

understanding of the immigrant may differ substantially with the values and meaning structures to which she must now become oriented. The newcomer must be able to interpret, and be interpreted; understand the socio-cultural milieu and have that environment become relevant to her lifeworld. The newcomer adjusting to a new social environment without adequate support and understanding from competent others may experience loss of meaning, confusion of orientations, anomie, alienation, psychopathologies, breakdowns in tradition and a withdrawal of motivation (Habermas 1984: 214-215).

Thus, for individuals who are experiencing difficulties in adapting to a new socio-cultural system, the above theoretical considerations have considerable import. Cultural values are not universal but are located within the lifeworld of a specific group or culture. Values are meaningful only in the context of a particular lifeworld. In order for participants - for example health care provider and consumer - to critique value standards, they must share a pre-understanding that is not merely at "their disposal but constitutes and at the same time circumscribes the domain of the thematized validity claims" (Habermas 1981: 42). Furthermore,

[t]he more cultural traditions predecide which validity claims, when, where, for what, from whom and to whom must be accepted, the less the participants themselves have the possibility of making explicit and examining the potential grounds on which their yes/no positions are based (:70-71).

Institutions

Social systems are produced and reproduced through social processes such as the family and the educational and health care systems which take place in social learning environments (institutions). These institutional structures promote specific social processes, practices and patterns of expression which provide the context for individual learning and understanding, and help to form the motivational basis for social action. Institutions such as the law, medicine and government can be seen as both products of culture as well as agents of societal reproduction and learning. On one level, institutional structures in society reproduce and reconstruct cultural beliefs through work processes and practices and the generation of knowledge which in turn provide the basis for social action

and societal learning. On another level, institutions act as storehouses for norms and thereby provide the social capacity for social recognition and cooperation among individuals in society (Forester 1986: 41-42).

Societal production and reproduction produces social learning in two dimensions. Social production and reproduction take place on one level through the activity of work as social action is rationalized for systemic ends or in other words for the material reproduction of society. These rationalization or work processes provide a context for individuals' actions, create knowledge, and generate means-ends strategies which are then applied to the forces of production and other social relations. In these ways, organizations such as professional licensing bodies, research companies, administrative and managerial departments and other information based services provide a context for individuals' actions that is distinctive. The context of course is not sufficient on its own to generate social action, regardless of whether the work activity is focused on a manufacturing process or taking a patient's history.

The organization of these social relations is dependent upon the "institutionalization of norms and the social capacity for mutual recognition and cooperation". Forester points out that the formalization of institutional norms occurs principally through "mediating organizational forms" such as legislative bodies, both governmental and professional, as well as boards of directors of organizations and agencies of the state. It is within these settings that decisions regarding which "rules and norms, standards of obligation, rights and entitlements may be proposed, at times contested, established, enforced, and later formulated" (1982: 39).

Forester suggests that in a similar way "the social capacity to pay attention to needs finds organizational form largely in the political economy." Private financial and economic institutions as well as public institutions, through the financial expenditures and legislative policies of governments, provide "the organizational setting in which decisions about the direction and formulation of particular investments [both economic and social] are made and selective needs are consequently addressed" (1982: 39).

Institutions through organizational settings create routine patterns of practices or program/service provisions which create social learning environments. These in turn

engender social recognition and acceptance of institutional norms, values and practices. Institutional practice - “the social basis for the mutual recognition of intentions” - “exists in the routinized patterns of social interaction and ritual performances” which are more popularly known as organizations, programs and associations.

In a parallel fashion, social systems reproduce their social identities through various rituals or socialization processes through expressions and patterns of dress, speech and other habits. Moreover, similar to the way in which individuals are able to evaluate each other’s participation or social action as a member of a cultural group, we are able to assess the consistency of what institutions or organizations state and ultimately do. On this basis, we are able to judge or assess the intentions and practices of institutions in society and how institutional actions communicate particular norms and values by mediating between specific local actions and relations and broader structural processes through policy statements and practices. By doing so we can assess how these ‘communicative infrastructures’ affect specific social action and other social structures.

Institutional Influence

Institutions mediate social action and social structure by producing techniques, strategies and propositional factual knowledge or beliefs; by directing or patterning attention; and by constructing patterns of consent, trust and mutual recognition. Through the establishment of practices and procedures, institutions produce factual beliefs and knowledge. If such claims are accepted and established or in other words legitimized, these procedures and practices promote social recognition and trust by individuals.

Institutional claims or perspectives are typically transmitted through well-formed linguistic utterances (discourse) or non-verbal media, as well as through the media of money and power. It is through these various claim-making procedures and practices that resources and attention are “selectively addressed to particular concerns and needs” (Forester 1982: 41).

Forester defines four principle ‘families’ of institutions and organizations that act as mediators between “specific practical action claims and structural processes of societal

development and learning” (: 41) and steer the economic and administrative systems through the media of money and power. These are: 1) administrative, technological, and scientific organizations; training programs; and information services which represent strategies, means and findings; 2) financial-economic organizations which formulate capital accumulation and investment; 3) legal regulatory agencies such as professional licensing bodies or Boards of Directors which establish norms and regulations for specific groups or organizations; and 4) social- moral organizations such as cultural and ethnic associations, service programs, family structures or special interest organizations which identify intentions via organizational performances (: 40).

The types of influences that particular institutions may produce is of course related to their *raison d'être*. For example, Forester points out that under a capitalist economy, legal institutions may treat issues related to the socialization versus privatization of production unequally through producing regulations and incentives which are structured and continually reproduced to reflect capitalist market relations. Similarly social-cultural institutions might be expected to reflect individualistic values and traditions in a capitalist economy. Nevertheless mediating institutions may be opened up to discursive examination to allow for a participatory democratic approach to addressing, for instance, the collective needs of various social groups in Canadian society.

The level of identification, significance and dominance that particular institutions have in specific action contexts is contingent on historical pressures, both systemic and popular. As a result these institutions may not develop in a unified manner. Systemic pressures may influence institutions to reflect the functional requirements of the local or extra-local economies or to legitimize present social relationships. Popular pressures may create a pull in the opposite direction through the efforts of certain social groups or collectivities to organize for their own particular needs. Therefore, despite their historical presence mediating institutions “may be contested, challenged, or alternatively accepted as proper integrating mechanisms for society”. For these reasons specific social action is conventionally guided, historically contingent and influenced by institutionally situated actions or practices, yet vulnerable to non-institutional pressures (Forester 1982: 41).

Institutions that have been developed and maintained within the same set of social

forces, processes and choices, are constituents of the same culture or society, can be seen to embody similar cultural understandings or worldviews. As a result, all the major institutions of a particular society will reflect and promote certain and particular social, political and economic realities. However, this is not to argue that there are structural determinants between the specific and situated knowledge of each institution, but rather to point out that similar philosophical traditions or cultural assumptions can be seen to underlie the specific knowledge and practices of each of the major institutions in a particular society. In other words, they are rooted in and dependent upon mutual bonds of understanding, trust, and identification and therefore can be seen to share basic cultural norms and values. Accordingly, as an institution develops specific and situated knowledge and practices for its own particular *raison d'être*, it remains at the same time concordant with other major institutional knowledge and practices in society.

Summary

Four main points may be made about the framework in relation to this thesis. First, the framework demonstrates at an analytical level how consideration of social structure must precede the assessment of specific or local social settings (which are the focus of the next chapter).

Second, this framework provides a guide for understanding how institutional processes function to shape and organize social interaction through policies and procedures - claim-making practices. At this level, it provides analytical insights by which to explicate the historical and cultural contingency of institutions in society. It indicates how the dominant institutions share and communicate certain ontological and normative assumptions about such notions as society, self, community, health and illness. These assumptions promote certain social processes and understandings while constraining and limiting alternative ways of knowing and social interaction.

Third, the framework explicates how individual intentions are to be interpreted socio-culturally; culture, values and ideology are always expressed in the thoughts and behaviors of individuals (Ohnuki-Tierney 1990: 8).

Fourth, it suggests how individual intentions interact with institutional processes; and conversely how institutional policies and practices influence individual social action. From this position, and based on the viewpoints of the various interest groups in this study, we can examine how the established service system managed the challenge of the development of the counselling program.

In sum, this theoretical approach will allow us to counterpose the established service system's interpretation of the health needs of newcomers against alternative ways of understanding and addressing the social needs of newcomers. As the topic of this study is the examination of the development of the cross-cultural counselling program, the framework provides a filter through which to view, at the level of individual interaction, the reproduction of institutional process and structure. Institutional policies and practices are analyzed as the providers of an interpretive frame or schema, for example, through the provision of services which privilege certain actions over other courses of action and thereby influence social action at the individual level.

The discussion will now turn to the influence of science and the philosophy of liberalism. The scientific tradition's claim of universality is disputed and then psychiatry is offered as a case in point of inherent bias. Finally, liberalism, as an approach to interpreting need in a heterogeneous society, is critiqued.

Science as Socio-Cultural Institution

In western societies since the Enlightenment, science, of which bio-medicine is a branch, is gaining a seemingly ever increasing level of identification, significance, and dominance as the preeminent socio-cultural institution. As a dominant institution, science provides a cultural ideology which serves to "institute and legitimate certain political and economic realities" (Lock 1988: 5; Gordon, 1988; Taylor 1985; Comaroff, 1982). In other words, scientific claims and ideas influence public (governmental) policies, the social values informing policies, and informal policies and cultural beliefs (Longino 1990: 84).

The ability of institutions to promote and sustain particular worldviews or cultural and social understandings is based on a culture's paradigmatic qualities. As bio-medicine

develops within the same set of societal forces as other institutions of society, similar cultural assumptions can be seen within its own specific set of knowledge and practices that are concordant to other institutional knowledge and practices. Like other major institutions in society, bio-medicine communicates specific and shared cultural and relational notions about self, health and society. Moreover, the discourse of science and bio-medicine claim substantive presuppositions which include ontological, epistemological and normative considerations. Embedded within these assumptions are claims of the universability of scientific knowledge and practices and its application to the understanding of human social behavior.

Specificity of Bio-medicine

Gordon (1988: 21) points out that the “tenacity of bio-medical assumptions and practices” results from 1) the efficacy of much of medical practice; 2) the extensive web of institutions; 3) the political, economic, and personal investments in the current model; and 4) the successful response of many physicians to criticism. Despite these strengths, Gordon argues that bio-medicine is increasingly being recognized as “culturally and historically specific and far from universal”. She cites a large body of literature which

demonstrates how biomedical knowledge and practices are eminently and irreducibly social and cultural....These studies reveal more and more how biomedicine evolves through social choices rather than natural inevitability and how, in fact, a sense of “natural inevitability” or “givenness” is constructed out of social choice (: 20).

Based on these studies, Gordon challenges the assumption that bio-medicine is somehow autonomous from society. She cites Taylor (1985) who, in his examination of the philosophical basis of science, demonstrated that the ontological basis of science is linked to notions of self as conventionally understood in western societies. Within the worldview of the scientific universe and the gaze of bio-medicine, the individual is viewed as prior to society and culture while society is considered the product of an association of individuals (Gordon: 34). Concomitantly, the understanding of social institutions is often limited to its provision of “means for realizing the ends of individuals, of realizing the

ideas in people's heads, rather than as expressive phenomena in themselves'" (Taylor 1979: 26; cited by Gordon 1988: 37). The worldview of science and its set of beliefs are concordant with the philosophical tradition of liberalism. Liberalism separates its understanding of self from socialization processes involved in the development and experiences of the self - namely those provided by culture and society.

Critiques of these western philosophical traditions have pointed out that their purported claims of universalism provide the ideological foundation for the development of highly ethnocentric and androcentric normative institutional structures and practice (Gilligan 1982; Benhabib 1986, 1992; Fraser 1987). The latter subsequently obscure and/or generalize the needs of marginalized groups in society. As will be discussed later in regards to health policy and service delivery, liberalism's proclaimed universalism as well as its ideal of moral autonomy leads to the privatization of the experiences of a plurality of modes of being human, including those of women and cultural others, and excludes these considerations from a moral point of view. As a direct consequence, how needs are defined, understood, identified and addressed in society are affected. Defining and addressing needs in instrumental terms based on 'rationality' and the individual, bio-medicine denies its own cultural values (Young, A. 1981: 317).

Biases Within Psychiatry

Of particular concern to this study is the theoretical orientation of psychiatry, a branch of the bio-medical socio-cultural enterprise. All mental health care professionals are to some extent educated within the psychiatric paradigm. Further, in their professional lives they are compelled to use psychiatric nosology for communicating with other health care professionals, for insurance purposes and professional recognition. In short, whatever their aims, health care professionals will usually take their ideas about health care provision from the stock of knowledge characteristic of their profession at the time. These pressures often result in the grafting of new considerations such as cultural accessibility onto the organizational and knowledge practices of the larger health care system dominant in the country. It should be noted that within social work and other professions, competing

paradigms which recognize the import of other socio-cultural considerations have begun to challenge the cultural basis of the dominant psychiatric paradigm.

Contemporary psychiatry's own knowledge base and subsequent policies and practices reflect bio-psycho-socio-cultural understandings and practices and consequently promote universal generalizations concerning health and wellbeing, illness and disease. However, as psychiatry's enterprise focuses exclusively on the social behavior of individuals, its communicative and symbolic character is more readily apparent than general medicine. Psychiatry's understandings and practices are necessarily articulated through the medium of language.

The socio-cultural biases of psychiatry are most visible during times of social change, times when they no longer coincide with emerging social beliefs. Gaines (1992) has traced the historical and cultural contingency of the present American psychiatric model. According to him, psychiatry and especially biological psychiatry, represented through its diagnostic text, the

DSM I through III-R, as cultural constructions...evidence a particular cultural voice. The voice of classification...[has an] implicit standard of normality. It is also clearly gendered (male), and age specific (adult). The voice articulates, constructs and maintains an idealized positive notion of self through the discourse asserted to be that of disease classification....[Furthermore as] professional psychiatric classifications, the DSMs are moments of a (re)creative, constitutive, cultural and historical process through which certain Western selves say something to and about themselves and Others (: 3).

A brief discussion of the current American psychiatric classification system's history is illustrative. Gaines states that the American, and by extension, North American understanding of mental disorders can be traced back to the first diagnostic system in the United States of 1840. A single term was then used to classify all cases of what was understood as mental illnesses. Forty years later, another classification system was developed with the number of categories expanding to include seven terms. Classification systems and the number of categories of mental disorders grew over time.

During this period of time, the classificatory work of psychiatrist William Menninger began to influence the field. Menninger argued that the proliferation of the

diseases by psychiatry characterized by the expansions of divisions to twenty-four with eighty-two subdivisions was unfounded. He argued that many of the phenomena which were previously classified as symptoms of specific diseases were better understood as simply as 'actions' or 'behaviors', and developed his own system with only five divisions of psychiatric illnesses.

Gaines argues that Menniger's reduction of the number of distinct disorders and their relationship to one another reveals that mental disorders "are not natural, universal entities that are simply discovered by medical science..., a view...that is at odds with psychiatry's own" (: 7). Gaines suggests that the medical classificatory systems should be understood as successive attempts to articulate particular cultural assumptions about self and society, health and illness.

A recent example of psychiatric cultural bias is its declassification of homosexuality as a disorder. Reflecting the homophobia among certain subcultures in society, homosexuality was listed in the DSMs prior to 1973 as a personality disorder. Although scientific studies were inconclusive, the views of psychiatry remained unaltered until gay and lesbian movements pressured for the removal of homosexuality as a mental disorder.

Women and other socially disadvantaged groups have pointed to how the treatment of other social variables in psychiatry is problematic. Rosser (1992: 224), in her examination of the androcentric and ethnocentric biases within the domain of psychiatry states,

Gender, class, race and ethnic origin may have considerable influence on our conceptions of parenthood, sex role socialization and sexuality for both men and women in our society. Gender is one variable that interacts with race, class, ethnic origin and other variables to form complex interlocking phenomena defining normal, healthy and acceptable mental order in our society.

She points to possible consequences of these cultural biases:

Differences in gender, race, class, ethnic origin and sexual orientation may separate the psychiatrist from the patient. A factor which further encourages this hiatus is the scientific foundation of psychiatry based in notions surrounding objectivity and distance between the observer and the subject of study (Keller 1985; Rosser: 224).

Rosser goes on to call attention to how the practice of psychiatry is similarly dominated by

white, male service providers.

In addition to the difference of gender, psychiatrists may also differ from many of their patients with regard to race, class, ethnic origin, religion, sexual orientation or other significant characteristics. Most of the theories and diagnostic categories reflect not only a male perspective but a white, middle to upper class, Judeo-Christian, heterosexual perspective. Since these same descriptors - white, middle to upper class, Jewish or Christian, and heterosexual - also typify most psychiatrists, it is less likely that their personal experiences will have provided them with opportunities which reveal bias emanating from those descriptors which become embedded in diagnostic categories (1992: 224).

Psychiatry can be seen to reflect a systematic cultural pattern which will differ from the way people from other social groups not depicted in psychiatry interpret themselves and others, and attribute meaning to social experiences and even society at large. Therefore the application of psychiatry "may prove problematic when applied to persons of alternative cultures and social backgrounds." Moreover these recognitions "highlight potential limitations, inherent in the enterprises of psychiatric diagnosis" (Fabrega 1992: 231).

The potential of the practice of psychiatry to exert a reifying influence on individuals should not be underestimated. Over time, these practices influence individuals' and social groups' definition of such social issues as gender and cultural relations according to the normative claims of professionalized knowledge and practices of psychiatry. Through claim-making practices, social problems can become individuated through the process of medicalization.

The Liberal Approach to Interpretation of Need

The worldview of science and its set of beliefs are concordant with the philosophical tradition of liberalism. Liberalism separates its understanding of self from socialization processes involved in the development and experiences of the self - namely those provided by culture and society. As a consequence, the individual is seen as prior to society and culture while society, as noted previously, is viewed as the product of an association of individuals, with social institutions often regarded as little more than instrumental tools of individuals, without the capacity to convey messages, to circumscribe

or afford opportunities.

Feminist theorists including Fraser (1987), Benhabib (1987), and Smith (1984) have drawn out the implications of an approach to public policy and the discussion of social needs and rights that is predicated on conventional liberal ideas about self, society and the interpretation of needs. They offer a critique which helps to demonstrate how despite the universalistic, moral claim of the discourse, particular group needs are selectively addressed while others are generalized and thereby remain marginalized.

It is important to note that ideologies or belief systems such as liberalism predate the individuals or social groups that claim and/or use them and as such they should be seen as part of the overall social formation. Dominant groups within the social formation use the belief system to combine different elements of social experiences into meaning generating constructs such as discourses and texts which are then used as explanatory frameworks for subsequent action and practices. It is through these processes that social consciousness or public understandings are partly self-created and partly parented by ideological discourse which already exists (Williams 1985: 13). Historically developed and contemporary ideologies combine with the practices of professionals and bureaucrats to shape institutional structures, understandings and practices.

In its classic form, liberalism promotes a conception of political relations between the individual and the state, and between individuals. Political relations among these groups are understood to involve individuals having shared basic human rights which are to be respected by others and defended by the state. Based on presumed rational, universalistic principles of justice, state policies through law or bureaucratic practices provide equality of attention to individual rights. Furthermore, the state is seen to act as a neutral arbitrator between individuals and interest groups within society. Participation in the public or political sphere is provided formally through representation rather than direct individual participation.

Over time, the classic form has been gradually extended to include a more pervasive and interventionist concept of social justice. Proponents of liberalism in its current form view the state and its institutions as instruments by which to amend certain types of social inequities in society. Moreover, acceptance of this ideology pervades popular notions of

appropriate politics and how society works - it organizes a range of social institutional structures and practices (Indra, D. 1989).

For example, the notion of the competitive economic market is a key theme in laissez-faire liberal ideology. Need is defined as the ability and willingness to purchase goods and services at a particular price. Services are to be provided outside of the market only in situations of market failure which occur when the market cannot fully encompass costs and benefits. State intervention by way of service provision occurs only when both the market failure and threats to social order in the absence of service provision occur simultaneously. This tends to render the definition of need for state financed services as narrow, residual, rigid and exceptional (Frankel 1995 [Personal communication]).

Limitations of Liberalism

Benhabib (1987) argues that the acceptance of liberalism and subsequently how political relations between the state and the individual are popularly conceptualized and pursued has far reaching implications for how and what social rights are subsequently addressed. Through an examination of the moral realm of liberal discourse, Benhabib argues that the purported “universalistic moral domain of liberalism as well as the ideal of moral autonomy that exists in universalistic contractarian theories” leads to the privatization of the experiences of a plurality of modes of being human, including those of women and cultural others, and excludes these considerations from a moral point of view (: 81).

Benhabib agrees with proponents of liberalism such as Rawls who believe that reciprocity, fairness, and equality are key ingredients in universalism. The identification of reciprocity can be seen as reflecting a basic social norm. As Alvin Gouldner (1960: 161) has stated, not only “is reciprocity a social norm but is rather the very concept of social norm.” The production and reproduction of social relations in a stable community requires a degree of reciprocity in the actions, expectations and claims of the group. The provision of reciprocity according to the expectations of the group, would then be judged as fairness by the group. Accordingly, members of a group governed by the relations of fairness and reciprocity are seen as equal. In this way these ‘formal structures’ are integral in the very

social logic of social relations and a stable social system.

What becomes problematic, as Benhabib points out, is that through history and across cultures the applicability of these structures are modified by the criterion of inclusion/exclusion, or in other words, who belongs and who does not. She questions

what aspects of human behavior and objects of the world are to be regulated by norms of reciprocity....[I]n terms of what is the equality of members of a group established: would this be gender, race, merit, virtue or entitlement? (: 413).

According to Rawls and other liberalists, these questions are irrelevant. The act of moral reciprocity requires only the capacity to take the standpoint of the other, to be able to put oneself in another's place through total abstraction. Within a liberalist moral universe, the self does not know "his place in society, his class position or status; nor does he know his fortune in the distribution of natural assets and abilities, his intelligence and strength, and the like," rather, "to know another as a human being is to deny such differences" (Rawls 1972: 137; cited by Benhabib 1986: 413).

Benhabib questions "whether such selves who do not know the particular circumstances of their own society can know anything at all that is relevant to the human condition....[A]re these individuals human selves at all?" (1986: 413). She submits that any human self cannot be defined solely by its capacity for action or potential for choice. Rather self identity must include consideration of the actuality of choices, how the self is a concrete, embodied individual, and shapes and fashions a personal and social identity according to the circumstances of birth and family, language, culture and gender.

Concrete versus Abstract Selves

Benhabib states that the liberalist tradition promotes the vision of the moral self as a "disembedded and disembodied being," though its reflection contains aspects of the white, male experience hence casting a shadow over the experiences of others. Thus she considers it "incompatible with the very criteria of reversibility and universalizability advocated by the defenders of universalism." She argues that these moral theories are

better termed as substitutionalist rather than as universal, and ought to be replaced by an interactive universalism:

Universalistic moral theories in the Western tradition from Hobbes to Rawls are substitutionalist, in the sense that the universalism they defend is defined surreptitiously by identifying the experiences of a particular group of subjects as the paradigmatic case of the human as such. These subjects are invariably white, male adults who are propertied or at least professional. I want to distinguish substitutionalist from interactive universalism. Interactive universalism acknowledges the plurality of modes of being human, and differences among humans, without endorsing all these pluralities and differences as morally or politically valid. While agreeing that normative disputes can be settled rationally, and that fairness, reciprocity and some procedure of universalizability are constituents, that is, necessary conditions of the moral standpoint, interactive universalism regards difference as a starting point for reflection and action. In this sense, "universality" is a regulative ideal that does not deny our embodied and embedded identity, but aims at developing moral attitudes and encouraging political transformations that can yield a point of view acceptable to all (1986: 406).

Benhabib's critique has considerable import for this study. At the conceptual level, her insights suggest that the liberal paradigmatic approach to social needs fails to acknowledge or incorporate an adequate understanding of how social identity is created, sustained, reproduced and structured through the processes of socialization or in her words the 'embodiment' of specific social and cultural values, norms and experiences of the individual. This omission obscures other possible and legitimate forms and expressions of self and others.

According to Benhabib, liberalism promotes a concept of a moral autonomy which denies social, cultural, and personal differences among persons and regards all persons as sharing a common set of formal rights and duties. Obscuring social, cultural, and personal differences among people, the individual is promoted as a self-sufficient unit. Thus all social needs are presented from "the standpoint of the generalized other". She argues that "the standpoint of the concrete other" must be recognized, whereby persons are understood according to their concrete individuality.

In assuming this standpoint, we abstract from what continues our commonality and seek to understand the other as he/she understands himself/herself. We seek to comprehend the needs of the other, their motivations, what they search for and what they desire. Our relation to the

other is governed by the norm of complementary reciprocity: each is entitled to expect and assume from the other forms of behavior through which the other feels recognized and confirmed as a concrete, individual being with specific needs, talents and capacities. Our differences in this case complement rather than exclude one another (: 411)

The Issue of Community Definition

In a similar fashion, Gillian Walker (1990: 31-32) points to how liberal notions of community obscure the understanding of the everyday concerns and needs of many individuals and groups contained within such definitional frameworks. She suggests that the need to problematicize the term 'community' and 'community organization and development' emerges from the recognition that the conventional liberal discourse about community popularly shared and practiced in work, speech and textual representations fails to account for issues related to gender, class, and race.

Conventional liberal discourse typically refers to 'community' in terms of a given geographical space or locale in which residents of the the area share common needs and concerns and thereby identify with one another. However, similar to liberal notions of individualism, the liberalist view of community denies differences among persons contained within its locale. Such notions of community promote the view that its residents are in unity with each under, a shared universe of needs, understandings, feelings and desires. It fails to consider how the lives of persons within communities are structured and shaped by broader social and historical processes which create substantial social and cultural differences among persons and are represented in concrete persons and not in the generalizability of liberal individuality.

Walker's review of the conventional literature found that the liberal notion of community was "so abstract as to render neutral, objective and gender-free every concept or activity involved" (1990: 32). She argues that in order not to fall into similar conceptual pitfalls, the understanding of community must illuminate the everyday activities and situations of peoples' lives and the broader social processes which serve to order, administer and shape society.

In her examination of conventional concepts of community, Young (1990) points to

instances where liberalistic notions of community are used to distinguish among groups of individuals according to race or ethnicity. She states that in Western societies, membership in a group is often defined by the sharing of a specific cultural heritage, common self-identification and set of norms. Young argues that the processes by which persons become identified as a member of a particular community, often entail

an oppositional differentiation from other groups, who are feared or at best devalued....[and that] racism, ethnic chauvinism and class devaluation...grow partly from a desire for community, that is from the desire to understand others as they understand themselves and to be understood as I understand myself (1990: 311).

What is just as problematic however, is when the notion of homogeneous community is not overtly racist. If the mutual understanding which the perspective of liberalism promotes is only possible within a homogeneous group that is defined by common attributes, then public institutions which operate exclusively on the basis of theoretical commonality and in practice *assume* commonality, don't look for normative differences due to race, gender or culture and other social constructs, or take them into consideration in the design of so-called 'universal' programs, for instance, health services.

This thinking promotes the dominant interests of one group over that of others through denying differences among individuals and groups, by viewing all individuals as separate but equal and without specific affective needs. Despite the heterogeneity and multiplicity of its membership, community is conceived as a homogeneous totality. For those individuals or groups which differ socially or culturally from that of the dominant group, their substantial and particular notions of self and interpretation of needs become opaque. In a liberal community, all individuals are seen to share common identification and to participate in symmetrical social relationships. As a result, the interpretation of needs of individuals within a defined community or geographical area are presented as homogeneous, natural and objective.

Implications for Health Policy

Liberalist proponents of the Canadian health and social service systems claim its

realm of services to be integrative, universalistic and redistributive. However, historically in Western, pluralistic societies, liberalism has provided the ideological foundation for the development of highly ethnocentric and androcentric normative institutional structures and practices which subsequently obscure and/or generalize the needs of marginalized groups. Based on the notion of a decontextualized and disembodied self, the constitution of needs - and what needs are to be addressed - is defined primarily through the core values of the dominant group.

Typically, under a liberalistic approach, when decisions are made regarding what social needs of a given constituency shall be undertaken by the state and to what degree, issues are framed in such a way as to allow only for a limited range of solutions. Debates tend to be cast in quantitative terms which deny qualitative, affective differences among groups (Fraser 1987: 104). Furthermore, under the guise of universalism, this form of thinking "in policy making which supports the view that everyone should be treated equally irrespective of existing inequalities and can and does serve to maintain existing...inequalities" (Ben-Tovim et al 1986: 22).

The foregoing has argued that the liberal interpretation of needs is based on specific, qualitative notions of self, normality, and social obligation that are presented as generalizable across society, regardless of ethnicity, gender, etc. The prediction of such a hypothesis is that government institutions grounded in liberalism will articulate a generic approach to meeting the differing needs present in a socially and culturally diverse society. The specific case for Canadian, and Manitoban, health policy is analyzed in the following chapter.

Chapter Four Historical Dimensions of the Canadian Mosaic

Ohnuki-Tierney (1990: 7) has pointed out that during a short period of time, changes at the basic level are almost never discernible, unless examined against the background of longer term historical processes. Accordingly, this chapter briefly reviews historical immigration patterns and the development of specific services for recently arrived newcomers in Canada. In part, the history of Canada is marked by past struggles of various social groups to establish certain social rights of citizenship. The development of the counselling program can be regarded as a contemporary example of the efforts of more recently arrived Canadian immigrants to make public their particular social needs. The historical background of public policy and practices illustrates past social challenges to, as well as accommodation and change in, the reproduction and maintenance of public institutions in Canada. Immigration patterns can be seen as both cause and effect: they are due to public policies (and historical circumstances in the world) and in turn contribute to the present plurality of Canada's population.

A sketch of the historical and cultural influences which have guided the development of public institutions and services in Canada is particularly germane to this study. I contend that Canada's history of largely European immigration has left a significant legacy: public institutions and practices have been developed to meet and regulate the social and cultural needs of a predominately white, Anglo-Saxon population. Changes in immigration patterns, specifically the make-up of the major source countries, have presented significant challenges to the socio-cultural orientation of public institutions in Canada. An awareness of the historical and cultural contingency of the normative orientation of public institutional processes and practices, will be important for the discussion in later chapters of specific health policies and the counselling program's emergence.

Immigration Patterns

Canada is principally a country of immigrants. Throughout its history as a nation, the ratio of foreign born to Canadian born has never been less than one in six and at times has increased to one in five (1981 Census of Canada; cited by Canadian Task Force 1988 (a): 6).

First colonized by the French and then by the British, the development of Canada has been largely shaped through the growth and dominance of a structural, cultural and linguistic duality reflected by the heritage of the two founding colonial powers. According to Birch (1992: 4), following Canadian federation, the first century of the Canadian government's immigration policy can be described as containing three objectives: 1) the allowance of free immigration to the British and Irish; 2) the discouragement of Asian, and any other non-White, immigration; 3) and the consideration of other prospective migrants based on their merits. As a result of the successful implementation of these objectives, there was unimpeded access for white British and American immigrants with black Americans refused on the excuse that they could not adjust to the Canadian climate. Asians were discouraged and at times some groups were prohibited from immigrating to Canada. For example, in 1885, a poll tax was placed on Chinese residents and between 1923-43, Chinese immigration was prohibited entirely.

In 1947, an attempt to determine national objectives for immigration was made by a federal Senate Committee on Immigration and Labour. Of particular note and irony, the Senate report cites contempt for discrimination based on race or religion while at the same time stating that discriminatory practices against Asians immigrant applicants should continue. These practices were upheld, based on the reasoning that what barriers existed were the result of problems of Asians assimilating into Canadian culture and therefore did not per se constitute discrimination (Hawkins 1972: 84 cited by Birch 1992: 8).

These objectives continued and went unchallenged until the 1960's. From 1946-67 inclusive, over sixty-three percent of Canadian immigrants came from 'white' European source countries while only six percent of Canadian immigrants came from 'non-white' source countries. From 1946-53, in addition to British, Irish and American immigrants,

tens of thousands of Germans, Dutch and Poles migrated to Canada, about 25% of the total. Birch (1992: 11-12) suggests that this marks the beginning of a demographic trend in Canada, the addition of linguistic groups whose first language is neither English nor French, a trend which has subsequently accelerated since 1954.

Further diversification of source countries occurred in the early 1960's as the result of international pressures over Canada's discriminatory immigration practices (Birch 1992: 12). In response, the Canadian government removed the ban on Asian applicants and their immediate family. However, Canada's immigration policy continued to discriminate as European immigrants were allowed to sponsor not only immediate family but brothers, sisters, as well as nephews and nieces, if they were under twenty-one and unmarried. Further, only the British, Irish and American applicants did not have to meet criteria relating to employment skills and training.

The lifting of the ban on Asians did not result in an immediate increase in applicants from these non-traditional source countries, as there were only three visa offices in developing countries. Dramatic changes in the composition of newcomers to Canada did not occur until 1967, when the Canadian government developed a point system. These policy developments removed discriminatory privileges for British and American applicants and included the establishment of visa offices around the world. By 1990, Canada had visa offices in fifty-five countries, thirty-one of them in Latin America, Asia and Africa (Birch 1992: 13).

As a result of policy changes as well as the deterioration of political and economic conditions in many parts of the world, the major source countries for immigration to Canada continue to change. For the years 1987-90 (inclusive), over sixty-nine percent of Canadian immigrants came from 'non-white' source countries and only twelve percent from traditional 'white' European source countries. Current political changes in Eastern European countries will likely add to the mixture of source countries.

Presently, over one hundred different ethnic groups make up what is commonly referred to as the Canadian mosaic. In 1992, over 200,000 immigrants came to Canada, with over 140,000 classified according to governmental criteria as visible minorities. A five year plan for immigration rates for the years 1991-95 has admission allowances of

250,000 per year. A recent review of fertility rates in Canada by Health and Welfare Canada indicates that the planned levels of immigration will only have a modest effect on slowing the declining long-term population of Canada (Birch 1992: 16).

It is evident that for Canada, immigration is a continual reality. Moreover, Canada is increasingly becoming more culturally diverse. Despite the increasing plurality of Canadian society an explicit and recurring theme in both immigration policy and settlement services is the focus on economic criteria concerning language acquisition in relation to employment training and status.

Settlement Services

Historically, the responsibility for the regulation and management of immigration to Canada lay with the federal government. As a result, the major initiatives in the area of settlement service provision by government were first developed at the federal level, largely in response to the increasing socio-cultural diversity of immigrants. In a recent review of settlement services in Canada, Lamphier and Lukomskyj (1992: 6) suggest that it is a history marred by mismanagement with several federal government offices providing ostensibly different but in fact overlapping services.

The Federal government's involvement in the direct provision of settlement services began in 1950 with the establishment of the Department of Citizenship and Immigration. It was the first formal institution to regulate immigrant and refugee services. Services were limited and consisted of language training and information services regarding citizenship. These were delivered by the provincial departments of education with teaching costs equally shared by the federal government.

In 1965, the federal Department of Manpower and Immigration was established. As part of its mandate, the Department provided reception, family and employment counselling to individual immigrant workers and paid for the costs of language training for adult immigrants in the workforce. The federal Department of the Secretary of State was given the jurisdiction to provide for the social, political and cultural integration of immigrants. The Citizenship Branch of the Department sought to facilitate co-operation

with the provinces and voluntary organizations in the provision of classes in language training and citizenship. Outside of these facilitative activities, the regulation and management of immigration remained an exclusive federal responsibility and there was virtually no consultation with the provinces in policy-making and planning.

The central focus of settlement services has been to establish the 'breadwinner,' typically the male of the family, with the recipient continuing to receive services until formally employed. By implication, women for the most part were not considered for language training or other orientation services, although recently a similar realm of services have been offered to immigrant women. The focus on employment also excluded the elderly from obtaining language training. It was assumed that children's language training would be accomplished by the education system.

Presently, federal and provincial government are encouraging ethno-organizations to assume increasing responsibility for the provision of various support services to their specific communities. Governments are contracting these organizations to deliver language and orientation services, for instance. Opponents of these practices argue that this is largely an exercise in off-loading of government responsibility in direct service provision onto essentially volunteer based organizations. The realm of services offered by these organizations has been "dictated by government norms, not by initiative of organization" (Lamphier and Lukomskyj 1992: 16). It can be argued that this practice discourages some ethnic groups from interacting with the established medical and social service systems and removes pressure on the federal and provincial government to address the cultural biases of public institutions.

It should be noted that there are differences in entitlement and voluntary sector involvement based upon immigration laws, for example between refugee and independent class. In addition, some provinces have always been involved in settlement service provision; and there is a growing role for many provinces in funding and delivering settlement services (Frankel 1995 [Personnel communication]).

Summary

As the noted earlier, the early history of European immigration has meant that public institutions and practices in Canada have been fashioned to meet and regulate the social and cultural needs of a predominately white, Anglo-Saxon population. The dramatic shift in immigrant source countries from European to Asian Pacific Rim, Central and South American countries (Manitoba Immigration Bulletin 1992; CIEC 1990) in recent decades has placed increasing pressure on all levels of government to transform public institutions to reflect the multicultural nature of Canadian society. As the following chapter will demonstrate, immigration continues to be a challenge confronting the provision of both settlement and established mainstream services.

Chapter Five Linking Culture to Health Policy

This chapter discusses relevant aspects of federal and provincial policy concerning services for newcomers and analyzes the normative orientation of the established medical and social service systems. While public policy statements by government clearly express official recognition of the legitimacy and necessity of cultural consideration within public institutional processes and practices, on the other hand, as claim-making practices, I argue that government policies nevertheless contain and promote certain normative assumptions, as suggested by the theory discussed in Chapter 3. Both Canadian and Manitoban policy statements are reviewed, in particular the Manitoba health reform plan. Multicultural community criticisms of the plan are described, as are selected government stakeholder comments.

The latter part of the chapter brings in theoretical considerations from the literature of newcomer health care and anthropology in order to disprove prevalent mainstream assumptions about newcomer needs. Specifically, the assumption that 'special' programs for newcomers will only be required on a short term basis, is contrasted with the literature arguing that health attitudes, as part of the normative schema of perception and understanding, are well entrenched within individuals. The significance of participation in and control over health services and of social support for well being is documented to further argue that ongoing, parallel, culturally specific care is necessary. Finally, an increasingly popular, liberal based approach to making the health care system culturally accessible, as articulated by Masi, is critiqued.

Change and Stasis in Policy

Stimuli

Over the past two decades, the multicultural nature of Canadian society has emerged as one of the most important political issues facing the country. Many social groups are

presently challenging the current normative orientations of public institutions and services and are struggling to transform these mediating institutions to accommodate and reflect the plurality of needs present in a multicultural society.

The public call for change can be seen as part of a larger and broader confrontation between traditional institutional practices and various disadvantaged and disenfranchised groups in society. Within this milieu, new social movements have increasingly begun to articulate differing images of public and private life which challenge dominant notions of self and society. Greater recognition of the disadvantaged largely began and continues through the lobbying efforts of various groups representing not only ethnic minorities and aboriginal peoples of this country, but women, the aged, and persons with disabilities. They have sought to have their lives and needs understood through their own voices. These voices have begun to raise critical questions about the ways in which their experiences have been explained and subsequently treated in the public sphere through public policy and institutional practices.

The shared characteristic of all these groups is their concern with questions of group identity. As Habermas has pointed out, the *raison de'être* for these social groups or movements consists not only of the compensations that the welfare state can provide. Rather, the question is how to defend or reinstate endangered ways of life, or how to put reformed ways of life into practice. In short, the new conflicts are sparked not only by problems of redistribution, but also concern the grammar of forms of life (1981: 33). Habermas further notes that to understand these new social movements requires not only a focus on the questions regarding the call for recognition of group identity but must include consideration as to how these movements interact with the established institutions in society. In their attempts to locate some 'autonomous space' for the promotion of their needs within these institutional settings, they seek institutional change. The call for institutional change is amply evident in the health care system.

The challenge of the health care system to be responsive and sensitive to the plurality of needs can be linked to the historical importance of the issue of universal and equal access in Canada. Over the last century, in Canada as in many other western countries, access to health care has been extended as one component of the social rights of

citizenship (Marshall 1964). As part of the social contract of citizenship, the principles of equity and access for all to health care services supports an important ideological liberal tenet that everyone in society have an equal chance to succeed.

Soderstrom (1978) points out that universal and equal access health care service can be viewed as fundamental to the social constitution of Canadian society. He suggests that the identification of an individual's right to health care along with education promotes deep-seated assumptions about what it is to be Canadian. He further points to how these principles are historically constituted and have been promoted above other possible social concerns such as equal access to food, housing or the distribution of income and wealth. These liberal beliefs remain dominant despite increasing evidence in the public health literature (Evans and Stoddart 1990; Mustard 1991) that universal and equal access to health care services have less to do with wellbeing than do income distribution, self-esteem, coping skills and resources and perception of control over one's life. Within these social contexts and sets of belief, the emergence of the cross-cultural counselling program and similar 'culturally sensitive' services can be historically situated with other social issues facing the Canadian health and social service systems.

Canadian Government Policy Statements

Formal recognition of the multicultural nature of Canada is exhibited in federal government policy statements and legislative enactments. Beginning in 1960, prohibition of discrimination by reason of race, national origin, religion or sex was enacted through the passing of the Canadian Human Rights Act. In 1971, the federal government gave formal recognition to the diverse cultural nature of contemporary Canada through the adoption of a Multiculturalism Policy. Since then, the recognition of Canada as a multicultural society has been enacted in the Canadian Charter of Rights and Freedoms in the Constitution Act (1981). Further recognition came in 1988 when the Canadian Multiculturalism Act was proclaimed by Parliament.

But beyond the proclamations of these legislative enactments and policy documents, there remains a need to reorient the present realities of public institutions which shape

medical and social intervention practices and service delivery to Canadians. This was articulated in a recent statement by the federal Department of Multiculturalism and Citizenship Canada: "...health and social services should be...[made more] responsive to the needs of Canadians of all backgrounds" (1990: 21). Despite these enactments and affirmations, there is no policy or action plan as to how such a transformation will be accomplished.

Nevertheless, a clear understanding of how public policy serves to shape and organize specific patterns of social action and practice has been expressed at the federal level. The preface of the last substantive federal government document on health, the Epp Report "Achieving Health For All: A Framework for Health Promotion" (1986), openly acknowledges that

[t]he potential of public policy to influence people's everyday choices is considerable....[P]ublic policy has the power to provide people with opportunities for health as well as to deny them such opportunities. All policies, and hence all sectors, have a bearing on health (: 10).

In addition, the Epp Report provides a clear definition of how health should be considered and how it can be achieved:

Health is envisaged as a resource which gives people the ability to manage and even change their surroundings. This view of health recognizes the freedom of choice and emphasizes the role of individuals and communities in defining what health means to them....It is a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments (: 3).

To meet these health promotion challenges, the report cites three major strategies: fostering public participation, strengthening community health services and coordinating healthy public policy. Incorporated into this strategic framework is a "commitment to: reduce [economic and social] inequities, to extend the scope of prevention, and to help people to cope with their circumstances within environments conducive to their health" (1986: 12). Of primary interest to this study is the focus on 'healthy' public policy and the commitment to assisting people with 'their' circumstances. These concepts have been applied to the mental health field in a National Health and Welfare document entitled "Mental Health For Canadians: Striking a Balance" (1988). Based on the above principles

enunciated by the federal government, logic would suggest that the need to transform health care services to meet the plurality of needs is well recognized and understood.

Manitoba Government Pronouncements

On May 15, 1990, the Manitoba government released a policy document on multiculturalism. Of particular relevance to the considerations of this study are the following statements:

Government will work to provide services and programs that are sensitive to cultural values and traditions; government by its leadership, will encourage institutions throughout Manitoba to follow this example.

Government will consult with members and representatives of Manitoba's cultural communities in the development of programs and policies.

Government will involve the community in regular review and revision of its policies and programs to ensure that they continue to contribute to the achievement of the multicultural ideal.

Government will consult broadly among Manitoba's cultural communities to seek advice on the best approach to specific initiatives in the areas of multicultural health, education in the multicultural society and immigration settlement and adaptation.

In 1988, 1990 and 1992, the Manitoba government also released a series of guidelines for the reform of the mental health system. A core principle of reform proposed that "[m]ental health services should be provided in a way which respects and guarantee's the individual's dignity, legal and human rights, culture, age, gender and other significant individual rights and characteristics" (1992: 3). Beyond these recognitions, meaningful institutional reform which encompasses these considerations remains notably absent from the most recent strategies and efforts put forth by the provincial government.

The Manitoba Action Plan

In May 1992, the provincial government released its reform plan for the overall health care system, "Quality Health for Manitobans: The Action Plan." The 'shared goals'

of the plan are:

- To improve the general health status of all Manitobans
- To reduce inequalities in health status
- To establish public policy which promotes health
- To foster behavior which promotes health
- To foster environments which promote health
- To provide appropriate, effective and efficient health services
- To develop mechanisms to assess and monitor quality of care, utilization and cost-effectiveness
- To foster responsiveness and flexibility in the health care system
- To promote reasonable public expectations of health care
- To promote delivery of alternative and less expensive services (: 2)

The above goals reaffirm conventional knowledge about issues facing the health care system. Through a well-formed strategy, the action plan seeks to draw citizens' attention to these particular concerns and needs. By these efforts such policy pronouncements seek social recognition and trust that the government is expressing truthfulness and expressing claims that address the needs of all its citizens. However, the text of the Action Plan suggests a generic or atheoretical understanding of the way public policy, social environments and individual behavior all affect the ability of individuals to live a healthy life, and hence does not pursue the implications of relations of gender, ethnicity and class.

It reflects an institutionally based health care system which develops and delivers generically based services, despite the heterogeneous health needs of a socially diverse population. The plan is written as guidelines generalizable across society, ignoring mention of the implications of the stated goals. The primary implication I argue of shared goals like equalizing health status, is a move away from *uniformity* towards the development of *variety* in program resources, design and delivery so as to address the expressed needs of diverse populations. That this recognition is not made explicit suggests that the government's understanding of wellness is narrow. The idea of health being a social construct means more than that universal programs ought to change over time: it also means that health needs will vary across populations at any point in time.

Thus the claim of shared goals is problematic. There is no substantial articulation or understanding of how the interrelationship of the so-called shared goals serve to shape,

organize and concretize the ability of an individual or groups to live a healthy life. Gender, race and community are used as descriptors, but without acknowledging that these factors have implications for what appropriate services are because there exists plurality in terms of need. Concrete recognition of how culture, gender and other significant individual and group rights and characteristics structure and provide contexts for wellbeing and social action is absent from the government's framework. The combination of statements and omissions within the Action Plan presents a decontextualized view of society which is acultural and gender-neutral.

The Action Plan strategies offered by "the executive leaders of health services" (1992: VII) remain limited to themes which continue to embody the dominant discourse and practices which have historically shaped and organized health services in this province, a discourse predicated largely on the philosophy of liberalism. A basic assumption within the health care delivery system is that the range and types of services are universally accessible and socially and culturally appropriate for all consumers. However, the normative orientation of services generated under the present institutional framework is premised on a specific social and cultural belief system which reflects liberal notions of normalcy, self, and society.

Public Criticisms of the Action Plan

This does not mean that this dominant liberal approach to self, community, health and the interpretation of needs are not called into question by others. For example, in January, 1993 the Manitoba Council for Multicultural Health, a community based organization representing various ethnocultural communities in the province, held a public forum to discuss current health care reform initiatives of the provincial government. The roundtable discussion brought together approximately sixty individuals - health and social service providers, representatives from various ethnocultural communities, academics and other interested individuals, as well as representatives from the Department of Health. The intent of the forum was to allow for the articulation of interests by various ethnocultural groups and others regarding multicultural health issues in Manitoba.

The written synopsis of the roundtable discussion raises several important issues. In general, discussants stated that the current strategy employed by the provincial government is limited and that the development of the Action Plan does not meet needs as expressed by Manitobans. Discussants said that the government's consultation process with consumers has been limited and that participation by community organizations in policy formation, health service development and evaluation must be expanded and ongoing in order for public policy to reflect the specific needs of various geographic, cultural, social groups, and communities within Manitoba.

Based on the presentations made to the forum by senior representatives from the Department of Health, discussants concluded that policy makers do not have an adequate understanding of how the specific and various social experiences and cultural values of consumers are integral to the development of accessible and appropriate health care services. Government representatives misused terminology such as community based services in their remarks to the meeting. Discussants suggested that these presenters were describing generically developed services which are then delivered to communities rather than services that are generated in a community context. According to the discussants, the development of community based services requires the participation of community members in the designing of appropriate programs and services through an assessment of specific community needs. Moreover, community based services require that public participation must be ongoing and that services are governed by local community representatives.

In addition, discussants linked the present lack of participation by consumers and community organizations in health services delivery and reform to issues of consumer accessibility to appropriate medical and social services. Through the recounting of personal experiences, evidence was provided of the lack of cultural sensitivity throughout the medical and social service systems. This suggested that systematic efforts are required which would include, but not be limited to, a greater emphasis upon cultural sensitivity at all levels of the educational system, including the continuing education of professionals. Several individuals pointed to an "outcry of unmet needs" in their specific communities, and contended that many of these problems could be prevented or resolved through health

education and early intervention by appropriate service providers.

Summary

It is through the result of many similar struggles and efforts by social groups and concerned individuals to have their identities and needs properly understood and addressed by government policies and practices that the dominant beliefs embodied in the practices of institutional structures in society are challenged. The qualitative acknowledgement by the Manitoba provincial government that “health services should be provided in a way which respects and guarantee’s the individual’s dignity, legal and human rights, culture, age, gender and other significant individual rights and characteristics” (Government of Manitoba 1992: 3) is the result of such struggles. The absence of these recognitions in Manitoba’s formal health reform plan suggests the dominance of other stakeholder beliefs and interests in determining generalized needs and practices.

Programming Considerations

Interview Highlights: Government Representatives

Statements by representatives of the units of the provincial government which deliver mental health and immigration and settlement services exemplify how the needs of ethnic minorities become understood and subsumed under long standing, structural formations and practices. A senior official in Manitoba Health spoke supportively, during his interview for the CCCU evaluation, of the usefulness of the cross-cultural counselling program, as long as its service provision was directed at providing short term interpretive and referral services and the program did not become ‘a parallel service’ in competition with existing mental health services in Winnipeg. This situated and interpretive comment illustrates how the needs of specific groups or individuals can become framed and generalized into the belief systems and needs of others by existing institutional support and practices. Essentially, from this official’s perspective, the consumers of the counselling

program are expected to readily adapt to the range and type of services developed for and by other social groups. This key theme will be taken up again below.

A representative of the Mental Health Division of Manitoba Health gave his perspective on how new programs are accepted and sustained by the government. He suggested that the future of the cross-cultural counselling program and similar services was dependent to a large degree on public pressure. In his mind, government fiscal decision-making concerning the development or sustainment of new services are directly related to the amount and degree of popular pressure that is brought to bear on the government. Similarly, another official involved in the provision of community mental health services explained how the initial developments of culturally based services for newcomers during the early 1980's were the direct result of a "ground swell of community recognition, acceptance and pressure including support by various professional caregivers" (CCCU Evaluation Interview notes).

These comments suggest that the development of culturally based services that are qualitatively different from mainstream services are dependent upon contingent, albeit conventionally guided institutional structures and practices (Forester 1985: x). Analysis of the development of social policy must consider the realm of relations in which historically situated subjects have variously skewed chances, abilities and capacities for influencing social action and change (: xiv).

Manitoba Settlement Services

A lack of support at the institutional level for meaningful cultural and social reform of health services is evidenced by the limited public sector change in the various levels and areas of service provision, despite the public call for changes by various ethno-cultural organizations and concerned professional caregivers.

In the early 1980's the need for cultural awareness in the social and health care systems began to be recognized at all levels of society. Community concerns along with support from various professional caregivers resulted in the provincial government's establishment of the Immigrant Access Services (IAS) in 1985. The initial mandate of the

IAS was to do problem assessment for refugees and immigrants and make referrals to mainstream services. The mandate of IAS is currently under review, with the service changing its role to one of providing information rather than direct support to newcomers.

In the mental health care field, the Winnipeg Region of the Ministry of Health created a cultural liaison position in 1990 through the conversion of a generic community mental health worker. This position was filled by a psychiatric nurse who presently coordinates services such as translators for newcomers who are attempting to access generic mental health and vocational rehabilitation services.

The social agencies which provide specialized services to recently arrived immigrants deal primarily with issues of initial settlement. Services range from the provision of housing, clothing and food; language classes; and basic orientation vis a vis the various human and health services. Immigrants are expected within two to three years to function independently and to utilize services such as banking, employment, medical and various forms of social services. Beyond this initial support and information, settlement service agency assistance is limited. As Lamphier and Lukomskyj assert, despite changes over the years in settlement service provision, government policies and practices still consider resettlement as "a discrete period with limited services to be awarded to the newcomer" (1992: 15).

The Permanence of Variety

The next sections deal with the theoretical basis for culturally specific health care, in contrast to the views dominant within the health care field.

Ingrained Understandings

In contradistinction to the limited range and type of settlement services offered, newcomers bring with them to Canada their own cultural model of self and what constitutes wellbeing. Their conception of physical and mental health is intimately connected to their relationships with others in their community as well as socially learned patterns of

expression and expectation. It is through cultural resources and personal knowledge gained from past social experiences that newcomers establish ties with human services. It is also through these cultural and social understandings that their needs as individuals and as a social group are identified and reproduced. It follows that the core values of a belief system 'deeply structure' what constitutes a need within their particular social group or community (Habermas 1981; White 1988: 70).

Through the process of socialization, individuals develop normative schema - help seeking guides and practices - that inform how they interpret and subsequently address the social issues that arise throughout their lives. These normative schemata are socially constructed, indeed structured through the particular set of organizational arrangements and processes present in their social milieu. Organizational arrangements include but are not limited to the economy, the family, and gender relations. Each of these arrangements have their own specific processes and habits, though all are steered or linked together by the overall reproductive imperatives of the social system.

This is not to argue that individuals do not live within specific social relationships but rather that these relationships are submerged within broader social processes which influence the ways in which we function as individuals and just as importantly, how we have been taught to understand our lives (Walker 1990: 40). Formed within the context of particular organizational processes, these normative schemata are an integral part of the personality structure or social identity of the individual. The formation of normative schema may also be understood as a process of normative development. These processes also reproduce group identity through the acquisition by members of a society of elements of culturally recognized patterns of social understanding, action, and structures which reflect particular norms and values. In sum, these cultural patterns or normative elements provide the 'background of assumptions' through which socio-cultural understandings and values become cognitively internalized by individuals and it is also through these processes that society is symbolically reproduced.

The internalization of the background of assumptions in the form of normative schema contributes to the motivational basis for subsequent social action. In addition, it is on the basis of normative schema that particular actions are judged by individuals and social

groups as rational or not. Consequently, the emotional appraisal of events by individuals and groups, and how social experiences are cognitively coded by individuals and groups, and subsequently elicited by particular types of events (Mesquita and Frijda 1992: 180), is based on the normative schema acquired through socialization processes within a particular milieu. Thus, different individuals and groups may not only experience different kinds of events in their lifetime, but can be expected to be differently affected by similar events.

The Myth of (Quick) Assimilation

Implicit in both federal and provincial immigration and settlement policy and programs is that following the initial "self establishment" period, the newcomer will be on the "same footing as other Canadians" (interview notes senior government representative). A necessary assumption of self establishment is that the newcomer has begun to replace internalized cultural and social guidelines relating to the disclosure of personal information, expression of needs and help seeking behaviors, with the normative orientations of native born Canadians. After the initial settlement period, it is assumed that the newcomer's cultural guidelines and solutions for problem solving, learned from childhood, have been transformed and now generate new blueprints for action. But, as Stephen White argues, "It is simply not psychologically plausible...[that] individuals can change their basic need structures in a chameleon-like fashion" (1988: 78). This does not deny that individuals have the capacity to reflect on the relationship between a norm and the need satisfaction it implies, but does maintain that individuals cannot in situations of normative conflict, bring about a wholesale change of their entire need structure.

Yet the assumption of rapid change exists in spite of the difficulties faced by many individuals and groups who become citizens through various migration processes. For recently arrived newcomers, settlement services do not address the emotional difficulties which accompany many individuals to Canada. Nor do these services adequately address or serve to prevent other social problems which may follow resettlement and which can emerge years following their migration. For example, many issues facing newcomers are similar to those of native born Canadian but differ in respect to the cultural and social

context in which they are embedded. This aggravates issues, often causing additional stress and contributing to problems for immigrant families or individuals.

Social adaptation causes stress when the normative schema internalized by individuals are dissimilar and in conflict with values, norms and roles that are implicitly or explicitly found within the social processes and structures of his or her new homeland. For example, while similar event types such as insult, humiliation, employment status changes, bereavement and marital unfaithfulness may be of cultural concern and cause emotional stress for both newcomers and native born Canadians, these events types are perceived and operationalized by individuals and socio-cultural groups according to specific shared social meanings (Mesquita and Frijda 1992: 180). Moreover, the universe of event types which an individual or group is emotionally affected by is directly related to the particular individual's or group's belief system as well as their own particular domain of social experiences. Applied to issues of the prevention of mental distress and the enhancement of health, these considerations help to explicate the importance of socio-cultural support.

Social Support

The import of these considerations for wellbeing has been repeatedly demonstrated through empirical studies (Berkman 1985; Cohen and Syme 1985; Cohen and Willis 1985; House 1981) that have examined the significance of social relationships⁷ as a health resource. House, Umberson and Landis's review of the literature concludes that social relationships contribute to wellbeing, both as a buffer to stressors and by providing main or additive effects on health. They further suggest that "social relationships have effects on

⁷ Based on a review by House, Umberson and Landis (1988) of the literature on social support, I adopt "social relationships" as an umbrella term which includes various constructs such as social support, social integration and social networks as well as their definition of the latter constructs. Social support refers to the emotionally or instrumentally sustaining quality of social relationships. Social integration refers to the existence or quantity of social ties or relationships which can be distinguished by type and frequency of contact. Social network structure refers to the structure which characterizes a set of relationships. These structural properties may be either dyadic, for example the relationship between the focal person and another person, or network variables, for example relationships between the focal person and two or more others (: 293, 302).

mortality, and perhaps morbidity, which rival those of most other known biomedical and psychosocial risk factors" (1988: 300).

However, the literature which has examined social relationships has been largely considered through the perspectives of biological and psychological mechanisms (House et al 1988: 314). This research has increasingly argued that psychological and perhaps even biological factors may be the underlying structures and processes of social relationships. Based on these premises, such perspectives have argued that physically or psychologically healthy individuals are assumed to be better able to establish and maintain supportive social relationships (: 309).

House et al suggest that while such assertions are appealing, relatively little empirical data has been made available to support them and that much of the available evidence contradicts such assertions. They point to how prospective studies (Billings and Moos 1982; Kaplan et al 1987; Lin and Ensel 1984; Pearlin et al 1981) have repeatedly demonstrated that controls for physical health status "cannot explain away the predictive impact of social integration on health" (House et al 1988: 309).

House et al also take exception to a number of psychologists (e.g. Hansson et al 1984, Heller 1979, Sarason et al 1986) who have asserted that the perception, structure and content of social relationships may be related more to the dispositional characteristics of the person than to social environment. While agreeing that personal skills and dispositions of individuals can affect their ability to maintain and sustain social relationships, House et al see little reason for the suggestion that dispositional characteristics can account for all or the majority of the effects of social integration or support on health. Rather they point to how "[p]sychologists tend to assume that personality dispositions are causally prior to current social circumstances". These psychologists have based their premises on cross-sectional data which does not allow for the determination of causal relationships between variables. Few studies have attempted to prospectively study personality and social relationship variables in relation to health, and "those that have done so have found that the associations of social relationships with health generally persist even with controls for personality" (House et al 1988: 309-310, see also Cohen et al 1986; Holahan and Moos 1981; Kessler and Essex 1979; Schulz and Decker 1985).

Despite these specific criticisms, House et al believe that the determinants of social relationships structures and processes are multifactorial and include biological, psychological and social factors. However, their review of the literature suggests that the recent literature has considered social relationships “almost exclusively as an independent, mediating and moderating variable”. They argue for the need to consider social relationships also as dependent variables of institutional processes, as well as seeing social relationships as independent causes or determinants of health. To complement biological and psychological understandings of social relationships, “attention[should be] paid to *how macrostructures and processes give rise to these more microsocial relationships and supports* [House et al.’s emphasis]” (: 301).

Studies examining the relationship between socio-cultural support and newcomer health have reached similar conclusions. The Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, based on a review of the literature, concluded that along with issues pertaining to socio-economic status, social support was one of “the most effective measures for preventing mental ill health...and enhance[ing] positive psychosocial adaptation” (1988: i). The review presents research which has demonstrated that ethno-cultural communities can provide necessary social and cultural support to newcomers through affirming the cultural and personal identity of newcomers which in turn helps to protect their mental health. In addition, it has been shown that newcomers “who settle in an area where their ethnic group has established a significant community, experience lower levels of distress and are much less likely to be hospitalized for a mental disorder” as compared to newcomers who do not have similar cultural resources present in their community (Canadian Task Force, 1988 (b): 17).

This common sense notion of social support by a like ethnic community can be extended to the issue of the importance of how cultural understandings and social processes are integral to the promotion of health. As Ferreira (1963) and Reiss (1981) have pointed out, the ethnicity of the newcomer guides the process of social adaptation. Chambon notes that “[e]thnicity is part of the...identity. Ethnicity shapes the...family themes and myths as much as family members’ roles and the rules of interaction” (1986: 4). In other words, ethnicity can be seen as a symbolic structure which provides continuity

and consistency for personal identity, while at the same time reproducing individual and collective identity.

Based on these understandings, it is apparent that public recognition and measures to resolve many health issues confronting individuals and social groups within the Canadian mosaic must adequately consider the socio-cultural basis of such issues. Numerous studies focusing on newcomer health have demonstrated that the efficacy of policies and programs is dependent on culturally appropriate resources and services delivered by providers who are culturally sensitive (Canadian Task Force 1988b: 18).

The logic of these findings should not be restricted to newcomer health issues but should also be applied to the consideration of program design and delivery for other socio-cultural groups which exist in Canada. Nor should these findings be applied only to possible sources of social support provided from individuals or groups within communities. Rather these understandings should be extended to the cultural orientations of the public institutions which serve to reproduce public space and subsequent service and resource provisions. Culturally appropriate services *are* a form of social support.

Critiquing the Liberal Approach

However, the dominant approach to addressing the cultural challenge to established service systems remains limited to a focus on the social interaction between the health care provider and the consumer. This liberal approach to addressing cultural challenges to public institutional knowledge and practices is apparent in the conventional strategy of culturally sensitizing the established medical and social service systems.

There is some danger in categorizing what has developed into a substantial body of literature concerning cultural considerations related to health care service delivery over the past decade. There are a variety of theoretical and political commitments to change in these works, ranging from those who promote a liberal approach which focuses on provider and consumer interaction, exemplified by Masi (1993), to those who have explicitly called for systemic change (Lock 1993; Anderson et al 1991). However, the latter group may be distinguished from the former, based on their explicit recognition that issues concerning

access to health care services and the promotion of health are determined by a broader set of social relations which simultaneously structure and organize the medical and social service systems.

The preeminent approach in Canada appears to be one of 'culturally sensitizing' the existing systems of health and social services. This liberal approach operationalizes culture as a variable which can be melded onto the existing service systems through the practice of culturally sensitizing practitioners and/or providing language/interpreter services. From this perspective, culture is seen to be related to the thoughts and ideas which guide the actions of individuals as well to the products of social interaction. While this viewpoint recognizes that the ideas and actions of institutions may not represent the cultural beliefs of all members of society, it argues that these obstacles or barriers can be overcome through culturally sensitive service providers.

Such insights contain the heart of a reasoned argument; culturally sensitive health professionals are an important issue. However, this approach casts insufficient light on how cultural meanings are appropriated, shaped and distributed through social, economic, and political processes (Brittan and Maynard 1984: 20). While many of the proponents of this 'sensitized' approach acknowledge that cultural differences exist among service organizations, practitioners and consumers, they appear to be situation indifferent. They do not take into active consideration how broader sets of social relations may influence the accessibility of the system for certain individuals and social groups.

To illustrate my argument, I have chosen to critique Masi's (1993) discussion of 'multicultural health principles and policies', since his approach is reflective of many other health professionals' also working in this area. He offers a framework of analysis which examines culture and health at the individual and community level. At the level of the individual, his analysis contains four areas of concern: a) risk of genetically inherited disorders; b) biological variation; c) mortality and morbidity risks; and d) verbal and non-verbal clues (translation, body language, mannerisms). If misinterpreted, these latter factors may lead to communicative difficulties between provider and consumer.

Beyond the mention (which he does not explicate) of the risk of miscommunication between the provider and consumer of health services, Masi offers little insight into the

range and complexity of communicative issues which may confront a newcomer attempting to access the established service system. The focus remains limited to the service encounter between the provider and the consumer.

Despite Masi's purported interest in the interaction between culture and care, the framework analyzes individual issues by way of genes, death and disease - the cultural discourse of science. Nowhere in this discussion are considerations concerning the social and normative implications of such discursive practices, or recognition that the problem of access is a consequence of the larger set of social relations which determines the socio-organizational structure and processes within which the interaction between the provider and consumer occurs. Further, Masi fails to recognize how the microinteraction between the provider and the consumer may help to reproduce a subjectivity which failed to adequately recognize the socio-cultural basis of health promotion.

At the level of community, Masi maps out four additional areas of concern: a) culturally sensitive health information; b) hours of operation; c) community norms and values (here, he specifically cites the need for some cultural groups to be given time to understand the patterns of acceptable behaviour such as normal patterns of family life in Canada.); d) consideration of community and individual interactions to the mode of service delivery. Masi submits that service delivery should correspond to the cultural orientation of a particular community in terms of whether the mode of service delivery should focus on the individual, family or the community. While he cites the need to consider the particular community's conception of the relationship of the individual to the community, Masi's units of analysis remain opaque as descriptors of socio-cultural factors or determinants of health. In this regard Masi fails to acknowledge that the process and desired outcome of his approach is not cultural reciprocity but rather cultural assimilation mediated in part through culturally sensitive service encounters.

For example, left undefined, Masi's statement concerning time needed for adjustment suggests that newcomers should assimilate into the 'normal' Canadian way of doing things. Accommodation for the cultural other is to be provided mainly through time and encouragement for individual adaptation. The system adjusts for the cultural other through adjusting hours of operation and the unit of analysis it caters to - be it the

individual, family or the community. It would appear that normative or contextual considerations beyond the choice of the unit of analysis, are secondary or not to be addressed.

Masi's considerations only highlight the obvious, that cultural differences do exist. His framework of analysis provides no substantive insight or explanation into the complex interrelationship of society, culture and health. Moreover, at the formative level of health care service delivery, Masi fails to articulate the limitations of the current medical care system which reflects the dominant liberal approach regarding access to medical care and social services and resources.

I contend that Masi's considerations have the appearance of resolution, if the discussion of health service 'access and equality' is limited to the goal of opening doors to the established service systems. Essentially, this approach is based on assimilation mediated through professional practice. In the end, the individual is expected to address his/her difficulties according to the normative and organizational practices of the established service system. The normative basis of the institutional environment goes unquestioned after the acknowledgement of cultural others. The socio-cultural basis of access difficulties are often reduced to generic problems like lack of information or language skills on behalf of the health care service consumer. Despite the recognition of cultural diversity, from this position, institutional/service differentiation which reflects social, cultural and ethnic differences (Jayasuriya 1987: 494) is not considered.

Arguments such as Masi's are instructive at the level of health service delivery only if one accepts that the established health service delivery is otherwise universally accessible, integrative and redistributive. However, at the level of substantive equality of health, such assumptions fail to consider broader issues such as the social context of illness and equality of outcome.⁸

For example, Anderson et al (1991: 102) have demonstrated that even when

⁸ Jayasuriya (1987) states that substantive equality is concerned with equality of outcome. Based on the tenets of substantive equality, health needs assessment would be considered in relation to achieving equality of outcome. On the other hand, procedural equality stresses issues of access and equality of opportunity. Based on the procedural (or liberal) notion of equality, the Canadian health care system is a universal system. Proponents of this claim point to the range of health services which are free at the point of delivery. However, at the same time they fail to consider the limited normative basis of these services.

cultural differences are apparent, the process of managing illness is primarily influenced by economic circumstances and social support or lack thereof from family, friends and employers as well as medical and social service providers. In other words, the social circumstances of individuals influence their ability to achieve both equality of treatment and distribution of health services and resources. Further, individuals from the same ethnic category do not necessarily share the same cultural meanings about illness nor do they manage their illness in identical fashion. In addition, some individuals and social groups, especially those who are non-English speaking, are excluded from understanding the discourse of science and practice of Western medicine as these individuals do not share the dominant ideas of society which the discourse of science reflects (: 111).

The realm of solutions considered by proponents of the 'culturally sensitive' approach as articulated by health professionals such as Masi, is in part related to the scientific paradigm and organizational practices of their profession. Whatever their aims, health care professionals will usually take their ideas about health care provision from the stock of knowledge characteristic of their profession at the time. These pressures often result in the grafting of new considerations such as cultural accessibility onto the organizational and knowledge practices of the larger health care system dominant in their part of the world.

It should also be noted that even within the normative jurisdiction of science, the ability of western medicine to solve a wide array of health problems such as chronic health conditions, has been openly challenged. Increasing evidence points to the overall importance of the social environment as a health determinant/indicator for individuals and communities to 'produce and consume health' (Evans And Stoddart 1990; Mustard 1991).

At the same time, I would like to acknowledge the efficacy of many medical practices. However as Hennen cautions (1992: ix) in his assessment of western medicine "one third of today's medical interventions have been found by modern scientific methods to be of established benefit, one third are of uncertain benefit and one third are suspect of not being beneficial at all", some healthy skepticism is needed.

What has been raised here is a series of issues which need to be addressed if public institutions and service provisions are to be transformed to reflect the plurality of social

needs in a multicultural society. The beginning of the cross-cultural program, like that of similar services initiated by newcomer groups and concerned individuals, demonstrates a process common to the institutionalization of the gains made by social movements. Recognition of the neglected needs of individuals and groups in society occurs almost exclusively due to the efforts and struggles of those directly affected. How these needs are eventually understood and subsequently defined by public institutions however, will inevitably be merged with the belief system of those who define and construct the boundaries of need within these institutions. Yet typically those who provide identification and solution to a problem or set of needs are outside the boundaries of that problem. Informing their decisions are value structures entailing subjective notions of normality and social obligation that are generally not those of the group affected by the issue, and this is problematic.

Chapter Six The Program Users' Needs

The purpose of this chapter is twofold. First, I will present a description of the socio-demographics of the counselling program's clients, their presenting problems and referral patterns, and offer insights from a review of the literature on social factors related to migrant mental health issues. This presentation allows the reader to begin to compare the social characteristics and difficulties of the clientele of the program against the patterns of needs interpretation of public policies and practices which were introduced and examined earlier. Next the chapter will present, through the voices of newcomers, their experiences with various medical and social service agencies. In addition, the perspective of service providers, both settlement workers and health care professionals, who had referred individuals to the cross cultural counselling program are presented. The latter provides an intermediary perspective between the views of clients who had identified the contributions that the counselling program has made to their lives, and the overall orientation of the medical and social service systems.

The intention is to present the differentiated patterns of how mental health needs are articulated by the three 'user' groups and to contrast them with 'the institutionalized patterns of interpretation' (McCarthy 1987) which emanate from the established human service environments.

Description of Clients

The Table 6.0 (see below) presents statistics for service use for both the number of clients seen during the demonstration year of the program (February 15, 1991 to February 28, 1992) and during the evaluation period (June 1, 1991 to February 28, 1992).

The majority of services were offered at the Clinic during Mount Carmel's hours of operation, though a considerable amount of time and effort was allocated to various

Table 6.0 Clients - Cases and Sessions

	<u>TIME PERIOD</u>	
	<u>FEB. 15, 1991 - FEB. 28, 1992</u>	<u>JUNE 1, 1991 - FEB. 28, 1992</u>
<u>Number of Cases</u>	147	109
<u>Number of Sessions</u>	714	455
<u>Mean Sessions per Case</u>	4.85	4.17
<u>No. of Sessions/Case > 10</u>	12	
<u>No. of Sessions/Case = 1</u>	17	
<u>No. of Referrals to External Agencies</u>		51

1. The number of referrals to an external agencies (for appropriate service) may be greater due to problems with record keeping by program staff. Further, The total number of clients (N) differs among the tables. This is the result of two factors. First, the thesis uses documented information which best describes the characteristics of the program and for this reason, additional information collected outside of the evaluation period of the evaluation study is included where applicable. Second, the evaluation forms and instruments which were to be routinely completed by the counsellors were not done for all of the clients seen by the program during the evaluation period. Third, data for clients who dropped out of the program will not be available for each table.

outreach activities including health promotion/education with students, various professional groups, and ethno-cultural communities and organizations. distribution. The client population is distributed over a span of several months to over a decade. This is clearly consistent with the findings indicating that difficulties with social adaptation can occur at almost any time during the life-long resettlement process.

Clients ranged in age from 5 years to 72 years of age with the largest percentage (39.3%) falling into the 36 to 64 years age range and the second largest percentage (26.3%) falling into the 26 to 35 years age range. The sample was 44.3% male and 55.7% female. The largest percentage (36.7%) of clients were married, with the second largest percentage (30.4%) of clients reported as single. Thirty-one percent of the clients could speak no English or 'only a few words'. The clients' ability to speak English ranged from 8.1% 'who could speak no English' to 23.0% 'who could speak a few words' to 25.0% who spoke enough to get by' to 15.4% 'who spoke English fairly well' with only 28.5% being fluent in English. It is important to note that English fluency does not necessarily mean cultural competency in the Canadian health care system. The majority of clients (39.1%) were full-time students with 37.1% of clients were unemployed or underemployed.

Clients of the CCCU come from 26 different source countries. The client population is predominately from Central and South America though newcomers from Africa and Asia make up a significant proportion of the client load (see Table 6.1). Clearly the CCCU is considered an important source of mental health care throughout most of the newcomer communities.

The absence of clients from Southeast Asia (ie. China, Vietnam, Cambodia, Laos) reflects several problems. First, the CCCU did not have a counsellor from any of these cultural areas. Second, the meaning of mental illness in the Southeast Asian context is a factor. Many individuals from this cultural group believe that it is 'disgraceful' to seek help for personal difficulties outside of familial resources and that even to think about their problems is harmful to their mental health. Consequently, negative stigma and social

Table 6.1 Country of Origin (N=139)

TWENTY SIX DIFFERENT SOURCE COUNTRIES - El Salvador, Chile, Guatemala, Nicaragua, Zaire, Ethiopia, Eriteria, Nigeria, Libya, South Africa, Sudan, Afghanistan, Egypt, Iraq, Iran, Lebanon, India, Italy, Poland, Rumania, Philippines, Argentina, Peru, Portugal, Trinidad.

Clients from:	Central America	79 (56.8%)	[El Salvador 68 (44%)]
	Africa	26 (18.7%)	
	Asia	16 (11.5%)	
	South America	14 (10.0%)	
	Europe	<u>4 (2.8%)</u>	
	TOTAL	139 (100%)	

meaning likely contribute an enormous barrier to accessing the CCCU for this population (Uba 1982: 215).

Table 6.2 illustrates that CCCU clientele are neither exclusively recent arrivals nor long-term residents, although over 63% of the clients have been in Canada less than three years. The skewness of 1.731 indicates an asymmetry toward the higher values as compared to a normal distribution. The range of problems identified by the counsellor after first assessment of a client is presented in Table 6.3 below. As would be expected from the program model, most clients sought assistance for adjustment and problems in social interaction within the family. It is important to note that the type and severity of problems of CCCU consumers are constructed by the counsellors of the CCCU and not by the researcher.

Some of the sources of stress which contributed to these problems are likely related to the experience of social adaptation which interacts with the normative developmental processes of the immigrant family or individual. The process of social adaptation can be seen as overlapping with the normative developmental stages of the life-cycle. Contributing to these presenting problems are the migration related experiences and circumstances of clients. For example, cultural differences or linguistic difficulties with a new language may contribute to mental health difficulties. Families may be fragmented as some families have not been able to migrate as a unit. Intergenerational problems may result from adolescents receiving more exposure to the new cultural norms and roles through schools as compared to their parents.

As well for some clients, the long term sequelae of post traumatic stress can interfere with their attempts to adjust to their new homeland. Persons who have been subjected to the experience of a natural disaster, war, or political persecution including torture or the disappearance of family members may suffer from post traumatic stress reactions. These reactions may "manifest themselves through nightmares, numbing of feelings and overwhelming feelings of guilt" (Epsin 1987: 495). It is important to note that post traumatic stress and similar difficulties "are often manifested several years after

Table 6.2 Time in Canada (N = 145)

Months in Canada	Number of Clients	Percentage of Clients	Cumulative % of Clients
0 to 6	31	21.4%	21.4%
7 to 12	23	16.0%	37.4%
13 to 18	10	6.9%	44.3%
19 to 24	9	6.2%	50.5%
25 to 30	5	3.5%	54.0%
31 to 36	14	9.7%	63.7%
37 to 60	14	9.7%	73.4%
61 to 120	21	14.5%	87.9%
> 120	<u>18</u>	<u>12.6%</u>	_____
	145		100.0%

1. Range = .08 years to 23 years
2. Mean = 4.21 years
3. Median = 2.00 years
4. Mode = 3.00 years
5. Standard Deviation = 5.04 years
6. Standard Error = 5.04 7. Skewness = 1.7315

Table 6.3 Presenting Problems

<u>TYPE</u>	<u>NUMBER</u>	<u>PERCENT</u>
1. ADJUSTMENT	28	19.4
2. MARITAL	28	19.4
3. FAMILY	23	16.0
4. DEPRESSION	19	13.2
5. POST TRAUMATIC STRESS DISORDER	11	7.6
6. ANXIETY	7	4.9
7. EMOTIONAL	5	3.5
8. PERSONALITY DISORDER	5	3.5
9. EDUCATIONAL	4	2.8
10. LEGAL	4	2.8
11. PSYCHO-SOMATIC	3	2.1
12. ASSESSMENT	3	2.1
13. TORTURE	2	1.4
14. SOCIAL	1	.7
15. ABUSE	<u>1</u>	<u>.7</u>
TOTAL	144	100.0%

the occurrence” of the traumatic events and clients may not recognize the link between present difficulties and previous events (Chambon 1986: 5).

Summary of Referral Patterns

Clients were referred to the CCCU program from five major sources: 1) Self or Friend; 2) Specialized immigrant serving agencies - Immigrant Access Service, International Centre, Interfaith, Immigrant Womens Association of Manitoba (IWAM), Immigrant Womens Employment Centre (IWEC), Refugee Settlement Unit of Canada Employment and Immigration, Immigrant and Refugee Community Organization of Manitoba (IRCOM); 3) Mainstream Health care providers - general practioners, psychiatrists, psychologists; 4) Mount Carmel Clinic; 5) Generic non-health, human service agencies - such as Child and Family Services, Worker’s Compensation, School Division #1, Legal. (See Table 6.4 below.)

Table 6.4 Source of Referral

SOURCE OF REFERRAL	NUMBER OF REFERRALS	PERCENTAGE OF REFERRALS
1. Self	6	25.5%
2. Friend	12	8.5%
3. Social Services ⁹	27	19.1%
4. Social Services ¹⁰	6	4.3%
5. Mount Carmel	23	6.3%
6. Medical	17	12.1%
7. Legal	9	6.4%
8. Cultural Organization	7	5.0%
9. Educational	<u>3</u>	<u>2.1%</u>
TOTAL	141	100.0%

* Total Referrals from Self or Friend n = 48 (34.0%)

Total Referrals from Social Services n = 33 (23.4%)

Total Referrals from Medical n = 25 (17.2%)

⁹ Social Services designed for specific needs of newcomers - International Centre, Interfaith, IRCOM, Immigrants' Women Employment Centre.

¹⁰ Social Services [Mainstream] - Child and Family Services, Workers' Compensation Board, Hospital Social Work Department.

The proportion of self referrals including those based on the advice of a friend indicates that the level of awareness of the service in various ethnocultural communities and organizations is reasonably high. Community awareness of the program also reflects the benefits of outreach work done by the CCCU with various cultural groups and organizations. In comparison, 1985 data from Family Services of Winnipeg indicates that 35% of clients were self-referred or referred by family or friends. Data from the government community mental health program in the Winnipeg region, however, indicates that for March 1992, under 10% of clients were self-referred or referred by a friend. This would suggest that as a new program, the CCCU has been reasonably successful in generating community awareness.

The high level of referrals from settlement agencies demonstrate that the CCCU is meeting many mental health needs that cannot be provided through settlement services. Referrals to the CCCU from legal and educational sources indicate not only a perceived need for cross-cultural counselling by these agencies but also a perception that alternative mental health resources may not be available in the mainstream mental health system. The above themes are further supported and explicated in statements from clients and service providers as described after the next section.

Social Factors for Newcomers

The range and complexity of the issues affecting clients of the counselling program suggests that attention be paid to how social factors related to the decision and experience of migration have affected the lifeworld of these individuals and continue to influence their lives and their health. Consideration must also be paid to how the social world in which they now live influences their ability to live a healthy life. Institutional processes help to shape the social context of the lifeworld of social groups and individuals by promoting certain relationships and supports, and neglecting or constraining others.

Adjusting to the new social context of their everyday lives in Canada may contribute to stressful social circumstances and subsequent health problems. The social context of life can be seen to consist of dimensions which serve to influence the ability of

an individual to live a healthy life. These dimensions are constructed and shaped through social processes such as the constitution and relations of gender, race, and ethnicity. Providing both boundary and interpretive force to these dimensions are the specific socio-cultural understandings held by individuals.

The importance of these dimensions to their lives and their health status become visible in their interactions with employment opportunities, human service systems and with other members within the society. The outcomes of these interactions can be also be understood as health determinants as they contribute factors or social contexts which have direct implications for health status. Several authors have demonstrated that issues such as feelings of self esteem and self worth, hierarchical position and control over one's life or conversely powerlessness are major contributors to health status (Evans and Stoddart 1990; Mustard 1991).

It is also important to view these social constructs from an interactive model. For example, the simultaneous experience of the social implications of race and gender for women may not only compound oppression but reconstitute it (Williams 1987: 13). Penning (1983) and Gerber (1983) have demonstrated that for elderly women, who are also members of a visible ethnic minority group, the social circumstances and dilemmas associated with their social position may present a 'multiple jeopardy' to their ability to lead a healthy life.

Results of Migration

Added to these considerations are social circumstances related to the migration process. Factors such as family dislocation, loss of networks of kinship and social associations as a direct consequence of migration, reduce an individual's social resources for support and friendship (Canadian Task Force 1988 (a): 15-22). Even the development of new friendships and social ties may be frustrating for some newcomers because of differing cultural expectations attached to friendships (Munoz 1980: 227).

Confusion over social identity may also arise due to new social demands including the presence of unfamiliar languages and different cultural ways of expression and patterns

of behavior of the new social world. It is through the use of language that social and cultural life is reproduced. The inability to communicate leads not only to the inability to coordinate one's actions with those of others but also contributes to a loss of the range of self expression available to the individual. As a consequence, the social identity of the individual may be challenged as their previously learned social skills and strategies for agency may be inappropriate or go unrecognized in their new homeland, resulting in stress (Mirdal 1984: 992-993). This points to the need to understand the migrant mental health issues in Canada, through migrants' previously learned coping strategies and resources of social support (Chan 1984).

There is a substantial body of literature showing that additional threats to self-identity may occur when patterns of behavior such as normative based roles ascribed by gender and age differ significantly between former homeland countries and resettlement countries (Walter 1981, Roskies 1978, Mirdal 1985; Morokvasic 1984). Changes in familial patterns have been associated with increased stressed for both men and women (Canadian Task Force 1988 (b): 7).

The Effect of Violence

Furthermore, the majority of the clients of the counselling program have migrated from war torn countries. How these individuals understand their present emotional issues and social circumstances is rooted in these past social experiences. In addition to family dislocation and loss of social networks, some individuals do not know whether their family and friends are dead or alive. Many of them have lived in areas where the chronic conditions of political violence have affected the way they now understand and interpret their lives.

A theoretical framework through which to understand the influence of the chronic threat of violence and uncertainty has been proposed by Levett (1987: 80). Based on the examination of surveys on child sexual abuse among girls, Levett found not only found high rates of sexual abuse and the widely accepted conclusion that sexual abuse causes psychological distress; she also uncovered the interesting anomaly that the rate of recorded

levels of distress were higher than reported levels of abuse. In addressing the latter finding, Levett suggests that while the experience of sexual abuse may result in psychological distress, the socialization process leading to the expectation of abuse, may by itself be a primary contributor to distress, whether or not abuse actually occurs. This contextual approach to understanding the effects of stress stands in contrast to the conventional linear causal model which assumes a direct relationship between stressors and responses, a perspective which for the most part ignores the interactive dimensions of the social context in which such relationships are mediated.

In a subsequent study, Schwartz and Levett (1989) applied this contextual perspective to explicate the effects of political repression on children in South Africa. They point to the everyday conditions under which children grow up in South Africa, and found that "living in what has been termed as a structurally violent society could produce psychological sequelae, not very different from those of acute experience". From this contextual framework, individuals may become psychological victims, simply by growing up in a society where such forms of violence occur and are directed towards their particular social group (: 747).

In a similar fashion, Jenkins (1991) argues forcefully for the need to explicate how present mental health difficulties of many refugees are the consequences of the embodiment of a political ethos, constructed by state sanctioned violence in their former homeland. Based on the plight of Salvadoran refugees in the United States, Jenkins argues that their present difficulties must be viewed within a framework which acknowledges how the actions of the state in their native country "have threatened their personal, familial and cultural survival." (Additionally, many hold the state in which they now currently reside largely responsible for the present and historical situation of chronic violence and poverty in their former homeland). Jenkins also concludes that political violence need not to be directly or acutely experienced to be experienced personally and to have long lasting, damaging affects on the lifeworld and health of individuals (: 140).

Based on these considerations, the effects of chronic repression and violence may continue in the phenomenological world of the refugee and be expressed through the sequelae of socio-psychological problems. For these reasons, political repression should not be

seen as a discrete event which is resolved through migration. For some individuals and social groups, different combinations or permutations of these factors may continue to influence their ability to live a healthy life, long after their physical relocation to a new homeland is completed. Given the reality of war, and the associated psychological difficulties and dilemmas which accompany the experiences of chronic violence, it should not be difficult to appreciate the enduring hardships of refugees. It is also important not to view these individuals in a restricted sense as victims, but rather as strong and resilient individuals whose personal histories are exemplified by the ability to overcome experiences and circumstances (which at times seem incomprehensible to those of us living in relatively peaceful settings). Finally, the issues confronting these individuals are rooted within a broad set of social processes and circumstances which continue to provide definition and interpretive force to their lives and struggles.

Perspectives of Newcomers

The following six case studies range from recently arrived refugees to non-native born Canadian citizens with over two decades of residence in Canada. These examples illustrate the need to understand adaptation from a range of perspectives including age, gender and familial considerations. It should be stressed that while each individual case is unique, problems of social adaptation depicted in the case studies are typical of the experiences of other clients of the program, and are strongly suggestive of the plurality of unmet needs in our multicultural society.

Generally, the respondents stated that they required a culturally responsive health service for their health problems which resulted from social adaptation and migration experiences. Access to health and social services was identified as an issue, as the health care or social worker approach to problem identification and treatment was seen to be not fully cognizant of, or does not acknowledge, the newcomer's lived experiences which to them may be related both conceptually and emotionally to the difficulties which they are presently experiencing. Despite a basic knowledge provided by settlement agencies of what mainstream services Canadian society offers, many individuals base their decisions

on previously learned strategies and orientations of help seeking (Lin et al 1982: 78). Newcomers require information and assistance to discover and adjust to how their difficulties are presently dealt with in Canada.

The majority of clients spoke¹¹ of difficulties of access to proper care caused by their own and mainstream service providers misunderstandings based on cultural and linguistic differences and differing life experiences. As one client remarked, the established service systems “assume North American norms and...ways” and do not consider the profound influence of culture and social experience on the experience and expression of mental health problems. Cultural and linguistic differences resulted, in some instances, in clients receiving inappropriate treatment and medication.

The first case example illustrates that while cultural and linguistic differences are to be expected, the normative orientations of newcomers are rarely accommodated in institutional responses to adaptational difficulties. The narrative reveals how an individual adjusts to new situations and circumstances through reflection upon prior social experience and internalized cultural understandings. Based on these dynamics both the motives of help seeking behavior and the interpretation of health and social services are formed.

Case Study I

Mr. B. is a 45 year old married engineer who arrived in Canada five years ago from Africa. He came to the CCCU for assistance after having learned about the program at an ethnocultural community meeting. He explained that following his arrival to Canada he had become increasingly frustrated. He felt this was the result of the loss of the familiar life context which he and his family used to identify with and utilize for social support in decision-making. Added to his difficulties was his inability to find employment and provide for his family. “In our culture unless you work you are considered a beggar....We are not considered as people until we can do something -- you cannot live here like this.” The cumulative effect of these various stressors was becoming too great for him and his

¹¹ The following quotes from clients, settlement workers and health care professionals are taken from CCCU Evaluation Interview notes.

family to bear and was leading to a breakdown in his relationship with his wife.

Mr. B. viewed his difficulties in conjunction with each other. This stands in contrast to how the tendency of the established service system is to fragment and separate problems according to the institutional patterns of interpretation.

He spoke appreciatively of how his CCCU counsellor helped him to understand the issues surrounding his distress:

Psychologically and socially....[c]oming here [to the CCCU] helps me with the culture and system and how it works...[This] service guides me [as to] how I should live in Canada. It saves me from wrong tensions. I don't think I understood how to handle these tensions....Before I came here I was really frustrated.

When asked if there was another place he could have gone for assistance, he reported that he wouldn't go anywhere - "I don't believe that there is anyone who understands us." Asked about his previous experience with health providers he replied, "The doctor can check you but he cannot understand the internal or psychological; these professionals need other professionals who have cultural experience or advice." He did not feel comfortable with the services he and his wife had used.

The main problem is that we cannot understand how they approach our problems. This may even be worse for some of our people who may have language problems. Even an interpreter may not work as he may be able to [only] explain the medical terms. For these reasons, we cannot find good service....There is a need for professionals...who know both cultures and can help the patient understand what the doctor's approach is and what the patient feels is the problem. Cultural background is important. In some backgrounds of problems you need to understand culture to advise....Language is very important as there are many things we cannot express by English but through our language we can explain a lot.

To overcome problems of social adaptation and prevent psychological distress he suggested that newcomers "need help to get to know culture...[They] need courses....A lot of people, a lot of women don't leave their home for eight to nine months; they are afraid to go out as they don't understand the culture or the system; they are in prison."

Mr. B's case illustrates his perception of the causes of his mental health problems as well as his experience with mainstream health providers. A constituent factor influencing his experience is the issue of access - to the care, the services and the support

he needs to live his life. In his case, as in many others, his distress is based on adjustment difficulties due to his employment status. Further compounding his stress is the lack of adequate access to educational resources to learn a new language and a new cultural set of guidelines so as to to gain an adequate understanding of 'how the system works.'

Another issue of access for some individuals may be the lack of knowledge of existing services. Outreach services are needed to ensure an awareness of the program(s) as well as to inform some cultural groups as to how certain social and health difficulties may be dealt with in a Canadian context. Mr. B., like many other immigrants, came to Canada with preconceived strategies of help seeking and patterns of social support which differ from the normative basis of help seeking behavior of other Canadians. When questioned on this subject, Mr. B. replied, "In our country there are elders who we ask - have consultation with them - or [we] go to church and pray... That's all." With the unavailability of former resources of care and support, new strategies of help seeking must be developed. The fact that he learned of the CCCU at a community meeting of his ethnocultural organization further illustrates this point.

Case Study II

Ms. M., a refugee from Central America, experienced a similar loss of social support and resources. She began by recalling how the cultural and linguistic differences between her and the new homeland were immediately apparent:

At the beginning we were disoriented. We didn't know how different the country was. The language was a big problem. We came here. We go to learn the language, to attend classes and we thought we could get some jobs. We understood we were different. We did not understand how different we would be.

Beyond cultural and linguistic differences, she cited the lack of former associations of family and friendship as contributing to feelings of alienation and isolation in Canada. She noted how she used to draw on these social resources to resolve difficulties.

We don't have any friends here. We are isolated. Very much is different. On one hand [there is the] problem of friendship. I thought we going to

come to a similar life. We don't have friends, there is the problem of language, the problem of getting a job. Even the climate is so different....In my former country I would talk to friends, use to trust friends there. We could talk about our problems which is not the situation here. Could go to church where we could receive some counselling. Here no friends and no church available - there are no services in Spanish, priest don't speak enough Spanish to understand problems.

She makes more comparisons of the differences between the two social worlds. Attempts are made to find continuity between the past and present experiences within the social dimensions of a new milieu and are interpreted through an embodied socio-cultural self of another social world.

Maybe I think what has affected me and many other people is to be thinking all the time about those differences, how life was like back in our country. How it is here....Thinking and thinking affects our physical health.

She commented on the difficulties of finding appropriate care givers for her particular problems which at times has led to the inappropriate prescription of medication.

I don't think that I have enough information about what kinds of doctors we can visit for what types of problems. Before coming here [to the Clinic I'd] seen many doctors. I have visited even naturalistic providers - a herbalist. So far no one has helped...for problems. I couldn't heal for problems that I was asking help for....For example, the doctor provides some medication but was not for my problem. Medication provoked side effects, and I had to go to emergency.

I think one of the main problems is that doctors don't pay attention enough to the problems of the clients. They listen briefly and then go and prescribe very quickly medication, without knowing the problems of the client....I would like to see doctors pay more attention to problems that the clients tell them so they take care of them...properly.

She went on to describe how, in contrast, the counsellor assisted her through the use of cultural resources:

On one hand, my counsellor has helped me to understand how my thinking can influence my physical wellbeing and how reorienting my thought in a proper way I can effect my body's functioning.

It's a matter of language and culture, only through this can I explain myself. Other people have tried before but cannot get my message across....Culture is important. My problem is they do not understand the customs we relate there....Here we are not understood.

Case Study III

Mr. C. is a 58 year old technician who moved from a Latin American country to Canada nearly two decades ago. He spoke of how his life is still 'rooted' to past experiences and the social ways of his former homeland. Beyond demonstrating the long term processes of social adaptation, this case illustrates the connection between Mr. C's personal history, how and why help was sought, and how generic human services responded to his troubles. His case further demonstrates how motives of help seeking and the interpretation of care giving are based on expectations derived from previous experiences. In his former country, Mr. C "used to fix problems at home, always with parents whom we would trust; better education when family close." The move to Canada removed these former sources of support.

Mr. C.'s motivation is oriented to his own wellbeing as well as creating or maintaining institutions such as his family life in which his conception of proper behavior and a good life with others is viable. The functional importance of this aspect of his social needs for his wellbeing were not recognized by certain caregivers. Like many others interviewed, his experience with the health care system involved a bio-medical management of his difficulties - a characteristic pattern of unnecessary drug and medical service utilization. "I saw different types of doctors, all different case treatments like drugs -- Valium...though nothing changed in my life." His search for help began seven years ago when the first doctor he visited thought he was an alcoholic. He describes the situation: "[The doctor]...treated me by pill, when I had a problem fighting with my wife [the doctor] gave me another pill....My second step: I went to church. I went. Then I didn't go. I was still having the same problems. Social adaptation was the problem."

Eventually a friend suggested that he go and see a counsellor at the CCCU. After some initial hesitation, he finally went to see a counsellor at the CCCU and has since resolved his problems.

I am a new man now, my life has changed in six months....Now I'm studying and working....My son is coming back home, my wife had ask[ed] for a divorce, but now is happy with me. Before I had so much hate in my heart. Now...I have a new life. I was really sad, my friend. You want to eliminate yourself because you create so much problems to the

people you love.

He perceived the problem as a misunderstanding between the mainstream health professional and the patient based on differing cultural and social values and beliefs.

[The doctors] don't go to the social level, they put problem into the universal. My counsellor was able to look for a reason for my attitude. It was positive to talk to him, he was able to take garbage out of myself, to understand though it took time. The key here is the language. I can communicate my feelings when the heart speaks....An interpreter is no good. The communication does not work. It would lose the feeling of expression which is needed between a sick person and doctor. Person expresses through the body and facial expressions, but you lose this through interpreters.

Case Study IV

Mr. G. came to Canada from Nicaragua. He notes how his difficulties are related to the socio-political processes of his former country as well as those in his new homeland. He left his former country due to persecution. Now in Canada, he faces another form of discrimination, as his family members have not been allowed to join him. His narrative highlights how the separation from family members is a primary factor influencing his health.

When I applied for a visa I believed after a few months my family would arrive here. But this has not happened. I have been here now nine months. [Asked whether these experiences affected his health:] 100%. When I left my country I was really nervous and tense because I was persecuted. Now here, I face another problem because I am frustrated. It's cheating the refugees who came here because when we arrive here we see the difference to what one was told and what the reality is. But not just in my case. We cannot learn 100% English and so have spent many sleepless nights. I don't feel any appetite. Sometimes, sometimes I feel the need to leave the country. I don't know why the government doesn't listen to us. A lot of people are here 3-4 years waiting for family to arrive. I don't feel I can stand it or handle it. That's why I seek help here to help handle it.

Further complicating his ability to live a healthy life is the lack of appropriate cultural and linguistic assistance from the established medical and social service systems.

It is painful to realize that we don't receive the services or medication we ask for. Because of language barriers it is difficult for us to visit a doctor who only speaks English. Many times we cannot explain to the doctor

what is the problem. You need always the help of a translator.

The assistance that he sought from the counsellor was how to handle the tension and stress he was experiencing over his separation from his family who remained in Nicaragua.

Well it helps me to feel relaxed, free from the tensions and anxiety which now I can actually stand. It helps me with the problem I have. I cannot speak properly. [He had begun to stutter during the war.]

Case Study V

The fifth example is of a recent refugee from the Middle East, who is suffering from the trauma of war, a condition exacerbated by her social isolation in Canada. This case pointedly outlines the plight of refugees whose adjustment to a new culture and language is further complicated by past traumatic experiences, dislocation from former sources of social support and involuntary migration. The migration experiences of the refugee is one of personal trauma, rapid change and cultural disorientation (Chambon 1986: 3).

Ms. Z., a refugee from Iran, was referred to the CCCU by a settlement worker at the Manitoba Interfaith Immigration Council. She arrived in Canada two years ago as a refugee. Her experience prior to arriving in Canada involved not only political oppression and economic deprivation but was also profoundly cultural. Like other refugees she had witnessed horrifying events on a daily basis. Her former way of life based on previously learned beliefs and principles no longer provided any certainties. Her relocation to Canada did not resolve her personal, social and cultural difficulties. In Canada, her customary sources of social support were not to be found. Her own behavior was not interpreted by others as it was intended. She became increasingly troubled, unable to make sense of the ways of her new homeland.

As a result of her particular experiences as a refugee and the social isolation she has experienced since coming to Canada, she came to the CCCU severely disabled. At that time she did not verbally communicate with her counsellor, as she had lost confidence in her ability to understand her environment and the intentions and actions of others. Initially,

she would sit and listen to her counsellor and leave following the session often without speaking a word. During my interview with her later in her therapy she quietly spoke of how she needed language assistance and help “to do basic things to help organize [her] life.” Coming for assistance at the CCCU, she explained,

helps to empty myself, with someone to talk to about problems. It helps to relax, to calm down....It helps to give me more confidence. I needed to know what to know to get better. [Here she was commenting on how she needed help to] be more informed about Canadian culture, education, about the economy - how to get a job, about the law,...how to live in Canada.

Like others individuals, refugees often seek help for personal problems such as depression or conflicts with others. However, underlying these problems are the particular experiences and circumstances surrounding their migration experience which they commonly do not recognize as being associated with their present difficulties. In addition, many refugees have enormous difficulties recounting their migration experience to others who have not shared similar histories because they feel this experience will not be believed nor comprehended. Mental health professionals who have worked with refugees have found that the opportunity to voice “what was sometimes felt as unspeakable...and to be believed can provide enormous relief for these individuals” (Epsin 1987: 495).

Case Study VI

Ms. A. came to Canada fourteen years ago from South America as a refugee but differs from many other refugees in that she was from an urban area, university educated and is integrated into a community of friends in Winnipeg. Of particular note is her continued preference to have her needs addressed socio-culturally. Moreover, her narrative is based on first hand experience of the established service system and her own personal struggle to promote the recognition of unaddressed needs of newcomers.

I don't have the special needs of the majority of refugees. Most immigrants have someone here, a whole community to back them up. Refugees don't have anyone. They don't know the language or the system. Their basic needs are more crucial, eg. some have concentration camp syndrome. Canada is far behind in these types of treatment.

She spoke of the need to provide culturally appropriate services for more recently arrived social groups in Canada:

I would like to see a more comprehensive family counselling program for immigrants- when people come from a particular culture and immigrate to another they bring with them their own customs and traditions. Mainstream society doesn't take this into account - they presume North American norms and democratic ways... I think it would be devastating for other people because of cultural differences....Language is very important - using a different language loses meanings.

Providing additional challenge to the ability of the newcomer to live a healthy life are the social consequences of migration. The social resources and networks and patterns of behavior that were available in her home country do not exist here.

In my home country, there was family and extended family to help with problems. Here we have nuclear families and it's only their problem. In our home country the whole community was involved. The perception of authority is completely different. There father is regarded with such authority.

The migration experience affected familial relations especially in the area of employment.

[The immigration experience] affects the relationships between men and women.

There is a switch in the economic sector: here most of the service sector employs women not men. This is a change from their tradition where men are the breadwinners. Here men cannot find a job but women can. This is a slap in the face for men on top of all the other problems an individual may have. Statistically the employment rate is increasing more for women than for men but income is less.

She explained that her education placed her at an advantage:

I feel comfortable with what I know now though I don't know everything. This is not the case for most immigrant women, even for women who are coming to Canada now. I should point out I don't know how representative [I am] of the immigrant community as I came here as a professional, [that] I'm an exception was a plus for me. A peasant woman barely speaks our own language- their problems and issues are therefore more crucial than my own. Although the period it took to settle was short, yet these women, [who knows] if ever they will feel comfortable in this society.

Despite these advantages she experienced difficulties in receiving appropriate care following her arrival in Canada:

I was pregnant when I came to Canada. There wasn't any gynecologist who spoke Spanish who could attend to my delivery. I went to a general doctor who spoke Spanish, but it caused lots of problems. I went into the labor room and at the last moment they asked me to do things I didn't understand. This lack of knowledge led me to injure myself and I was lucky I didn't lose my child. Luckily now there are prenatal classes offered by Mount Carmel and Planned Parenthood -- better service for particular needs.

She cited gaps in the range of services:

One of the things that bothers me is the total lack of services for victims of torture. Most victims are males who are the head of a family, and though the experience [is] only his, the experience affected the whole family. There are lots of families breaking up because the individual is not treated in time. This service is crucial. Our community is crying out for this service. It is well expressed in Cambodian, Vietnamese, Salvadoran communities. There needs to be a more comprehensive program for torture victims for all communities, each would be unique. The problem is a time bomb especially in the Salvadoran community - young people in their late teens, early twenties, mainly males, spent 2-3 years in concentration camps. Most of their childhood and teen years spent in the horrible conditions of concentration camps. They may look normal and have built in defense mechanisms but the problems will lead to the formation of gangs, increased prostitution and the spread of AIDS. Victims don't want to talk about the need to reach out to family, to talk to parents....Amazingly we can see who is and who is not a political prisoner by what area you lived in [in El Salvador]. We estimate 20% are victims of torture but none are getting help.

Summary of Client Issues

The specific issues raised by clients, while diverse and numerous, may be summarized as follows:

1) Inaccessibility of the health and social service systems. Despite a basic knowledge provided by settlement agencies of what mainstream services Canadian society offers, many individuals base their decisions on previously learned strategies and orientations of help seeking. It is only after problems have arisen that these individuals begin to realize that former approaches are no longer available to them. It is at this time that they require information and assistance to discover and adjust to how their difficulties can be dealt with in Canada. Moreover, newcomers require instruction beyond the organizational

framework and functioning of the human service environments. They require information concerning the underlying normative processes which guide the established service system environments.

2) The majority of individuals spoke of difficulties of access to proper care caused by misunderstandings both on their own part and on the part of certain service providers based on cultural and linguistic differences and differing life experiences. These recognitions have been repeatedly demonstrated in the literature (Brown 1987; Elgie and Montgomery 1985; Cohen 1981; Downie 1983). Further, these studies have pointed to the need for the current service system to provide programs which are culturally appropriate and delivered by service providers who are culturally sensitive.

3) As compared to the Western view of psycho-social problems and practices, for many newcomers, the same social and health issues may be perceived and expressed through a traditional cultural orientation of physical complaints - somatization. Expressed by newcomers as a medical problem, these difficulties were often misinterpreted by providers resulting in the prescribing of drugs and unwarranted utilization of bio-medical services. The short time spent with the health care provider was cited as a factor contributing to misunderstandings.

4) While an individual's realm of difficulties may involve the consideration of multiple dimensions and features which to the individual may be understood both conceptually and emotionally as inextricably intertwined, the tendency of the established service system is to separate and treat such issues within different organizational frameworks and settings.

5) There is presently a dearth of services for refugees. As the Canadian Task Force on migrant mental health issues pointed out there is a need for specialized services aimed at and within this population group (1988 (b): 9).

6) Similar to other Canadians, the health status of newcomers is related to various health

determinants: physical needs such as the provision of food and housing; social resources such as education and social support; as well as economic factors such as employment status and income distribution.

Perspectives of Referral Agents

This section contributes additional detail to the dialogue of needs interpretation and service provision. Based on their everyday experiences, settlement service providers and other social service providers describe how the social processes of the established service system addresses the concerns of newcomers and how the human service system attempts to regulate and manage the health consequences of the social system. Further, they portray how an individual's understanding of issues, while affecting their ability to live a healthy life, are embedded in the normative structures which they also draw upon for their identity. These considerations strongly suggest the need to treat as problematic the socio-cultural biases of the normative orientation of the dominant institutions of society which function to regulate and maintain specific norms and patterns of behavior.

According to these settlement workers, many of whom are newcomers themselves to Canada, the mental health needs of newcomers must be understood through a socio-cultural perspective. In addition, the issues raised by these respondents illustrate the need to appreciate the 'socio-political construction' of newcomers' difficulties (Farias 1991: 167; Jenkins 1991: 139) including pre and post-migratory experiences. These issues stand in stark contrast to the realm of services offered by the various social agencies which provide specialized services to recently arrived immigrants. Generally these agencies deal primarily with issues of initial settlement. Services range from provision of housing, clothing and food, to language classes, to a basic orientation as to how various human and health services work. Immigrants are expected usually within two to three years, to function independently and to utilize services such as banking, employment, medical and various forms of social services. Beyond this initial support and information, settlement service agency assistance is limited.

This suggests the need to view the range of issues not only through the first person

perspective of the difficulties of individuals or the family unit which currently dominates the literature on issues affecting the mental health of newcomers. It must also consider however, the same set of issues through a social perspective which focuses on the normative orientation of the social processes which guide the established public institutions and practices and the range and provision of health and social services. This approach stands in contrast to the majority of clinical and community based studies where the theoretical foci is limited to unitary individual characteristics (Canadian Task Force 1988 (b): 16).

Many of the workers pointed to how the health of the newcomer is related to her or his ability to participate effectively in society. The responses provide an understanding of how the "mental health needs of newcomers are diverse as a person's wellbeing is related to the person's ability to function in the community" (Evaluation - Interview Notes). Like other Canadians, the health status of newcomers is related to various health determinants: physical needs such as the provision of food and housing; social resources such as education and social support; as well as economic factors such as employment status and income distribution.

A settlement worker who co-ordinates a range of information based services for immigrants described the current settlement service sector for newcomers:

Basically, services are aimed at settlement assistance which provides job searches, basic settlement such as the International Centre, and InterFaith, with some projects like IRCOM that provide housing targeted for refugees with special needs. Other than that there is not much else. There is a mental health multicultural specialist who works with newcomers who are experiencing extreme difficulties.

[T]here are a lot of limitations as services are only targeted for very recently arrived newcomers which provide basic settlement needs and orientation. [There is a] lack of specialized services with the mental health area being a good example.

She tied the issue of the limitations of services to the dearth of understanding on the part of policy makers concerning the complexities of the adaptation process. The present realm of services neglects the socio-emotive aspects of adaptation and the need for the establishment of new associations of support and assistance.

There is a lack of understanding. [The] main problem is with a policy maker's belief...that newcomers, after a short two to three years, are able to integrate into our society. But the majority require a much longer time to integrate than is being assumed....Establishing life from point zero is quite difficult when one does not have enough support and one feels unwanted here -- thinks he is a burden to society. Here lots of problems could be prevented.

According to other service providers, the dearth and limitations of services for newcomers is complemented by the inaccessibility of the established service system. A settlement worker who counsels immigrant women stated that the established mental health service system is inaccessible for many social groups as a result of cultural and linguistic differences between care providers and consumers. To overcome these barriers she suggested that the health system requires care providers who are culturally sensitive and cognizant of the social basis of difficulties as well as the current limitations of the service environment.

Mental health system doesn't have access because of culture and language and a lack of professionals who work with newcomers. The system is very hard to get into.

The differences are in culture and language. They have specific needs which are very difficult to access services for as their issues are different. [It is similar to] native relations - lost dignity and esteem, they go into a vicious cycle of becoming victims of the system financially and otherwise. They get involved in alcoholism and related violence....[Mainstream service providers] never understood their issues, that they were damaged [in such a way] that it takes them a long time to get control over their lives. [In addition to] adaptation to a new country, they have higher expectations which they brought here and are not met and then they get depressed, as well as suffering from discrimination because their beliefs differ from those of mainstream Canadians. This in turns affects their self esteem.

A big group are those who are refugees who have experienced torture or jail - all persecuted because of ideas. It sometimes becomes a crisis here. It can come after 2, 3, or 5 years [and may be exhibited through] experiences of other symptoms- eating sleeping, ulcers, headaches....As an immigrant woman myself, my concern is that the emphasis is often on helping the head of the family with the wife being left out. She is often worried about her husband but because of the focus on the head of the family, she and the children are left out.

A settlement worker who came to Canada as a refugee has observed several problematic features of the current institutional approach to adaptational issues affecting

newcomers. From his standpoint, the orientation of immigration services does not adequately consider the socio-emotive aspects of adjustment. Rather services for immigrants are geared toward providing the physical aspects of resettlement such as housing; processing the newcomer into the established information systems; and the limited provision of second language training within the first six months to a year of their arrival in Canada.

There is a lot of misconception about adaptation and adjustment [for newcomers]. The ability to speak the language doesn't mean the individual has adjusted, it takes longer to adjust emotionally. Within the first year of arrival or 1st month they receive a basic orientation at the International Centre and Inter Faith, and are provided with a social insurance number, medical card and moved here or into a house. He/she then takes ESL for six months. Normally then we would try to locate them in the labour market. Due to the economic situation there are no jobs.

For many newcomers the basis of their difficulties centered on the lack of information to adequately understand the normative orientation of Canadian society. The established service system provides a description of the structural functioning of the society through the provision of its services, but it does little to promote an understanding of the underlying normative processes. Lack of information concerning the social patterns and behaviors of the new social world directly impacts their ability to live a healthy life.

The cause isn't really a medical problem but it is psychologically and emotionally - it is a sociological problem. They don't know how to socialize in Canadian society. They are locked in outer space: have direction but cannot go in that other direction because gravity is zero.

He stated the need to broaden the provision of services to consider the socio-cultural experiences of the newcomer. He points to the historical and cultural contingencies which shape the identity of the newcomer and influence their ability to adapt to new situations and cultural contexts.

Mental health among newcomers has been affected. [They] bring with them problems along with the implementation process which is very vague. We must deal with these issues differently as they are not rooted in health but deeply rooted in the experience they went through, the emotional experience, turmoil and [they must learn to] look back deal with these experiences effectively. A high percentage of refugees are affected by the social, economic and political situations in their homeland - many are victims of torture. They have come here without much support and

assistance and after their arrival here they start another stage. We need to assist them to keep moving along their journey. These efforts need to be more concrete and solid....

Based on his own personal experiences, he pointed to how mental health needs are contextually embedded, culturally understood and expressed by newcomers. He notes that this recognition is in contrast with the acultural claims of the medical model which guides the established service system - "Yet, based on the concept of what mental health is in the medical model, there is no difference between any culture." He argued forcefully that the cultural basis and values of the medical model become noticeably problematic when cultural differences separate the health care provider and the consumer.

But culturally, one of the issues is that when the mental health professional is dealing with a patient, there are two sets of values [those of provider and client]. How to reconcile these differences? How can the health professional assist the patient to understand what mental health means, as this is a very significant word. We have to identify at what stage a mental health professional is needed [as well as] where a boundary may be drawn between the client and the professional. How can the client influence the professional and the professional influence the client to change information/understanding as they both fall back on their own culture as it is the safe place and can be protected and defended - a place not usually open to outsiders.

He further added that the understanding of newcomers' difficulties should not be restricted to cultural differences. The socio-political construction of newcomer experiences must also be appreciated and accommodated. He reflected on his own experiences and how they affected his health:

In my life, during 1972-75, for three years as I went back and forth to school in my former country, I would see blood and war, and experience life and death. I am not scared of death anymore. Linked to this experience is a feeling of the complexity of emotions from joyfulness to sadness to feelings of guilt for leaving, which lead to my mental health [problems and] is a very natural process. All refugees experience turmoil, resistance of anti-colonialism, war, starvation. This is the majority of experiences of the immigrant. The refugee has no protection at all. 80-85% experience mental health problems.

In the case of a refugee client, he suggested that such experiences may create additional barriers between the provider and the consumer which may further impede the recognition, understanding, and appreciation for the social basis of the newcomer's experiences:

It is very difficult for a mental health professional to understand the experience, the history of being colonized. The professional who is

Canadian never experienced colonization, never experienced torture.

A settlement worker from an employment training centre for immigrant women points out the stages newcomers pass through in adjusting to a new country:

Following the honeymoon period [six months after arrival] their new found reality is one of the need to accept the new system. For many individuals the first six months involve ESL classes with the rest of their time spent at home depressed no matter what ESL level they come from.

She further stated that the recognition of the stages must be accompanied by service provision which accommodates cultural differences in the conceptualization and expression of mental health. These considerations must be further combined with the allowance of time required by individuals and social groups to trust and accept service resources and providers. Conjointly these factors contribute to the the utilization of services and the disclosure of difficulties by newcomers and their willingness to seek assistance.

The mental health needs of newcomers are expressed differently. Mental health problems are usually hidden, doesn't surface...not comfortable with it. No one raises the issue, the need for available help, and a lot of them keep it inside themselves. They keep faulting the system rather than realizing that they need to begin to work within. [Furthermore] they have a lot of fear in dealing with the establishment, be it medical or government.

To overcome the impediments of current approaches to the provision of assistance to newcomers, she suggested that "newcomers need services through their mother tongue to explore their new life, which in turns offers a glimpse of the life they have known - 'where I came from.'"

Another worker saw that the mental health system was starting to move in the direction of awareness of deeper cultural needs but further improvement was needed. Using the CCCU as an example, the worker suggested that even at this exemplary service, caregivers need to be more cognizant of the differing life experiences of newcomers. The CCCU was sometimes seen as "getting too technical, adopting more of a North American approach". The worker stated,t

These individuals who are seeking help need more of an explanation of why they are experiencing these issues. For example, [the North American] cultural norm of choices, the choice of freedom to choose, to decide, did not exist for them. They now have to make choices and they feel a great deal of stress in having to make

choices. Three to four clients have come back to use our service have talked highly about the CCCU but a common remark among them is that I don't know what he [the counsellor] is talking about. Maybe more time is needed in explaining the stages of adaptation and how this is related to how they feel....[The service provision] has become too elevated, they forget who they are talking to, [the counsellor] needs to go down to their level. [Many clients] don't feel comfortable enough to ask him what he is saying. Usually comments have been very positive and we [our service] have used them [CCCU] extensively.

If a service as well-developed as the CCCU occasionally has problems in reaching clients at a level and context suitable to the client, it is little wonder that most settlement workers hesitate to refer people to mainstream agencies. One worker voiced this concern by offering the following explanation:

[You] can't refer them to anywhere else as other places don't have the language facilitation or cultural understandings, and for these reasons we hesitate to refer an individual to mainstream services. If we refer these people to mainstream, do these refugees trust these agencies? Most do not trust anyone because [of] their experience of being betrayed even with people who speak the same language. They fear that their family background may...[jeopardize them] even if they have been here for a long period of time. The CCCU shortens this period of time needed to develop trust between the counselor and these people as the CCCU service understands where these people come from, who they are, what they went through - [service provision through mainstream] may require a longer time ...[for] the mental health professional to establish trust and understanding.

These considerations point to how both social experiences and normative orientations shape help seeking behavior and interpretation of health and social services. Based on these considerations, settlement workers commented on the need to provide support through community-based forms of outreach work fitted to various cultural groups, organizations and communities, and thereby assure them of the legitimacy of their problems and need for service. Many felt that the CCCU was the only service that would be trusted to do this kind of outreach work.

The mental health needs of newcomers are expressed differently. Mental health problems are usually hidden, [don't]...surface....[they're] not comfortable with it. No one raises the issue, the need for...help, a lot of them keep it inside themselves, they keep faulting the system rather than realizing that

they need to begin to work within.

From the perspective of a mainstream service provider, a worker from Winnipeg Child and Family Services supported alternative approaches to 'generic service' intervention and realized the need to refer these individuals to a culturally appropriate service for further counselling. The worker recognized that resolution of the problem would lie in examining and working within the validity of cultural claims and explanations offered by the clients. To achieve this, she sought a culturally informed service provider with whom her clients could share a common understanding necessary to examine the grounds upon which their position and actions are based. The worker remarked that "someone who is not...[from] that culture...would have taken months to get ahead."

The implications of the above cases for the provision of multicultural mental health services are considerable. In general, the experience of immigration is potentially stressful and the disruptive effects upon one's way of life may last anywhere from several months to a lifetime. Experiences of dislocation and migration may become problematic long after relocation to a new homeland has been functionally established. Enveloping these issues of adaptation is the need for policy makers to fully appreciate the profound differences in the normative orientation of new Canadians.

Perspectives of Mainstream Health Care Service Providers

This section presents the interpretation of needs concerning mental health issues affecting newcomers from the perspectives of four mainstream health care providers who have provided professional assistance to newcomers.

The following comments are from a psychiatric nurse. Her position entails the coordination of services such as translators, for newcomers who are attempting to access generic mental health services and vocational rehabilitation services. When questioned about the mental health needs of newcomers she reflected upon her own work:

I pick up cases who have been here 10, 20, 40 years who still speak their own language and culture. I must ask how these people have been treated.

These comments provide further evidence that despite having almost spent an entire lifetime in Canada, many individuals continue to interpret their needs and solutions according to the culture in which they were first socialized.

She went on to comment from her perspective of the need to reorient these individuals' understanding of their problems to the conventional institutional framework of the established service system, and the difficulties inherent in achieving this objective. These remarks reflect the liberal approach of attempting to meld cultural considerations to the existing institutional practices. To reiterate this approach is for the most part, is limited to the addition of service providers who have trained to become sensitive to cultural differences and through the provision of language interpreters. However, it is expected that over time, the individual patient will be converted over to the belief system of the established service systems.

These people require a lot more attention...given language and some cultural barriers. I encounter religious cultural beliefs....These individuals are not willing to accept western psychology or medicine. I have to work through these beliefs to gain their acceptance.

[Problems of access] are related to language and cultural barriers, red tape: who to talk to. There is a need for someone to act on their behalf, to break some barriers around access, not only for immigrants and refugees. Appropriate language services, information are necessary. We need to have in place, not mental health providers for each country, but people who are sensitive to other people's cultures; increase awareness among workers, mental health workers about cultural backgrounds. More time is needed to gain information as often we lack information about family background and [therefore] hit and miss with treatment. Eg., is it an adjustment or schizophrenia problem?

No [language is not important]. I have dealt with all sorts of cultures and language groups and this did not prevent treatment or medication to stabilize the individual. It's not a major problem.

The following comments are from a native born Canadian psychiatrist, who within his own hospital based practice has provided services to immigrants and refugees. Essentially, he believes that newcomers have the same mental health needs as other Canadians, though he acknowledges at the same time that some individuals within certain subpopulations may have specific needs related to their experience as an immigrant or

refugee.

The vulnerabilities are the same. What some may require are language services. First issue is the problems of barriers to access and receiving services that are generally available to the population as a whole. In addition there are specific needs that are related to the experience of being an immigrant or refugee that are unique to newcomers and may lead to mental health problems and require services.

The unique experiences of immigrants and refugees translate into specific problems of family disruption, trauma, feelings of guilt for having moved, to finding oneself in a new place.

[Further] mental health problems like family and sexual problems are by their very nature extremely tied to individuals' worldview as compared to sickness and injuries.

He further commented on the importance of language and cultural considerations in relation to appropriate service provision.

Culture is always a factor. It is not always manifested. It may be invisible as the client may not want to show it and I don't know how to see it. For example, the client doesn't believe in maintenance of medication. They get better [feel better] and stop using it. Sometimes it is necessary or useful but it is not possible to examine the cultural normative structure of some individuals.

He went on to point out the issue of intracultural variability between service providers and consumers who share similar cultural backgrounds and how such pairing does not necessarily remove all the cultural barriers between the two participants. Even among individuals who share similar cultural backgrounds, social differences between the service provider and consumers may exist and preclude appropriate service provision. His remarks point that it not only newcomers who feel that many public resources and services are either unavailable or socially inappropriate. In short, he argued that certain assumptions within the debate over the need for cultural similarity between provider and consumer were overly simplistic and required further consideration.

It is not just group but individually oriented. The ability to understand an individual is limited to how deep you get into the other person's moccasins. There is a mythology that some services/approaches don't take the cultural background of the client into account and others do. Even when for those who work with clients of the same cultural, social and political background there are still gaps in understanding and culture. The more differences between a therapist and a client exist, the more barriers there are to overcome. However it may be easier to remain more conscious of the

differences. Many people won't seek service and this is true for newcomers and a variety of people. There are other people who will refuse any form of services that involves individuals from their own cultural and linguistic background. For example I have seen a number of clergy people who seek non-Catholic service providers.

He went on to admit that institutions have their own particular subculture which may present access barriers to service provision for populations who do not share like-minded or similar cultural understandings of help-seeking and needs interpretation.

Also there are institutional subcultures. System issues may differ on the definition of what is the problem, the means of help-seeking and what constitutes seeking help in different cultures.

[The current health care system responds to newcomer needs] partially and in a variable way. The present mental health system deals with certain numbers of newcomers to the best of its abilities. There are many people we don't see for a variety of reasons. These are not addressed due to one, failing access. Other issues are that the individuals seen receive service that is highly variable and takes place over a gulf of language, culture, worldviews, secrecy. There are also unintended repetitions of experiences that are like oppression - aspects of institutional services that unintentionally reproduced and echo traumatic experiences suffered in the past. Mainstream services are not deliberately abusive, neglectful or racist in dealing with newcomers but they are sometimes unintentionally heavy handed and counter therapeutic. Mainstream services don't fit the needs, worldviews or experiences of newcomers.

These latter comments point to the lack of reflection on the part of the established service system to consider its own social and cultural orientation to problem definition, identification and the realms of solutions provided to individuals seeking professional assistance.

Approaching the issue from a system perspective however, he did not believe the answer to appropriate service provision for the different subcultural groups which exist in Canada would be achieved through the provision of culturally specific services.

This won't be solved in a larger way by providing culturally specific services. It's a mulberry bush. Race, gender, sexual orientation, and cultural pairing of the counsellor to the client is grossly unrealistic, though these issues are instructive. Also, this line of argument lets lots of mainstream services off the hook as they don't have to deal with Central American refugees or those individuals who are psychotic, have Aids or have forensic individualized special problems. There is no need for parallel services except in very restricted services.... We don't have to have a specific system for newcomers from [each different cultural] area.

Within this perspective, a possible short term solution to these problematic issues may lie in acceptance of cultural others into the professions of psychiatry and other related mental health disciplines in order to begin to address the differing patterns of needs interpretation which exist among various subcultural populations in Canada.

The next two cases consist of foreign trained health professionals who are themselves non-native born Canadians. In direct contrast to each other, these two case examples provide a differentiated pattern of understanding and approach to mental health issues affecting newcomers, despite both individuals being educated within the same scientific paradigm. Before presenting their particular views on mental health issues affecting newcomers and how they should be addressed, it is useful to provide the comments from an individual who had sought help from both practitioners.

The individual in question had recently arrived from a Central American country. He was experiencing difficulties adjusting to his new cultural surroundings as well as experiencing grief over his separation from his wife and children whom he left behind because of the chronic political violence in his homeland and threats made to his life. He first visited Dr. A., who upon the first session prescribed medication. The individual felt that the physician did not ask sufficient information nor adequately listen to the context of his situation. After taking the medication over a two week period, he felt that his difficulties remained despite the medication. He contacted Dr. A. again and was told to double the intake of the prescribed medication. His difficulties continued. Later, still unsatisfied, he heard through community members of another Latin American physician, Dr. B. and subsequently sought out his services. Dr. B. ran a complete physical and after listening to the context of his difficulties suggested that he quit taking the prescribed medication and seek counselling from a culturally sensitive care provider. Dr. B. referred him to the cross-cultural counselling program. The same individual remarked how the counselling service helps him "to feel relaxed, free from tensions and anxiety [so that he] can handle it."

This example illustrates that despite Dr. A. having immigrated to Canada himself, he did not take into consideration the social context, specifically the migration experiences which permeated through this individual's difficulties. Rather, Dr. A. labeled the patient as

depressed according to his professional training and readily prescribed drugs as a solution. The approach of the other physician, Dr. B., was to spend additional time with his patient, eventually concluding that a better solution to his difficulties lay in counselling and information to help him better understand and cope with his present circumstances. While neither of these approaches resolved the individual's socially based difficulties, the final solution offered to the individual - social support through a counselling service - was the most efficacious.

The following example is based on an interview conducted with Dr. A., a foreign trained psychiatrist. Dr. A. practices both general medicine and psychiatry. He boldly stated with regard to the importance of culture in relation to mental health that

[n]ewcomers' mental health needs are the same as anyone else's. The difference is that people speak a different language....I don't believe culture is important but what is important is what you bring in your personal history no matter where you come from....[The idea that culture plays a role in mental health] is a big myth! Knowing culture [makes service provision] more complete and detailed. To say anything else is idealism. It's only language. The only thing that is important is the confidence and rapport between patient and counsellor in the original language but the matter of diagnosis will come to be the same, and the treatment will be essentially the same. To understand depression is to get to an understanding of the person....These problems cannot be prevented. The problem is language.

Culture doesn't shape illness but instead what the person will say. Some people will tell you what their problems are while others will take more time. You don't need to understand culture but that there are different kinds of patients. Mental health needs are not expressed differently. [For example,] I have two patients, one from El Salvador who abuses drugs and gets psychotic, while the other patient is from Thompson. Both have the same problems in that they are paranoid -- both have hallucinations. Human nature is the same everywhere in the world....The personality of surgeons is the same - arrogant, active, and narcissistic.

These comments suggest a tendency to reinterpret the understanding of patients' everyday experiences into the cultural based nosology of Western medicine. As this physician remarked, the particular circumstances surrounding an individual's difficulties is not a primary concern. If you are depressed, the treatment will be the same - the prescription of certain drugs by which to manage the labeled illness.

The last example is of a foreign trained surgeon who at the time of the interview

was licensed and practiced general medicine at a walk-in clinic. He reported seeing the unintended consequences of cultural misunderstandings through his practice:

I see approximately 20 new immigrant patients everyday. {A} big problem is misdiagnosis of the problems of these patients. [Using patients seen the previous day as examples:] One patient was seen by sixteen different doctors while what was needed was a simple stool test [for a parasitic condition] with over \$10,000 spent. Generally there are adjustment disorders. Mainly most patients were tortured, jailed or were members of the National Guard with lots of anxiety. In general these patients have organic diseases plus [a] psychological component. [Citing another example:] Another doctor said a woman had heart disease when [in fact] she had a disc broken. [The] big barrier is the culture everyday. Canadians only see [the] problem of language but not culture. Another patient was given a CAT Scan, [the attending] doctor think[s] the lady is crazy but she has [a] broken disc. Another patient has [a] large stone in [his] gland but was told you don't have [any]thing.

He commented as well that cultural values play an important role in the disclosure and expression of health problems. He stated that his patients did not understand the "new culture, different language, for example how to communicate differing values and beliefs about what you can say and who to":

They are made to feel like they have a handicap - can't communicate. The system works OK for health, shelter, food. Principally they fail when they have to put people to work. People have lots of skill but don't find anything. They are set up to fail. There is a need for a special unit with different languages [to assist people during] the first few years as they need special advice. I saw a lady three months ago who was pregnant and had an adjustment disorder: she just couldn't adjust. There are two different kinds of refugee, economic and political. While the political refugee had no choice there are mild differences between the two's disappointments, frustration and anxiety. Political refugees come with problems and have additional problems in a new society with language and cultural differences. Many people do not know of the clinic. These people need more time and more assessment. Most will have adjustment problems....[A]djustment [is made easier]...through more support services and education to understand their problems.

From his perspective, Canadian doctors too readily prescribed drugs to manage the social difficulties of newcomers. He further suggested that part of the problem lay in communication between provider and consumer as "99% of diagnosis is language. Simple words mean depression and anxiety." The solution he recommended was the creation of better support systems.

Summary

The above discussion illustrates the existence of differing patterns of needs interpretation among and within differing interest groups within the public sphere. In general, newcomers expressed their dissatisfaction with the realm and type of services within the established medical and social service systems. Here, they cited the lack of cultural and linguistically appropriate service provision which inhibited access and in some instances resulted in the provision of inappropriate services and prescription medicine. Clients further pointed to a range of unaddressed issues which were affecting the health of individuals and groups within their particular, for example, the lack of services and resources for refugees. The ways of understanding of needs among newcomers may differ as the result of specific social experience and circumstances, including both pre and post migratory experiences.

Referral agents confirmed the themes and issues presented by clients of the counselling program. They expressed frustration at their inability to offer the forms and range of assistance required by certain individuals and groups due to organizational imperatives. Social service workers representing various social agencies further supplemented the cultural critique of public policies and practices.

Respondents from the medical service system provide additional insights into the issue of the cultural accessibility of the established service systems. Like other respondents, the understanding of newcomer needs by medical service providers from the established service systems are influenced both by their professional and other social experiences. However, this latter group provides further evidence of the need to recognize competing understandings within as well as among differing interest groups. This helps to affirm that while certain social understandings may be dominant within the public sphere, and are produced and reproduced through a broad set of social relations which in turn help to determine what are needs and how they are to be addressed, competing interests and motivations - what may be termed as forms of resistance- are present throughout differing social groups.

Chapter Seven The Birth of the Program

This chapter will explicate the establishment and the course of expansion and development of the counselling program. It will describe the organizational processes and contradictions within this movement, analyzed through the actions and statements by various individuals and stakeholders¹² who promoted the program. Facts and insights from the relevant literature are interspersed where such context can clarify the various issues entailed. The major theme developed is that while the program was initiated through the expressed needs and members of a particular community, eventually institutional processes served to shape and organize the functioning and direction of the program. I will argue that paradoxically, a program initially developed to respond to unmet needs was slowly shifted towards the perspective which has failed to adequately consider these needs.

Conception and First Years

The program's start came about through the efforts of numerous concerned individuals from the Latin American community. At the community level, members of the Chilean community had recognized that the mental health needs of various members of their community were not being met and had begun to voice their concerns to others within and outside their community. The chronic emotional problems experienced by large numbers of Chileans in Canada despite many having immigrated over two decades ago to escape state sanctioned violence in their home country, indicated that their difficulties were not appropriately dealt with within the institutional environments of established settlement and mainstream health and social services. These unmet needs demonstrate a serious inadequacy both at the level of settlement services for newcomers as well as in the accessibility and relevance of the mainstream health and social service system.

I would like to stress however, that the present situation is due to the lack of service resources rather than the lack of recognition of unmet needs of newcomers by settlement

¹²Unless otherwise indicated, quotes from stakeholders are from CCCU Evaluation Interview notes.

workers. At the social service level settlement workers, many of whom are also newcomers to Canada, had realized that many newcomers were experiencing emotional difficulties as a result of their migration experiences.

Based on these recognitions and through the initiatives of two settlement service workers, a volunteer mental health project was started in 1985 at the provincial government settlement program, Immigrant Access Service. One of the settlement workers, the co-ordinator of IAS and a member of the Latin American community, contacted a mental health professional who had recently migrated to Canada from El Salvador. She inquired whether he would be willing to provide counselling to individuals who were experiencing emotional difficulties related to their migration experiences. He immediately agreed to the request but as he was in the process of regaining his professional credentials, he was only allowed to practice within the institutional setting of a teaching hospital in Winnipeg. As a result of his professional standing in Canada, he first had to gain permission from the Head of the Psychology Department, his supervisor, to oversee his activities outside of the institution.

The initial intent of the program at the Immigrant Access Service was to provide emergency counselling to individuals who were suffering emotional distress due to adaptational difficulties. This immigrant mental health professional stated that he began "to provide advice to newcomers on how to handle the settlement process." At first he said he "saw only a few cases and had referred others on to the mental health system." However, after several of months of offering his services, the demand for the program began to increase. As he recalled:

A lot of cases came in. Others started to demand the service; not just newcomers were interested. I started seeing Chileans who had been here for over twenty years. Though first created as an emergency service for individuals who had recently migrated to Canada, I was then seeing individuals who had been here for a long time.

Over time it became apparent to the founders of the program that a greater need for culturally sensitive counselling existed than even they had initially anticipated. It was evident that such need could not be met by the modest service they had begun.

As a result of increasing demands for services by a wide range of individuals from

Central and Latin America, the founders began to recruit others to provide counselling and to “formalize the service in order to make it accessible to a wide range of Latin Americans”. In 1986, a foreign trained psychiatrist and a psychologist, both from Central America, started to provide volunteer counselling. Later, several other foreign trained health professionals from various cultural groups, joined the volunteer based counselling group. At that point in time, the counselling program included service providers from Africa and the Philippines as well as from various countries in Central America. Later service providers from Iran, Poland, and Egypt would join the program.

Not only had the service grown but the intent of the service had changed as well. The purpose of the program was no longer to assist only those recently arrived migrants with supportive counselling regarding their initial difficulties with resettlement. As one counsellor put it, now the aim of the program was to assist a wide range of newcomers as to “how to cope with the demands of the adaptation process over the long term - what is the way of living here - the cultural basis of the emotional issues which they are confronted with and may experience in the future.”

Service demands continued to increase as did the number of foreign trained counsellors who were volunteering their services. It became apparent that a new location had to be found for the program. Not only had the program outgrown its original purpose, it had become “obvious that the provision of counselling for emotional problems was not within the mandate of the Immigrant Access Service” where it was currently located. Efforts were then made to find a location for the project within the mainstream health care system.

During this time considerable effort and time was spent in making presentations to various groups, such as church groups, settlement agencies, and health care organizations. These efforts were aimed at beginning a social learning process to educate various groups in Winnipeg of the unmet needs in many communities, and the subsequent social and personal costs resulting from the neglect of the social issues which accompanied these needs.

It is also important to note that during this time the counselling program operated on a consensus building model among the volunteer group of service providers, with the aim

of meeting the expressed needs of community members. Their efforts were principally centered on providing direct assistance to clients. Decisions affecting the direction and development of the program were arrived at by consensus among all the volunteer service providers. As efforts were made to secure the program within the established health care system, this decision-making model would be modified to comply with organizational setting and processes within the formalized social and health care service environments.

The connection between the expectations of community members and the orientation of the counselling program should not be underestimated. As a program which began through the struggles and concerns of concerned community members, their intentions and struggles were integral to the generation of the service program. Unlike programs or services which are principally developed at the institutional level, community based programs are generated through a meaning centered perspective focused on the expressed needs or the needs assessment of community members. In this way, community based programs better reflect the needs and issues as understood by individuals who are receiving the services. As the program attempted to address issues and needs which the established system had not yet formally recognized or addressed, the the genesis of the program necessarily flowed from the involvement of community.

The volunteer counsellors who further developed the program understood many of the health issues facing members of their cultural communities both from their personal experience, as well as from their own professional backgrounds and interests. As a group, the counsellors were all newcomers to Canada. They understood the need to consider the cultural values both of their clients as well as those values expressed by others within the new homeland.

As refugees themselves, many of the counsellors understood from personal experiences the trauma and continuing effects of the circumstances surrounding their forced decision to flee their homeland. These counsellors, having personal experience of oppression and torture, consequently understood the adaptational processes which continue to influence life afterwards. As one of the counsellors who has been in Canada for over a decade remarked, the circumstances surrounding his migration experience continues to shape and influence how he understands and deals with his life. The counsellors further

appreciated the need to convey how these issues are further influenced by cultural perceptions.

The preference of some newcomers for health care providers who share similar life experiences and cultural understandings is not a new issue. Similar circumstances have confronted health care providers since the turn of the century as newcomers from Italy, Eastern Europe and China brought with them their own help seeking patterns and behaviors and were often ambivalent towards 'strange' healers and their practices (Kraut 1990: 1807). As noted above, changing immigration patterns throughout the history of Canada as a nation has continuously challenged public policies and practices to accommodate the increasing pluralistic nature of Canadian society. For example, representatives from the Italian community in Toronto reported to the Canadian Task Force on Mental Health (1986) that although "they represent one sixth of the city's population, and have resided in Canada for the last three generations, the Italian community 'felt excluded from [public] service delivery'" (Carpentier, Dorvil and Lesage 1991: 287).

The development of trust between a counsellor and client was an important consideration of the program. Past experiences with governmental services in their home countries sometimes inhibits newcomer's identification of professionals 'who can be trusted' and may prevent some individuals from seeking help from mainstream services. Trust also includes expectations that their counsellor will understand the cultural realities which underlie the client - counsellor relationship (Arredondo et al. 1989: 32). The common 'cultural' understanding between counsellor and client facilitates a focus on issues affecting them, be it depression, anxiety or guilt, within a context which recognizes and appreciates the contribution of customs and beliefs to the illness experience. For example, in some cultures there is a reluctance to talk to the health provider according to the norm of providing limited information to non-family members (Chambon 1989: 11). The similarity between counsellor and client, for example in race, culture, ethnicity, and/or social background, has been shown to contribute to improved communication and positive health service outcomes (Sanchez and Atkinson 1983; Proctor and Rosen 1981; Evans et al. 1986).

The Importance of Social, Cultural, and Linguistic Similarities

The social and cultural match of counsellors with clients was a primary consideration of the counselling program. Based on their own experience of migration and adaptation and combined with a thorough understanding of their client's social and cultural backgrounds, established by similar life experiences, the counsellors believed they were best able to provide assistance to newcomers. The counsellors pointed to how their own 'lived' experience of migration and adaptational processes provided them with the knowledge and experience of how new situations of normative conflict can be interpreted. The counsellor's ability to reflect upon the differences between the two cultures enabled them to provide guidance to a client based on the general principles and modes of behavior - the cultural definitions that shape the unique life history and motivations of the newcomer. This reflexive ability allowed them to draw to the attention of the client the core values of both cultures, which in turn facilitated an effective and efficient therapeutic relationship between the therapist and counsellor. In the words of one counsellor,

It's the ability to talk to communities, knowing the culture provides both parties with a sense of familiarity. For a Lebanese client, being able to speak the same language provides a 'trust factor', not that everyone needs this but it is important to those who have fled their homeland....The client mirrors himself in the counsellor....The counsellor should be able to 'play both ways' culturally. The counsellor needs to have spent enough time here to understand Canada, to be able to play that role. On the other hand, a native born Canadian's knowledge of another culture is not enough....The counsellor must be born and raised in that culture to have a proper understanding of the complexity of that world. They need real experience in both cultures...in order to understand how cultural norms work and may be applied by an immigrant. Their understanding of SES (socio-economic status), political situation, familiarity with regional differences helps the counsellor to move more quickly to the root of the problem.

These comments point to how the pragmatic conditions of communicative tasks involved in the therapeutic encounter are further influenced by the social economic class from which individuals have come. Shaped by social norms and experiences are different cultural assumptions concerning the circumstances surrounding issues as well as what would be considered appropriate behavior and intentions. These cultural conditions influence how information is structured, how

an argument is presented and validated. As a counsellor stated,

A very important factor in cultural translations is the client's SES level. I would use a technique where I almost speak in a different language for those who I identify as coming from a lower social-economic class. SES background is very important in the Philippines [in relation to interpersonal behavior]. The upper class is given a great deal of respect from the lower classes.

These complex issues were elaborated by another counsellor. He remarked on the difficulties that he experienced when attempting to offer assistance to individuals who were from a social group different from that of his own.

In dealing with working class individuals, even I have difficulties understanding the differences between us - different norms and values. For example, wife abuse is generally accepted and is not an intense state of guilt for males. When an explanation is given about values in Canadian society concerning such actions, new norms are not accepted, not even by females. A man beat his wife quite badly - she later complained to a friend who her told her to report the incident to the police - and the police placed him in jail. (He had broken her leg and arm.) She told me this thing was not so serious. She didn't think her husband would go to jail - this shows the difference in relationships.

In agreement, Abel, Metraux and Roll (1987: 22) point to this need to recognize that "all individuals do not have equal access to the content of culture; differentiation of roles carries with it a corresponding differentiation of knowledge, activities, skills, and viewpoint". As such, these authors state that within a specific culture there are many versions of the culture, but collectively these versions are for the most part, congruent with each other. No perfect match will exist between a counsellor and client but cultural similarity increases the level of mutual understanding for the task at hand.

Another counsellor discussed how the process of social adaptation may differ among individuals according to religion, age, gender, socio-economic status and individual social experience:

In counselling we must first relate...[the problems] to our culture which provides a tool or skill with cultural issues.... We first have to work with beliefs, norms, and in some cases religion, as it is very strong. We have to deal first with the feelings wrapped up with their beliefs in order to promote changes. One of the major problems that I'm seeing in my cultural [community] is caused by immigration. Many things change. Men enjoyed

a high position, high status in family and society then gradually they are faced with a loss of their power...which is really difficult for them to understand. We have to deal with this before dealing with the presenting problem in the family. Some families have been here for ten years...and are still struggling with a loss of power.

A fourth counsellor explained how the expectations of both the client and the counsellor as to how problems are expressed and counselling service is offered, can substantially differ if cultural norms are not understood or fully appreciated. In her culture

[b]ody language is another important way of communicating. As compared to Canadian culture, Filipino culture is much more expressive...[F]or example, the willingness to hug and be hugged by another individual - even though you may not know each other very well.

The same counsellor expressed the need to appreciate the cultural variance in how similar concepts may be understood and expressed. She illustrated this point through the problem of trying to translate standard Western psychiatric diagnosis into another cultural context:

Depression is another area where understanding differences between the two cultures [is important]. [I]n the Philippines we have no direct translation for depression, rather we have differing grades and shades of depression: Malungkot (sad); hinagpis (sadness with regret) and so forth.

The counsellor further added that there was need to understand the rhythm, pace, and tone of the encounter process between the therapist and the client:

For therapy to work one must allow a person time to slowly tell us what the problems are facing them. It is a big milestone for a person to come to a clinic...[because of] the stigma that only crazy people come here. The therapist must be patient with the pace of the therapeutic encounter.

Language is another important consideration because of its affective and cognitive implications in the provision of mental health services. For some newcomers, even those functional in English, their first language continues to be the language of emotions because it was within their first language that affective understandings were first formed. To decode those meanings through the use of another language is problematic at best (Epsin 1987: 496).

The complexity of language and how its various levels of presentation contribute to the reaching of understanding between individuals is generally not well understood. The act of speaking is often taken to involve the use of grammar and lexicon and rarely involves the consideration of how the rhythm, tone and idioms of speech are used by individuals to interpret as well as communicate at several different levels of meaning. Cook and Gumperz state that through the use of these devices speakers “simultaneously signal both context and about content” (1987: 13). They further argue that miscommunication between members of different socio-cultural communities results from differences in style or speech presentation than grammar or word use (Erzinger 1991: 92).

The employment of “a different set of unconscious linguistic connections (such as the tone of voice) to emphasize, to signal connections and to indicate the significance of what is being said in terms of overall meaning and attitudes by different cultural assumptions” (Cook and Gumperz, 1987:12) is constitutive of speech acts or ways of speaking and being understood. Awareness of how and why such devices are employed by individuals is intrinsic to understanding the motives and meanings concerning what has been spoken.

Erzinger (1991) points to research which has demonstrated how the effects of these subtle aspects of communication influence how people receive health services. She cites literature from the mental health field (Flaskerud 1986; Chaves 1979; Padilla et al. 1976) which has shown that conversational features based on cultural attitudes influence the communicative tasks between the health professional and the Latino patient. She further points to the work of Triandis (1984) who has noted that the communicative qualities of Latinos such as a “concern for others expressed through personal warmth may take precedence over the task at hand” (1991: 92). The ability of the counsellors to offer linguistically appropriate and culturally sensitive services to newcomers prevents unnecessary misunderstandings and facilitates the therapeutic process.

Summary

To reiterate the most pertinent points from the above history:

First, the counselling program arose out of the expressed needs of various newcomer populations and through the motivations and efforts of health and social service providers who were themselves newcomers to Canada. As the recognition of the availability of volunteer counselling services increased within various newcomer communities both demand for, and the type of services offered, broadened. Counsellors were now assisting recently arrived newcomers as well as individuals who have resided in Canada for over two decades.

Second, despite the expressed need by community members, and the recognition by settlement workers that certain issues regarding the successful adaptation of some newcomers to their new homeland were not being addressed by current settlement service provisions, the birth of the program required substantial effort on their part, both to begin and sustain services which would address these unmet needs.

The lack of attention on the part of government to these issues is related to several factors. One, there is a lack of understanding throughout the established health and social service environment of the range and complexity of issues facing different individuals and social groups who have recently migrated to Canada. Related to this point is the fact that established services have been historically shaped and formed to meet and regulate the needs of cultural groups which differ from those cultural groups who currently make up the majority of migrants to Canada. Two, there is at present no meaningful policy directive or procedural mechanism to promote social learning at the institutional level of service provision so that the cultural and social basis of the health and social needs of the more recently arrived social groups would be addressed.

The History of Mount Carmel Clinic

To understand the transformation process of the program following its relocation to Mount Carmel Clinic, it is necessary to outline the history as well as the organizational structure and functioning of Mount Carmel Clinic. The Clinic is marked by its establishment to serve the unmet needs of Jewish immigrants in the mid-1920's by members of the Jewish community. Later its direction was influenced by others who

promoted the expansion of its service orientation to include the consideration of the diverse and changing community needs of the area of Winnipeg in which it is situated. The present orientation and future direction of the Clinic continues to be debated at the organizational level of Mount Carmel.

Mount Carmel Clinic is a community health care clinic which “evolved from specific needs of a particular ethnic group” nearly sixty -five years ago (Rizo 1987: 1). Within its first decade of existence however, the Clinic began to serve other immigrant and indigent populations in Winnipeg. Since that time it has continued to serve newcomers as well as, more recently, aboriginal populations who have begun to reside in the vicinity of the Clinic.

According to a long time Board member DeeDee Rizo, author of Mount Carmel: A History 1926-1986, it was during the years from 1948 to the mid 1960's that Mount Carmel “changed its emphasis from an ethnically based Clinic serving all who wished to use the facilities to an aggressively community oriented service catering to the needs of the socio-economic group of the community in which it was situated” (1987: 15). It was during this time that Anne Ross, who joined the clinic in 1948 as a nurse, began to exert increasing influence over the direction of the Clinic. Through her endeavors, the Clinic began to expand first its medical staff which in turn allowed the Clinic to attract new patients. Patients who came to use the Clinic at this time were a reflection of the immigration period. As Rizo recounts, the immediate post war period

saw an influx of Jewish refugees, the 1950's saw an increase in immigration from countries such as Hungary, Yugoslavia, Poland and Germany. Inevitably the Clinic reflected the immigration pattern of the period as it continues to do today with the presence of patients from South America and South East Asia. The Clinic became a touchstone for many immigrants who needed medical care....It was also a convenient location for them since the North End tended to attract many of the immigrant groups because of the socio-economic nature of the area...The result is that the North End at various times over the years has become a microcosm of the different ethnic groups that have settled in Winnipeg (1987: 16).

Rizo affirms that though the initial efforts to move out into the community were “modest....[they] served to make the Clinic realize the needs of the community and formed the basis for future expansion of services in response to community needs”(16). Over

time these efforts gained recognition by formal service based organizations such as the welfare department which began to refer individuals to the Clinic.

These changes marked a change in the philosophy of the Clinic from “a passive dispenser of services to a more active role assessing and responding to community needs.” (: 16) The philosophical change was attributed largely to the efforts of Anne Ross and other forward looking members of the medical staff. Anne Ross was later to become the first Executive Director of the Clinic, a position which she held until 1985.

These changes however, did not go unchallenged by certain factions within the Clinic membership. A critical juncture in the Clinic’s history occurred in the early 1960’s when a split occurred between long standing supporters who viewed the clinic as principally a Jewish facility and individuals such as Anne Ross who were attempting to move the Clinic towards servicing the needs of the general community. The Jewish members saw that control of the clinic was slipping away from them. To remedy the situation, they submitted to the Board of Directors a proposal to have the Clinic annexed so as to become part of the Jewish Old Folks Home. The Board of Directors were split on the issue, with the majority opposing such an action. The motion was eventually defeated later at the annual meeting largely through the political efforts of the Ladies Auxiliary, who “mobilized their forces to ensure a good turn out at the meeting” (: 17).

Rizo notes that at the same time that the Jewish Old Folks Home had submitted the proposal to the Board, they had also unsuccessfully attempted to lure Anne Ross away from the Clinic by offering her a job at double her present salary. She comments that one may assume that these efforts acknowledged Anne Ross as the driving force behind the expansion of the Clinic.

Beyond the membership debate concerning the direction of the Clinic, financial means had to be obtained to secure a broader application of health services for the community. To achieve its expansion into the wider community, the Clinic has continuously lobbied for funding from public and private community organizations with varying success. On some occasions, the Clinic has received donations from organizations for specific purposes. However, financial restrictions coupled with the hesitancy displayed by some members of the Board to expand services, continues to limit the base of services

offered by the Clinic (Rizo: 19).

In the foregoing review of the history of Mount Carmel Clinic are several issues which have relevance to this study. First, similar to the cross-cultural program, Mount Carmel Clinic began through the expressed needs of a specific community. The Clinic initially had to struggle to gain acceptance by the wider health and social service environments.

Second, the development and direction of the Clinic has been further shaped and influenced by the broader social processes in which it is located, such as the increasingly diverse neighborhood in which it is situated. In addition, the acceptance of government funding while allowing for an increase in service provisions, also allowed the government the opportunity to influence and shape how programs were to be delivered.

Recognition of the interlocking organizational processes should not be overlooked. Most administrators of service organizations are aware that maintaining a supportive environment with funding agencies is often the primary consideration when compared to concerns with the actual delivery of services to clients. As Ferguson notes in her review of the literature on management of service organizations, the "pursuit of this goal usually results in the fragmentation of services, lack of co-ordination among staff, zealous defense of territory and domain, and rejection of undesirable clients" (1984: 134).

Third, the direction of the organization has been and continues to be influenced by its organizational structure, and consequently by the Executive Director of the Clinic. It is clear that since her arrival as a head nurse at the Clinic and later as the first Executive Director, Anne Ross has exerted tremendous influence on the further development and current direction of the Clinic.

Further to the latter point, it should be stressed that in organizational settings such as Mount Carmel Clinic, the Executive Director can exert a great deal of influence regarding the overall management and direction of the organization. Despite the role of the Board of Directors as the overall decision and policy-making body of the organization, the Executive Director, through her position as day-to-day manager, is the co-ordinator of the organization. As co-ordinator, the Director helps to shape how and what information is transmitted to the Board concerning the functioning of the operations of the organization.

In this way, the views of the Board concerning program development are in part constructed through the actions of its Executive Director.

Based on these historical and organizational considerations, the relocation of the cross-cultural counselling program to Mount Carmel Clinic can now be recounted in light of the institutional processes of Mount Carmel.

The Demonstration Project

Reasons for the Move to Mount Carmel Clinic

As a result of the increasing demand for services, efforts were made to relocate the counselling program within the formal health care system. The program had operated as a settlement agency for nearly four years. It was felt that the delivery of mental health services was not within the mandate of a settlement agency (provision of assessment and information services).

Moreover, it was believed by some of the founders of the program that it should be attached to a health centre. They reasoned that many of their clients were reluctant to visit what they considered to be an "official office, mainly because of the identification of government services with its utilization for repressive purposes back in their countries of origin." In addition, the counsellors stated that by providing their services at a health clinic, clients would be less likely to be identified as sufferers of mental health problems. An unstated reason may also have been that the majority of the providers were trained health care providers - psychiatrists and psychologists, who were attempting to gain professional accreditation in Canada.

However, the framing and labeling of the problems and issues within the parameters of a mental health model created problems of accessibility for some groups. Some individuals and socio-cultural groups did not view the issues affecting them as constituting 'individualized' mental health problems but saw such issues within a broader socio-political framework which identified the issues as arising out of definite social relations and larger processes which in part reflected the social organization of Canadian

society. They viewed appropriate services as including a political dimension/analysis of the difficulties which they face. Therefore in some instances, the process of the integration of the program into the normative organizational framework of Mount Carmel contributed to the submersion of the political basis of certain health difficulties experienced by individuals.

Let us recast these rationales for moving to Mount Carmel within the context of the program's stated *raison d'être*, and Nyman's analysis of the typical barriers facing this type of program and its attempt to address these. The intentions of the counselling group were to offer a range of services which did not previously exist. They were trying to

fill the gap observed in existing services regarding the access of immigrants and refugees to the mental health system by using qualified professionals (licensed or not) to deliver such services to a specific ethnic community [on a volunteer basis]. By no means [does] this type of service pretend to create a parallel service to those actually existing (CCCU Procedure and Orientation Manual 1991: 1).

The counselling program's stated objectives were to:

- operate a demonstration project and ultimately a community based education and support unit for those at risk in adaptation and victims of violence/torture
- provide direct assistance for individuals and groups utilizing different techniques in providing supports
- develop a network of professional assistance for clients and for the Unit's activities including developing appropriate referral mechanisms to meet specialized service needs
- develop mechanisms for educating professionals about the effects and cross-cultural aspects of adaptation and torture/oppression (CCCU 1991: 15).

As noted previously, community members had defined the lack of cultural, social and linguistic understanding by service providers as a primary factor inhibiting mental health service utilization for members of their communities. This sentiment is born out by Nyman's review (1991) of cultural barriers to mental health and social services. She found that five classes of barriers limit access to mainstream services: impediments related to inadequacy of service supply, inappropriate geographic location, the manner in which

service systems are organized, costs to the client to consume the service, and provider and client attitudes. Nyman specifically reviewed the features of the CCCU and noted (1992: 8-10) that it had been designed to address the aforementioned barriers in the following ways: (1) provision of service by staff knowledgeable about the client's background; (2) provision of service by staff who understand the adaptation process and complicating factors; (3) provision of information through ethnocultural community organizations and immigrant serving agencies; (4) easy geographic accessibility; (5) relatively short waiting time for service; (6) absence of fee for service; (7) assistance to follow-up on referrals when they are made; and (8) an emphasis on educating mainstream health professionals.

In sum, the decision to actively pursue moving the counselling program into Mount Carmel Clinic was an attempt to further lower these barriers to access. The new setting would reflect a particular organizational model thought to be preferable to a segregated parallel service: a specialized service unit within a mainstream service organization (Frankel 1990; Matsuoka and Sorenson 1991; Uba 1982). This would have distinct advantages including improving the possibility of linking clients with other mainstream services, avoiding inefficient duplication, and providing increased opportunity to sensitize mainstream service providers. As the following sections will describe, the disadvantages would be the difficulty in accommodating the pursuit of the program's original objectives within the organizational philosophy and processes of the larger health system - as experienced within Mount Carmel Clinic.

The Beginnings of Changes to Come

In late 1988, informal talks began with the administration at Mount Carmel Clinic, initiated by an individual from the Chilean community who was a member of the counselling group and also worked at Mount Carmel Clinic as a social worker. Based on these efforts, the program began on a very informal basis at Mount Carmel in May 1989. Throughout this time considerable time and effort was expended to secure funding for the project.

The service functioned on a strictly volunteer basis at Mount Carmel Clinic from

May 1989 until February 1991. At this time funds were secured to operate a one year pilot project. Primary funding was provided by the Neighborhood Services Program of the Winnipeg Core Area Initiative (\$47,400) and the Winnipeg Foundation (\$25,000), along with a smaller contribution from the Immigration and Settlement Services Branch in the Department of Family Services of the provincial government (\$7,500). The funds allowed for the hiring of a full-time co-ordinator / counsellor, one full-time counsellor and a full-time secretary.

An Advisory Committee consisting of a broad base of professionals who work within the mental health field as well as other professionals who provide assistance to immigrant populations was established to provide professional guidance and legitimacy for the further development and refinement of the program. In addition to these representatives, two members of the Board of Directors of Mount Carmel sit as members of the advisory committee along with three senior level administrative staff of the Clinic and both the co-ordinator and the secretary of the CCCU. The committee meet monthly to discuss issues regarding service delivery, program priorities and ongoing funding strategies.

Notably absent from the advisory committee were specific lay community representatives from newcomer populations, despite the assertion in the terms of reference of the advisory committee that it "shall be a Community Advisory Committee" (Operation and Procedural Manual for the Cross-Cultural Counselling Unit Mount Carmel Clinic, June 1991: 3). While many of the representatives on the advisory committee are themselves newcomers to Canada, their position on the committee was based primarily on their professional capacities. The absence of lay members from newcomer communities may have reduced the range of considerations and the complexity of newcomer needs discussed by the Committee.

Prior to securing these funds, the volunteer program was based on a consensus building model among the volunteer group of service providers with the aim of meeting the expressed needs of community members. Their efforts were largely spent on the provision of services. Decisions regarding the direction and future development of the program were equally shared among all volunteer service providers. However as the next section will

illustrate, once the program became formalized within the organizational structure of Mount Carmel Clinic, the structure and functioning of the program was continuously modified to complement the institutional setting of Mount Carmel Clinic and as well the wider demands of the mainstream social and health service environments.

The Counselling Program's Settlement Process - More than Just an Event

The relocation of the program to Mount Carmel Clinic occurred during a period of time when the Clinic itself was undergoing a certain amount of change. Several representatives of Mount Carmel stated that it was in a state of flux over the issue what type of changes if any should be made to the current traditional provision of health services that the organization offered. In addition, due to growth over the years in the range and type of services which the Clinic offered, space for any additional program developments was a crucial issue. Furthermore, among the various stakeholders involved in the development and delivery of services, including the Board of Directors, the administration and staff, there appeared to be no clear consensus as to how or where the institution should head in terms of possible future program offerings.

Against this background the cross-cultural counselling program, having been defined chiefly as a mental health service by its founders, presented many challenges to the current status quo of service offerings. First, as Mount Carmel does not offer any formalized mental health services, this program was seen as an opportunity to broaden the current range of services offered by the Clinic. Second, and perhaps the more contentious challenge, was the type of program that it was seen to be by some of the stakeholders. For some stakeholders the program reflected the historical development of the Clinic by offering health services to newcomer populations. Others viewed the program with a certain amount of suspicion since the program had been developed from outside of the Clinic and therefore was not perceived to be 'one of their own'.

Reasons For and Against Adopting the Counselling Program

From the perspective of the Board, one member commented that there appeared to be several perspectives regarding the development of mental health services at the Clinic. For some members of the Board, there was a need to develop services targeted to the Aboriginal population which the Clinic currently served. Another group saw the need to develop a generic mental health position which would serve the general clinic population and act as a referral agent to other mental health services within the broader health care system. A third group supported the adoption of the counselling program as they felt that historically the Clinic had served immigrant and refugee populations. Other members were concerned whether the Clinic had become too large, too fast and therefore did not need to develop further programs and more importantly, accept programs which were not developed from within the Clinic.

The Executive Director of the Clinic, in describing the views of the Board regarding the counselling program, commented:

Mount Carmel has a very strong, very traditional type of Board. The Clinic has been around for some 65 odd years and the Board has the perception that the Clinic is a very special, very unique place, as it should be. They in the past have relied very heavily on their own resources. They have not networked or affiliated with the rest of the community until maybe the last five or six years. I think that when they are approached by another group from the outside with a program that didn't arise out of the Clinic they tend to be very suspicious and very resistant of changing their role to one of collaboration with other people. I think that there has always been a general philosophy that...we don't need other people. But I hope that is changing and I think it should change. I don't think that it is an appropriate way to act these days. This may be construed as a criticism of the Board but I think it is more of an evolving issue in terms of long-term Board membership and the difficulty of getting people to change their minds. I have already dealt with the fact that there has been a great deal of resistance upon the part of the Board to taking on both the CCCU and POWER (another program developed externally). I have already identified the reasons. Partly it was philosophy because it wasn't our program, that it wasn't suggest by us. Partly it was suspicion of whether people had ulterior motives for using Mount Carmel Clinic. Partly some hesitation on the Board of where do we draw the line? Do we want to get any bigger? Do we want to stay the way we are? In that regard in fact the Board has launched itself a strategic planning process to determine the future of the Clinic and do we want to get bigger at all?

Based on the differing perspectives at the Board level concerning future program developments at the Clinic, it would appear that support for the program had to be engendered from below.

The rationale for the adoption of the program from the standpoint of the Executive Director was that “the Clinic is seen to be a facility in the community” and that the addition of the counselling services was congruent with the Clinic’s own mandate of offering “a wide realm of health and social services” at the local level.

In addition, the program fit into the developmental plans of the Clinic. Mental health was one area of service provision not yet included within the ‘wide realm’ of services offered by the Clinic. This gap had recently been cited in an internal report by a team of outside evaluators who had reviewed the comprehensiveness of the Clinic’s service provision. The adoption of the cross-cultural counselling program would fill this void. As the Executive Director remarked:

Why this program fits so nicely is because it is part and parcel of...so many programs we do. We have so many programs that don’t impact on mental health. This one is more completely mental health than anything else we do.

Beyond the aspirations of certain stakeholders within the institution, the administration stated that in general, the potential for adoption was based on the following considerations. First, the philosophy of the CCCU services was consistent with the present scope and future planning of the Mount Carmel Clinic. The program had begun through the expressed needs of community members and involved community based service provision. Second, Hispanic and other recently arrived newcomer populations were already using other services at Mount Carmel Clinic. Third, it was felt that the location and identity of the Clinic enhanced the accessibility for these populations. Fourth, Mount Carmel Clinic is situated in a neighborhood where newcomers often first settle. In addition, since the building offered other health services, clients could avoid the potential stigma associated with mental health problems, and perhaps be encouraged to use the other services within the Clinic.

Concerns and Problems with Integration

Despite the apparent compatibility of the program with the overall orientation of the Clinic, the acceptance of the program under the umbrella of the Mount Carmel Clinic created a new set of tensions and challenges not only to the Board of Directors and the administration of Mount Carmel Clinic, but as well as to the structure and direction of the counselling program and its service providers. Simply put, the adoption of the program raised questions for all concerned about the congruency and compatibility of the program and its staff within the institutional setting of the Clinic.

Initial concerns for administration were the fact that the program 1) was not developed by Mount Carmel; 2) the program in its current form was not shaped or organized to fit the institutional setting of the Clinic; 3) the administration was not acquainted with the service providers and 4) ongoing funding had to be secured. Together these factors created caution on the part of the administration to accept the program as one of its own. As the Executive Director stated, "I had some reservations about whether it was a useful program for Mount Carmel Clinic. Was it the kind of thing we should be adopting?"

It is of interest to note however that when she was questioned as to her own reservations regarding the potential for adoption of the program, the Director framed her responses in terms of the Board's concerns, to whom she was directly responsible regarding the day to day management of the Clinic:

Stress came from our Board which I saw as a serious problem....[The Board] raised the issue whether the Clinic should accept programs developed from outside the Clinic or should programs solely emerge from within the Clinic. This issue created serious splits on the Board. It was a philosophical issue that split on the Board. It became clear that they did not want to accept financial responsibility. This was a twofold concern - was the administration being stretched too far. Whether other people [from outside of the Clinic] can derive from Mount Carmel prestige in order to gain funding for their projects. With the Board it was a question of whether the Unit was using the Clinic for funding in that they stood a better chance of obtaining funding - a problem for the Unit which would be resolved with the Clinic behind them.

It became clear however, from discussions with one Board member, that these questions were not derived strictly from the concerns of the Board. From this Board member's point of view, the information given to the Board was limited and served to shape the Board's stance or what may be better termed as a lack of a position, towards the program. She recalled how she came to understand the relationship of the program to the Clinic:

I am personally confused about the situation. I never understood it [the program] to be a separate entity or whether it was meant to be a Mount Carmel program. But it is separate...[The program is] not integrated into Mount Carmel....its been hung by itself. Though I never remember this position being debated at the Board level.... [S]uch a decision should have been debated at the Board level as it comes under the guise of decision by donators. Rather the decision was made by the administration.

From her standpoint this was an organizational error. It is the role of the Board, she explained, to prioritize what programs are developed and where the energies of the staff should be spent. She added that the administrative grip over the future of the program did not begin nor end with the Director's interaction with the Board. She noted that there were three senior administrative staff in attendance at the Advisory Committee meetings. From her point of view such attendance was strictly a function of control. The administration's apparent preoccupation with the status of the program caused her to continuously wonder,

[i]f it was not a Mount Carmel program why the number of administrative staff at the Advisory Committee meetings...as this is very time consuming....When I asked a question regarding these issues I faced a blank wall of frozen faces.

Despite "administrative staff resistance" to the program, she felt that "it was a very important program, as it meets the needs of a changing community which Mount Carmel has historically served." Moreover, the program in its current form reflected the overall orientation of Mount Carmel as "it is more comprehensive...than a generic mental health position." In her mind, "the program should be promoted not modified: Let's concentrate on something no one else is doing."

As far as the (physical) relocation of the program to Mount Carmel, the Executive Director of Mount Carmel saw the process as a "three phase approach which included: 1)

the installation of the program through provision of rooms for counselling; 2) a collaborative process between the volunteers of the CCCU and Mount Carmel to obtain funding for a demonstration project; 3) some method of obtaining ongoing funding and the program becoming a part of Mount Carmel.”

The relocation of the program “created...stress as more time had to be spent on administering the program than was originally anticipated”. From the standpoint of the Executive Director,

because of the increased costs to the administration, [initial] work was required to collaborate the two parties, to become fully formed in order to take on and administer the conflicts which had arisen over how...must the program change to fit comfortably in the Clinic. If the program is too large for the Clinic then the program must become smaller - from the Clinic's perspective the program had to be modified. Also there was expectations from funders that we are all going to have to change. All sorts of differing expectations created stress.

For the administration, collaboration meant gaining control over the functioning and direction of the program. As the program was now to function under the auspices of the Clinic it had to be made to fit the organizational structure of the Clinic. The program had come to the clinic developed and packaged, by and with its own set of service providers. As one Clinic representative commented, “she (the administrator) obviously did not want a kingdom within a kingdom.” It became increasingly apparent during the year of the demonstration project that the issue of who controlled the program would not be easily resolved and that there would be no honeymoon following the marriage of the two parties.

Funding Implications

Beyond these structural issues, for the Executive Director “becoming part of Mount Carmel” required other changes. It became apparent over time that the administration's willingness to adopt the program was based on the precondition that the Clinic secure long term funding. In addition, the adoption of the program would also require changes to the form and function of the program. The program would have to be downsized to fit within

the availability of space in the Clinic and be modified to meet the differing expectations of the administration and potential funders, principally the provincial government. While the administration of the Clinic awaited word from potential funders, the administration and delivery of the program became increasingly formalized within the organizational processes of the Clinic.

As for potential funders, the provincial government, specifically the Health Services Commission, was targeted by Mount Carmel as the appropriate funder for the program. The Clinic's application for funds for the demonstration project of the counselling program stated that the "long range intention is for the project to be...funded by the global budget provided by the Health Services Commission. Funding will be sought from the Mental Health Branch. This projection would be entirely dependent on funding being made available" (Winnipeg Foundation Grant Application, October 5, 1990). The attempt by Mount Carmel to place the program within the health care system was inescapably linked with the organizational structures and processes of the various units of the government which might be affected by the development of the counselling program.

The provincial government's response to the program would not only be conditioned by a liberal, acultural notion of mainstream health care, but also as attempts to preserve organizational order. Units of government, similar to other forms of bureaucratic structures, are established organizations which have fixed duties; specific jurisdictions; stable, rule governed authority channels; and a vertical structure of authority entailing the supervision of its jurisdiction and duties. A main purpose of these organizational arrangements is to secure continuity and stability and to remove ambiguity in relations among participants (Ferguson 1984: 9-10).

An Illustrative Meeting with Government

As the counselling program claimed to address unmet needs, its service provision had the potential to challenge the comprehensiveness of several different government departments or areas within the health and social service system. The departments that felt challenged by the emergence of the program began a process to enable them to better

understand the program's objectives as well as to monitor its activities. Part of this process was a meeting called by a representative of one of the governmental units in order to discuss the direction and orientation of the program with representatives of Mount Carmel. What is of particular interest is not only that a special meeting was held in the first place, but what was discussed, how it was discussed and by whom.

The meeting took place on June 10, 1991 and was held at Mount Carmel Clinic. It was attended by senior representatives from Culture, Heritage and Citizenship; the Mental Health Division of Manitoba Health; representatives of the two major funders of the demonstration project, the Winnipeg Foundation and the Core Area Initiative; as well as two additional representatives from the Winnipeg Region of the Mental Health Division of Manitoba Health. Representatives from Mount Carmel at the meeting included two senior administrators as well as the coordinator of the counselling program.

According to a representative of the Department of Culture, Heritage and Citizenship, the meeting was called to obtain the "objectives, mandate and activities of the program" in order to compensate for the "lack of understanding on the part of agencies, government and funders regarding what the project is...and what direction it is headed in....a categoric or generic approach to service...[and] where is Mount Carmel Clinic going in the future ie. mental health services - a settlement service, generic service or a categoric service." In other words, which jurisdiction or unit of government was being challenged by the emergence and continuation of the program?

Examination of the meeting notes, recorded by a government representative, provides some insight as to the objectives, mandate and activities of these representatives regarding the relationship between the program and the units of government which they represent. It is apparent from the following excerpts that an unstated objective of the meeting was a desire to monitor the program: "much of the discussion at the meeting centered on the referral system...[and] there were questions regarding the lack of referrals to Mental Health of the Department of Health given that it is a mental health project." Implicit from these comments is the assumption that the program was to provide short-term emotional assistance and to refer individuals on to the mental health system if they required further assistance.

Further, it was stated that “the project could make referrals of clients regarding housing, employment, education, financial assistance, immigration, child and family matters etc. to the Immigrant Access Service.” It was apparent that if the government was to provide long term funding for the project, the activities of the service would have to be coordinated with established agencies and services. Furthermore, the representatives from the specific units of government wanted to provide a definition of the program which would place it outside the current mandate of their particular jurisdiction so that it would not become a philosophical challenge to existing services nor compete with them for funding.

Indications were also made at the meeting by the senior representative from the Mental Health Division of Manitoba Health that “the Department of Health was not interested in supporting parallel services particularly since resources are limited”. Thus needs addressed by this service should be short-term in nature; users of the service must readily adapt to service provisions within the realm of established service system. In other words, the assumption was that once provided with information on how the system worked, newcomers could then adjust their internalized need structures accordingly.

These concerns, as expressed by government representatives, communicated to Mount Carmel what the relevant parameters for decisions about the direction and formulation of the counselling program were if long term funding was to be a goal. In this way, the government provided the organizational setting and direction as how to rationalize the program and what selective needs could be addressed. As Mount Carmel received the vast majority of its operating funds from the Manitoba Health Services Commission, mutual recognition and cooperation regarding the organizational setting and practices within which it was situated seemed imperative.

Conflicting Opinions

Control of the Program

The formalization of the program following its relocation to Mount Carmel Clinic resulted in several notable changes. As mentioned previously, the organizational structure

changed dramatically. An advisory committee was struck to provide professional guidance, support and legitimacy to the program. The formal direction of the program was no longer in the hands of its founders.

As a group, the volunteers who had developed and delivered the program saw issues related to the program differently than other stakeholders concerned with the program. Perhaps more importantly, as a group who had developed the service, they presumed ownership of the program and therefore were hesitant to allow the administration of the Clinic to take over the direction and control of the program.

Related to the issue of ownership is the social and political background of the counsellors. Many of the counsellors are committed and politically active members in their communities. Based on their social and political experiences in their countries of origin as well as in Canada, they tended to discuss their actions through a broader, more critical analysis of social and political processes than did other stakeholders concerned with the program. The consensual nature of the program's past decision-making fitted well with their political beliefs.

They did not share an affinity with the organizational orientation and the prescribed goals of the established service system as their collective experience with its processes was limited. They viewed their actions through the lens of an outsider to a foreign human service system and the larger social system they now inhabited. As a consequence, they conceptualized social issues and explained events through previous experiences and learned strategies.

Decision-Making Structure

Second, with the formalization of the co-ordinator position, the former horizontal decision-making process was replaced with a vertical structure which complemented the institutional setting of Mount Carmel Clinic, though not without problems of a dual hierarchy as mentioned above. Prior to this change, the volunteer program was based on a consensus building model. Regular meetings were held by the counsellors to share their expertise, issues they were confronting in their counselling, and to consider the overall

direction and development of the program as well as to discern what the counsellors as a collectivity saw as possible solutions. As one member of the counselling group noted:

Before Mount Carmel, it was a very loose program with everyone willing to provide help where needed. There was no real leader. It was a very good, unique approach. It was a collective approach.

Following the move to Mount Carmel, the co-ordinator of the program - who was a member of the program's counselling staff - began to assume greater control over decisions which were seen by other members of the counselling group as requiring the consensus of the collective to decide. The issues cited by the counsellors included not only the direction of the program but as well the sharing of responsibilities concerning the promotion of the program.

For many of the counsellors, the co-ordinator was seen to have monopolized the responsibility of making public presentations on behalf of the group. This decision was viewed as undemocratic by other counsellors who thought that promotion of the program should be shared among the counselling group. It was also apparent that these efforts, while needed to promote the program to mainstream service providers and representatives, adversely affected the coordinator's own ability to serve clients. As a result of the time demands of these interests, clients who had come to the Clinic for assistance specifically from the co-ordinator were either asked to wait for a considerable time before receiving service or were turned away, despite the coordinator's presence in the institution during many of these instances.

At times, some of the counsellors spoke to the Clinic's administrative assistant concerning the lack of supervision over the program. There were no longer regular meetings held to update the counsellors and discuss issues related to the present functioning or future developments regarding the program. Here again the co-ordinator was cited as "monopolizing the information going to and from the Advisory Committee meetings ... information which was never shared with the rest of the team."

The organizational setting and decision-making processes of Mount Carmel helped to encourage and reinforce this type of organizational/management behavior. But despite the formal placement of the program into the vertical decision making structure of Mount

Carmel, in the minds of the counsellors, they were *still* the owners of the program. As a consequence two sets of structural processes were at work, placing the co-ordinator of the program in the difficult position of intermediary between the counsellors who felt themselves to be the defenders and representatives of the communities using the service, and the administrators ultimately answerable to and providing information to, the Mount Carmel Clinic Board.

Debating the Program's Purpose

The tensions and challenges which were created as a result were further complicated by the particular personalities, professional perspectives, and working styles of the various staff members including administrative staff, and the paid and volunteer counsellors. Combined, these factors contributed in various degrees to the motives and goals of specific staff members. As a result, the motivational basis and plans of action of many staff members did not necessarily coincide with selected practices of Mount Carmel Clinic.

An important example of both personal and structural influences is the tension that existed between program staff and the Clinic administration and board over tactics vis a vis the public forum. In concordance with the counselling group, the co-ordinator viewed the program as 'filling a gap' that existed for many social groups in the mainstream medical and social service system. He actively promoted the program through various public presentations. The stated purpose of the presentations was to inform various professional groups including medical and social service providers, school officials and other concerned individuals, of the need for increased sensitivity around cultural differences and how culture modulates ways of expression and influences the definition of health problems.

The contentious aspect of the promotional activities was that they were also aimed at countering the implicit socio-cultural bias of the established service system. Based on these aspirations, the promotional plan of the counselling group was not limited to contesting the actions of individual practices. Rather, their aim was to challenge the cultural bias of the mainstream system, as exemplified by the socially structured and culturally patterned behavior and practices of groups and institutions. By confronting the biases of the

established service system, the actions of the counselling group were overtly political.

The counsellors did not accept the limited parameters of service provision for 'their' program as put forth by representatives of the established service systems of 'short-term crisis intervention and referral program' or parallel (ie duplicate) service. For the counsellors, it was at best conjecture on the part of government representatives that individual clients, after attending five to six sessions/hours of culturally appropriate counselling assistance, would be able to resolve social issues affecting their health. In confronting such claims, the counsellors pointed to the fact that these individuals had previously found the range of services provided within the established service environment inaccessible and/or inappropriate due to socio-cultural or linguistic barriers. As a consequence, the assumption made by government representatives that these individuals would now be able to effectively access and use the same range of services was openly challenged by members of the counselling group.

The overt conflict between the counselling group and the established service system disconcerted the administration of Mount Carmel. As part of the established service environment, Mount Carmel was expected to support motivations and behaviors that were consistent with the overall service environment. In practical terms this meant that lobbying for the funding of new services was to be accomplished through the submission of funding proposals and not through the public media.

Commenting on the contrasting objectives between these two groups, an Advisory Committee member remarked:

Tensions existed between [the co-ordinator] and Mount Carmel. [The co-ordinator] wanted an agency that did more than refer. He sensed that was what Mount Carmel wanted. Mount Carmel was caught between...what funders would fund and being well-meaning. The Administrator was frustrated that [the co-ordinator] wouldn't deal with what could be done.

In the mind of another Advisory Committee member, Mount Carmel supported only certain aspects of the overall orientation of the counselling group, specifically mental health service provision and public education regarding the need for greater cultural sensitivity among service providers. Mount Carmel was believed to be very uncomfortable with the political activities of the program:

Mount Carmel is uncomfortable with political lobbying. They pick their own issues and address them through providing health care services instead of lobbying the government over social issues....Mount Carmel is not happy to be connected with out-spoken community education.

Professionalism

Another influence upon the development of the program were Canadian professional licensing bodies, specifically their lack of recognition of foreign trained health providers' credentials. The foreign trained psychologist who first volunteered his services had to gain permission from his Canadian trained supervisor prior to being able to offer his services to community members. The issue of recognition of immigrant credentials affected the practices of other foreign trained counsellors as well. Despite many of them having gained professional credentials elsewhere and exhibiting considerable motivation and skills here, they must supplement their professional credentials with further education and training in Canada.

These issues not only point to the counsellors' commitment to use their expertise to assist other newcomers to Canada but to a broader public policy issue, barriers to the recognition of credentials of immigrants. It can be noted here as well that employment barriers and difficulties faced by immigrants to Canada, are in many cases, a significant contributing factor to the mental health problems facing many newcomers (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees 1988). The policies of the medical professions actually reduce the supply of culturally diverse health care providers, working at cross purposes to federal immigration policy's objective of supplementing the Canadian employment pool with a well-educated and highly motivated immigrant workforce (McDade 1988).

These particular circumstances influenced what the program could and could not do. It directly affected relationships between the different stakeholders of the program. For example, within the organizational setting of Mount Carmel, tensions existed between the co-ordinator of the program who was a foreign-trained psychiatrist and the medical group which was contracted by Mount Carmel to provide medical services. Despite the

acceptance of this counsellor as 'a gifted health care provider' by the administration of the Clinic, neither the administrative nor the medical staff were willing to recognize him through title or action as a doctor. Indeed Clinic receptionists were specifically instructed to correct clients who used 'Doctor' as a form of address. This was in direct contrast with how the counsellor's abilities and motivations were understood and respected by other foreign-trained health professionals, several licensed health care providers in Winnipeg, and members from his own socio-cultural community. For the most part the reference 'Dr.' was used out of respect or deference and did not necessarily denote professional license.

However, for the medical staff reference by the title Dr. was an issue of territoriality, and for the Executive Director of the Clinic, it was a question of legality. As one respondent commented:

Dr. [name withheld] was going to oversee how the reports were signed....As a program now in an institutional hierarchical structure, the influence of professional regulatory bodies must be recognized. This doesn't occur in volunteer organizations. This scrutiny limits the naming of problems. For the medical group, it's a matter of territoriality.

Here is an example of the institutional influences on social interaction at the individual level. It is an example of a professional regulatory body's attempt to limit who is allowed to participate in the dialogue of need interpretation. Power is exercised through the ability to name and regulate problems as well as through the ability to determine who is allowed to interpret needs and to provide services.

Record Keeping

In addition to these monitoring practices, further regulation and control over the counselling program was established by Mount Carmel through formal demands placed on counsellors to produce statistical information on 'their program'. The counsellors were asked to complete patient forms, formalize record keeping procedures and complete various instruments for evaluative purposes. Previous to the move to Mount Carmel the volunteer-based counselling group, similar to other volunteer organizations, had expended their

energies on service delivery and promotional activities rather than on formal record keeping efforts. Many of the counsellors did not accept the task to complete patient forms or instruments for evaluative purposes. For some of the counsellors, this omission was the result of time constraints and not an issue of accountability, since their limited time at the Clinic was occupied with direct service provision to clients. For others it did not appear to be an issue of time constraint but rather hesitancy for whatever reason(s), including political ones, to participate in the evaluation process. However as the co-ordinator was responsible for ensuring that forms were completed, his supervisory responsibilities in these respects occasionally contributed to tensions between himself and various counsellors.

Theoretical Insights and Conclusions

Institutional Influence

Government representatives' comments reflect a particular orientation in terms of thinking about newcomer health. They display an atheoretical approach to the social issues facing clients of the program and a tendency to ignore the socio-cultural basis of newcomer experiences and perception of themselves and society. Their remarks further imply that the socio-emotive context of an individual's difficulties can be stripped away or at the very least, that the emotive content of these issues should be dealt with outside the formal support system. Their remarks about the CCCU reflect administrative understandings, processes, and practices.

Governmental authority to make funding decisions reinforced their institutional influence or claim making power upon the possible patterns of interaction for both the counsellors and clients of the counselling program. Moreover, the larger bureaucratic requirements and biases resulted in an environment detrimental to the community based service's original, grass roots defined purpose. The following discussion will elaborate this point by considering the various aspects of the relationship between health problems and the health care system as experienced in Western societies.

Compartmentalization & Privileging of Issues

An individual's realm of difficulties may include several problematic dimensions and features which are related both conceptually and emotionally to each other, yet the expectations and tendency of the human service system is to separate these issues. Through the bureaucratization of social issues, issues tend to be separated and engineered to fit the workings of the larger organizational systems and subsystems. Thus, we have separate divisions for culture, employment and economic supports, health etc., despite the fact that a newcomer's changed employment status may be affecting their ability to lead a healthy life, for instance. In so far as newcomer problems become visible, they are submerged under the generic problems of lack of information or language skills thereby characterizing their deprivation and personal troubles as being due to their way of life, their culture. In other words, their problems are understood as defects of socialization which can be corrected through professional guidance (Piven and Cloward 1972: 219 cited by Ferguson 1984: 142). One resulting view, expressed by a government official above, is that mainstream culture / language skills are readily assimilated by newcomers in a relatively short time period.

Ferguson writes that such an approach to social issues is characteristic of living in a Western society where citizens are expected to master "certain social, cultural, psychological, political and linguistic arrangements" (1984: 9). Individuals are assumed to be competent in the knowledge of how social issues are understood and addressed by agencies and institutions of the society. Characteristically, the human service agencies and organizations claim that they "operate on the basis of rules which are neutral, objective, and scientific, while clients are seen to operate on the basis of values, which are personal, subjective and biased" (: 137). This reflects a liberal notion of science, and by extension formal organizations, as being value-free. This sentiment ignores internal structural forces acting within the organization, and the influences of the larger society's dominant cultural institutions.

Reality and Belief Interactions

At the level of service acquisition, system driven processes require the individual to abide by bureaucratic rules and regulations - and bureaucratic divisions - in order to receive certain forms of assistance. Lipsky suggests that such practices require individuals to "learn to treat themselves as if they were categorical entities" (1980: 53 cited by Ferguson 1984: 145).

At the societal level, these institutional processes exert a reifying influence on individuals. Not only do individuals come to redefine their difficulties in terms of bureaucratic understandings but over time they influence individuals and social groups to view normative areas of life such as family relations, education, old age, physical and mental health, according to the normative claims of professionalized practices and knowledge. Individuals are influenced to conceptualize social problems as individual ones, not amenable to collectively oriented solutions. Professionalized practices and knowledge constantly individuate social members and their difficulties by administrative, instrumental strategies and techniques and are based on the so-called scientific and neutral discourses found within the dominant institutions of society (White 1988: 113). As a result, norms and values are extracted from the understanding of everyday life situations, and replaced with administrative logic. The predominance of this administrative approach constrains and reduces the diversity of cultural and social expressions of ways of life possible within a pluralistic society.

Habermas (1987) suggests that the phenomenon of increasing use of regulation by public bureaucratic driven institutions creates several interrelated processes which penetrate and influence the belief systems at the individual and group level. While increased regulation serves as a mechanism for the reproduction of bureaucratic practices and processes and the overall social system, it has dire consequences for cultural and social groups in society because it creates an inevitable "pressure toward the redefinition of everyday life situations" (White 1988: 113). According to Habermas, such systemic pressures lead inevitably to the colonization or the breakdown of the lifeworld of social groups - the background of beliefs and feelings against which human action occurs.

Various social groups' understandings of everyday life are co-opted to fit to bureaucratic rules and relationships. Accompanying these changes is the attendant loss of cultural ways of knowing - how individuals come to understand themselves and the social world which they inhabit.

Administrative logic's displacement of cultural ways of knowing is problematic because it tends not to be wholistic, and to ignore these cultural factors. In the case of health, it meshes better with a biomedical, rather than a wellness model, of health. The administrative logic and biomedical discourse of the Canadian health care system not only subvert cultural diversity but themselves embody a cultural bias from the dominant culture they reside within and simultaneously produce and influence. The chances of cultural others being served appropriately by these institutions are consequently reduced.

Critiquing the Options

We can deepen our analysis of the issue of barriers to newcomer health access, by critiquing the realm of options available, rather than assuming a strict focus on barriers to existing services. Instead of viewing the counselling program as a bridge to the established service system, the program may be seen as the creation of an appropriate alternative for many groups who feel excluded from the current service delivery system.

Patterns of Resort

These considerations are related to what is now popularly referred to as the determinants of health. For example, at the individual or group level, the ability to live a healthy life is, in part, dependent on what resource and service options are available to individuals or groups. It is within the context of the existing choices that individuals and groups base their help seeking decision-making practices.

Allan Young (1990) describes such help seeking practices as "patterns of resort" - decision-making paths that people create as they seek relief and/or assistance by picking and choosing among options within the context of systems. Young (: 205) suggests that

patterns of resort are related to the range of individual options. These options are generally a product of the combinations of determinants present within the contexts of available systems. These determinants include: 1) the range of likely diagnoses and/or appropriate categories of diagnosticians; 2) the perceived seriousness of this sickness for this patients; and 3) the relative (perceived) effectiveness of the medical traditions that co-exist within this medical system. He further states that there may be other forms of knowledge that are distinguishable from beliefs concerning the diagnosis and evaluation of sickness but may determine patterns of resort. These would include: 1) the attributes of specific practioners; 2) the economic and geographical accessibility of various options; 3) the perceived cost-benefit of choosing a particular option; and 4) the socially and culturally determined appropriateness of this treatment and/or service/care provider for this patient under these particular circumstances. Should 'appropriate' care not exist, a possible consequence of a limited system of options is that the person will reframe their own definition of problems and solutions to mesh with the basis of understanding which underlies the range of options that exist (Lock and Dunk 1990: 257). The problem with this outcome is that the reframed 'solutions' may not really be solutions at all, merely substitutes with varying, or no, efficacy.

One can argue that this is precisely what happened to many of the clients before they found the counselling program. They had accessed the main stream health service and had not merely been verbally misunderstood, but often misdiagnosed according to the biases of a bio-medical tradition based upon Western paradigms and cultural assumptions. Could they successfully access mainstream services in the near future? Or services with 'sensitized' practitioners as Masi argues? To the extent that their problems fit a biomedical problem, perhaps. But to the extent that their difficulties cannot simply be translated into the biomedical paradigm, this alternative is a poor second. Moreover, one could argue that providers in the cross-cultural counselling program who were narrowly educated in the biomedical paradigm and brought up within Westernized households in their country of origin, embody the Masi alternative to the extent that they perform as translators sensitive to culture, but prescribe biomedical health care solutions to mental health problems whose origins are socio-cultural.

Summary

The cross-cultural counselling program began at the community level during the mid 1980's, primarily created by individuals who, based on their own migration experiences and interaction with the human service environment in Winnipeg, recognized a need to provide supportive counselling related to social, cultural, and linguistic issues facing newcomers to Canada. By beginning the counselling program and through continued efforts, community members and the volunteer counsellors attempted to provide a culturally appropriate service option for individuals who had found the formal health and social service systems culturally and/or linguistically inaccessible.

In this way the development of the counselling model is similar to that of a social movement. Like other social movements, concerned individuals began to promote the needs of their communities through lobbying efforts as well as by providing services and resources for their members which did not previously exist. To accomplish these goals they began to build a base of supporters by educating various stakeholders within the mainstream health and service systems. They voiced the needs and experiences of their fellow community members and by doing so revealed how their needs were not being addressed by current institutional arrangements and practices. Constructing, maintaining and promoting the values of a social movement is "fundamentally politically oriented social action." Typically these efforts seek "to build a membership, to educate a base of supporters, to articulate a sense of possibility of a better life, to reveal relations of control that function to systematically repress, exploit or deprive a vast number of people of what might otherwise be theirs" (Forester 1982: 45).

The efforts of these concerned individuals eventually led to the relocation of the counselling program under the organizational direction of a provincially funded community health centre. The institutional relations governing Mount Carmel Clinic and the wider health care service environment provided an organizational environment which began to increasingly shape and organize the goals and direction of the program towards the professional and social processes and practices which had failed to adequately consider and address the needs of newcomers in the first place.

To some extent, the different structural setting of the Clinic caused problems of control. The Clinic program's are the legal responsibility of its Board of Directors, to whom information is relayed through Mount Carmel administrative staff with their own particular concerns over work load, responsibility and chain of command. Not surprisingly, this provoked a power struggle over direction of the cross-cultural counselling program. Not only had it been organized by a different socio-cultural community/ies, the service providers were de facto representatives of said community and (had) exercised considerable control over the program's operations. Disparate approaches to effecting political change on the part of Clinic members and the program's supporters reflect different life experiences and organizational positions within society, with a clear possibility that program users' needs might be compromised, at least within the short term.

The bureaucratic imperatives of a government bureaucracy already tight for funds also contributed a structural pressure, in this case to confine the CCCU to the role of short term service feeding into, rather than competing with, the existing service system. Further, government's power over the purse strings necessarily steers actors attempting to win funding. Beyond this however, is the underlying ideological bias of government and mainstream society which interprets needs in a fashion contrary to cultural others' expression of needs. Remarks by government representatives evidence a lack of appreciation for the rootedness of health perception in diverse lifeworlds, and by extension, of mainstream health care's inherent socio-cultural assumptions. This point of view, and the bureaucracy's pressures, particularly over money, reduced the formerly independent, volunteer run program's ability to remain faithful to its *raison d'être* once ensconced within the formal health system.

At the local setting of the counselling program, competing understandings, intentions and expectations concerning the goals and direction of the counselling program existed among various staff members as well as other concerned groups and individuals. At various points in time, these differences became apparent and were exhibited during the interaction among and within differing stakeholder groups. It should be stressed that despite these social dynamics and the disagreements over the direction of the counselling program, efforts were sustained by all staff members of Mount Carmel Clinic including the

counselling group to promote, albeit various versions of, the program.

Chapter Eight Conclusions

In so far as the government has begun to address the issue of cultural diversity in health needs, the approach it has taken has been to create ports of entry to the established service systems such as organizational maps, sensitized providers, and language interpreters. Cultural others are expected to adjust to the new 'normscape' through the assimilation of basic knowledge provided by settlement agencies about what mainstream (established) services Canadian society offers. Newcomers receive minimal instruction on the organizational framework and functioning of the human service environments. For the most part, the normative basis that guides which health needs are selected and addressed goes unexamined.

The medical system's response to the challenge of newcomer's (cultural other's) demands has been the promotion of culturally sensitized health care providers. Interpreters may also be provided to overcome language barriers. This strategy has a limited focus. It seeks only to overcome the communicative difficulties between the provider and the consumer. Within this conceptual approach, the health provider is promoted as the bridge for the consumer to cross over to the wisdom and ways of the established service system. Hence, the therapeutic dimension of the encounter between the provider and the service provision necessarily encourages each consumer to translate their culturally and experientially shaped beliefs into the interpretive schema of the service provider. The cultural understandings of the consumer, rather than being ignored, are now to be transformed through a culturally sensitive process.

This thesis recast the problem of accessibility to the health system. Instead of looking at cultural barriers between caregivers and patients, it examined the institutional and ideological factors which inhibit the transformation of the established service systems to reflect the plurality of needs in a multicultural society. This formulation acknowledges the culturally specific underpinnings of the Canadian mainstream health system, in contrast to the assumptions of universality governing most discussions of health care institutions. Specifically, I have investigated the emergence of a cross-cultural counselling program

presenting a direct challenge to the socio-cultural basis of the established service systems.

The remainder of this chapter will recap some of the main findings and conclusions from this exploration. The approach has been multifaceted, thus this summary will highlight the various dimensions, both in their empiric and theoretical aspects.

Individual Impacts

Newcomers

Individuals using the CCCU represent a variety of cultures. Those counted during the demonstration project came from 26 source countries. The majority of the client population is from Central and South America though newcomers from Africa and Asia make up a significant proportion of the client load. Over 63% of the clients during the demonstration year had been in Canada less than three years, though 13% of clients had lived in Canada more than ten years. These statistics suggest that newcomer difficulties with the mainstream health system are relatively long-term, with problems lasting more than the couple of years as planned for by immigration, health and social authorities.

Consumers of the counselling program spoke of how the established medical system failed to understand the socio-cultural basis of their difficulties. This experience has been repeatedly demonstrated in the literature. As a direct result of misunderstanding, newcomer difficulties were often misinterpreted by providers resulting in the unwarranted utilization of biomedical services. The majority of clients attributed the lack of proper care to misunderstandings both on their own part and on the part of the service provider due to cultural and linguistic differences, differing life experiences, and the brevity of their encounter with a provider.

Clients' further articulated a sense of having their problems not seen holistically. While physical needs, social resources, employment status and income level are determinants of health, they are rarely addressed in health service provision. Medical diagnosis has not tended to take these matters into consideration. To the extent that government services exist to address problems in these areas, they are usually fragmented

into separate departments. This is consistent with bureaucratic growth in society. Solutions to an individual's realm of difficulties may require a multifaceted approach to handle the interdependent issues, but since portions of the problem are separately addressed by different organizational frameworks and settings the most efficacious remedies are often overlooked.

Settlement Workers' Comments

People who work most closely with newcomers recognized the cultural shortcomings of the established service system. According to settlement workers, many of whom are newcomers themselves to Canada, the mental health needs of immigrants must be understood through a socio-cultural perspective. In addition, the issues raised by these respondents illustrate the need to appreciate the socio-political construction of newcomers' difficulties, including both pre- and post-migratory experiences.

Based on personal experiences as a refugee and later as an employee of the established service system, one worker pointed to evidence that mental health needs are contextually embedded, that is culturally understood and expressed by newcomers, as well as by other Canadians. In his opinion, the acultural claims of the medical model guiding the established service system are ironic given the many ways of understanding mental health difficulties. He argued forcefully that the cultural basis and values of the medical model become noticeably problematic when cultural differences separate the health care provider and the consumer.

Many of the workers emphasized that the newcomers health is related to their ability to participate effectively in society. An individual's understanding of issues affects their ability to live a healthy life. This understanding is embedded in normative structures, processes or ways of thinking about themselves and their environment that can differ markedly from culture to culture, and from person to person depending on life experiences. These comments support the notion that newcomers' lifeworlds cannot quickly be replaced to match the orientation of their new society's services.

The Short-term Nature of Settlement Services

The above observations and opinions are in stark contrast to the realm of services offered by the various social agencies providing specialized services to assist newcomers. These agencies' work was noted as dealing primarily with issues of initial settlement. Services range from provision of housing, clothing and food, to language classes, to a basic orientation as to how various human and health services work. Beyond this initial support and information, settlement service assistance is very limited. Immigrants are expected usually within two to three years to function independently, utilizing medical and various other forms of social services.

Other Stakeholders

CCCU staff tended to conceptualize newcomer needs in a similar fashion to the settlement worker paraphrased above. Commentary from mainstream health care providers, on the other hand, varied widely and provided the most extreme example of differing perspectives within a single interest group. Opinions among these physicians ranged from the contention that culture is fundamental to the patient's perception of their situation and feelings of ill health and consequently to the health care provider's understanding of the problem and ability to give suitable care; to the view that culture is just a layer that can quite easily be seen through to make a generic diagnosis.

The most notable comment by the government stakeholder group was to the effect that the CCCU should be a feeder service to the established system, in effect operating like settlement services as a short term orientation before clients adapt to mainstream offerings.

Individuals associated with Mt. Carmel Clinic tended to be unwilling to openly challenge the government's definition of the program, supportive instead of the more moderate position of public education promoting cultural ports of entry.

The views of the various stakeholders represent a series of differentiated patterns of needs interpretation in the public sphere, illustrating a premise at the heart of this thesis. Not only is there a plurality of needs, there is disagreement over what the needs are. This

makes the interaction of the different players vis a vis the establishing of a new service, particularly one claiming to address unmet needs, all the more interesting and problematic.

Discourse, Liberalism & Public Policy

The study inquired into the social meanings embedded within social programs; meanings which structure what and how needs are addressed and which are themselves seldom scrutinized. The ways newcomer needs regarding mental health services are constructed, promoted, maintained and understood were the specific focus. The description of competing meanings, motivations and interests within existing policies and practices necessarily brought into the discussion the role of discourse in defining what are social needs and establishing how they are to be considered in public dialogue. Based on the analytical work of several critical theorists, I contended that the conventional approach to the interpretation of needs is based on a liberalist philosophical tradition which promotes specific ways of understanding and addressing social needs. The liberal tradition seeks to promote its particular pattern of needs interpretation as generalizable or universal across society despite its implicit normative biases.

As the arguments of feminist theorists like Benhabib, Fraser and Young showed, needs in Western society are selected and addressed according to a highly ethnocentric and androcentric normative belief system. The Canadian established service system is necessarily premised on specific normative assumptions. The history of immigration, and of health and settlement service development in Canada, as well as the comments of newcomers themselves bear this out.

In practical terms, the normative assumptions of public policy serve as a guide to direct analysis and action in the area of needs assessment and service provision. Public policy statements by both the federal government and the provincial government in Manitoba note the importance of social factors such as cultural and gender in the promotion of health. The practice however, as exemplified by the dearth of culturally appropriate services for more recently arrived cultural groups to Canada, suggests a system resistant to change. The assumption that biomedical and related Western health practice is universally

applicable persists, as exemplified in the failure of Manitoba's health reform plan to concretely discuss the different approaches that health care might take in order to meaningfully address the issue of inaccessibility due to cultural or social factors.

The Manitoba Action Plan articulates and promotes a generic or atheoretical understanding of the way public policy, social environments and individual behavior all affect the ability of individuals to live a healthy life, and hence does not pursue the implications of relations of gender, ethnicity and class. In it, gender, race and community are used as descriptors, but without acknowledging that these factors have implications for what appropriate services are - that there exists plurality in terms of need. As a policy tool, community is used as a generic descriptor void of considerations of social diversity. Through the use of such opaque descriptors, needs may be understood, presented and addressed through quantitative terms and promoted as generalizable across society.

Provincial and federal public policy is reflective of an institutionally based health care system which develops and delivers generically based services, despite the heterogeneous health needs of a socially diverse population. In contrast, shared goals like equalizing health status require a move *away* from uniformity towards the development of variety in program resources, design and delivery so as to address the needs of diverse populations. The absence of this recognition suggests that the government's understanding of wellness is a narrow one. Complicating factors like funding shortages and bureaucratic practice further temper government's willingness to allow fundamental changes in this direction.

Organizational Effects

I have attempted to demonstrate the manifestation of power in the discursive practices of government policies and practices, specifically the provincial health care system. Through policy, governments actively promote the classification and management of information and the subsequent realm of solutions to be sought and forms of service provision to be considered. In this way, these discursive practices can be seen as providing the determinants of service utilization, which predetermine the choices for

consumers. They also influence the organizational settings and indirectly the micro level processes which occur within these settings.

The recent history of the CCCU's attempt to gain long-term funding illustrated the established service bureaucracy response to the challenge of a cultural other - here in the form of an organization. Similar to the treatment of the culturally different individual, the existing system - both the Health Ministry and Mount Carmel Clinic - attempted to define organizational needs and to shape the program to conform to the social understandings evident in the normative organizational arrangements of the established medical and social service systems in the province of Manitoba.

Existing service practices and provisions are necessarily privileged and newly created services or practices must gain acceptance. This situation can bring the competition between different interests, and the effects of structural policies and practices on social interaction at the individual level, to the surface. There were several manifestations of these effects. CCCU staff's articulation of the only recently public issue of newcomer problems in the area of mental health, were countered with government representatives' versions of the most suitable means to address the need. Government imposed its definition of that need through Mt. Carmel via the funding structure. Consequently, conflict arose over the disparity between the counsellors' more far-reaching critique of existing services and the Clinic's more conciliatory approach to government. Along with traditional bureaucratic pressures, institutional influence aided the shift in power from community members and counsellors to Mount Carmel Clinic's administration. The most obvious example of this process was the cessation of direct collective staff decision-making input into counselling program planning and operational issues.

These changes and conflicts highlight the dynamics of institutional - individual interaction. Public policy, an interpretive pattern of needs interpretation and its derivative, the provision of health services and resources, help to influence and organize social interaction throughout organizational arrangements - from administrator to provider to consumer - by providing form and content through the distribution of certain roles and responsibilities. On the other hand, power is also exercised in the micro processes of interaction. The actions of individuals based on personal motivations and interests

contribute to societal stasis and change. Through carrying out their specific role within an organizational structure, individuals contribute to the reproduction of the organization, but they can also contest dominant discursive practices with alternative ways of understanding and practices. The existence of multiple meanings and ways of understandings suggests that power is not a simple possession but rather is constituted through a set of social relations in which actors have skewed opportunities for action and influence. Individuals on the social periphery of the system, such as the counselling group members, are in a position to challenge and attempt to effect change in the ways of understanding and the dialogue of need interpretation in the public sphere.

Summary

The intent of this study was to describe the development of the Cross Cultural Counselling Unit, juxtaposing its normative orientation with the discursive practices of government. Rather than a strict focus on the cultural incongruity of the newcomer, I choose to explicate the response of the established medical and social service systems to the emergence of a culturally specific service claiming to address unmet needs. The statements of the counselling program's originators, users, and referral agents were contrasted against the claim making practices of an established service system purportedly delivering a universally accessible services. These differing patterns of need interpretation provided a dialogue to communicate the CCCU's struggle.

This involved discussion of the discursive practices, specifically the norms and assumptions, of the institutional relations which structure and organize the established Canadian medical and social service systems. The response of the established service system provided insight into how the normative orientation of the discursive practices reacted to challenges to its particular pattern of need interpretation and claims of universality. The history of psychiatric definitions of mental health problems was given as an example of cultural determination in medicine, and the liberal philosophy of science as the basis of claims to a 'universal', yet nevertheless culturally imbued, health system in Canada.

The experience of the counselling program's integration within Mount Carmel Clinic provides a striking example of the clash between the expressed needs of newcomers and the existing system's service orientation. The program started with a volunteer group of foreign trained professionals providing mental health services oriented to Latin Americans and later to other newcomer cultures. In order to enhance the program's security and accessibility, it was moved into the Mount Carmel Clinic, an established community health centre within the provincially funded health and social service systems. The program's internal workings changed to accommodate a bureaucratized structure regulated by governmental insurance and medical bodies, though not without resistance on the part of counsellors.

The very mandate of the CCCU was a source of conflict to the established pattern of need interpretation in the public sphere. In response to the challenge, representatives of the existing service system attempted to provide interpretive boundaries to the service parameters of counselling program. Here power was exercised by the established service system's ability to provide the dominant pattern of interpretation by which health needs are understood and addressed by public institutions. This success was made evident as the counselling program was absorbed into the Clinic's organizational structure. The program became increasingly steered by the social relations of the system rather than by the particular needs of the people it was intended to serve.

This study has presented a window on the dynamics of societal change and stasis in the provision of health services and resources to an increasingly culturally diverse Canadian population. The recent response of the Canadian state to this complex challenge, popularly known as the culturally sensitive approach, I contend is more supportive of societal stasis than reflective of cultural change or accommodation. This approach implies a limited role for services which fall outside of the normative orientation of the established service system. At best, competing or 'cultural other' services will be relegated to the relatively non-threatening periphery position of a feeder service to the existing established service system. It can be argued that this represents a preliminary phase in the evolution of the system, with recognition of cultural difference eventually being manifested within the normative orientation of the entire health system. This may be a naive proposition

however. The findings of this research suggest that unless the normative implications of the current discursive practices evident in policy and realized service practice and provision are acknowledged, contrary to the legacy of liberalism and positivistic science, the system will retain its current culturally imbued character.

Yet, given the success of various individuals and groups in making public the import of the relationship of socio-cultural considerations to health, it is extremely unlikely that the culturally sensitive approach will be embraced fully by those whom it was intended to appease. Similar to other social movements, these individuals and social groups will likely continue their efforts to have their lives and experiences understood through their own voices and to have these considerations included in the public dialogue of need interpretation.

Appendix A

Interview Sources

Mount Carmel

Interviews were conducted with the various individuals involved with the Cross Cultural Counselling Program at the Mount Carmel Clinic - administrative and program staff, members of the Advisory Committee of the (CCCU), and clientele of the programas well as a Board member of the Clinic.

Referral Agencies

International Centre of Winnipeg, Manitoba Interfaith Immigration Council, Immigrant Access Services, Immigrant Women Association of Manitoba, Immigrant Women's Employment Counselling Service, Refugee Settlement Unit - Canada Employment and Immigration, Immigrant and Refugee Community Organization of Manitoba Inc., Child and Family Services (Winnipeg), Worker's Compensation Board of Manitoba, Health Sciences Centre (Winnipeg) - [Emergency Department, Social Work Department], Canadian Mental Health Association (Winnipeg), family physician.

Mental Health Providers

Government Representatives

A senior representative from the Winnipeg Region of the Mental Health Services, Division of the Ministry of Health.

Director of Immigration and Settlement Services, Department of Culture, Heritage and Citizenship.

Appendix B

Interview Schedule - CCCU Clients

1. What health services do you see as available for you to use in Canada?
2. How did you learn about what health services exist for you to use in Canada?
3. Do you feel you have enough information about what services are available for you to use?
4. What health services have you used since you came to Canada?
5. a) Did the service meet your needs? explanation
b) Would you use the same service again? explanation
6. What do you think would help in making these services better able to meet the needs of individuals from your community or cultural group?
7. Are there services you would like to see made available?
8. a) Where do you go for help for a non-medical problem?
b) Where would you go for help in your former homeland (country) for a similar problem?
9. Where would you go for help in your former homeland for a medical problem?
10. How did you learn about this service (CCCU)?
11. Does this service help you with your health needs?
12. Does it help you in any other way?
13. Do you think the CCCU service could be improved?
14. Do you know of other places where you could get help?
15. Would a counsellor from a cultural background different from your own be able to help you with the problems that your counselor here is helping you with?
16. Is the cultural background of your counsellor important in his/her ability to help you with your problems?
17. What did you expect would be different in your life when you moved from your former homeland to Canada?
18. How does your experience differ from these expectations?
19. Do you believe these differences have affected your health?
20. Are there any other types of assistance that would help individuals to gain an understanding of Canadian culture and adapt more easily to Canadian society?

Appendix C

Interview Schedule - CCCU Counsellors

Obtain background of counsellors - where they are from, education, training, other relevant experiences.

1. What do you see as the objectives / goals of this service provision?
2. Describe other cross-cultural services available for newcomers in Winnipeg? awareness of; opinion.
3. How could the external system be enhanced to better equip individuals to adapting to a new country and thus prevent many health related problems?
4. What is your estimation of the percentage of individuals (clients) experiencing problems due to not understanding how Canadian society is structured/functions ie. employment, health and social institutions etc. versus pre-migration psychological problems?
5. Is there a logical separation of social work versus psychological counselling cases as seen by the CCCU staff?
6. Do you see torture or exile syndrome as a primary target population for the CCCU?
7. What aspects of the service delivery ie. the interaction between the counsellor and the client is directly related to the social and cultural background of the client?
8. How do these cultural aspects become manifested in the interaction?
9. What are the social and cultural similarities between the counsellor and the client that are used in the counseling sessions?
10. How are these similarities drawn upon (used) by the counsellors in their sessions?
11. What devices do counsellors use to show that they are knowledgeable about a client's cultural group?

Appendix D

Interview Schedule - Referral Agents

1. What services does your organization provide to immigrants and refugees?
2. Describe the mental health service needs of immigrants (newcomers) and refugees?
3. As compared to native born Canadians are immigrant (newcomer) mental health needs expressed differently?
4. Does the present mental health system meet the needs of immigrants (newcomers) and refugees? If no, in what ways --how could the system be improved?
5. How long have you known about the CCCU service?
6. How did you learn about the CCCU service?
7. Describe what the CCCU service provides?
8. Could the CCCU service be improved? If yes, how?
9. Have you referred individuals to the CCCU? If yes, for what reasons?
10. Is there another service(s) that could provide similar assistance for these individuals?
11. Do you believe that the adaptational problems experienced by these individuals could have been prevented? If yes, then how?
12. Has the CCCU service referred individuals to your organization? If so, for what purposes?
13. Are there other services that should be made available to assist newcomers in adapting to Canadian society?

Appendix E

Interview Schedule - Mental Health Providers

1. Describe the mental health service needs of newcomers - immigrants and refugees?
2. As compared to native born Canadians are immigrant (newcomer) mental health needs expressed differently?
3. Does the present mental health system meet the needs of immigrants (newcomers) and refugees? If no, in what ways --how could the system be improved?
4. Have you provided mental health services to immigrants (newcomers) and refugees?
5. Does the social or cultural background of the immigrant client become manifested in the therapy?
6. If yes, what aspects of your health service is directly related to the social and cultural background of the immigrant client?
7. Have you provided mental health services to individuals who lack an adequate understanding of the language in which your health service provision is offered? If yes, how have you dealt with this issue? If no, and this were to occur how would you deal with this issue?
8. Do you see language similarity between the health service provider and her client as an important aspect of health service provision? If yes, why? If no, why not?
9. How long have you known about the CCCU service?
10. How did you learn about the CCCU service?
11. Describe what the CCCU service provides?
12. Could the CCCU service be improved? If yes, how?
13. Have you referred individuals to the CCCU? If yes, for what reasons? If no, would you refer clients to the CCCU? If no, why not? If yes, for what reasons?
14. Is there another service(s) that could provide similar assistance for these individuals?
15. Do you believe that the adaptational problems experienced by these individuals could have been prevented? If yes, then how?
16. Has the CCCU service referred individuals to your organization? If so, for what purposes?
17. Are there other services that should be made available to assist newcomers in adapting to Canadian society?

Appendix F Socio-Demographic Schedule for CCCU Clients

File Number: _____

(1)

Date of Birth: Day/Month/Year _____

(2)

Age: _____

(3)

Sex: Male _____ 1 Female _____ 2

(4)

Marital Status: (5)	Single	_____ 1
	Married	_____ 2
	Common Law	_____ 3
	Divorced	_____ 4
	Widowed	_____ 5
	Separated	_____ 6

Date of First Contact: Day/Month/Year _____

(6)

Country of Origin: _____

(7)

Arrived in Canada: Day/Month/Year _____

(8)

First Language: _____

(9)

English Speaking Ability: (10)	Not At All	_____ 1
	A Few Words	_____ 2
	Enough To Get By	_____ 3
	Fairly Well	_____ 4
	Fluent	_____ 5

Occupational Qualification: (11)	Homemaker	_____ 1
	Unskilled Labour	_____ 2
	Skilled Labour	_____ 3
	Professional	_____ 4
	Self Employed	_____ 5
	Farmer	_____ 6
	Unable to Code	_____ 7

Current Occupational Status:
(12)

Unable to work Due to Disability,	___1
Pregnancy or Child Care	___2
Full-time Student	___3
Unemployed Student	___4
Employed But Not Enough Hours	___5
Employed But Not In Qualified Area	___6
Employed	___6

Type and Severity of Presenting Problem:
[as assessed by counsellor]

Individual's Problem
(13)

	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
Clinical (1)	-----	-----	-----
Cultural Adjustment (2)	-----	-----	-----
Psychopathology(3)	-----	-----	-----
Psychosomatic (4)	-----	-----	-----
Alcohol/Drug Abuse (5)	-----	-----	-----
Social Legal (6)	-----	-----	-----
Torture Victim (7)	-----	-----	-----
Other (Specify) (8)	-----	-----	-----

Couple's Problem
(14)

	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
Due to Adjustment (1)	-----	-----	-----
Emotional Relationship (2)	-----	-----	-----
Sexual (3)	-----	-----	-----
Financial (4)	-----	-----	-----
Ideological (5)	-----	-----	-----
Other (Specify) (6)	-----	-----	-----

Family's Problem
(15)

	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
Children's Education (1)	-----	-----	-----
School (2)	-----	-----	-----
New Cultural Norms (3)	-----	-----	-----
Other (Specify) (4)	-----	-----	-----

Appendix G Help-Seeking Patterns - CCCU Clients

1. File Number: _____
2. Was the Consumer Referred to the CCCU: Yes ___ No ___

a) If Yes, By Whom?

Self ___
Family ___
Friend(s) ___
Mount Carmel
(specify) _____

Medical
(specify) _____
Mental Health Service
(specify) _____
Social Services ___
Legal ___
Educational ___
Settlement Service ___
Other
(specify) _____

3. Has the client previously utilized the CCCU program: Yes ___ No ___

4. a) Date of first (current) session at CCCU: _____
(Day/Month/Year)

b) Date of last (current) session at CCCU: _____
(Day/Month/Year)

5. Total number of counselling sessions: _____

a) When was initial problem first recognized? _____
(Day/Month/Year)

6. Who Recognized the Problem:

Self ___
Family ___
Friend(s) ___
Medical ___
Social Services ___
Legal ___
Educational ___

Settlement Services__
Other_____

7. Has the consumer sought help for the initial problem from anyone else?

a) Yes __ No __

b) If Yes, From Whom?

Self__
Family__
Friend(s)__
Medical __
Social Services__
Legal__
Educational__
Settlement Services__
Other_____

c) If Yes, indicate appropriate number of contacts: _____

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