Enhancing and Developing Policies, Models and Practices to Address the Mental Health Needs of Immigrant and Refugee Women in Saskatchewan

By

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A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfillment of the requirements of

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Abstract

Research studies have identified the underutilization of mental health services by immigrant and refugee women, but have not adequately discussed the relevance and appropriateness of many of these services to the needs of immigrant and refugee women. These concerns risk being ignored in Saskatchewan because of the low numbers of immigrant and refugee women living in this province. Yet, women continue to carry out significant caregiving roles in Saskatchewan, at the same time that they are coping with migration, settlement, and integration issues.

This thesis has used a case study method which focuses on the context of Saskatchewan. The thesis has used a critical multicultural theoretical approach to guide the development of this study. Individual and focus group interviews were conducted with immigrant and refugee women, and with service providers living in Saskatchewan. The thesis has described the mental health issues affecting immigrant and refugee women living in Saskatchewan. These have included many of the issues that have been identified in previous studies: culture shock, language and literacy, trauma, isolation, difficulties in having foreign credentials recognized, employment barriers, losses, and racism. The study revealed some issues specific to immigrant and refugee women living in Saskatchewan such as concerns for families in countries of origin, and a sense of responsibility relating to taking care of those "back home". Issues such as violence and the pressure to remain silent have also been identified. Participants described the stigma attached to "mental health". Participants also discussed the lack of capacity among "mainstream" service providers to address the needs of immigrant and refugee women because of the small population size, and the lack of actual contact or experience working with this population.

The conceptualization of "mental health" that immigrant and refugee women described was very broad and could best be described in terms of their "mental health and well-being". As such, the study has concluded that the kinds of approaches or multicultural structures that would best fit for immigrant and refugee women could not be limited to the traditional clinic model, but needs to be multidimensional in order to consider the diversity among immigrant and refugee women. In addition, the thesis has concluded that it is important to consider the needs of immigrant and refugee women, and also the specific needs of refugee women who are at high risk of suffering from trauma.

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Chapter 1

Introduction

As Saskatchewan continues to embark on a road to increase the number of immigrants and refugees to the province, the issue of the mental health needs of this population is beginning to be raised more and more. There is some recognition of the extremely difficult situations that newcomers have left behind, and of the ongoing challenges they face as they build their home in Canada. This dissertation is a response to the belief that immigrant and refugee women carry out significant caregiving and community building roles, while at the same time having to cope with the traumatic experiences in countries of origin, on their journey to Canada, and during the settlement process in their new country. A point of departure is the belief that few immigrant and refugee women are using traditional mental health services. This has been derived from existing literature and from anecdotal evidence. Another point of departure is that many immigrant and refugee women are coming from countries where the helping systems and approaches may be very different from those in Saskatchewan. Given these assumptions, an objective of the dissertation is to focus on the mental health needs of immigrant and refugee women, and then to propose ways of developing or enhancing policies, models, and practices to better address these needs.

One of the beginning tasks in this journey was to understand the different conceptualizations of mental health. Much of the current literature on mental health attempts to define "mental health" broadly (World Health Organization, 2006; Health Canada, 2006; Conway, 2003). The World Health Organization (World Health Organization [WHO], 2006a) defined it as "a state of well-being in which the individual

realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (p. 1). Health Canada (2006) has referred to mental health as a "crucial dimension of overall health and an essential resource for living" (Health Canada, 2006). Health Canada (2006) further noted that mental health influenced "how we feel, perceive, think, communicate and understand" (Health Canada, 2006). In general, the literature has distinguished between mental illness, mental health disorder, and mental health problems (Conway, 2003; Health Canada, 2006). "Mental illness" has been used in reference to alterations in mood, thinking, or behaviour (Conway, 2003; Health Canada, 2003, 2006). The condition may last for an extended period of time. Eventually, the individual may be impaired in his or her ability to function effectively in daily activities. The term "disorder" is used to refer to conditions where there is intense alteration of thinking, mood, or behaviour, and when this may result in significant dysfunction (Conway, 2003). In the literature, "mental health problem" is the term used to refer to less severe signs and symptoms (Conway, 2003).

Population health research has exposed the economic and social costs that are incurred when mental health is not addressed (WHO, 2006b). Researchers have identified some populations that are particularly at risk of poor mental health. These include refugees, victims and survivors of disaster, and women and children living in or exposed to situations of violence and abuse (World Health Organization, 2006b). Yet, these broad conceptualizations and the findings of population health research are hardly reflected in mental health programs and practices to address the needs of these "at risk" populations.

The stories of women's survival within very challenging circumstances, attest to their coping strategies, their strength, and to their resilience. They continue to play a

variety of roles within their communities and families (Bretell & Simon, 1986). They have their own ways of getting help, and there may be ways in which these helping approaches can be complemented. A premise of this dissertation is that the current mental health system in Saskatchewan has failed to evolve to meet the needs of the emerging multicultural population in the province. As such, the system does not adequately meet the needs of immigrant and refugee women living in Saskatchewan. The thesis therefore proposes that immigrant and refugee women, mental health service providers, and policymakers can learn from one another about ways of enhancing current mental health systems and practices to meet the needs of immigrant and refugee women. This will involve knowledge about the different cultural contexts from which women come and within which they live, and the relationship between cultural understandings and the conceptualizations of mental health held by immigrant and refugee women living in Saskatchewan. Another area to be considered will be the relationship between dominant perspectives on mental health and the ways in which women have traditionally gotten help in their countries of origin, and the ways in which they now get help. The thesis proposes that mental health service providers and policy makers will have to engage in a process that must end in a transformation of the ways in which mental health work is conceptualized and effected in order to better respond to the mental health needs of immigrant and refugee women. Moreover, an assumption is that this transformation will be beneficial to the Saskatchewan population as a whole.

Statement of the problem

There have been several significant studies that have identified a broad spectrum of mental health needs and issues specific to immigrant and refugee people (Canadian Task Force on Mental Health Issues Affecting Immigrant and Refugees, 1988a, 1988b; Immigrant, Refugee and Visible Minority Women of Saskatchewan [IRVMW], 2002, 2003; O'Neill, 1999; Austin & Este, 1999; Aldous, 1999; Henry, Tator, Mattis, & Rees, 2000; Penketh & Ali, 1997; Merali, 2001). The studies have highlighted the relationship between settlement and integration issues and immigrant and refugee people's mental well-being. Some studies have discussed the underutilization of mental health services by immigrant and refugees (Williams, 2002; IRVMW, 2002, 2003).

The Canadian Task Force on Mental Health Issues Affecting Immigrant and Refugees noted that "only 20% of people with mental disorders who need care actually receive it somewhere in the formal health system" (Canadian Task Force on Mental Health Issues Affecting Immigrant and Refugees, 1988a, p. 37). They highlighted that this was an even greater problem among immigrants and refugees. Almost 20 years later, there is some evidence that immigrant and refugee people still do not access mental health centres for help (Williams, 2002; IRVMW, 2002, 2003). The literature suggests that there are many reasons why they do not use traditional services: social stigma, language and cultural barriers, lack of understanding of mental illness and mental health services, fear of the mental health hospital, fear of deportation, fear of ostracism from cultural community, experiences of racism within mental health institutions, racism, fear of losing jobs, fear of not getting a job or finding housing (Fei-Yeng-Kwok, 2004; IRVMW, 2002, 2003).

There is little discussion about whether the programs and services are themselves the most relevant and appropriate. That is, the studies do not adequately address what needs to change or be in place at the level of the organizational structure or service model. The literature seems to be relatively silent on this aspect and focuses instead on the cultural competence, skills, and attitudes of the workers. As well, there is little discussion about traditional and current practices of immigrant and refugee women in getting help to address their mental health needs, and about how knowledge of these might be used to enhance policies, models, and practices. Once these discussions begin, the next step would be to revisit conceptions of mental health, the readiness of service providers, their cultural competence, skills and attitudes, within the context of models and systems that may be different from the way they are now.

The current approaches of mental health services in Saskatchewan do not adequately reflect the broad definition of mental health as is consistent in many policy documents. This is evidenced by the current dominance of a medical model amidst the critique that this model makes certain assumptions: patient sickness, which is to be cured by the expert; and inconsistent recognition of the inter-relationship of biological and pychosocial factors (Payne, 1997; Saskatchewan Children's Advocate Office, 2004; Hicks, 2002). At the same time, Saskatchewan has joined other voices in the journey towards primary health care and in health promotion.

One of the main contentions of this study is that the mental health needs of immigrant and refugee women living in Saskatchewan risk being ignored because of the relatively small immigrant and refugee population in this province. Immigrant women represent approximately half of all newcomers to Saskatchewan. Elliott (2003) noted that

there were more women immigrating to Saskatchewan than men. They are a diverse population coming primarily from Africa, Asia, the Middle East, Central and South America (Neuwirth, 1999; Statistics Canada, 1998; Chard, Badets, & Howatson-Leo, 2000; Lamba, Mulder & Wilkinson, 2000). The numbers of immigrants self-identifying as "visible minority" increased from 23.7% in 1991, to 28.3 in 1996 (Lamba, Mulder & Wilkinson, 2000). This study focuses on the experiences of immigrant and refugee women in Saskatchewan:

- Because of anecdotal stories about the incidence of violence against immigrant and refugee women, and of the oppressions that immigrant and refugee women continue to experience;
- Because of their roles (paradoxically) as major caregivers and leaders within their families and communities;
- Because recent immigrant women (arriving after 1980) tend to earn less than non-immigrant women and are generally employed in food and beverage services where salaries are low.
- Because of the need to enhance the knowledge, skills, and capacity of social workers and other human service workers who provide mental health services in Saskatchewan; and.
- Because of the small immigrant and refugee population and their invisibility (which put them at risk of being ignored).

Overall, the study focuses on the experiences of immigrant and refugee women because of their unique experiences with migration, settlement and integration (Boyd, 1986). Current literature continues to report ongoing accounts of the extremely difficult

situations that many immigrant and refugee women survive in countries of origin, and during their journey to Canada (Merali, 2001; Richmond, 1994). In addition to those women who have come from situations of extreme turmoil (in particular, refugee women), there are women who migrate for various other reasons including those related to seeking economic and educational opportunities (Merali, 2001). Women living in subordinate relationships within family and communities in countries of origin, often continue to live within these same relationships when they arrive in Canada, but usually without the traditional supports that would have made it easier to cope in countries of origin.

Throughout this dissertation particular emphasis is placed on the need to acknowledge the diversity among and within this population, arguing that mental health policies and practices have hardly evolved to recognize this diversity. The study also recognizes that migration has generally resulted in dramatic changes in the lifestyles of all immigrant and refugee women. Another important aspect of this study is the recognition that while there is a steady number of immigrants and refugees, there is also a steady exodus from the province. Policymakers and politicians are aware of the need to attract and keep immigrants and refugee people in the province, and so this study may contribute to their awareness of ways to enhance the settlement and integration experiences.

Given the slowly evolving multicultural nature of Saskatchewan, it is important to raise awareness of the specific issues facing immigrant and refugee women, and to explore ways of addressing the mental health needs of a population that is at risk of being ignored. One response to address the exodus from the province would be to develop strategies to support families so that they create a home for themselves in Saskatchewan. Yet, the mental health sector has not adequately responded to the complex and diverse mental

health needs of immigrant and refugee people living in Saskatchewan. This study focuses on the ways that the mental health sector can respond to immigrant and refugee women's mental health needs because of the significant roles that immigrant and refugee women play within their families and communities.

There are five key areas being addressed in this dissertation:

- Conceptualizations of mental health among immigrant and refugee women;
- Understanding about the mental health issues facing immigrant and refugee women;
- Relevance of programs and services to addressing immigrant and refugee women's mental health needs;
- Capacity of agencies to address the mental health needs of immigrant and refugee women;
- Accessibility of agencies.

In order to achieve its goals, questions have been framed around the following:

- Service providers' awareness of the mental health issues affecting immigrant and refugee women living in Saskatchewan;
- Service providers' perceptions of the relevance to immigrant and refugee women's mental health needs of the programs and services provided by their agency;
- Service providers' perceptions of their agency's capacity to respond to the mental health needs of immigrant and refugee women;
- Service providers' perceptions of their agency's accessibility/inaccessibility when considering this population;

- Service providers' description of how their work had evolved to respond to the growing immigrant and refugee population in Saskatchewan.
- Immigrant and refugee women's conceptualization of mental health and their mental health needs, and their identification of the issues affecting their mental health;
- Immigrant and refugee women's description of the ways in which they got help to address mental health needs in countries of origin, and their experiences getting help;
- Immigrant and refugee women's description of the ways in which they get help to address mental health needs in Saskatchewan and their experiences getting help;
- Immigrant and refugee women's knowledge of the programs and services that are available in Saskatchewan and their attitudes to these.

A primary question related to how services could be changed or enhanced to better meet the needs of immigrant and refugee women. In particular, the intent of the question was to get responses that would be helpful in making recommendations with respect to the models of service delivery or helping approaches that would be most effective for immigrant and refugee women.

Organization of the dissertation

Chapter 2, the *Literature Review*, includes a historical overview of immigration trends in Saskatchewan and Canada; and a focus on the evolution of mental health services and programs, with specific reference to Saskatchewan. The chapter also includes a review of literature on the topic of citizenship and how this relates to the dissertation topic; a review of international, national, and local policies relevant to the mental health needs of immigrant and refugee women. The chapter emphasizes that an understanding of the social, economic, and political contexts of immigrant and refugee women's lives is a key component in understanding the mental health issues and needs of immigrant and refugee women.

Chapter 3 *Theoretical Framework* introduces critical multicultural theory as the key framework being used in the dissertation. The chapter includes a description of the key concepts and elements within this framework: critical theory, culture, multicultural processes and multicultural structures. The chapter expands on the "critical" nature of the framework by defining terms, concepts such as feminism, anti-oppressive approaches, empowerment practice, anti-racist, and gender inclusive approaches. In providing discussions about these themes and concepts, the chapter stresses their relevance to the topic of immigrant and refugee women's mental health. The chapter also describes the application of the framework.

Chapter 4, *Method,* describes the application of the case study method to the dissertation. The chapter further describes the research method through description of the processes of data collection, recruitment, interviewing, transcription, and data analysis. The chapter describes the ethical challenges. Chapters 5 to 9 describe the data findings,

with each chapter focusing on broad aspects or themes. Chapter 9 presents the recommendations of participants with respect to enhancing and developing services, models, and policies. The final chapter, *Chapter 10*, provides an analysis of the findings, and represents an analysis based on the author's viewpoints. The chapter uses the theoretical framework to develop an analysis that is respectful of all participant views, and that presents a critical analysis.

Chapter 2

Literature Review

Introduction

This chapter will provide a review of the literature relevant to the topic of immigrant and refugee women's mental health in Saskatchewan. In keeping with the case study approach, the review describes some contextual aspects relevant to the research topic. The first important aspect is a description of the place of indigenous peoples in Canada's history, and specifically in Saskatchewan. Indigenous peoples in Canada and in Saskatchewan continue to grapple with the impact of colonization and racism, as they continue on their journey towards self-government. The chapter begins with this history in order to acknowledge the significant place of indigenous peoples in Canada's history, and to recognize the ongoing struggles for equity among this population even as we continue to welcome newcomers to the country. The chapter provides a brief overview of immigration trends in Canada and in Saskatchewan. This review describes the situation with respect to immigration trends in Saskatchewan: that the numbers of immigrants and refugees to the province are much lower than those of other Prairie provinces; that these numbers have been relatively stable; that the demographic population reflects the liberalization of immigration policies and that most immigrants and refugees to Saskatchewan are now coming from developing countries rather than the traditional European source countries.

The review also provides literature about the evolution of mental health services and specifically mental health services in Saskatchewan. This review describes the struggle to move from a purely medical model to an understanding of the relevance of

population health to the topic of mental health. The literature focuses on the relationship between migration and immigrant and refugee women's mental health, and on values and beliefs with respect to mental health, and describes multicultural processes that have particular impact on immigrant and refugee women's mental health. That is, the literature begins to identify some of the cultural traditions, values, and beliefs that have an impact on immigrant and refugee women's mental health, and serves to demonstrate the relevance of using concepts such as multicultural processes, as well as the connections with population health approaches.

This chapter concludes with discussions based on the literature on citizenship and then international, national, and provincial policies. Thus the chapter ends with literature that identifies the various mechanisms (international, national, and provincial) that are in place and that would be relevant to the creation of an equitable environment that would address the mental health needs of immigrant and refugee women.

Saskatchewan- background

Like other provinces of Canada, Saskatchewan's contact between indigenous peoples and white settlers, traders, and hunters led to significant changes in the lifestyle of the first peoples in Saskatchewan (Allen, 1979). The resistance of Big Bear, Louis Riel and others represented examples of visionaries who sought to maintain values and lifestyles of indigenous and Metis peoples. In a report prepared for the Aboriginal Healing and Wellness Strategy and the Kanaweyimik Child and Family Services, Raven Sinclair (2000) noted that colonial policies "aimed at dealing with the "Indian problem" (p. 4). She suggested that the Indian problem "was that Indian people stood in the way of unfettered

access to land and resource expropriation" (p. 4). Sinclair (2002) added that "policies focused on assimilation and integration of Indian people as the best means of achieving colonial ends" (p. 4).

The establishment of legislation such as the Indian Act and residential schools served to systematically entrench the assimilation of Indians. The assimilation process has been damaging to Aboriginal people. The resultant effects include "trauma, grief, loss, post-traumatic stress, suicidal ideation, sexual abuse, physical abuse, emotional and mental abuse, spiritual abuse, loneliness, depression, anger, and rage" (Sinclair, 2000, p. 3), as well as other more indirect ones such as "alcohol and substance abuse, family violence, and poor self esteem" (Sinclair, 2000, p. 3).

Canadian government as it evolved in the late 19th century emerged from the settlers who took control of this land and created their own economic, social, and political systems (Allen, 1979; Lalonde, 1979). Under the Saskatchewan Act, the province of Saskatchewan was established in 1905. Its constitution was built on the British parliamentary system and British common law (Lalonde, 1979):

> After the British parliamentary system and British common law became established in the North American colonies in the early years of settlement, they were adopted without question in the constitution of the new Dominion of Canada when it came into existence in 1867, as well as in the provinces first entering Confederation. Following the pattern thus established, the new western provinces accepted these features as a natural heritage and looked both to the Canadian government and to England for precedents, modifying and adaptation as necessary. (Lalonde, 1979, p. 140)

The Saskatchewan Act was influenced by the British North American Act which set out guidelines with respect to federal and provincial jurisdictional issues (Eager, 1979; Mishra, 2001).

One of the challenges of the province is to be able to maintain a strong commitment to addressing the atrocities and processes of disempowerment to which Aboriginal, First Nations, and Metis peoples were subjected, while at the same time developing programs, policies that will address the goals of social inclusion and equity for other sectors of the population, including immigrant and refugee people. Another challenge is to learn from the past history of colonization and to avoid repeating a history whose policies of assimilation were so harmful to Aboriginal, First Nations, and Metis peoples.

Immigration trends-Canada

Since the arrival of the first settlers, there has been a steady flow of immigrants to Canada with most immigrants continuing to settle in larger metropolitan centers. Eighteen per cent of Canadian residents are immigrants. Earliest immigrants and refugees included individuals and families from the United States, Africa, and Europe (Pachai, 1987; Walker, 1980; Winks, 1971; Christensen, 1999, 2003, 2005; Henry, Tator, Mattis, & Reid, 2000). Immigration has therefore played an important role in shaping the fabric of this country. This has led to a long history of cultural and ethnic diversity. However, this history has been characterized by discriminatory policies intended to restrict entry into Canada by using factors such as "race", climatic suitability, country of origin, and nationality as criteria for selection in order to restrict entry into Canada (Green & Green,

1996; Christensen, 1999, 2003, 2005; Henry, Tator, Mattis, & Reid, 2000). Britain and the United States have consistently been on the list of preferred countries (Green & Green, 1996; Christensen, 1999; Henry, Tator, Mattis, & Reid, 2000). By the end of 1956, Canada began opening its doors to immigrants from all European countries. At the same time, the Minister of Citizenship and Immigration was given greater discretionary power to deal with immigration and residency rights (Green & Green, 1996). While the doors appeared to be open, discrimination and stereotyping against certain groups continued.

Immigrants from certain European countries might not have been on the list of preferred countries but were generally able to "blend in" after one generation (Christensen, 1999, p. 295). This was not necessarily the case for many immigrants coming from developing and non-European countries. Immigrants from less preferred countries and groups found themselves in low paying jobs, unpopular jobs (Christensen, 1999, 2003, 2004; Simmons, 1999). For example, in the 1950s, women from the Caribbean were welcomed to Canada under the Domestic Scheme Program. These women could work as domestics since these jobs were unattractive to local residents (Silvera, 1983). Work conditions were often problematic but women endured in silence and isolation for fear of losing residency status (Silvera, 1983). Simmons (1999) suggested that their roles as domestics and nannies, reinforced gender and racial stereotyping.

Canada adopted an official policy of multiculturalism in 1971 (Christensen, 1999; Walker, 1980; White, 1998; Winks, 1971; Sheppard, 1985). Changes in immigration entry policies resulted in the arrival of immigrants from African, Asian, Caribbean, and Latin American countries (Canada Immigrant Job Issues, accessed at www.canadaimmigrants.com/statistics.asp; Frideres, 1999; Henry, Tator, Mattis, & Rees,

2000; Rice & Prince, 2000). By 1996, most immigrants and refugees were arriving from developing countries with the majority coming from Asian countries. Ongoing accounts of racism have suggested that there is resistance to the current levels of diversity. The events of September 11th 2001 which involved co-ordinated attacks on the United States (including the destruction of the World Trade Centre) resulting in the death of approximately 3,000 people, have added fuel to these tensions. Government policies that scrutinize newcomers from "certain countries" and the intensified attention to security issues and strategies have resulted in racial profiling (Hussain, 2004). In short, while the doors have opened, these tensions suggest that there are still preferred source countries. This situation has led to incidents of racism and discrimination which have an impact on the mental health of some migrants.

Immigration trends-Saskatchewan

The above is the backdrop to the current situation of settlement and immigration to the Prairies and specifically to Saskatchewan. In Saskatchewan, according to the 2001 census, only 5% of the population are immigrants (Elliott, 2003). Most immigrants have tended to gravitate towards larger centres. About 73% of immigrants who came to Canada in the 1990s settled in Vancouver, Montreal, and Toronto (Statistics Canada, 2004). According to Citizenship and Immigration Canada (Citizenship and Immigration Canada, 2004) in 2003, there were 54.1% permanent residents in urban areas of Ontario, 17.9% in Quebec; 18.9% in British Columbia, 7.2% in Alberta; 2.9% in Manitoba, and .8% in Saskatchewan. 50% of immigrants arriving in Saskatchewan prior to 1961 settled in Saskatoon or Regina. This figure rose to 60% after 1961.

One impact of these trends has been the development of a relatively strong body of literature and research relating to the experiences of immigrants and refugees in those provinces where there is a "significant" immigrant population. The focus in this dissertation will be on the population of immigrant and refugee women living in Saskatchewan where the immigrant and refugee populations are relatively small.

One of the most frequent comments made about general demographic trends in Saskatchewan is that the province has not been growing. In a report for the Saskatchewan Intergovernmental and Aboriginal Affairs Department, Elliott (2003) noted that Saskatchewan has the highest proportion of people over 65 and under 15 in Canada. He concluded that this meant that "there are, compared with other provinces, relatively few of Saskatchewan residents in the 15 to 65 age group" (p. 12). Another important characteristic relates to general outmigration trends which, according to Elliott (2003), "move in waves" (p. 25), but which are consistently troublesome. Elliott (2003) reported that Saskatchewan was not alone with respect to outmigration since Manitoba, Newfoundland and the North had similar experiences. While young people are often the ones to leave (outmigration), this is particularly so for Saskatchewan where youth outmigration rates have been higher than in other provinces (Elliott, 2003). Outmigration among the 50-54 age range was also considerably high. In most years, outmigration rates among seniors was the highest in the country (Elliott, 2003). In Elliott's report he concluded, "that a strategy to attract people from other provinces and countries would probably be more successful than a strategy to stop current residents from leaving" (p. 96). He also suggested that it did not seem that out-migration was "driven by controllable factors such as taxes but by perception and momentum" (p. 96).

The demographic overview shows that Saskatchewan has been receiving significantly fewer immigrants that the other Prairie provinces. Nevertheless, while the young people might leave the province, this is offset somewhat by the young working age immigrant youth arriving in the province. The following table (Table 1) represents information presented by Abu-Laban, Derwing, Krahn, Mulder, and Wilkinson (as cited in Lamba, Mulder & Wilkinson, 2000), and are based on 1991 census information:

Table 1-Total number of immigrants by major city and province

PROVINCE	Total number of immigrants	Major City	Total number of immigrants
Alberta	381,510	Calgary	151,805
		Edmonton	152,805
Manitoba	138,585	Winnipeg	113,165
Saskatchewan	57,815	Regina	15,900
		Saskatoon	17, 120

The percentage of immigrants to Saskatchewan is smaller than that of other Prairie Provinces. However, in the past, the actual intake has been relatively stable (Lamba, Mulder, & Wilkinson, 2000).

More recent statistics (Citizenship and Immigration Canada, 2003) have shown that when compared to larger provinces and to other Western provinces, the immigrant population to Saskatchewan is still quite negligible. The following table (Table 2) illustrates the situation with respect to the percentage of the total immigrant population received by Canadian provinces in 2003 and the percentage that was projected for 2004.

Table 2-Percentage of immigrants by province and percentage projected for 2004

PROVINCE	% of total immigrant population received in 2003	% of total immigrant population projected for 2004
Alberta	7.15	6.95
Manitoba	2.93	3.14
Saskatchewan	.75	.83
British Columbia	15.92	15.71
Quebec	17.86	18.78
Nova Scotia	.66	.74
New Brunswick	.30	.33
Yukon	.04	.04
Nunavut	9 immigrants	8 immigrants
Ontario	54.09	53.07

With respect to the composition of the immigrant population, the flow from the United States has been relatively stable. Prior to 1961, most immigrants to Saskatchewan were coming from Northern Europe. There were also waves of relatively small numbers of immigrants from various Caribbean and Latin American countries from the 1960s and beyond. Since the 1960s more immigrants started coming from Southern Europe and the former Yugoslavia (Elliott, 2003). Most immigrants have been coming from African and Asian countries since the 1980s.

A characteristic of the migration trends is that in 1996, 13.1% of migrants to Saskatchewan had come as refugees (Lamba, Mulder, & Wilkinson, 2000). This has been

identified as considerably higher than the national average of 7.2% ((Lamba, Mulder, & Wilkinson, 2000). That is, Saskatchewan, with a relatively small population of 1.2 million people, has been welcoming a significant number of people who would most likely have survived very traumatic experiences such as war, poverty, and other disasters. This has implications for the kinds of mental health needs one would expect mental health practitioners to be addressing.

The Saskatchewan immigration figures may pose challenges for advocates wanting to advance policies, services, and programs to enhance the lives of immigrant and refugee women and people in Saskatchewan. That is, policymakers may choose to ignore a population whose numbers appear to be so small. This is reflected in comments made by statistician Doug Elliott (2003):

> International and emigration flows can be analyzed in the same way as interprovincial migration flows. In practice, however, the number of people immigrating to Saskatchewan is too small to justify that kind of detailed analysis. In the last five years, there have been less than 2,000 people per year coming to Saskatchewan. This compares with 15,000 to 20,000 moving here from other provinces and 25,000 to 30,000 moving from Saskatchewan to another province. Except for a brief period in the 1970s, immigration has not been a major factor in Saskatchewan's population profile. (p. 42)

The total population of Saskatchewan continues to hover around one million residents, even at a time (2006) when the economy appears to be doing exceptionally well (largely as a result of high oil prices). There is movement into the province, but there is also a steady outflow of immigrants and non-immigrants. While immigrant young people

are arriving in the province, they have been joining other young people heading out of the province in search of other opportunities (Elliott, 2003). The immigrant retention rate in Saskatchewan in the 1990s was 57% as compared to Alberta whose rate was 86%, and Manitoba whose rate was 78%. Certainly, as identified by other researchers, the lack of resources or services in smaller communities makes it difficult for immigrants and refugees to remain (Abu-Laban, Derwing, Krahn, Mulder, & Wilkinson, 2000).

Economic growth in neighbouring Alberta is also an immense magnet for immigrants and non-immigrants. The small size of towns and rural communities, and the sprawling nature of rural communities, do little to attract and retain those immigrants and refugees who may be craving contact with a critical mass of people from their ethno-cultural communities. One can speculate that the high immigrant retention rates in provinces like Ontario and British Columbia where the immigrant populations are also quite high, reflect the presence of a critical mass. While immigrants and refugees in Saskatchewan may find it difficult to live in rural communities because of the small population, those in large centres are also finding it challenging. The larger centres in Saskatchewan (Saskatoon and Regina) are themselves also "small" as reflected in the fact that on their own are too small to be considered as metropolitan centres. According to Lamba, Mulder, and Wilkinson (2000), their populations have been added together in order to accommodate this fact (Lamba, Mulder, & Wilkinson, 2000). Lack of employment opportunities and underemployment continue to be major problems. This factor alone leads to tremendous stress on individuals and families. Lamba, Mulder, and Wilkinson (2000) have speculated that Saskatchewan's relatively high rate of self-

employment (25% compared to national average of 12%) may be related to the labour market entry barriers.

Nevertheless, on many fronts, the immigrant population is important for the growth and development of Saskatchewan, and some of government announcements appear to support this opinion. In May 2005, Judy Sgro, Minister of Citizenship and Immigrant Canada [CIC] and Pat Atkinson, Saskatchewan's Minister Responsible for Immigration announced an agreement in which both governments would jointly contribute approximately $260,000 towards research and planning activities under the Enhanced Language Training (ELT) for the 2004-2005 year and then renewable for the next four years (Enhanced Language Training Agreement Helps Saskatchewan Immigrants). The intent of this agreement was to respond to employment needs in various sectors, and to governments' commitment to facilitating the integration and retention of immigrants to Saskatchewan. A month later, on June 1, 2005, the Minister of Citizenship and Immigration- Joe Volpe and Saskatchewan Minister Responsible for Immigration - Pat Atkinson announced the signing of an agreement (Canada-Saskatchewan Immigration Agreement) that would define how the governments would respond to immigrants, temporary workers, students and others who want to come to Saskatchewan. Minister Atkinson noted that the Saskatchewan government considered that immigration would play a key role in the future of Saskatchewan:

> From its creation one hundred years ago, Saskatchewan has always been enriched by the cultures of people the world over. By creating a province that's welcoming and supportive of newcomers, we help ensure a prosperous, dynamic future for all Saskatchewan people. (Government of Canada, a)

One of the ways in which immigrants make a contribution to Saskatchewan is through the influx of young adults (25-34 years) (Elliott, 2003). As noted by other researchers (Lamba, Mulder, & Wilkinson, 2000), the growing ethnic diversity within Canada necessitates continued attention to cultural sensitivity in policy and programs. As well, settlement and integration policies and programs will need to reflect an understanding of the complex backgrounds and needs of new immigrants and refugees.

In short, the literature review describes how the multicultural nature of Saskatchewan has been evolving at a slower pace than that of other Prairie provinces. The majority of newcomers are coming from developing countries with significant numbers coming as refugees. The literature identifies a wide range of potential needs of immigrant and refugees and described the challenge of raising awareness of the issues facing a segment of the population whose numbers are so small.

Evolution of mental health services: Historical context

Much of the dominant literature about the early history of services to the mentally ill has focused on events in Europe beginning with developments in the field of psychiatry (Dickinson, 1989; Shorter, 1997; Alexander & Selesnick, 1966). The literature has described how the client population of psychiatrists expanded after the 1950s to include individuals who were experiencing emotional difficulties as a result of pressures of the depression, urbanization, industrialization, war, modernization, and work (Shorter, 1997; Ralph, 1983). The literature has also included accounts of the evolution of mental health services from an essentially institution based approach to one committed to de-institutionalization. A review of the literature has revealed that few supports were put in

place for those leaving institutional settings. Other important developments that influenced the evolution of mental health services were a mass public health conception, some community based therapies, the acceptance of multidisciplinary teamwork, and the development of prevention services with employers and organizations (Ralph, 1983).

The evolution of mental health services in Saskatchewan is reflected in the changes in legislation: for example the change from the 1879 Act Respecting the Safekeeping of Dangerous Lunatics, to the 1906 Insanity Act (Dickinson, 1989). The primary role of institutional workers was to provide custodial care (Dickinson, 1989), with the major criterion for discharge from these institutions being ability to work (Dickinson, 1989). On a national level, the Canadian National Committee for Mental Hygiene [NCMH] was created in 1918 and encouraged multidisciplinary work. As part of this work, the organization developed a training program for social workers and lobbied for the recognition of social workers as part of a professional psychiatric team (Dickinson, 1989). The role of these workers was to encourage families to care for their mentally ill relatives at home, and to promote de-institutionalization. Nevertheless, change was slow in Saskatchewan and the province did not adopt this kind of team approach until 1944. (Dickinson, 1989)

Ralph's analysis of the post war responses of the mental health sector was that the state and its practitioners became agents of control (Ralph, 1983). Her concerns were that therapeutic interventions did little to address root causes and so practitioners were unable to bring about real social change. Ralph (1983) added:

> Among the war-spawned therapy techniques which have become standbys of community psychiatry were group therapy, brief talk therapies, modified

> electro-convulsive treatments for non-psychotic patients, and psychotropic drugs (amphetamines, narcotics, and barbiturates) designed explicitly to cheaply improve the working efficiency of normal people under stress. (Ralph, 1983, p. 91)

That is, mental health practitioners seemed to medicalize responses to social issues and conditions and tried to "cure" them within a mental health clinic setting. Ralph (1983) noted,

> Counselling and drugs make workers more tolerant of dangerous working conditions and help them adjust to near accidents. Most importantly, they mute labour militancy. By anaesthetizing workers individually, the new treatments prevent them from recognizing problems and acting on them collectively. They only help workers bear their "madness"—alone. (p. 109)

Mental health services in Saskatchewan continue to struggle with these tensions. The calls for a biopsychosocial model and for a more holistic approach to policy and program have continued to be raised and are particularly significant within multicultural societies. Social, economic, and political conditions in multicultural societies have significant effects on the mental health of immigrant and refugee peoples, and logically, the solutions should involve more than a focus on "fixing " the individual.

Immigrant and refugee women's mental health

A review of the literature shows that Canada has played a lead role in the area of population health research and that there have been important writings regarding the conceptualizations of health determinants (Reid, 2002; Blanch & Levin, 1998). Nevertheless, as already mentioned, research also suggests that this knowledge has not

necessarily been translated into action. Consequently, many researchers have continued to argue in favour of a holistic approach and of including focus on biopychosocial aspects (Reid, 2002; Morrow & Chappell, 1999).

Reid (2002) emphasized the importance of using a holistic framework that would include physical, emotional, intellectual, social, and spiritual aspects. Morrow and Chappell (1999) made similar comments when they noted "women's mental health cannot be understood in isolation from the social condition of our lives" (p. 3). They reported that racism and settlement issues were not routinely recognized and addressed within the mental health system. Certainly, an overview of the experiences of settlement and integration of immigrant and refugee women highlights the significance of these and other factors. It would seem logical that the responses to these issues would require a multidimensional framework.

Relevance of values and beliefs to women's mental health

Women's health researchers have discussed the various contexts from which women migrate and within which they currently live, and the relevance of this information to understanding and responding to women's mental health issues. Research studies have also shown that values and beliefs are an important consideration when trying to understand women's health. For example, research studies have explored the impact of harmful beliefs and practices such as female genital mutilation on women's health in African countries (Kisekka, 1990; Edemikpong, 1990; Peddle, Monteiro, Guluma & Macaulay, 1990). With respect to women in China, in 1999 this country had one of the highest rates of female suicide in the world (Weizhen, 1985; Hsu, 1985; Livingston &

Lowinger, 1983; Wan, 1999; Kane, 1999; WHO, 1999). In addition, China was the only country in the world where women were committing suicide at a higher rate than men (WHO, 1999). Wan (1999) suggested that women's subordinate roles within Chinese society, their sense of hopelessness, lack of self worth, and poverty in the midst of economic growth were all factors in this disturbing trend (Wan, 1999). Thus, women in rural areas, with their easy access to pesticides, were at particularly high risk of suicide.

Other research has described women's health in Latin American countries. These writings have discussed the impact of patriarchal norms and values on women's health. The writings have emphasized the diversity among Latin American populations and the need to understand how different factors such as social class, family's cultural values and expectations, and physical have an impact on women's mental health (Flores-Ortiz, 2000; Lopez-Baez, 1997; Rafuls & Marquez, 1997; Flores & Carey, 2000). Whatever the conditions, women continue to play major caregiving roles within families and communities, and continue to grapple with living with "cultural" patterns that may have positive aspects on their mental health but that may also have harmful ones.

Migration and immigrant and refugee women's mental health

Migration to Canada offers enormous possibilities to immigrant and refugee women. Nevertheless, the processes of migration, settlement, and integration have their own unique kinds of stresses (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada, 1988a, 1988b; Boyd, 1999). Loss of social supports, loss of family members, and separation from family and friends may lead to a sense of isolation among immigrants and refugees if these are not replaced with new support

networks. The lack of proficiency in either French or English, unemployment and underemployment, racism, and not having out of country credentials and experience recognition all create additional stress on immigrant and refugee women (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada, 1988a; Boyd, 1999; Henry, Tator, Mattis, & Rees, 2000; Lamba, Mulder, & Wilkinson, 2000; Christensen, 1999).

Immigrant and refugee women are coming from cultural contexts that are quite varied. The diversity among women within countries is reflected in this statement that discussed the situation of African women:

> Social ritual is often long-lived. Anything concerning the essence of the feminine, whether it is little girls' upbringing, young women's initiation, or dominant beliefs about marriage or maternity or even death, marked by a complicated heritage still felt heavily today. It is perhaps even less possible today than before to speak of "the" African women. What common denominator is there between a country girl and a city girl, between an educated girl and one who has never seen the inside of a schoolroom, between the women who works within the capitalist system and one working in the informal sector, between the woman endowed with children and one who is sterile, between the one who uses contraception and AIDS prevention and the woman who is beyond all hope because she lacks the means to imagine what she might wish for? Diversity in class, culture, religion, ideology makes the problem even more complex. (Coquery-Vidrovitch, 1997, pp. 200-201).

Women are generally arriving with a set of beliefs and values, as well as norms and traditions that are familiar to them, to other family members, and to other members of

their ethno-cultural communities, based on a wide range of influences (Stevens, 1993). Those immigrant and refugee women who live in dependent relationships, are particularly at risk of abuse. The Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada (1988) referred to the vulnerability of these women.

> The factors, which create dependency in migrant women and permit abuse to occur also prevent women from escaping abuse situations (Wiebe, 1985). Cultures which socialize women to dependent roles also limit the circumstances under which they may leave their husbands. In the absence of her parents or other important family, a woman may be more vulnerable to abuse; she is also blocked from the one traditional escape route- back to her family—that she may know. (p. 76)

That is, those who did not necessarily come with extended family support do not always have the family and community support that could act as a buffer against abuse. Lack of language skills further exacerbates this problem. The task force noted that the "higher incidence and intensity of risk factors, and the reduced access to mitigating factors, created special mental health needs for immigrant and refugee women" (p. 78).

The situation of violence against immigrant women in Canada was also highlighted in a study released after 2003 by the Canadian Council on Social Development (Smith, 2004). Smith reported that immigrant women faced unique vulnerabilities because of language barriers, isolation, lack of traditional supports, fear of ostracism from ethno-cultural communities, fear of leaving and the risk of poverty, and lack of knowledge of the legal system in Canada (Smith, 2004). Narayan (1995) raised similar issues in a study about immigrant women's vulnerable situation in the United States.

Overall, immigrant and refugee women's mental health needs cannot be measured solely in terms of admissions to traditional institutions such as hospitals, or by their use of traditional mental health clinics. Rather, they require an understanding of the socioeconomic and political contexts of women's lives, exploring their roles as mothers, spouses, workers and community members, understanding the diverse cultural traditions and practices that serve to maintain traditional roles, and analyzing how these lived experiences affect their mental health. This includes understanding the traditions and initiation rites that perpetuate messages regarding women's serving and subordinated sexual and caretaking roles within marriage or concubinage (Peddle, Monteiro, Guluma, & Macaulay, 1990; Weizhen, 1985; Hsu, 1985; Livingston & Lowinger, 1983).

Immigrant and refugee women use various forms of help in their countries of origin. These forms vary depending on many factors, including social status, locality and/or geographic location. One challenge for social workers in the mental health arena is to understand these dynamics, and to understand where immigrant and refugee women are situated within these dynamics. Another is to understand the kinds of help immigrant and refugee women require and use here in Canada, the gaps that might exist, and ways of enhancing service to this population. The literature clearly describes the extent to which women's mental health is affected by the values and beliefs of the world around them. It would follow that the structures (for example, policies and programs) that would respond to these conditions and contexts would involve a multidimensional approach that would ultimately include a community development approach. The importance of a multidimensional approach is an important component of population health research and approaches. A particular goal of this study is to explore how the mental health needs of

immigrant and refugee women are being and can be addressed in Saskatchewan, given the reality of a particularly small yet diverse immigrant and refugee population.

Mental health community programs and services in Saskatchewan

Various agencies have been recognized as providing mental health services. However, in general, these agencies have minimal experience with working with immigrant and refugee populations because of the underutilization by immigrants and refugees (IRVM, 2002, 2003). An overview of the range of programs and services that can potentially address the mental health needs of immigrant and refugee women suggests that there have been several partnership initiatives between traditional mental health agencies and immigrant serving agencies. However, these have been inconsistent and unsustained, usually because of funding constraints. An example is that Saskatoon Child and Youth Services (Saskatoon Health Region) had a joint program with Saskatoon Open Door Society that focused on the needs of immigrant youth. Once the funding for this program ran out, the program ceased to exist. That is, these initiatives have disappeared, and have not had much impact on the way core mental health services are delivered.

One of the policies or programs that offers some hope for change is the Schools Plus initiative which is based on a belief in the shared responsibility of families, students, educators, and community and in their working together to ensure that children and youth get what they need to succeed in school (Saskatchewan Teachers' Federation, 2002). The belief in an integrated approach to service delivery came out of a report by the Task Force on the Role of Schools which was released in 1999-2000 (Saskatchewan Teachers' Federation, 2002). The Task Force emphasized that schools should be centres of learning,

support, and community. Certainly the Schools Plus initiative makes a strong case for the development of strong community partnerships as a way to address immigrant and refugee women's mental well-being. Evaluation studies which ought to offer feedback about the effectiveness of this initiative appear to be absent in the literature.

In speaking about the situation of racialized women in Saskatchewan, Elabor-Idemudia (1999) suggested that community-based organizations had an important role to play in bridging the gap between mainstream or traditional mental health services and newcomer populations such as immigrant and refugee women:

> The hope for meeting this gap in power lies in the fact that ethno-cultural and racially specific community-based agencies are growing to fill the gap in service delivery created by the failure of mainstream institutions to serve the needs of a multiracial, multicultural, immigrant population. The agencies spend their time identifying the challenges and barriers to women's quality of life and demanding amelioration of the situation through advocacy and lobbying. (p. 43)

Community based organizations have the potential to bridge the gap between the public and immigrant women's communities (Rose, 1997). They can also serve as a location where the meaning of "diversity" can be discussed and further explored, and from where valuable lessons and insights can be gained regarding practice with ethnically and culturally diverse populations.

While these organizations strive to fill the gaps, there are many reasons why they are not able to adequately respond to the mental health needs of immigrant and refugee people. As the literature has already noted, few immigrants and refugees use the formal mental health services. Those immigrant and refugee people who use settlement and other

agencies may do so in order to address "mental health needs" but not all the agencies are professionally equipped to provide the kinds of service that are required. Settlement agencies provide a range of services and programs to immigrants and refugees. These agencies received regular funding from the federal and provincial governments. Services and programs include:

- Employment training and assistance
- English as a second language training
- Translation and interpretation
- Hosting, airport meeting services, and assistance with securing temporary accommodation for newcomers
- Provision of resource material
- Counselling, support, and orientation
- Income tax assistance

These services are provided by a multidisciplinary team including teachers, counsellors, social workers, support staff, volunteers, and students.

Settlement agencies include:

- Moose Jaw Multicultural Council
- Prince Albert Multicultural Council
- Regina Open Door Society
- Saskatoon Open Door Society

The above agencies provide employment programs, counselling and support services, English as a second language programs, and other programs and services based on

requests, needs, and resources. In addition, there are other immigrant and refugee serving community-based agencies :

- Global Gathering Place (Saskatoon)
- Immigrant Women of Regina
- International Women of Saskatoon (formerly Immigrant women of Saskatchewan)
- International Women of Swift Current
- Mennonite Central Committee
- Saskatchewan Intercultural Association

In Saskatoon the Refugee Coalition is a coalition of the immigrant and refugee, and settlement agencies already identified. Individuals who have been refugee sponsors and church sponsoring groups also attend meetings. In addition, various ethnocultural organizations provide a range of cultural, educational, and social supports to their members.

The Canadian Task Force on Mental Health Issues Affecting Immigrant and Refugees (1988a) identified that very few settlement agencies had counselling expertise, but that all agencies were providing some counselling services. Nevertheless, these are not "formal" mental health services. The agencies have contact with newcomers and therefore have relatively good understanding of the cultural complexities of those entering their agencies. Therefore, while there might be few in-house professional counsellors or practitioners with professional training to deal with mental health issues, the workers do the best they can to respond to the needs of the individuals and families. This includes making referrals to mental health services. However, as already mentioned, the accounts of partnership with traditional mental health centres are sporadic and inadequately

formalized.

Saskatoon Adult Community Mental Health had a "program" in place that was specifically developed to meet the needs of immigrants and refugees. The program was unofficially called "The Immigrant Program". Once the intake worker received a request to provide service to an immigrant or refugee person, individuals could be fast tracked to one of the counsellors who had particular expertise in this area. Up to 2005, the agency received fewer than six of these referrals annually. This program is no longer officially in place but because of the history of having provided this service, the agency has continued to find ways of ensuring that individuals self identifying as immigrants or refugees receive prompt service.

There has been little literature dealing specifically with the Saskatchewan situation. A relatively recent study on the situation of violence against immigrant and racialized women described some of the services in provinces that had large numbers of immigrants, and so did not include specifics about services in Saskatchewan (Smith, 2004). Other studies have described some programs and models in other provinces (Austin & Este, 1999; Smith, 2004; Canadian Task Force on Mental Issues Affecting Immigrant and Refugee People, 1988a; Sexuality Education Resource Centre, 2003). The Canadian Task Force on Mental Health Issues Affecting Immigrant and Refugees (1988a) reported that the Saskatoon Open Door Society had written that immigrant clients could be sent to the community clinic for counselling. They noted that the Saskatoon Community Clinic was already overloaded and that clients were unable to access private practitioners because of lack of resources. Immigrant, Refugee, and Visible Minority Women of Saskatchewan [IRVM], in their 2002 study, reported that mental health professionals were

reporting non- utilization or underutilization of services by immigrant and refugee (Immigrant, Refugee, and Visible Minority Women of Saskatchewan, 2002). Yet, as was suggested by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988b), only a small percentage of individuals who require mental health services ever access them. Appendix A identifies the key agencies that provide mental health services within Saskatchewan.

Given the growing diversity within the province, it is important to continue discussions about how mental health models and practices can be more responsive to the needs of immigrant and refugee women in Saskatchewan. In particular, as immigrant and refugee women strive to achieve the goals of full citizenship with Saskatchewan, every effort must be made to ensure that they have access to the kinds of services that will facilitate these aspirations.

Citizenship

Throughout its history, the concept of citizenship has raised questions about rights (Sweetman, 2004; Hadow, 1923; Barbalat, 1988; Miller, 2000; Vandenberg, 2000; Curtin, 2000; Turner, 2000). Sweetman (2004) suggested that these questions ranged from focus on "entitlement to a range of rights" (p. 2), to focus on "participation in governance" (p. 2). The literature on the topic of citizenship demonstrates the extent to which the concept of citizenship has not always embraced the notion of equal rights for all. The discussions about citizenship and about the notion of equal rights are particularly relevant to multicultural societies striving to achieve goals of social inclusion.

The early Greeks believed that the state was all-powerful and "all embracing" (Hardow, 1923, p. 6). Harlow has suggested that the population size of the Greek states was relatively small and made it possible for there to be a certain amount of harmony:

> Hence the civic feeling was close-knit by personal acquaintanceship and community of interests, and the whole city was bound together in a sort of family union by which patriotism was intensified as well as narrowed (p. 7).

Nevertheless, this "harmony" did not mean that everyone had equal rights. For example, men were citizens, but not women (Sweetman, 2004). In Athens, immigration was encouraged, and immigrants received generous benefits, but these benefits did not extend to voting rights, access to public office or the legal systems (Hardow, 1923, p. 7). Instead, citizenship rights were "reserved for citizens of pure descent on both sides" (p. 7). Aristotle (2000) stated this sentiment very clearly when he reflected: "A citizen proper is not one by virtue of residence in a given place: resident aliens and slaves share a common place of residents [with citizens, but they are not citizens]" (p. 208). Aristotle continued to emphasize that not everyone had right to citizenship.

Similarly, the Roman conception of citizenship included the right to vote, eligibility to office, right of appeal, private right to free trade and marriage. However, these rights were not enjoyed equally by all (Hardow, 1923). The concept of citizenship in the United States and Europe in the 17th and 18th centuries recognized civil and political rights (Sweetman, 2004; Vandenberg, 2000), but as Sweetman (2004) noted, it too did not recognize the impact of inequitable relationships and circumstances on the ability of some to gain access to these rights. The discussions that were raised in earlier times are not very different from those raised in more modern times when conditions are put on rights to

citizenship, or where inadequate attention is placed on ensuring that there are no barriers to full citizenship for those holding citizenship status or striving to attain those rights.

T. H. Marshall recognized the importance of civil and political rights but also added the concept of social rights (Marshall, 2000; Armitage, 2003; Sweetman, 2004; Barbalat, 1988). Marshall's writings on citizenship defined the different rights. He defined civil rights as those "necessary for individual freedom" (Marshall, 2000, p. 39), and suggested they are a form of power. He defined political rights as "the right to participate in the exercise of political power, as a member of a body invested with political authority or as an elector of the members of such a body" (p. 211). The final aspect (social rights), he defined as

> the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society. The institutions most closely connected with it are the educational system and the social services. (p. 211)

Barbalat (1988) has noted that there are many different interpretations of Marshall's work and suggested that it is important to consider the various aspects of Marshall's arguments and not leave out some. That is, as Barbalat (1988) noted, the "strength of Marshall's theory is partly in its complexity, in its ability to proffer almost opposite possibilities without being contradictory" (p. 11). In the discussions about rights and exercise of rights, Barbalat noted that "rights are created through being exercised, and that it is the exercise of rights which generates the capacities associated with them" (p. 16). Therefore, individuals may have the right to access and use particular services, but if

these services are perceived to be irrelevant, and they not used, then these individuals may not be taking advantage of a mechanism to build capacity through exercise of their rights. As well, it might mean that other mechanisms need to be developed that would better fit for the particular population. Barbalat (1988) has argued that citizenship rights are "rights of participation in a common national community" (p. 67). However, he suggested that social rights "maybe required for the practice of citizenship in so far as they enable such participation" (p. 67). He noted that: "Social rights are only meaningful when they are substantive; and substantive rights can never be universal. Finally, social rights are always conditional upon an administrative and professional infrastructure, and ultimately upon a fiscal basis: thus as conditional opportunities" (p. 67).

Marshall's thinking continues to have an important influence on the world today. Development agencies have been challenging institutions to ensure that they are providing equitable services to all citizens so that they can participate fully in the life of their communities (Sweetman, 2004). This can also be extended to the situation with respect to immigrant and refugee women living in Saskatchewan. The literature has described a range of issues affecting immigrant and refugee women's mental health. These issues identify that many immigrant and refugee women have struggled to achieve equitable status in many societies in which they live, and that their lived experiences with these issues have a negative impact on their mental health. Equitable services to immigrant and refugee women, as this relates to addressing mental health needs, would involve a review of the ways in which programs and services are conceptualized, developed and delivered. That is, access to social rights, as discussed within discussions about citizenship as proposed by Marshall, would include acknowledgement of the right to appropriate mental

health services and programs to enhance immigrant and refugee women's full participation within their communities in Saskatchewan.

Immigrant and refugee women, living within a country that espouses an official multicultural policy, have the right to the kind of policies, programs and services that meet their mental health needs. The provision of these services marks the commitment to a conceptualization of citizenship that recognizes that the provision of these rights is consistent with goals for a just society (Inbaraj, Kumar, Sambili, & Scott-Baumann, 2004). The final sections of this chapter will provide a description of some of the policies that shape the contexts within which immigrant and refugee live. With respect to the United Nations documents, those that are identified, are those to which Canada is a signatory.

International and national policy documents and their relevance to immigrant and refugee women

International conventions are statements of values that lay the foundation for policies to ensure the full participation of all citizens, including women. The commitment to ensuring women's equality rights is reflected in the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which defines "discrimination against women" as:

> Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political,

economic, social, cultural, civil or any other field. (United Nations Division for the Advancement of Women, n.d.)

This convention (article 3) calls on states to take "all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men". (United Nations Division for the Advancement of Women, n.d.)

The United Nations World Conferences on Women have continued to focus on women's equality rights and other equality seeking rights documents. For example, the Beijing Platform for Action reaffirmed a commitment to equality rights and principles which are expressed in documents such as the Charter of the United Nations, the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child (http://www.unhchr.ch/html/menu3/b/k2crc.htm), the Declaration on the Elimination of Violence against Women, and the Declaration on the Right to Development (http://www.unhchr.ch/development/right.html). Section 9 of the Platform's Declaration called for the "full implementation of the human rights of women and the girl child as an inalienable, integral and indivisible part of all human rights and fundamental freedoms" (United Nations Educational, Scientific and Cultural Organization, 1995). Section 13 stated: "Women's empowerment and their full participation on the basis of equality in all spheres of society, including participation in the decision-making process and access to power, are fundamental for the achievement of equality, development and peace" (United Nations Educational, Scientific and Cultural Organization, 1995).

The Committee on the Elimination of Discrimination Against Women recognized that:

> [A] purely formal legal or programmatic approach is not sufficient to achieve women's de facto equality with men, which the committee interprets as substantive equality. In addition, the Convention requires a woman be given an equal start and that they be empowered by an enabling environment to achieve equality of results. It is not enough to guarantee women treatment that is identical to that of men. Rather, biological as well as socially and culturally constructed differences between men and women must be taken into account. Under certain circumstances, non-identical treatment of women and men will be required in order to address such differences.

The committee stressed that contexts must be considered and emphasized the importance of new ways of thinking be adopted

> The lives of women and men must be considered in a contextual way and measures adopted towards a real transformation of opportunities, institutions, and systems so that they are no longer grounded in historically determined male paradigms of power and life patterns (General recommendation No. 25 on article 4, paragraph 1, on the Convention on the Elimination of All Forms of Discrimination against Women on temporary special measures, accessed on November 1, 2006, at www. http://www.un.org/womenwatch/daw/cedaw/committee.htm).

These international statements operate within global contexts where the incidence of violence against women and children continues to exist in alarming proportions. Rape,

female genital mutilation, and all other forms of sexual violence have a tremendous impact on the mental health of women and their families. As such, when many immigrant and particularly refugee women come from war affected countries, the likelihood of them being victims or survivors of violence is high. Women and their families are also likely to arrive from cultural contexts where values and traditions perpetuate violence and inequity. Women are then faced with the task of making decisions about how they live within their new homeland. Global poverty and inequity are other factors that have been an impetus to migration, and impact on women's mental health. International documents provide mechanisms that can be upheld to counter some of the inequities that women experience.

On a national level, the Canadian Charter of Rights and Freedoms states:

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. (Government of Canada, p. 6)

While the "Charter" states that all individuals are equal under the law, it still acknowledges that some groups or populations may be particularly disadvantaged, hence the inclusion of a clause (Article 15 (2)), that would allow for appropriate and specific programs, and policies to protect and better serve these groups/populations:

> Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. (Government of Canada, p. 6)

Other policy documents are intended to work within this framework of inclusiveness. Citizenship and Immigration Canada (CIC), through the 2001 Immigration and Refugee Protection Act (IRPA) has identified principles that lay the foundation for the goals of social integration of newcomers (Department of Justice Canada, 2001). CIC states that newcomers are to learn about the cultures and values of Canadian society, and that Canadians are to learn about the cultures and values of the newcomers. The department highlights four elements that affirm this commitment. These include:

- The notion that integration is a two-way process involving the commitment of Canadian citizens and newcomers to learn from one another, and to adapt to one another's cultures.
- The ability to communicate in one of the country's official languages;
- The ability to participate in the economic and social life of Canada and the responsibility of communities to facilitate this.
- The responsibility on the part of Canadians to share with newcomers, the principles, traditions and values of Canadian society such as freedom, equality and participatory democracy.

The Department of Canadian Heritage co-ordinates policies and programs that seek to promote the goals of multiculturalism (Government of Canada, 2005). While there has been past recognition of the multicultural nature of Saskatchewan's population (The Task Force on Multiculturalism, 1989; Sheppard, 1985), the 2000s have been a time of renewed focus on this aspect of the province. In many ways the 2000s have also been a reaffirmation of commitment to the 1997 Multiculturalism Act. This 1997 Act recognized the diversity of Saskatchewan's people (including diversity with respect to ancestry,

religion, ethnicity), and stated a commitment to the promotion of a multicultural society. The Act also has also stated an objective of working with community groups and organizations to promote multiculturalism throughout Saskatchewan.

The Department of Canadian Heritage encourages policies and activities that promote the participation of ethno-racial minorities in public decision-making processes, community engagement in anti-racism strategies, the elimination of systemic racism, and the development of programs that respond to ethnic diversity. In addition to these broad goals and objectives, other policy documents state a commitment to supporting women's equality rights, and lay the foundation for the provision of programs and services that contribute to their well-being. That is, statements about women's equality rights and about the country's commitment to inclusion are woven throughout federal policy statements.

With respect to immigrant and refugee women in particular, the Department of Canadian Heritage and the Status of Women Canada have administered financial assistance programs, which offer funding and technical support to organizations striving for the achievement of these goals. Immigrant and refugee serving agencies and organizations have tended to obtain some of their funding from the Department of Canadian Heritage. Immigrant women's organizations have also received funding from the Status of Women Canada's Women Program.

The Status of Women Canada was founded in 1973 in response to a report from the Royal Commission on the Status of Women (Status of Women Canada, n.d.; Bergqvist & Findlay, 1999). The Program was initially located within the Citizenship Branch of the Secretary of State. The Citizenship Branch aimed at supporting voluntary organizations in the promotion of citizenship and promoted special citizenship programs for disadvantaged

groups (Schreader, 1990). In 1995, the program was integrated within Status of Women Canada as part of the federal plan for gender equality (Status of Women Canada, 1998). This plan recognized that:

> Current social, economic, cultural and political systems are gendered; women's unequal status is systemic; that this pattern is further affected by race, ethnicity and disability; and that it is necessary to incorporate women's specificity, priorities and values into all major social institutions. (Status of Women Canada, 1998, p. 14)

The Women's Program developed several core principles in order to advance the federal plan for equality rights. Overall, the Women's Program has continued to state a commitment to responding to women's equality rights by ensuring that women's organizations play a key role in addressing this process. One of the objectives of the program is to ensure that those women most affected by issues have a voice in decisions that affect them. It also endeavours to build awareness of the systemic nature of women's inequality, and to promote the integration of gender analysis into all policies. An important focus of the Women's Program is on action and strategies that will address women's economic, social, political and legal situations.

The Women's Program provided both program and project funding until April 1998, when it shifted to a project funding strategy. This was not the first change to the program since its inception. The Women's Program initially funded "small, locally-based radical feminist groups" (Schraeder, 1990, p. 187), but was supporting mainly national and provincial women's groups by the end of the 1970s. As well, the Program became more bureaucratized, resulting in a slower process for approving applications (Schraeder, 1990). Schraeder (1990) suggested that the emphasis on fiscal restraint reflected an

ideological position that stressed cost effectiveness, which in turn emphasized tighter budgetary controls, which impacted negatively on the work of community organizations.

The accompanying emphasis on accountability within the context of inadequate funding led to a situation where organizations have been struggling to maintain staff and stability, and to survive. One effect of these changes has been an increase of instability among women's organizations that have traditionally been significant sites of support for immigrant and refugee women. This is particularly true for community organizations that have long influenced the development and provision of social services in Canada and in Saskatchewan. They pioneered the creation of many services that are now run by government agencies. They also continue to deliver a range of services to communities, and have tried to fill the gap when services have been withdrawn or cut back by governments. Most importantly, they continue to be advocates, seeking to address policy and other issues related to program and service delivery. The strengths and challenges of community organizations were recognized in the Accord Between the Government of Canada and the Voluntary Sector (Voluntary Sector Task Force, 2001).

Finally, the work of Health Canada is particularly relevant to the topic of immigrant and refugee women's mental health. Health Canada has recognized the need to adopt a broad definition of health and mental health and have acknowledged the unique reality of women's health through the Women's Health Strategy. The strategy has continued to integrate a commitment to gender-based analysis in their work. It recognizes the diversity among women including the diversity with respect to ancestry and ethnicity. In particular, the strategy recognizes the biases within health systems and the resistance to using a broad definition of health: "Narrowness of focus is also manifested in the

reluctance of the health system to view health as more than an absence of illness and health system interventions as more than medical or surgical" (Health Canada, Bureau of Women's Health and Gender Analysis, 1999). The strategy also attempts to respond to the recommendations in the Platform for Action, which was produced following the Fourth United Nations Conference on Women in Beijing in 1995.

Final comments

This chapter has provided a range of literature describing the historical, social, cultural contexts within which immigrant and refugee women have lived. The literature has provided material that describes various aspects of the Saskatchewan context, and introduced material tracing the evolution of mental health services with specific focus on the situation of Saskatchewan. The review identified some of the strengths and challenges that organizations and communities face as they engage in work aim at enhancing women's participation within their communities. Overall the review has described the contexts of the case study including a description of the uniqueness of the Saskatchewan situation.

Chapter 3

Theoretical Framework

Critical multicultural theory

The starting point of this study was to begin using a critical multicultural theoretical framework to explore the relevance and appropriateness of mental health policies and services to the mental health needs of immigrant and refugee women in Saskatchewan. Multicultural theory recognizes that social work professionals, policy makers, and consumers working within multicultural (diverse) societies bring different cultural conceptualizations to their relationships (Lee, 1997a, 1997b; Pederson, 1999). In using a critical multicultural perspective, this study has used a broad definition of culture that takes into account the varied ways in which cultural practices and traditions influence all levels of decision-making (Pederson, 1999; Mullaly, 2002). This critical perspective stresses the centrality of issues relating to power imbalance, inequity and context (Blanch & Levin, 1998; Bryan, 2001).

The framework strives to integrate anti-discriminatory and anti-oppressive perspectives (Payne, 1997). This includes emphasis on feminist theories and on the intersectionality of oppressions (Lather, 1991; Van den Bergh & Cooper, 1986; Collins, 1991; Dominelli, 1988; hooks, 1981, 2000; McIntosh, 2000; Pateman, 2000; Mullaly, 2002; Woodward, 1997; Payne, 1997). An argument in the dissertation is that the dominant medical model does not adequately recognize the relationship between women's experiences within a patriarchal and violent social context, and their mental well-being. Critical multicultural theory makes an assumption that Canada's multicultural population comprises individuals whose lives have been shaped by global forces, both negative and

positive. External forces account for much of the distress that occurs in the lives of Canadian residents, including immigrant and refugee people. In extreme cases, this distress may result in severe mental illness. This study therefore acknowledges the reality that individuals may suffer various forms of mental illnesses. Mental health policy framework must represent these complex realities and needs.

A critical multicultural theoretical perspective offers an integrative framework for addressing issues of diverse societies. This framework recognizes several principles:

- Understanding critical theory and being able to apply it in mental health policy and practice with immigrant and refugee women;
- Understanding the broad definition of culture;
- Understanding the concepts of multicultural processes and structures;
- Maintaining a commitment to feminist principles.
- Maintaining an anti-oppressive perspective, and highlighting the relevance of a gender inclusive and anti-racist perspective in addressing the realities of immigrant and refugee women; and

All policy and practice must respect these principles if they are to respond to the mental health needs of a multicultural population.

Understanding and applying critical theory

Integrating theory and practice and maintaining commitment to emancipation

Critical theory offers a philosophical base for anti-oppressive social work practitioners because of its commitment to justice and social change (Kincheloe & McLaren, 1994; Mullaly, 2002; Rubin & Babbie, 2001; Ingram, 1990; Bronner, 1994). It

has been described as offering "emancipatory promise" (Bronner, 1994, p. 321) and as "evaluating the justice and happiness of societies" (Ingram, 1990, p. xviii). Ingram (1990) suggested that critical theory is idealistic and noted:

> Social philosophy that accommodates itself too much to social reality achieves a kind of practical and theoretical relevancy that renders it irrelevant as a form of critical enlightenment. For no amount of knowledge about the way things are in the world will tell us how they ought to be. It seems that critical theory is caught in a dilemma. Either it remains faithful to its philosophical heritage, in which case it runs the risk of becoming lost in utopian speculation. Or it tries to be faithful to human nature as it really appears, in which case it ceases to be critical. (Ingram, 1990, p. xxiii)

Ingram has described this as the "theory/practice problem" (p. xxiii) and added:

> Critical theory is critical of both the utopian idealism of social and political philosophy and the uncritical realism of social and political science. Social and political theory ought not be so far removed from actual practice as to be useless. Yet it ought not to limit itself to describing the regular patterns of existing social practice for fear of becoming an uncritical tool in the service of government officials and public-opinion manipulators bent on maintaining the status quo. Somehow social theory must combine social philosophy and social science, social idealism and social realism, theory and practice, without assimilating one to the other. (Ingram, 1990, p. xxiii)

Ingram's ideas have been echoed by Bronner (1994) who also identified the need to translate "theory into meaningful forms of emancipatory practice" (p. 322). The

reflections of these writers continue to be relevant today. Ingram (1994) noted that the Frankfurt School, where critical theory had its roots, sought to "critique scientific knowledge and rationality from the standpoint of a social theory proffering "moral" enlightenment and to critique capitalist society as a crisis laden system frustrating human freedom and fulfillment" (p. 1). As the writings of critical theorists evolve, it is clear that the concern is about being relevant to changing contexts, situations, and histories.

Multiple approaches and interventions

Alway (1995) has suggested that if one were to speak of a conception of politics in critical theory, it would be described as "a politics of plurality of agents, a multiplicity of actions, and a vastly expanded arena of political struggle" (p. 129). She further summarized the shift occurring in the writings of Habermas:

> In extricating Critical Theory from the bounds of philosophy of consciousness, Habermas has shifted from issues of consciousness to problems of language, from the subject-object relation to the intersubjective relation, and from the instrumental to a communicative conception of action. The effects of these shifts is to change the very terms by which both the possibilities for and the practices of social transformation are understood. (Always, 1995, p. 129)

Thus, critical theory has its challenges: engaging in philosophical discussion and at the same time remaining committed to social change and to emancipatory processes (Ingram, 1990). Ingram (1990) argued that both actions are important and suggested that critical theory offers possibilities for challenging or questioning what is taken for granted:

> I noted above that critical social theory cannot avoid addressing the philosophical problem of justice and happiness. This is a philosophical problem because the mere fact that people in a given society happen to think that their social relations are just and mutually fulfilling does not necessarily make them so. Slaves can be taught to accept slavery as the most just and fulfilling system for people "like themselves" who are "by nature inferior in intelligence, weak and dependent"...In short, people can rationalize existing injustice and unhappiness by convincing themselves that it is the natural thing that all human beings –or at least, all human beings of a certain rank—ought to be. (Ingram, 1990, p. xxiv)

Critical theory is a significant component of critical multicultural theory because the emphases on developing a philosophy about human relationships, about reflection on issues of justice and equity, on social transformation, on change, and on action are at the very core of what critical multicultural theory seeks to advance. Therefore, an important aspect of the application of critical theory would be to explore issues of justice, equity/inequity, power relationships (including relationships between men and women, and among cultures), and then to propose ways of achieving more equitable relationships, and of creating structures that achieve this. Approaches such as community development approaches, consciousness-raising, popular education, and group work may occur simultaneously.

Ingram (1990) defined critical theory's conception of justice as one that recognizes "instituting procedures of democratic electoral representation in which all have an equal chance to fully participate" (p. xxvii). Ingram noted that full participation and democratic representation would necessarily involve "positive access to healthcare, education, and

income" (p. xxviii). Other writers such as Bronner (1994) have recognized that there are always new and emerging situations and issues that require constant review of the way issues or concerns are addressed. Bronner added: "[c]ritical theory was always based on a commitment to freedom and the need for ongoing revision in order to confront new questions posed by new historical circumstances" (p. 322). In keeping with these tenets, this current study seeks to explore how mental health policies and practices need to change or evolve to meet the needs of changing populations and specifically to the needs of immigrant and refugee women living in Saskatchewan.

Summary

The literature on critical theory acknowledges the challenges of defining concepts such as happiness (Ingram, 1990). Ingram (1990) suggested that happiness "is related to aesthetic notions of balance, harmony, and integrity" (p. 175), which is also related to the discussions about immigrant and refugee women's mental health. One can speculate that the failure to do so will have an impact on their overall well-being in the world. Critical theory is relevant to this study because in many ways critical theory states a commitment to exploring the issues that pose a barrier to the well-being of people. Critical theory identifies oppressive practices and proposes alternative, empowering options (Kincheloe & McLaren, 1994; Mullaly, 2002; Rubin & Babbie, 2001). In addition, there is a commitment to ensuring that language is accessible so that knowledge can be shared and made accessible (Mullaly, 2002). While there is diversity in approaches among critical theorists, there are some common assumptions. These include the assumption of the importance of considering social and historical factors on events; that ideologies are

systems of beliefs and values that drive all levels of decision making processes; and that capitalism breeds various levels of inequity that impact on all aspects of human life and thought. Kincheloe and McLaren (1994) have also noted that oppression has manifested itself in various forms, and is reinforced both by its acceptance by oppressed groups, and by mainstream research practices. A critical theory paradigm can provide a framework that allows social workers to be more inclusive and responsive in their work with people living with oppression(s). There are many theories that would fall within the domain of critical theory. These include feminist theory that will be discussed further in this chapter.

Understanding the broad definition of culture

Researchers have repeatedly emphasized that culture needs to be defined broadly (Maiter, 2003; Pederson 1999; Al-Krenawi & Graham, 2003; McGoldrick, Garcia Preto, Hines, & Lee, 1991; Falicov, 1995; Henry, Tator, & Rees, 2000; Murphy-Shigematsu, 2000; Onwuachi, 1966). Pederson (1999) suggested that culture includes "any and all potentially salient ethnographic, demographic, status or affiliation identities" (p. 3). Culture describes "the total way of life of a people including their interpersonal relations as well as their attitudes" (Pederson, 1999, p. 7). Falicov (1995) has also provided a comprehensive definition of culture:

> those sets of shared world views, meaning and adaptive behaviours, derived from simultaneous memberships and participation in a multiplicity of contexts, such as rural, urban or suburban setting, language, age, gender, cohort, family configuration, race, ethnicity, religion, nationality, socioeconomic status,

> employment, education, occupation, sexual orientation, political ideology, migration and stages of acculturation. (p. 375)

As Onwuachi (1966) noted, culture is

> the sum total of the integrated learned behaviour patterns characteristic of members of a society. It is the sum total of a people's customary way of doing things. This will include all aspects of their life-- their social organization, economic patterns, socially standardized techniques of doing things, and feelings shared by members of the society. (p. 289)

Cultural identity is therefore fluid, and forever changing (Murphy-Shigematsu, 2002; Roy & Montgomery, 2003; Bryan, 2001; Falicov, 1995; Henry, Tator, & Rees, 1995). Onwuachi (1996) observed that culture "constitutes the social heritage of every new generation" (p. 289), is passed on from one generation to another, and that individuals are shaped by the cultures within which they live. Researchers have cautioned about the dangers of exaggerating single aspects such as cultural differences only, or cultural similarities only, or supposed idiosyncrasies (Baubock, 2002; Murphy-Shigematsu, 2002; Roy & Montgomery, 2003; Nelson & McPherson, 2003; Penketh & Ali, 1997; Payne, 1997; Falicov, 1995). They have also critiqued the Eurocentric nature of mental health assessments and practice, including the colonialist biases of the Diagnostic and Statistical Manual (DSM) including the DSM-IV (Falicov, 1995; Kirmayer & Minas, 2000; Caplan, 1995; Kutchins & Kirk, 1997).

Caplan (1995) discussed how indigenous Americans and Canadians were given "disorder" labels because of their drinking and little or no attention was paid to the impact of the residential schools and to colonization in general. Kutchins and Kirk (1997) have

referred to "the issue of racial differentials in psychiatric disorders" (p. 225) and described how one research report *Alcohol abuse and dependence in the rural South* repeated the "enduring pattern of racism in the identification of mental disorders" (p. 227). The authors have identified other studies that highlight racism in practice and concluded:

> When a diagnostic system, such as DSM, that appears to be free of racism actually permits the introduction of racial biases, a sequence of events is triggered that influences public perception about the incidence of mental disorders among minority groups. These perceptions confirm, then reinforce, and finally expand the system of beliefs about racial inferiority. (p. 229)

Kutchins and Kirk have acknowledged that the American Psychological Association tried to address "ethnic and cultural issues" (p. 233). However, these authors also identified some problems such as the assumption that "the clinician is from the dominant culture and the client is a member of a minority group" (p. 233); that being of the same ancestry will lead to correct "diagnosis"; that clinicians are from the dominant culture. In addition Kutchins and Kirk have suggested that there is limited attention to specific cultures except when referring to "dominant white culture in America" (p. 235).

A critical multicultural theoretical framework applied to mental health policy planning and analysis recognizes the complex dimensions of culture, and is committed to a multidimensional approach within mental health policy and practice. The significance of culture is expressed by Bryan (2001): "Culture influences not only the value placed on particular elements of life, but also helps to determine who has the power in the system-whose opinions are important, whose decisions are followed" (p. 109). Critical multicultural theory offers a vision to practitioners and policymakers to recognize power

imbalance, and to create a culture committed to the creation of a just society (Fleras, 2001). That is, it offers a way of viewing the world, one that can move policy makers towards statements and guidelines leading to practice that is committed to social inclusion and empowerment. This framework therefore lays the groundwork for social workers to use an integrated approach based on the complexities of mental health conceptualizations and needs of immigrant and refugee women.

Understanding multicultural processes

Travel and migration activities contribute to the enormous amount of interaction among international peoples in Canada and elsewhere. While this contact may be fleeting, it may also involve shared experiences of resettlement and the consequent adjustment and learning among and between newcomers and residents of countries (Leong & Santiago-Rivera, 1999). These contacts influence cultural processes such as values and beliefs among individuals and groups (Leong & Santiago-Rivera, 1999). The decisions about how to address needs within society are strong indicators of societal values and beliefs (Fraser, 1989).

"Values" have been defined as "the most fundamental of fundamentals" (McGilly, 2001, p. 43). Values represent cultural choice about what is good, and perceptions about what is preferred, and is not static (Leong & Santiago-Rivera, 1999; McGilly, 2001; Wilensky, 1965; Durst & Delanghe, 2003). Onwuachi (1996) referred to the term "value" as "the implicit or explicit socially standardized concept of what is desirable or undesirable in the culture" (p. 289). He noted that " [in] any culture-contact situation, the

values of the cultures in contact do invariably change resulting in somewhat new cultures" (Onwuachi, 1966, p. 289). Onwuachi (1966) further concluded that

> The new cultures or ways of life must, however, have a realistic relation to the on-going patterns of existence, if they are to be meaningful and beneficial. In other words, the new cultural values must be properly woven into the existing fabrics of the culture. (p. 289)

"Beliefs" refer to what is conceived to be true (Leong & Santiago-Rivera, 1999). They are not absolute, but are culture specific (Bochner, 1999). Beliefs are more rigidly held onto, and are strong influences on behaviour (Leong & Santiago-Rivera, 1999). The values and beliefs of people influence their attitudes towards one another, how policies are formulated and implemented, and the choices that are made at all levels of society. In discussing the integration needs of immigrants to Canada, one might be able to conclude that Canadians and newcomers both hold fabrics of a culture and that the challenge is to determine how each will incorporate the changes that will occur with contact.

Onwuachi (1966) has suggested that in "primitive or simple societies" (p. 289), family and community traditionally played a primary role in the socialization of community members. At the same time, Onwuachi (1966) recognized the diversity of experiences within countries and cited the example of African countries. He identified the "cultural variations and conditions of diversity" (p. 289) that existed within African societies:

> It was within the continent of Africa that the Great Pharaohs of Egypt lived in decadent splendor while Europe, as we now know it, wallowed in primitivity and dark ages. It was within the territorial boundaries of Africa that some of the key

> elements of the present Western Civilization were developed. Paradoxically, Africa still maintains some of the most traditional and primitive cultures. The impact of Western Civilization in Africa has created many problems and changes. Among these are the problems of cultural adaptation and the incorporation of Western laws and customs into existing tribal ones. There are also the problems of urbanization which have brought about a radical transformation of the character of African social life. There is also the issue of detribalization which processually has created conditions under which the individual African natives were deprived of cultural constraints to which they were traditionally attached. (Onwuachi, 1996, p. 289)

The processes for passing on values and beliefs are also varied. For example, elders in indigenous African societies have taken a lead in teaching about values and beliefs through traditional stories, and a lead in organizing rituals and practices (Onwuachi, 1996). Onwuachi (1996) described these approaches as "the pedagogical tools in the indigenous African Societies" (p. 290). Alongside these traditional mechanisms, school or education institutions have also served mechanisms for enhancing knowledge and skills. Onwuachi (1996) described the African "school" approach as a "regimented, schematized system of Western education" (p. 290). He also added: "The school curricula were formulated, fashioned, and relished with Western cultural ideals and values. Very little reference was made to indigenous African social and physical ecology as well as cultural values and ideals" (p. 290). That is, intercultural contact has the potential to bring about new knowledge and awareness among those who come into contact with one another, but

Western colonialists have often proven to be less respectful and mindful of the values and beliefs of other cultures when this might threaten their own dominance.

The state plays a role in defining the values of society because it makes cultural choices about governance issues. Individuals and communities also have their own conceptualizations of values. These are viewed as complex systems that interrelate, sometimes in contradiction with one another (McGilly, 2001). Tropman (1981) expressed this complexity in terms of dilemmas. He suggested that dilemmas clash and identified them in terms of:

- Inner- versus other direction- the struggle between an individual's life being directed by the inner self, versus being directed by outside forces;
- Contest versus sponsored mobility- the dilemma that individuals may be involved in a struggle to achieve, while others have been granted privileges which then eliminate the need for these individuals to struggle;
- Achievement versus equality- the dilemma that individuals believe they have achieved their status (or strive to do so) through their own personal struggles and qualities; and then that status may result from one's citizenship status. Tropman (1981) has suggested that this creates some tension between these two group: "To the extent that we emphasize equality we create, it seems, a situation which threatens the personal property of achievement" (p. 14).
- Public-regardingness versus private-regardingness- the dilemma that the state provides benefits to all versus the state providing personal benefits to some.

- Freedom versus control;
- Self-reliance versus dependence;
- Performance versus quality- this can be described in terms of the way in which individuals are evaluated.

Yet, as Sartorius (2000) has suggested, understanding what is "good" and "bad" and coming to a universal consensus about moral behaviour is not easy because of the broad range of differences around the world. Sartorius (2000) and Okasha (2000) have noted that ethical guidelines and codes have been created precisely because of this desire to have cross-culturally valid standards, and to protect against abuse of power. Sartorius (2000) argued that these "consensus-based statements" (p. 6) must be open to challenge since new knowledge and perspectives should be allowed to flourish and influence existing conceptualizations. A critical multicultural theoretical framework seeks to confront rather than avoid the question of values. This framework strives to balance individual and collective needs, and recognizes the unique realities of women and other minorities.

With respect to immigrant and refugee women, it is important to understand the values and beliefs that have a direct bearing on women's mental health. These complexities are not always recognized. A critical multicultural theoretical framework states a commitment to recognizing the complexities, recognizing the diversity of backgrounds and experiences, striving for the goals of social inclusion, and to addressing systemic inequity. Critical multicultural theory's emphasis on multicultural processes and structures also provide opportunity to consider the intersection of traditional values and beliefs, and those of others, and how the understanding of this intersection can enhance

policy and practice. For example, Onwuachi's discussions about how values and beliefs are taught also suggest the need to understand the dynamics of intercultural contact and the various outcomes of this contact. With respect to the aims of this dissertation, understanding of cultural beliefs, values, and traditions that have shaped how norms, behaviours, decision making practices, and educational and socialization processes will be helpful throughout the entire research process. The framework insists on an antiracist and gender inclusive approach to mental health policy and practice. These stated intentions are essential to immigrant and refugee women's mental health needs.

Understanding multicultural structures

Multicultural structures refer to the policies, legislation, and regulations that frame the context within which multicultural contacts and multicultural processes occur (Bochner, 1999). They reflect society's institutionalization (systematization) of what is the norm, what is acceptable. The complexity with respect to developing institutional structures to address the needs of multicultural societies is evident from the debates on social integration, and from the different descriptions of citizenship models. Of important note here is that the concept of citizenship, as expressed within this dissertation, is one that recognizes how the concept has to become transformed to reflect understanding of the equitable rights of all members of multicultural societies. Yet, critics of multiculturalism suggest that current policies do not adequately give guidelines to achieve anti-oppressive, equity seeking goals. Critical multicultural theory provides a framework through which these concerns can be addressed.

Within multicultural societies, cultural diversity poses an enormous challenge to achieving these goals of equity. Beiner (2003) argued that "dislocating shifts of identity provoked by mass migration and economic integration, accompanied by defensive reactions to bolster these jeopardized identities" (p. 22) are some of the issues that lead to questions about "what binds citizens together into a shared political community" (p. 22). However, as the issues of citizenship suggest, a primary issue for some relates to their equitable access to the rights that will afford them full citizenship. Castles and Miller (2000) noted that immigrants are particularly concerned with citizenship so that they can achieve the same legal status as other residents. Another argument of this dissertation is that civil, political, and social rights are equally important components of citizenship. The denial of these will have a direct impact on the mental health of immigrant and refugee women. As well, access to services and utilization of services are relevant to social integration processes.

Citizenship models and culture

Castles and Miller (2000) described four models that show how culture has been incorporated into policy development in different countries (Castles & Miller, 2000). These models reflect values of policy makers and governments:

- The imperial model whereby the same ruler governs everyone (including diverse populations or nations). Castles and Miller (2000) suggested that this type of model helps to mask the fact that one group actually has power over another. Mental health policy and practice may not acknowledge this

reality and so these issues are not addressed in practice. No attempts are made to develop ethnospecific services.

- The folk or ethnic model within which factors such as ethnicity and language define citizenship. Focus is on understanding the individual groups and on the characteristics of each group but little attention is paid to overall system and structural issues. Mental health practitioners recognize issues such as ethnicity but do not necessarily acknowledge or respond to broader issues, which may have a direct impact on the lives of immigrant and refugee people.
- The republican model which is based on an assimilationist approach. Newcomers are admitted into the country as long as they "adhere to the political rules and are willing to adopt the national culture" (Castles & Miller, 2000, p. 44). Castles and Miller (2000) described the example of the French republican model. France claims to offer equal social rights to immigrants but there is great differentiation between groups (some groups have more rights and privileges than others). Policymakers blamed social problems and immigration and assumed that assimilation would eliminate problems. Mental health problems are therefore viewed as related to the individual psyche. The focus is therefore on individual change and less on systemic change.
- The multicultural model that operates like the republican model but also recognizes the role of ethnic communities. Mental health practitioners recognize the values that ethnic groups may bring, acknowledge the unique

issues related to these groups, and work with individuals so that they can learn the values of the host countries, and learn to live within the host countries. While practitioners try to understand newcomers, it is with the view of helping them (newcomers) to work with existing systems.

Roy and Montgomery (2003) have described three other approaches to addressing diversity and integration:

- A culturalist model (evident in the 1980s), which stressed the values and beliefs of immigrant communities, and focused on cultural differences (Roy & Montgomery, 2003; Yee & Dumbrill, 2003). Service providers focused on cultural competency training (Roy & Montgomery, 2003; Yee & Dumbrill, 2003).

- A social contract model, which stressed systemic barriers related to housing, employment, and unequal power relationships (Roy & Montgomery, 2003).

- A citizenship model which emphasized shared values and universalism. Roy and Montgomery (2003) have suggested that this model may not give sufficient recognition to the specific issues of discrimination and inequity facing disadvantaged populations.

Roy and Montgomery's approaches complement those described by Castles and Miller For example, the folk or ethnic model and the culturalist model are similar. However, through the naming of "culture", Roy and Montgomery also identify a broad range of

issues. Roy and Montgomery's social contract model recognizes equity issues and systemic barriers, and names the issues in a way that is not done by the other authors.

Baubock (2002) has proposed a fourth model: a catalyst model, which recognizes the influences that newcomers have on host countries, and views integration as a transformative process. The above-mentioned first three models respond to some aspects of the needs of diverse communities, while the fourth appears to add a dimension that has often been neglected. The models and approaches presented by Castles and Miller, and by Roy and Montgomery are helpful in understanding the different political and policy contexts within which immigrant and refugee women live and within which mental health policy and practice exist. The perspectives of practitioners and policy makers may fall within any one of these models or approaches. The Baubock's model provides a challenge to mental health policy makers and practitioners to learn from immigrant and refugee women about their experiences with mental health policy and helping models, and consider how these might influence the ways policies and practices are implemented in Canadian contexts. This study will draw on Baubock's model in the analysis of policy documents because it acknowledges that systems need to change or evolve in response to changing populations and dynamics. Using this model in conjunction with critical multicultural theory will allow me to recognize systemic issues and to recognize the significance of culture in the analysis.

Murphy-Shigematsu (2002) has suggested a definition of a multicultural theoretical framework:

> This is a metatheoretical approach that recognizes that all helping methods exist within a cultural context and represent different worldviews. Conventional

counselling is regarded as just one approach among multiple helping roles developed by culturally different groups around the world. (p. 6)

A metatheoretical approach deals with overarching assumptions within theories (Morrow, 1994). Critical multicultural theory can be described as a metatheoretical approach because it attempts to describe the weaknesses of existing theoretical frameworks. Using this framework, one can then begin to explore factors essential to immigrant and refugee women's mental well-being, and then to make recommendations for change. What is being proposed is a multidimensional approach which moves away from an emphasis on a medical-clinical model to one that represents these complex realities and needs.

Integrating feminist theory within critical multicultural theory

One of the most significant contributions of feminist theories has been to ensure that women have a central place in theoretical analyses. Another important contribution has been to move beyond abstraction to a role of guiding and informing practice (Bryson, 1992). Despite the common focus – "women", the range of feminisms and feminist theories, reflects the diversity among women and their differing ideological stances (Mitchell & Oakley, 1986; Saulnier, 1996; hooks, 1981, 2000; Bryson, 1992; Collins, 1991). Feminist theories can enhance critical multicultural theory because they challenge policymakers and practitioners to integrate gender inclusive analysis into their work, and in particular, to maintain focus on women.

The literature on feminist theories has included discussion about liberal feminism, Socialist feminism, Marxist feminism, Radical feminism, and Global feminism (Collins,

Bryson, 1992; Saulnier, 1996). These theories have helped to advance the goals of women's equality. At the same time, the range of feminist "theories" reflect the diversity among women. Black feminists and global feminists have done much to emphasize the notion of class, and the reality of diversity among women. As feminist theories evolve, there is greater consideration of the broad issues of social justice. There is focus on advancing understanding of women's unequal situation, but also a concern with justice for all. With respect to critical multicultural theory, the use of a feminist theoretical approach helps me to maintain the focus on women. I found Black feminist and global feminist theories have been particularly helpful as I tried to focus on work that reflected feminist practice with multicultural populations, and specifically with immigrant and refugee women. Their longstanding tradition of recognizing the intersectionality of oppressions, especially their writings with respect to the impact of "race", class, and gender have added to my own understanding of oppressions. Moreover, I have been guided by Black feminist and global feminist theories because these theorists have given me opportunity to listen to the voices of Black women who live the experiences of being racialized and oppressed, and to listen to the global perspectives of women from various parts of the world who live in situations of oppression. Bricker-Jenkins (1991) has suggested, "the work of the feminist practice movement is the creation of a method of practice designed to engage all persons in the process of personal and political transformation" (p. 271). She also noted that feminist practice has gone beyond a focus on non-sexist and women's issues to a more humanistic focus (Bricker-Jenkins, 1991). In addition, she named some common beliefs among feminist theorists:

- That self actualization is an essential goal of human life;

- That there are many systems that pose barriers to self-actualization and individual and collective capacities can be mobilized to achieve actualization;
- That everything is interconnected and interrelated.
- That "reality is a multidimensional process" (Bricker-Jenkins, 1991, p. 273);
- That diversity has many positive aspects;
- That woman's "histories, conditions, developmental patterns and strengths" (Bricker-Jenkins, 1991, p. 273) must be understood.

Hooyman (1991) has also added to the literature on the application of feminist theories by discussing some principles of feminist leadership. These included (pp. 260-267):

- Affirming the value and dignity of each person;
- Valuing multidimensional thought processes;
- Reconceptualizing power;
- Creating open problem-solving structures; and
- Valuing process.

The notion of using "feminist" theories with immigrant and refugee women can pose the same challenges as when attempts are made to use feminist theories with any population of women. That is, there are women who will not necessarily use the language "feminism". Having accepted that, I have chosen to use feminist theories (particularly Black feminist and global feminist) to guide my work because I believe that these theories can help me in my commitment to advancing the goals of empowerment and social justice.

The belief that "the personal is political and the political personal" (Agger, 1993, p. 3) expresses the recognition by feminist theorists of the interconnectedness between public and private issues. Agger suggested that if "we separate the personal from political, everyday life from overarching institutions, we defuse the dialectic bridging present and future and hence subvert democracy" (p. 2). Agger identified some of the tensions between feminists and critical theorists based largely on the notions that early critical theorists were sexist, and suggested that "a new totality theory can avoid male supremacy by carefully rethinking its own critique of domination in such a way that feminism is no longer considered an appendage but informs and transforms the very logic of critical theory" (Agger, 1990, p. 2). Agger talked about critical theory that did not fully integrate feminist theory as "male critical theory" (p. 2).

Nevertheless, the literature notes that not all women are comfortable with feminism. In discussing the notion of refugees as feminists, Baczynskyj (1991) noted:

> Although feminism for many refugee women is not the primary espoused goal, the actions of these women capture its essence. While men go off to fight wars of struggle out of which most refugees are born, women both fight and tend the home fires. However, it is not in comfortable living rooms, but amid the stark reality of babies crying from hunger, bombs shattering, and dangerous escape, that they must live. This is reality for all Third World women, for all survivors not privileged to partake in the discussion of equal wages and status. The women with whom I work have raised themselves well above all slogans of feminism, they are women

> who, seemingly unprepared for fighting a woman's cause, have embraced a human one—that of equality for all. (p. 219)

Baczynskyj (1991) added that Americans' image of Southeast Asian women is of a "demure, quiet, sweet, feminine, and subservient" (p. 219) individual. She noted, however, "these are women who have walked through jungles, maneuvered their survival, and safeguarded their partners, children and loved ones" (p. 219). Having also lived as a refugee, Baczynskyj (1991) understands what it is to live as a refugee, and understands the strength and resilience of refugee women. Her definition of feminism has evolved from her own experiences:

> joining in and making it more possible for people to be recognized as who they are. ...feminism is an opening of opportunities, a drawing of lines in the commonality of human interests, and a process of cooperation rather than rejection". (p. 221)

Overall, the aspects of feminist theories that I have chosen to incorporate within this work are those that stress the importance of working as a team, focusing on the goals of self-actualization, focusing on ensuring culturally and linguistically appropriate services, and understanding the significance of relationships in the lives of women. I have also included the notion of engaging in political action to eliminate structural oppressions. Feminist practice in mental health settings must therefore be committed to expanding beyond the boundaries of the individual counselling model, to incorporate a multidimensional approach. For immigrant and refugee women, this will reflect a better understanding of their needs and situation.

Maintaining an anti-oppressive, anti-racist, gender inclusive perspectives, and a commitment to empowerment practice

A critical multicultural theoretical framework, in its metatheoretical approach, recognizes the diversity and complexity of immigrant and refugee women's mental health needs and perspectives. This framework promotes an anti-oppressive approach that attempts to move away from traditional models of mental health delivery (medico-clinic model) to one that falls more within the realms of primary health strategy. That is, it strives to develop programs and services in consultation with various community populations. Critical multicultural theory provides a framework for addressing immigrant and refugee women's needs by exploring what the core issues are, and then proceeding to develop models that best respond to these issues. Immigrant and refugee women are not being asked to fit their needs into existing models that may be inadequate or inappropriate. Instead, everyone is being asked to enter into dialogue to share experiences, learn from one another, and then to dare to make changes to existing policies and models. This theoretical framework draws on critical theorists, anti-oppressive, empowerment and Black, global and feminist approaches that all recognize the complexity of issues, the intersectionality of oppressions, and the need to address issues on different levels (Gutierrez & Lewis, 1999; Collins, 1991; Mullaly, 2002; Payne, 1997).

Black feminist writers opened the door to an understanding of the complexity of Black women's lives. Repeatedly, they named the concepts of multiple oppression and the "interlocking systems of oppression" (Collins, 1991, p. 222):

> Afrocentric thought offers two significant contributions towards furthering our understanding of the important connections among knowledge, consciousness, and

> the politics of empowerment. First, Black feminist thought fosters a fundamental paradigmatic shift in how we think about oppression. By embracing a paradigm of race, class, and gender as interlocking systems of oppression, Black feminist thought reconceptualizes the social relations of domination and resistance. Second, Black feminist thought addresses ongoing epistemological debates in feminist theory and in the sociology of knowledge concerning ways of assessing "truth." Offering subordinate groups new knowledge about their own experiences can be empowering. But revealing new ways of knowing that allows subordinate groups to define their own reality has far greater implications". (Collins, 1991, p. 222)

One of the difficulties of identifying the issues of "race", class, and gender is that this seems to highlight some oppressions. It is certainly a challenge trying to maintain a commitment to an anti-oppressive perspective and to inclusivity while at the same time naming a few. I believe that the lessons from Black feminist thought is that Black feminists have identified "race", class, and gender as the "axes of oppression" (Collins, 1991, p. 226) that are particularly significant when engaging in analysis of issues of oppression in the lives of Black women. Black feminist writings have also noted that different groups can explore how the matrix of domination operates for them, and these do not have to be the same as what is defined by Black women:

> This approach to Afrocentric feminist thought allows African-American women to bring a Black women's standpoint to larger epistemological dialogues concerning the nature of the matrix of domination. Eventually such dialogues may get us to a point at which, claims Elsa Barkley Brown, "all people can learn to center in another experience, validate it, and judge it by its own standards without need of

comparison or need to adopt that framework as their own" (1989,922). In such dialogues, "one has no need to decenter anyone in order to center someone else; one has only to constantly, appropriately, 'pivot the center' " (p. 922). (Collins, 1991, p. 236)

The lessons for immigrant and refugee women, as well as for policymakers and human service practitioners is that we need to provide a forum for immigrant and refugee women from different ethnocultural and socioeconomic groups to meet, share their knowledge, dialogue in an environment of honesty and respect, and be active participants in the process of program and policy development. The Immigrant Women's Association Against Violence community project in Winnipeg, Manitoba (Canada) is an example of how anti-violence work with immigrant women could be effectively done (Blum, Heinonen, Anchan, Migliardi, & White, 2003). The facilitators listened as women spoke about their varied experiences of violence, their needs, and then supported them as they (the women) set the agenda for addressing these needs.

Policymakers and decision makers need not create new services but they need to explore how current services and models can be enhanced, modified, or changed to adapt to the changing population. In addition, policymakers and decisions makers may be encouraged to consider the extent to which the benefits as a result of enhancements, modification, or changes to models and policies may extend beyond the immigrant and refugee community.

Mullaly (2002) has added to the writings on multiple oppression and intersectionality of oppression. He suggested that the intersectional model must go beyond this "trinity or triumvirate of race, class and gender forms" (Mullaly, 2002, p.

152), and must avoid setting up "hierarchies of oppression" (Mullaly, 2002, p. 152). Mullaly (2002) has recognized that there are no easy answers:

> The intersectional nature of oppression holds significant implications for an anti-oppressive social work practice. It helps the social worker to see that oppression seldom comes in a single form...Social workers should also be aware of the ways that different forms of oppression intersect with each other and how these intersections contain oppressive effects themselves. (Mullaly, 2002, p. 156)

Other researchers have suggested that when particular aspects of oppression are not addressed, there is a risk of limiting change because of a lack of "a coherent strategy for systemic intervention" (Williams, 2002, p. 21). Indeed it is important to recognize the issue of multiple oppressions, without losing sense of how individuals and groups may experience particular elements such as racism and gender oppression.

In addition to discussing the notion of multiple oppressions and the intersecting nature of oppressions, anti-oppressive theorists and Black feminists also have discussed how oppressions are located at different levels (Collins, 1991; Mullaly, 2002). Collins (1991) suggested that individuals "experience and resist oppression" (p. 227) on a personal biography level, the group or community level of the cultural context, and the systemic level. Mullaly (2002) referred to these levels as the personal, cultural and structural levels. He described the personal level consisting of "thoughts, attitudes, and behaviours that depict negative prejudgments of subordinate groups" (Mullaly, 2002, p. 52). He suggested that oppression on this level "is usually based on stereotypes and may manifest in conscious acts of aggression and/or hatred, but today it tends to be in the form of unconscious acts of aversion" (Mullaly, 2002, p. 52). He described oppression at the

cultural level as occurring when the dominant group's culture is privileged and repressive subordinate ones (Mullaly, 2002). Oppression at the structural level represents "the means by which oppression is institutionalized within society" (Mullaly, 2002, p. 97). The strength of Mullaly's work is naming the overlapping nature of these levels. For example, the individual or personal level occurs within the context of the cultural and structural levels, and the cultural level within the context of the structural level (Mullaly, 2002). As well, Mullaly has continued to stress the diversity that exists within and among oppressions (Mullaly, 2002).

A multicultural theoretical framework not only states a commitment to understanding the concept of multiple oppressions but also identifies strategies for addressing the needs of immigrant and refugee women. It seeks to incorporate change in order to bring about social justice and the empowerment of individuals, groups, communities, and families. Payne (1997) has suggested that empowerment "seeks to help clients gain power of decision and action over their own lives by reducing the effect of social or personal blocks to exercising existing power, by increasing capacity and self-confidence to use power and by transferring power from environment to client" (p. 266). Social justice is a central principle in an empowerment approach (Payne, 1997; Gutierrez & Lewis, 1999). Power is also a major component in the quest for social justice and so the issue of power and its multidimensional nature are recurring themes in empowerment theory (Gutiérrez & Lewis, 1999). Power relates to the ability to control actions, one's capacity to influence public life and policy, and then one's access to decision-making and resources (Gutiérrez & Lewis, 1999).

Community workers have increasingly recognized the significance of this issue. In the case of the Immigrant Women's Association of Manitoba's violence intervention project, the evaluation identified the need to consider the power imbalance between facilitators, service providers and grassroots women who formed the advisory group (Blum, Heinonen, Anchan, Migliardi, & White, 2004), and explore ways of addressing this in future projects or programmes. In another study, adult women survivors of childhood sexual abuse came together to talk about the cost of providing health care services in a traditional way, and proposed alternatives (Burgess, Watkinson, Elliott, MacDermott, & Epstein, 2003)

Similar to the writings of Black feminist theorists and those of anti-oppressive perspectives, writings about empowerment practice identifies the different levels at which individuals function. Gutièrrez and Lewis (1999) named the personal level as the level at which individuals feel "personal power and self-efficacy" (p. 11). On the interpersonal level, individuals are able to influence; and on the political front, individuals engage in social action and change (Gutièrrez & Lewis, 1999). It follows, therefore, that empowerment practice involves a multidimensional approach, with various levels of intervention and a vast array of skills. Empowerment work can be achieved through education, participatory approaches with individuals, families, groups and communities, and capacity building (Gutièrrez & Lewis, 1999).

Overall, the strength of critical multicultural theory is that it names the social context as one that is multicultural, evolving, and that requires mental health policy and practice approaches to be multidimensional. Policymakers and practitioners are called on

to address multidimensionality by considering how issues occur on several levels. The key levels are the personal, group or community, and structural levels.

Application of theoretical framework

Critical multicultural theory offers a framework to assist practitioners and policymakers to be inclusive of the complex realities and needs of immigrant and refugee women. The framework includes focus on multicultural processes and multicultural structures. It also includes a commitment to a critical approach that is informed by feminist, anti-racist, and anti-oppressive perspectives. By naming feminist, anti-racist, and anti-oppressive perspectives, my goal has been to clarify and emphasize how I approached the analysis. While one might suggest that critical multicultural theory (on the basis of its focus on critical theory) includes or implies these aspects, I wanted to ensure that they are not lost. In my opinion, naming feminism and feminist theories, and anti-racist and anti-oppressive perspectives allows me to acknowledge the diversity among women and in particular allows me to take a stance in solidarity with poor, racialized women. I wanted to address the potential for watering down of issues that racialized and oppressed women have sought to highlight. I believe that people may use different language but that they share many of the same goals for social justice and equity. Including the different perspectives allows me to embrace the diversity among people who are wanting the creation of a just society. That is, the dissertation's focus on programs and services to address immigrant and refugee women's mental health needs, represents a belief that immigrant and refugee women have the right to access services and programs to address their mental health needs. A goal of this dissertation is to ensure that the services and

programs are delivered in ways that are relevant to the needs of this population. In addition, there is acknowledgment of the breadth of issues that pose a threat to a just society.

All policy, program and service delivery approaches must recognize the contexts from which, and within which immigrant and refugee women live. That is, there are historical, social, economic, and political contexts from which immigrant and refugee women come to Canada. These must be understood even as women settle and find their place in Saskatchewan. Lacroix (2003) has suggested that multicultural social work in the era of globalization must address the new and emerging issues facing different countries. These would include issues such as those related to gender and migration, and post-traumatic stress disorder (Lacroix, 2003). One of the early tasks in the process of policy and program development and/or analysis would be to consider whether the policies and programs adequately reflect an understanding of the issues facing immigrant and refugee women. These issues relate to the values and beliefs that exist within countries of origin, and which may continue to influence the lives of women even in host countries. These can be included in background documents to help guide policy and program development.

With respect to anti-oppressive and feminist theories, gender-based analysis guides exist that would help policymakers and decision makers to ensure that questions relating to gender are integrated through their work (Government of Canada, Gender-based analysis guide-March 1997; Citizenship and Immigration, nd, a, d). Black feminist theories and an anti-oppressive perspective can further guide this work through the reflections about how individuals experience oppressions on multiple levels: the personal, community or group, and the systemic levels (Collins, 1990; Mullaly, 2002).

In approaching the data analysis, I acknowledge that I come to the process as someone who self-defines as feminist and who identifies strongly with writings from a Black feminist theoretical perspective. As already stated, not all immigrant women are comfortable with the language "feminism" so while I have drawn on feminist principles, I have not assumed that the research participants were all feminists or would necessarily be comfortable with feminist theories. I have tried to reflect their views as accurately as possibly. However, the process of analysis has been an independent piece of work that reflects who I am, and my own conclusions based on readings, conversations, and life experience.

Writers and academics from a range of backgrounds have struggled with the notion of including diverse voices including their own in their writings (Anzaldua, 2002; Collins, 1990; Reinharz, 1997). Patricia Hill Collins (1990) posed ideas about how to address some of the challenges facing Black women intellectuals who want to develop Black feminist thought, and who want to avoid excluding others:

> Bell Hooks offers a solution to this problem by suggesting that we shift from statements such as "I am a feminist" to those such as "I advocate feminism." Such an approach could "serve as a way women who are concerned about feminism as well as other political movements could express their support while avoiding linguistic structures that give primacy to one particular group" (1984, 30). (p. 35)

Reinharz (1997) also reflected on the challenges of maintaining the self in research. She suggested that we

> both bring the self to the field and create the self in the field. The self we create in the field is a product of the norms of the social setting and the ways in which the "research subjects" interact with the selves the researcher brings to the field..
>
> (p. 3)

Reinharz suggested that these selves are relevant to the participants in any study, influence the relationships that are formed during the research, and therefore have a profound effect on the kinds of knowledge that the researcher obtains. One of the things I was very aware of during the entire research process was that I was an immigrant woman myself, I was a social worker, a community worker, and an educator. I had been actively involved in working with other immigrant and refugee women and so I had a viewpoint of the issues from these various perspectives. These perspectives and the knowledge I had acquired from the work I was doing, helped me to ask the kinds of questions and prompts that I did. During the research interviews, I did not pretend that I did not have this knowledge and my own perspectives on the issues. This helped to make the interviews rich and added to the depth of the conversations with all research participants.

Empowerment theory within critical multicultural theory

The final aspect of the theoretical framework is the integration of empowerment theory. I have chosen to include this aspect because I believe that it offers some concrete ideas about how to work with groups that are living with various kinds of oppression. More than anything else, empowerment theory also identifies the significance of power (Freire, 1987; Lee, 2001; Gutierrez, Parsons & Cox, 1998). In many ways, mental health work with immigrant and refugee women involves working with them so that they can

develop the power to make decisions about the kind of world in which they want to live (which also involves living within equitable societies). It also involves the power to celebrate their cultural traditions, to share their values and beliefs, and to be able to engage in meaningful dialogue and intercultural exchanges that will enrich their communities. As Lee (2001) suggested, empowerment is "the process of gaining power, developing power, taking or seizing power, or facilitating or enabling power" (Lee, 2001, p. 33).

Empowerment practice, which is informed by empowerment theory, has been described as

> an integrated method of social work practice driven by the unified personal: political construct and a commitment to the unleashing of human potentialities toward the end of building the beloved community, where justice is the rule. It is therefore a clinical and community-oriented approach encompassing holistic work with individuals, families, small groups, communities, and political systems. (Lee, 2001, p. 30)

The "clinical" aspect of this work has been defined as "broad-based and tailored to individuals' unique personalities and needs" (Lee, 2001, p. 31). Individuals suffer various kinds of pain and abuses and clinical intervention provides a way to respond to biopsychosocial needs. Empowerment theory stresses the importance of not blaming and revictimizing service users. Lee concluded:

> The healing, however, does not come from an expert's hands but from the collaboration of people with peers and helpers in a self-healing and self-empowering process. It is community-oriented because living, growing, empowered people can not adapt to dead communities. They change them

> or leave them in the process of active adaptation (Germain, 1991). (Lee, 2001, p. 31)

As already noted, a primary component of empowerment theory involves an understanding of power and powerlessness. The literature has recognized the interrelationship between personal and political power and discussed the direct and indirect power blocks that serve to maintain oppression. For example, factors such as poverty, stress, helplessness can lead to a sense of powerlessness. Labelling can also disempower (Lee, 2001; Mullaly, 2002). Factors specific to immigrant and refugee women, and to refugee women have been identified in this research. At the core of action to address the mental well-being needs of immigrant and refugee women is an empowerment process leading to the development of services, models, and programs to address these needs. Power included elements such as "[c]ritical consciousness and knowledge of structural inequities and oppression" (p, 34). Lee concluded that empowerment was about working with individuals with the aim of reducing the powerlessness that results from various kinds of oppressive conditions including racism, or discrimination. Many of these issues have been identified in the discussions about the lives of immigrant and refugee women.

The literature on empowerment practice has identified some key elements (Lee, 2001; Gutierrez, Parsons & Cox, 1998):

- Recognition of the significance of attitudes, values, and beliefs;
- The development of positive self-identity;
- Importance of validation through collective experience;
- The development of knowledge and skills for critical thinking and action;

- The development of resources, knowledge, and skills to address issues that operate on personal, interpersonal, and institutional levels.

The literature on empowerment theory describes work at the personal level as working to address some of the negative valuations that have a damaging impact on the self-esteem and self-concept of individuals (Lee, 2001; Gutierrez, Parsons & Cox, 1998). At the interpersonal level, there is recognition that strong family, community structures, ability to live in different cultural worlds are the important elements that help individuals to cope with oppressive conditions (Lee, 2001; Gutierrez, Parsons & Cox, 1998):

> The structures that mediate against personal damage caused by oppression and the tremendous force of direct power blocks are strong family, group, and community structures and biculturality, the ability to live in two cultures: the nurturing culture of one's own group and the wider culture that oppresses even as it offers some opportunities for acculturation. (Lee, 2001, p. 51)

Power at the interpersonal level also involves "the ability to influence others to attain desired resources and goals" (Lee, 2001, p. 52). One's connection with others and the ability to work collectively, are all forces that can lead to positive change and the achievement of goals:

> Those who are securely attached to loved ones and community are bolstered against the forces of oppression. The primary group, whether natural or formed, is a vehicle for enhancing relatedness and motivating, directing, and accomplishing change objectives (Lee, 1987, 1990, 1991). Collective action depends on the affiliation of persons in groups (large or small) who come together to plan and take

> action towards change goals. Both consciousness-raising and critical education take place most effectively in groups. (Lee, 2001, p. 52)

The political level involves the step of taking action. Oppression is recognized as a political problem. Both workers and service users must build knowledge and skills to engage in this work and collective action is again seen as a mechanism to help develop the knowledge, skills, and strength to do this work.

I have chosen to include the aspect of empowerment as a final component of critical multicultural theory because it takes us back to the place of naming the issue of power. I believe that mental health work with immigrant and refugee women is about recognizing women's power and powerlessness, and working with them so that they can continue to gain the power to determine how they live their lives in Saskatchewan, and that as a community we work with women to address the blocks to their power.

Chapter 4

Methodology

A case study approach

This is a case study of the experiences of enhancing and developing policies, models, and practices to address the mental health needs of immigrant and refugee women living in Saskatchewan. A goal of the dissertation is to understand the different conceptualizations of mental health that immigrant and refugee women, and mental health service providers have. An area of focus has been on the relationship between dominant perspectives on mental health, the ways in which women have traditionally received help, and the ways in which they now get help in Saskatchewan. The choice of a case study methodology provided an opportunity to identify some of the unique features of providing mental health service to immigrant and refugee women within Saskatchewan, a province where the overall population is small, and where the immigrant and refugee population has been traditionally stable, but significantly smaller than that of other provinces. The case study method allowed opportunity for in-depth focus on the services, programs, and policies. It also provided opportunity for focus on the stories of migration, immigration, and settlement of immigrant and refugee women who were living in Saskatchewan, and about their mental health needs. The "case" under study is therefore multidimensional. The case is about the situation of responding to the mental health needs of immigrant and refugee women within the province of Saskatchewan. That is, there is a geographical boundary that defines the case, and there is a boundary with respect to the issue under study. Both aspects are equally important and interconnect to make this particular case study unique.

This is consistent with literature about the case study methodology. The case study approach allows the researcher to define the boundaries of the study, and to do systematic and in depth study of a case or cases (Berg, 2004; Grosof & Sardy, 1985; Stake, 1994, 1995; Yin, 1994, 2004). Case studies also help researchers to gain greater insight into particular issues through the use of multiple data collection measures. The researcher peels off the many layers of the particular case, in an attempt to understand its complex and multidimensional aspects (Maxwell, 1996; Stake, 1995). This methodology encourages researchers to acknowledge the relevance of contexts, all of which influence how an issue is experienced (Stake, 1994; Smith, 1994). Conditions may include co-existing factors such as time and space, physical setting, historical background, ethics, economics, politics and the law (Stake, 1994, 1995; Creswell, 1998).

Overall, the primary goal of the case study methodology is to gain in depth understanding of the case or cases rather than on making generalizations (Reinharz, 1992; Yin, 2004). "Particularization", as emphasized by Yin (2004) and by Reinharz (1992) is an appropriate term of reference. This dissertation combines an instrumental and intrinsic case study approach. The intent of an instrumental case study approach is to gain understanding of issues through focus on a case. In this case it is important to understand the issue of how to develop and enhance policies, models, and practice to respond to the mental health needs of immigrant and refugee women living in the province of Saskatchewan. While the overriding intent is to enhance understanding of how to enhance immigrant and refugee women's mental well-being, and to make recommendations for improving models and practices, another related intention is to highlight the uniqueness of the Saskatchewan context. Therefore, this study also integrates an intrinsic case study

approach because there is particular interest in understanding what is occurring in the Saskatchewan context. Intrinsic case studies allow us to learn about the uniqueness or particularities of particular cases.

The fit between theory and method

The application of a critical multicultural theoretical framework is an appropriate fit for this methodology because it offers some direction with respect to how one might present the multidimensional aspects of the case. This theoretical framework provides assistance with respect to the kinds of questions that might be asked in order to build knowledge, and create in-depth understanding of the issue(s). There is acknowledgment "that all aspects of an individual's social life are interconnected and often one of them cannot be adequately understood without consideration of the others" (Berg, 2004, p. 252).

An important and particularly relevant aspect of critical multicultural theory is its emphasis on understanding cultural contexts. Some of the questions relevant to this study would be: what are the various contexts from which immigrant and refugee women have come? What are the cultural beliefs, values, and traditions that have influenced women's lives? What are the cultural elements that now influence women's lives? That is, the case study methodology, used with critical multicultural theory is an appropriate approach aimed at achieving in-depth understanding of the situation with respect to:

- The specific experiences and needs of immigrant and refugee women living in Saskatchewan;

- The mental health needs of immigrant and refugee women living in Saskatchewan;
- The conceptualizations of mental health as held by this population;
- The contexts of Saskatchewan, including contexts within which immigration and settlement have been occurring, and policy contexts;
- Historical and current approaches to mental health service delivery in Saskatchewan.

Relevance of case study methodology

A case study approach using a critical multicultural theoretical framework is relevant and appropriate for study with immigrant and refugee women because both the methodology and the theory allow for multidimensional approaches. The case study approach also provides a framework for researchers to explore the individuality and particularity of cases, and the relevance of context to the experiences of these subjects. The opportunity to do in-depth study of how the mental health needs of immigrant and refugee women are addressed in the province of Saskatchewan will contribute to the current body of cross-cultural research. Researchers have identified the dominance of individualist ideologies within traditional social work practice, as compared to the tendency towards a collectivist ideology in other non-Western contexts (Lacroix, 2003; Al-Krenawi & Graham, 2003). The intent of a case study methodology is to develop material that responds to critiques that describe current social work and helping approaches as Western oriented because of their emergence within a Western, Eurocentric dominated world (Falicov, 1995; Kirmayer & Minas, 2000; Lacroix, 2003). Reinharz

(1992) has suggested that the use of case study methodology with cross-cultural research will help researchers to address ethnocentrism in research. One of the ways in which this is done in this dissertation is through the process of learning about the different conceptualizations of mental health, about the different ways in which women got help in their countries of origin and here in Canada, and then to present a vision about how mental health practices and services could evolve to reflect the needs of the emerging multicultural population.

Some researchers have already begun to explore different ways of working with ethno-cultural populations. Al-Krenawi and Graham (2003) have described how working with Canadians of Arab background requires consideration of the importance of the "collective identity of the family" (p. 184) and about how "the individual is embedded within this collective identity" (p. 184). These authors have suggested that interventions with families and individuals of Arab ancestry will require exploring how to work within a cultural context where the family, extended family and community play significant roles. Amestica, Houlding, Kiegler, and Ksienski (1999) described a cross-cultural counselling program in Calgary that developed in response to changing demographic, budgetary constraints, and the efforts on the part of mental health services to better respond to the needs of the growing numbers of immigrants in that city. The project used culture-and–language appropriate methods and concluded that many of the gains made were due to the willingness among the various partners and staff to recognize the changing community demographics, and to their openness to providing services differently. This is similar to the Immigrant Women's Action Against Violence program discussed earlier (Blum, Heinonen, Anchan, Migliardi, & White, 2003).

This case study provides an opportunity to add to existing literature on settlement and integration experiences of immigrants and refugees by focusing on the situation of immigrant and refugee women in Saskatchewan. According to Reinharz (1992), case studies provide opportunity for responding to the "distorted understanding of women" (p. 167). In short, this case study will help to broaden the scope of understanding about issues that affect immigrant and refugee women's mental well-being in Saskatchewan, and about how policy, models, and practices can enhance their mental well-being.

Identifying the boundaries of the case and the subject matter under focus

I used the definitions of "immigrants" and "refugees" as defined by the Government of Canada. Accordingly, "immigrants" are being defined as individuals "who are or who have ever been landed immigrants. Landed immigrants are people who have been permitted by immigrant authorities to live in Canada permanently; some will have lived in Canada for a number of years, while others have arrived recently" (Statistics Canada, 2001). "Refugees" are individuals in Canada or out of Canada who fear returning to their home countries (Citizenship and Immigration Canada, n.d, e; Citizenship and Immigration Canada, n.d, b; Citizenship and Immigration Canada, n.d, d). 9 out of 10 immigrants came under the skilled, family, and refugee classes.

An important goal in this dissertation was to focus on the experiences of immigrant and refugee women now living in Saskatchewan. As the literature notes, the majority of immigrants and refugees are now coming from Asian, African, and other developing countries. Many are coming from war affected regions, or regions of extreme unrest or instability. The literature review has identified the extent to which women have

been vulnerable to various kinds of violence and abuses. Yet, they continue to play major caregiving and breadwinning roles within their families. It is hoped that the case study approach will provide opportunity to build understanding of this population, their unique experiences within the Saskatchewan context, especially with respect to how women's mental health needs area addressed, and then to focus on how one might address these needs within the Saskatchewan context.

An area of focus has been on identifying current mental health services in Saskatchewan. The provincial government department, Saskatchewan Health supports the different health regions that provide a range of services and programs. The regions provide generic services which are delivered by a large body of professionals. This body includes licensed practical nurses, paraprofessionals, psychiatrists, psychologists, registered nurses, registered psychiatric nurses, and social workers who provide mental health services in hospitals, private practice, and in community health centres (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988b; Saskatchewan Health, 2002; Conway, 2003). Traditionally, these professionals provide group work, individual counselling, in-patient, and outpatient services. A description of the mental health services provided by the different health regions is provided in Appendix A.

A description of mental health services provided by other community-based organizations such as the Family Service Canada agencies and the Community Clinics is also included in this appendix. With the exception of one of the mental health centres, there does not appear to be programs or services specifically targeted for immigrant and refugee people. However, a list of immigrant and refugee serving agencies (including

settlement services), along with a description of their programs and services is provided in Appendix B. The information provided in the appendices has been taken from the Saskatchewan Health's website (www.health.gov.sk.ca/ps_mental_health_rehab.html), and from the websites of the other organizations and agencies. In identifying participants for the study (in particular, service providers), these are the agencies from which participants were recruited.

Conflict of interest and power relationships

I was aware of the potential for conflict of interest because of my community work within Saskatchewan, and especially within immigrant and refugee serving agencies and organizations. Some of my roles have included:

- Past President of the Congress of Black Women, Regina Chapter;
- The Past President and board member of International Women of Saskatoon, formerly Immigrant Women of Saskatchewan, Saskatoon Chapter;
- A member of the interim board for the provincial chapter- Immigrant, Refugee and Visible Minority Women of Saskatchewan;
- A past board member of Saskatchewan Intercultural Association;
- Contract counsellor with Family Service Saskatoon;
- Member of Advisory Board on Moving Forward project (a project focusing on the needs of children and families who have experienced war).

I was very comfortable with approaching and inviting service providers to participate in this research. I found myself very hesitant to move forward with interviews with

immigrant and refugee women. One of the reasons for this hesitations is that I am aware of the extent to which researchers have entered these communities, collected data, and not done enough followup with the participants or communities involved. However, once I began to do the interviews, I realized that the interviews gave women an opportunity to come together to reflect and dialogue. I believe that women were happy that they participated in the interviews because they were able to share their experiences with me and with other women. My sense was that the interviews could be seen as part of the process of community building and making home in Saskatchewan. Several women thanked me for inviting them to participate because it was a helpful process for them. I believe that hosting these meetings at homes contributed to this outcome.

While I was hesitant about my own leadership role and the potential for conflict of interest, I also realized that I was able to do many of these interviews because of the trust I had developed with other immigrant and refugee women. This highlighted that research can be part of a process of community building, and that we do need to take the time to build relationships. This will address some of the resistance, trepidation, and fear of research. I was always reminded about the mutual process of the interviews. The participants have all had an enormous impact on my own learning about the topic. I have also learned from the process and know that this will help in work as a social work educator and practitioner.

Data collection

Recruitment of participants

All participants were recruited using both purposeful and snowball sampling methods. Letters of introduction were sent to agencies, organizations, and individuals. Follow-up telephone calls and personal visits were made to agencies and individuals as part of the recruitment process. Posters were left with agency staff so that they could be placed at strategic points at various agency sites. I also asked staff to distribute letters of introduction and posters. Samples of posters and letters of introduction are included in the appendices. Only one person participated in both an individual and focus group interview.

Six focus group interviews with service providers and five focus groups with immigrant and refugee women were completed. Eleven individual interviews were completed. A total of 52 individuals participated in the study. All of the immigrant and refugee women who participated in the interviews had a competent level of English, which eliminated the need for interpreters. Focus group and individual interviews with service providers were conducted with staff from community-based organizations and mental health centres throughout the province. Most of the locations hosted programs and services specifically targeted for immigrant and refugee serving people in Saskatchewan. One agency that was invited to participate in the research interviews did not because (according to one of the managers) staff did not have any immigrant or refugee clients. This was in contrast to a similar agency that reported no experience with seeing immigrant and refugee clients, but still agreed to participate in this study because of an interest in the topic.

Interviews

I conducted all interviews, using interview guides along with prompts to enhance the interviews. Before beginning the interviews I prepared myself by reflecting on the role I would play within these interviews. With respect to the interviews with service providers, I felt that I was able to ask the questions and add comments that drew meaningful dialogue. In most cases, I felt that I was engaging in true collaborative, team conversations with service providers, to explore this topic.

I tried to conduct focus group interviews with immigrant and refugee women in settings that were comfortable and convenient for the women. One focus interview with immigrant and refugee women was conducted at a community-based agency. This was done because it appeared to be the most convenient for the women. One individual interview with an immigrant woman was also held at a community agency. Again, this was convenient for the individual who was being interviewed. All interviews with service providers were conducted at their agencies.

The idea of treating the interview as a conversation has been raised in the literature. Kvale (1996) identified three uses for conversation: as part of everyday interaction; as part of professional exchange; and as part of philosophical dialogue. Kvale suggested that in everyday conversation, spontaneous interactions may move to a level of focused conversation. However, the process of questioning is not necessarily a systematic one. In philosophical discourse, there is more reciprocal questioning and participants or speakers are on an "equal" level. Professional interviews could take a variety of forms. With respect to research interviews, the interviewing is purposeful. There is awareness of the nature and forms of questions. Kvale (1996) has suggested that the interviewer is in

charge "of a more or less voluntary and naïve subject" (p. 20). Kvale further noted, "In contrast to the reciprocal interchanges of everyday and philosophical conversations, there tends to be a one-sided questioning of the subject by the professional" (p. 20). Kvale insisted that professional conversations are characterized by asymmetrical power, and that underlying purposes may sometimes be contradictory. The interviews with service providers were interactive. I appreciated the willingness of the service providers to provide excellent critical reflection in these sessions.

The focus group interviews with immigrant and refugee women were different. The level of spontaneous conversation was different depending on the composition of the groups, the life experience of participants, their comfort with discussing the topic, and their comfort with one another. In particular, once participants were comfortable with one another, we were able to have the kind of "real talking" to which constructivists have referred (Belenky, Clinchy, Goldberger, & Tarule, 1973) and conversations flowed more spontaneously.

Throughout the interviews and during the analysis, I was aware of Gadamer's comments that asking questions is more difficult than answering them (Gadamer, 1998). Gadamer suggested that "the essence of the question is to have sense" and that when the question is asked "it breaks open the being of the object" (p. 362). Gadamer suggested: "In order to be able to ask, one must want to know, and that means knowing that one does not know" (p. 363). I observed that when the group composition worked, my role was quite specific: ask the questions, follow-up with prompts in order to clarify and engage participants to go deeper into the topic. When interviews flowed, the participants engaged in true conversation with one another, challenging one another, drawing out one another.

When the group composition did not work, the prompting was more frequent and a lot was left unsaid. Another observation is that the way the question is asked is part of the process of asking the question. Therefore, I had to be cautious about how I framed questions. For example, when I invited service providers to dream, I think I gave them an opportunity to put all options and possibilities on the table. However, I had to be cautious that I was not "staying in the box". When I asked about the kind of help that immigrant and refugee women used in Canada, I had to be cautious that I was not leading participants to think solely about counselling services and about traditional mental health services. Being aware of these issues helped me to frame questions so that indeed I could represent the voices and also ask the kinds of questions that would help with the creation of new knowledge.

By the end of the interviews, I had begun to peel away the layers and realized that there was much more to uncover. As I moved along this process of knowledge building, I was able to recognize the assumptions that I had brought to the research process, and then was faced with the task of dealing with these assumptions. While my own final analysis may not be the same as the participants, I hope that I have managed to represent their voices accurately and respectfully.

Interview guides

Four different semi structured interview guides were used: one for individual interviews with service providers; one for focus group interviews with service providers; one for individual interviews with immigrant and refugee women; and one for focus group interviews with immigrant and refugee women (See Appendices B-F). Critical

multicultural theory provided a framework to assist in asking questions and eliciting responses that would paint a comprehensive picture of the issues at stake. Other frameworks (anti-oppressive and feminist) helped to complement this broad framework.

Some of principles inherent within multicultural theory were considered when doing the interviews:

- The questions reflected an understanding of the various factors and attributes that interrelate and affect women's lives;
- The interviews reflected an understanding of women's oppression within different cultural contexts, including how women experience violence in many forms;
- The interviews reflected an understanding of the diversity within and among immigrant women; and recognized the relevance of context.
- The questions reflected recognition that individuals interact with one another based on sets of values and beliefs which are influenced by social, economic, cultural, and political contexts and experiences.
- The questions reflected recognition of the range of helping approaches that are experienced globally and that globalization may have resulted in the movement of these approaches across borders.

Mental health service providers at traditional mental health centres generally reported not having much experience working with immigrant and refugee people. Settlement workers had different experiences because their work involved providing services to immigrant and refugee people. In both situations, I found it useful to keep thinking about the issues of gender, about feminist perspectives, and about the importance

of ensuring that the voices of women and the stories of their unique experiences were reflected in the study. For example, I asked about how service providers responded to the issue of violence against women because I felt that women's experiences with violence were quite unique and that we need to hear how service providers addressed this important issue. That is, whether there was minimal or great contact with immigrant and refugee people, I kept remembering to ask questions that would draw out the unique experiences of women, and that would reflect their diverse voices and perspectives.

I used my own personal knowledge of the issues affecting immigrant and refugee women, my own knowledge of services and programs, and the knowledge gained through literature review to guide me in the prompts. During the analysis I repeatedly asked myself whether I had considered the various perspectives and dimensions. Another consideration included being mindful of women's strengths and resilience.

Individual and focus group interviews with service providers

The questions in the interview guides intended for service providers, explored whether the agencies recognized the specific mental health needs of immigrant and refugee women, how they responded to these needs, and their recommendations for change. I hoped the interview guides with individual service providers would supplement the information that I would get from the focus group interviews. I wanted to find out:

- How individually service providers viewed their knowledge of the mental health issues affecting immigrant and refugee women;
- Whether they recognized the changing needs (because of population changes);

- Whether their work had changed or evolved to reflect this work;
- How they acquired the knowledge and skills to do this work;
- How they viewed the capacity of their agencies to do this work;
- How their agencies addressed accessibility issues;
- What recommendations they would make for enhancing or developing services and programs;
- What innovative work was being done by service providers and agencies how work this had affected them personally.

Critical, anti-oppressive and feminist perspectives helped with the selection of prompts. That is, if participants' responses did not seem to go beneath the surface, I probed so that they could go deeper and address these issues. As a strengths-based practitioner and educator, I continued to believe that women had knowledge about their experiences and the issues that affected them, and my role was to be able to create the kind of environment that would result in women's sharing of this knowledge.

Individual interviews and focus group interviews with immigrant and refugee women

Interviews with immigrant and refugee women comprised two components. After consent forms were signed, I began the sessions with a short survey (see Appendices M and N). This allowed me to collect some demographic information relating to the participants of interviews. The final question in this survey asked whether participants still wanted to proceed with the interviews. Only one participant did not complete the survey. I

did not ask the question but my impression was that this individual was an extremely private individual and was not open to sharing personal information such as age.

The questions with individual immigrant and refugee women were intended to complement the information that I gathered during the focus group interviews. One of the objectives of the focus group interviews was to invite women to talk about their conceptualizations of mental health and about what they identified as the major issues affecting immigrant and refugee women's mental health. I constantly reviewed how I asked the questions. A second objective of the interviews was to have women talk about their experiences with getting help to address their mental health needs in their countries of origin.

The women I interviewed were generally uncomfortable with this question because their own understanding of "mental health" was clearly related to a medical, disease model. Once I introduced at least one prompt, asking about specific kinds of issues such as how they dealt with personal problems and family problems, women would begin to speak more freely. A third objective was to find out about women's knowledge of services and programs to address their mental health needs, their opinions about existing programs and services. The final objective was to hear about the recommendations that women would offer for programs, services, for helping immigrant and refugee women to have their mental health needs met. I hoped that the individual interviews with immigrant and refugee women would complement this data. During the individual interviews I asked women specifically about any experiences they had with using mental health services and programs. This allowed me to hear personal stories in a more comfortable setting for women, with the individual interview process allowing them a degree of privacy. I left a

list of resources (counseling agencies and mental health agencies) with all the women. I hoped that this would partly address the potential for any emotional distress that might occur as a result of the interviews.

One of the interesting observations for me was that most immigrant and refugee women said they would not necessarily use traditional mental health services unless they were very desperate because they had found other ways of coping with emotional distress. Because I was conforming to the suggestions of the Research Ethics Board, I gave a list of names and addresses of the mental health agencies to the participants. One participant said that she was glad she had the list because she would keep it as a backup and thought she would be able to share the list with other immigrant or refugee women.

I used a Panasonic digital recorder and Sony recorder to record all interviews. Once the interviews were completed, I transcribed all interviews and had them printed. I transferred all interviews to regular audio cassettes. I also transferred them to compact discs. I have stored all the data (compact discs, audio cassettes, and hard copies) in a secure cabinet. I will be storing these for five years. They will be destroyed after this period. I have also stored copies of signed consent forms. Readers of this study will have an opportunity to consult summary sheets of collected data in the appendices section of this study. Samples of consent forms, letters of introduction, and interview guides have been included in the appendices. The consent forms included a question asking whether participants were interested in summaries of the dissertation. Summaries will be sent to those participants who have requested summaries. Participants have been informed that the dissertation document will be a public document and that they can contact me to find out where copies of the dissertation are located.

Transcription

I have also tried to ensure that the final product reflects the diversity within and among immigrant and refugee groups and communities. Tapes were transcribed immediately following the interviews (or as quickly as possible following interviews) in order to respond to the risk of out-migration since I had wanted to be able to contact participants following transcription in order to get feedback. I had hired an individual to transcribe the tapes but this individual was unable to do this because of illness. In the end, I transcribed all the tapes. One of the advantages of doing this myself was that through the process of playing and replaying the recordings, I became even more familiar with the participants and with the data. The participants were informed that every effort would be made to include all perspectives into the dissertation. I have tried to represent the different views respectfully.

Analysis

Within-case analysis involves data reduction, and a process of ongoing reflection and analysis in order to complete in-depth analysis of a particular case. I began by identifying all the themes and then sorting and resorting so that eventually they were placed into broad theme areas. I included the different sub-themes within the broad theme areas. I used a critical multicultural theoretical framework to assist with the analysis of the data. The framework helped me to determine what questions needed to be addressed in order to make sense of the data. Some of the questions I asked were:

- What was unique about immigrant and refugee women's mental health needs and experiences?

- How can mental health practitioners provide services and programs that are equitable and responsive to the mental health needs of immigrant and refugee women?
- In what ways can understanding of women's needs help with enhancing accessibility?
- How could information derived from the responses about the different conceptualizations of "mental health" help to advance understanding of mental health as it relates to the experiences of immigrant and refugee women and ways of responding?
- In what ways do the service providers reflect an understanding of the diversity among immigrant and refugee women, including their understanding of the different ways in which women have traditionally received help, and about the different needs of multicultural communities?

I continued to ask these and other questions based on the framework. I kept going back to the framework to find out what other angles I missed. One of the tasks I had was to continue to draw on the different aspects of the framework to get as comprehensive an analysis as possible. As already mentioned, I also wanted to be mindful of women's strengths and resilience. I found it particularly useful to keep thinking about multicultural processes and structures. That is, I found that one of the great assets of the framework was its help in reminding me that issues occur in different contexts, that we all bring our own values and beliefs into these different contexts. I also made an assumption that in a multicultural world the structures should reflect acceptance of this diversity.

While the intent of this case study was to focus on the specific situation of Saskatchewan, the assumption is that the lessons from this case will be relevant to other contexts. This is consistent with some of the writings on case studies. I believe that the analysis and recommendations will give useful information that can be helpful to practitioners working with populations beyond the immigrant and refugee populations.

Ethical issues and challenges

Consent

All field research has the potential to raise ethical and other challenges (Punch, 1994). These include responses to the written material and ideological issues and concerns. There may be concerns with respect to confidentiality and anonymity, or to perceived power differences between researchers and research participants. During the data collection process, I was very aware that I was conducting research interviews in a province where the overall population is small, the service provider population relatively small, and the immigrant and refugee populations also small. I was very concerned about issues related to confidentiality and anonymity.

When I raised this issue with service providers, they were generally less concerned that I was. I did not encounter the kind of discomfort with signing consent forms that I had anticipated with immigrant and refugee women. One reason may be that some individuals are beginning to become quite accustomed to being research participants and they were beginning to trust this process more. In some cases, participants understood the research process because of their own educational and professional backgrounds. In other cases, I believe that the participants knew me and were willing to participate because of this

relationship. I had made arrangements to have a research assistant complete the research process with immigrant and refugee women, but I realized that this was not necessary. None of the participants had literacy challenges.

Confidentiality and anonymity

Participants were informed that I would make every effort to respect issues of confidentiality and anonymity. Focus group participants were reminded that they were expected to respect issues of anonymity and confidentiality. Nevertheless, while I spoke about respecting anonymity and confidentiality, I informed participants that I could not guarantee this because of the small population. I explained that I would not be using names but would incorporate the data anonymously into the dissertation. I explained to individual participants that if necessary, I would use pseudonyms to represent their voices. While this was not possible with focus group participants, I believe that the quotations give strong representations of their voices. I avoided identifying communities where the interviews were conducted because of confidentiality and anonymity issues. There are some unique differences between the experiences of living in very small, rural communities and I wanted to highlight this. One of the ways in which I addressed this was in the literature review. I made specific reference to one community (Wynyard) that has been described as the "poultry capital of Saskatchewan" and that has been employing large numbers of newcomers. When I reported on comments made by individuals in rural communities or communities outside of Saskatoon and Regina, I have talked about "a participant in a rural community" without identifying the name of the town.

Likewise, I have discussed the programs, services, and policies that exist within different regions and locations. However, when I discuss interviews and use quotations, I do not identify participants in terms of which agency they represent. In the literature review, I drew on socioeconomic and political studies that focus on particular countries and regions (for example, China, African and Latin American countries). However, I do not associate any interview with country names. In some cases I have used continent names: for example, Africa.

Chapter 5

Data findings

The challenge of identifying the population

Introduction

Chapter 5 is the first of five chapters that present data findings. The findings are based on the feedback from interviews with immigrant and refugee women and with service providers. These findings reflect interviews that were conducted between the fall of 2005 and Spring 2006. The theme of this chapter, which is about the challenge of identifying the population under study, was one of the unexpected findings of the research. I entered the research assuming that the term "immigrant" would not present any difficulties and that participants would be able to launch into discussions very easily. My own assumption was that we would be referring to all immigrants, racialized and non-racialized. However, during the first interviews, service providers would repeatedly raise the question of who an immigrant was. To whom was I referring? This chapter reflects the discussions regarding the difficulties involved in identifying the "immigrant", along with some of discussions regarding why this question was being asked.

Defining "immigrant"

Service providers questioned whether I was defining "immigrant" in terms of all people who had come from another country and settled in Canada, or whether I had another way of defining "immigrant". As I proceeded to respond, and engaged in dialogue with the interviewees, it seemed to me that participants were defining "immigrants" in terms of racialized immigrants:

> Through the Employee Assistance Programs we service a number of people....women who have worked in the health region...they [immigrant women] do end up, a lot of women, in getting jobs in the health services...I know from the sound of the names.

Further discussion suggested that some service providers were relying primarily on physical attributes and accents to determine who was an immigrant.

During the various interviews with service providers I continued to prompt interviewees so that they could continue to reflect on how they were identifying "immigrants". Marianne responded,

> That raises a whole issue about visibility. I am not talking about visible minority people...I am thinking about visibility in terms of identity. .....I think it is invisible with a lot of people and it doesn't come to the fore with their identity when they present to us. It may be emerge as part of the information. I think you are right...staff see a lot of immigrant people...they don't even know maybe that they are immigrant people.

There were comments that referred to the diversity among immigrant and refugee women. However, on several occasions, when there was reference to immigrant and refugee women, it seemed that immigrant and refugee women were being discussed in terms of them being marginalized and living in subordinate situations. For example, Karen reflected,

> In some cultures [women] aren't treated in the same way that we are ...they are second class citizens, they wouldn't do anything without men there ...in their lives...on their own...they couldn't relate to coming here for services or supports.

The service providers and I continued to raise other questions. How might we ask the question to help with identification in a way that was respectful? Should we ask the question or wait to be told? Should we deduce the answer from the stories of the "clients"? How do we record this information so that it forms part of the data collected by the health regions or agencies?

One service provider warned about moving along a "path of creating victim, constructing victim out of anybody who has been harmed...who has suffered harm". She added:

> The word dialectical comes to mind...because you are talking about something...you are talking about identity; you are talking about identity as it serves to get service, as it serves to get the most appropriate service...identity as it serves to represent the person as a whole person. Yes, and I ...maybe like victim...what you get on this side, if you self identity you get this but you lose this. If you don't self identify you get this but you lose that. I don't think there is any one firm answer about it.

She stressed that what was important was knowing when identification was important. She discussed some research that had been completed years ago in which she reported that the majority of research participants said they wanted the "issue of difference to be put front and center".

Another service provider argued that self-identification was important. She also suggested that immigrant and refugee women's needs for self-identification might vary depending on when and at what age they migrated to Canada:

> I think it has to be identified. I think of my mom who would still identify herself because I think her cultural beliefs and traditions ...everything is still much more influential in her life than we would consider mainstream here. But you may have a young person who is in the same socio-economic place and of the same country who may not identify. So I think that it would have to be self-identified. How do we ask that kind of question?

Overall, the feedback to me suggested that participants had a history of seeing clients from traditional source countries such as England and the United States. They wanted to clarify whether I was focusing on all immigrants, or only on racialized immigrants and those coming from what would have been perceived to be non-traditional source countries prior to the liberalization of immigration policies. If I was focusing on racialized immigrants and those coming from non-traditional source countries, then they wanted to emphasize that they had limited experience working with this population.

Actual work experience with immigrant and refugee people/women

The discussions about who an immigrant was, also related to the experience that service providers actually had with immigrant people. Some practitioners could recall work they had done years previously with immigrant and refugee populations but emphasized that they had little recent experience: "I am similar to [Liz] except actually when I [worked in another professional setting] ....I probably had more exposure because I worked when the Laotian and all the boat people came over". One participant added, "And incidentally it just occurred to me I probably did more work 30 years ago when I

worked at [name of agency]". Another referred to involvement with the "boat people" in the 1970s but in another province.

An interesting observation was that agencies had little statistical evidence to support the assumption that immigrant and refugee women were not going to mental health and/or counseling agencies. Agencies had almost no mechanism in place to adequately measure or record this:

> Well there is a lot more than that and the ones who have ...let's call them generic mental health issues, they might just be put into the individual or ...or whatever kinds of things. I can't tell you how many people we have, [be]cause I don't know who are actually immigrants.

The early identification of this theme illustrated the extent to which the acceptance of a dominant Eurocentric culture is firmly embedded within mainstream Saskatchewan society. Generally speaking, the practitioners whom I interviewed were those who wanted to explore ways of enhancing their practice, and who seemed to be interested in making a contribution to policy changes that would help to achieve this. However, there was still ambivalence and more often a lack of awareness that they too had accepted this dominant Eurocentric culture as *the* Saskatchewan way (and the Canadian way). Therefore, those immigrant and refugee women who came from non-European source countries were the *Others* whom they did not understand and wanted to get to know. Nevertheless, these *Others* would stay on the margins as long as they were different. Those individuals who came from cultural backgrounds that were similar to what the practitioners were accustomed to, were seen as individuals who would do better because they understood the dominant culture, or were more assimilated.

A difficulty in this study was an issue that I identified in the Methodology chapter: finding practitioners in rural areas who had actually provided service to immigrant and refugee women. Lamba, Mulder, and Wilkinson (2000), in their study *Immigrants and Ethnic Minorities on the Prairies* reported that there was a disproportionately higher number of refugees going to mid-sized than those going to the major metropolitan centres. These authors pointed out that refugees did not stay in these smaller centres because of lack of resources or support services. These comments were supported during this current research. Expectations regarding employment were still a major factor in the lives of immigrants and refugees but support services to make settlement and integration work were also very important. For example, while some immigrants and refugees might still go to Yorkton, few seem to remain. There used to be a settlement agency and Immigrant Women's Organization in Yorkton but these no longer exist. Agencies such as these have served as a buffer to isolation and have helped newcomers to create a sense of home and community. In short, there was little opportunity to interact with racialized immigrant and refugee women and practitioners, minimal opportunity to engage in discussion about the racism and discrimination, and about ways of addressing these issues.

Racism and discrimination among practitioners

These early discussions highlighted how racism operates at all levels and also reflected the links between the lack of awareness of one's racism and the systemic racism when policy makers and those in power make decisions about how programs and services should operate, and about the kinds of models and programs that citizens require. This

theme also emphasizes the importance of engaging in discussion about citizenship rights, about who qualifies for these rights, and about how we go about ensuring that everyone is able to enjoy these rights. This is particularly key at a time when there is growing ethnic and cultural diversity. That is, if we continue to hold assumptions that do not challenge the dominance of Eurocentrist ways of being within Canadian society, as the Canadian way, anyone who falls outside of that will have less entitlement to full citizenship rights and the mechanisms to achieve these.

Statistics Canada reported that in 2001, 13% of the population self-identified as "visible minority" and that this figure is expected to increase anywhere from 19 to 23% by 2017 (Statistics Canada. 2005). Statistics Canada has also noted that immigration is clearly related to this growth. Research literature and Canadian government documents acknowledge that as the country's multicultural population continues to grow, so too do the stories of racism and discrimination (Canadian Race Relations Foundation, 2000; Alladin, 1996). Racism within Canadian society is not new, is pervasive and deeply rooted, and the Saskatchewan experience is no different. What makes Saskatchewan unique is that the racialized immigrant population has been slow to grow and so many practitioners and policymakers have not had to "deal with" the issue of racism with this sector of the population.

The discussions raised during the interviews reflected how much practitioners have tended to belong to a dominant, privileged group that did not hesitate to define the Other and who viewed them as a subordinate group. In discussing race and ethnicity, Alladin (1996) noted that the "dominant group has the power, and therefore capacity, to use physical and social features to define socially a subordinate group" (p. 6). This thinking

reflects dominant values and beliefs. These values and beliefs are also reflected in the institutional racism which Alladin defined as "those established laws, customs and practices that systematically reflect and produce racial inequalities, regardless of whether the individuals maintaining those practices have racist intentions" (p. 12). Alladin provided examples such as the situation of Aboriginal people in the criminal justice system, the way in which Christian values were traditionally dominant in schools, and the dominance of a Eurocentric world view in many books.

Some professions have already begun to challenge the systemic racism embedded within their systems. One of the common threads in the discussions has been about the practitioners' lack of awareness of their own racism, and about the institution's lack of awareness and failure to address systemic racism (Alladin, 1996; Marchak, 1996; Donaldson, 2001; Yee & Dumbrill, 2003; MacDonald et al., 2003; Howard, 1999; Goodman, 2001). These concerns were clearly reflected in the discussions of practitioners. Several social work texts have emerged over the past several years focusing on multicultural social work in Canada (Al-Krenawi & Graham, 2003; Lie & Este, 1999; Shera, 2003). These texts have emerged in response to the ongoing concerns of racism and discrimination within the profession and about the failure to change.

The strength of applying critical multicultural theory to this issue is that an exploration of the values and beliefs that practitioners bring to their intercultural contact with their "clients" exposes the unquestioned assumptions of practitioners. As Alladin noted, the racism may not be intentional, and practitioners may be well-meaning. However, their failure to recognize these assumptions means that opportunities for change are blocked and that systemic racism continues, unchallenged.

Nevertheless, I was conscious throughout many of these interviews, that many practitioners were well-meaning and that those who participated in these discussions were generally open to learning and to change. I was aware that even after this research, I wanted to be able to walk with them, and to engage with them in ongoing social change work. Howard (1999) suggested:

> In multicultural teacher training, as in any other educational endeavor, our pedagogical approach ought to be developmentally appropriate for the audience we are attempting to reach. Rather than blaming unaware White teachers for the sins of past dominance, we need to start where they are, which for many White teachers means dealing with the earlier stages of White identity development, including pre-contact, contact, disintegration, and reintegration. When we employ the language of blame and guilt with Whites who are in these early stages of development, we essentially contribute to the perpetuation of the very denial and resistance we are attempting to overcome. To this end, it is important to remember that the "enemies" in our multicultural healing work are dominance, ignorance, and racism, not White people. (p. 110)

I have continued to reflect on Howard's work and to see how it can be applied to the work that social work practitioners do with immigrant and refugee women. I have had to accept that the interviews with mental health practitioners and service providers included professionals from various backgrounds (psychology, social work, educational psychology). My sense is that in social work we have begun to have these discussions and so we may be able to raise the discussions in ways that might not necessarily be the same for professionals from other disciplines. Nevertheless, stories from the field about the

racism among social work practitioners point to the need for ongoing work. The discussions in this chapter suggest that we have to continue on this journey.

Chapter 6

Data findings

Mental health issues facing immigrant and refugee women

The 1988 Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees reported stories of immigrant and refugee people's experiences with respect to addressing their mental health issues. This next comment from the executive summary of that report captures the essence of that study's findings about the issues:

> In Canada, negative public attitudes, separation from family and community, inability to speak English or French, and failure to find suitable employment are among the most powerful predictors of emotional distress among migrants (Executive summary).

This current chapter describes participants' identification of the mental health issues facing immigrant and refugee women in Saskatchewan.

All of the service providers who were interviewed had some knowledge of the issues facing immigrant and refugee women. They were not necessarily knowledgeable about the intricacies of immigration and settlement policies, but were aware of broad issues such as culture shock (adaptation to climate, food, and lifestyles), isolation, trauma, and difficulty in having out of country credentials recognized, employment barriers, losses, and racism. In particular, mental health practitioners suggested that they had sound generic knowledge and skills in the area of trauma and loss, but minimal experience working directly with immigrant and refugee women. Immigrant and refugee women's comments intersected with those of the service providers. Those service providers who had worked with or had particular relationships (through volunteer or other community,

non-professional relationships) with immigrant and refugee populations made an enormous contribution to this study.

Several immigrant and refugee women reported that their initial response to this current study topic was that it was not relevant to them. They explained that they grew up in cultures where "mental health" was narrowly defined and so they could only think in terms of "crazy people". They also talked about the strong stigma attached to "mental health". Nevertheless, once they agreed to meet and began to talk about the issues that affected their mental heath, they identified settlement and integration issues. They identified other issues such as violence against women and isolation as major issues affecting their mental health. The following issues were identified during the interviews with service providers and with immigrant and refugee women.

Concerns for families in countries of origin

Relationships were very important to the immigrant and refugee women who participated in the study. Women talked about their experiences with respect to their roles as caregivers, parents, siblings, relatives, friends, spouses, and community people. These were the people who had made up many of the strong social support networks that women had in countries of origin and they still valued these tremendously.

One woman talked about plans to go back to school so that she would be busy and would be distracted from thinking about what was happening elsewhere: "After this program I decide to go to something like this like school because I don't want to stay at home and because if I stay at home I focus just for my family in [country of origin]".

Another woman talked about how depressed she felt for days following conversations with family members.

Other participants added the dimension of the high expectations and demands placed on immigrants and refugees living in Canada by those family members and friends who remained in countries of origin. In some situations women might feel burdened by the stories of need and their inability to respond to each crisis about which they have been informed. The woman who talked about telephone conversations to her family back in her country of origin explained that these conversations usually kept her informed about crises and problems. Yet, it seemed to her that there were few happy tales about the family situation: "If I give you a personal example, my family is not just my husband and my daughter. I have all the issues, and when I phone home you won't believe me, for two days I am just depressed". This participant added that she would ask whether there were any happy stories. One service provider with close ties to the immigrant and refugee communities reflected:

> The second thing that I am seeing more and more and maybe I didn't see it as much earlier or it wasn't happening as much earlier, but the minute people set foot on this soil, all their relatives think they are rich and start making demands. And they are powerful demands for medical treatment, or food. For whatever. And a lot of refugees don't know how to handle that very well so they send money they don't have or deny themselves or start engaging sponsors or church groups to help them and then people get worn down not just helping the refugees but all their relatives.

That is, relatives and family members are making various kinds of requests and have expectations of what their relatives in Canada can do for them. For immigrant and refugee women who are accustomed to taking care of others, the pressures can be overwhelming.

In discussing the flight experience for refugee men and women, one service provider noted that refugee men felt the stress of not being able to provide for their families. While recognizing the diversity of stories and situations, she suggested that there were unique pressures for women:

> As far as the actual flight, that is often a much greater stress for the women because it is often the men who leave first. Now they have their own stress in terms of getting to safety, worrying about their family, trying to reconnect but in the meantime, the women have 100% of the responsibility for everything else.

In other situations, immigrant and refugee women may end up taking care of their children as lone parents. Spouses may have died, disappeared, been divorced, or never been actively a part of the family. The challenge of being lone parents in a new country, without traditional supports, and often without adequate language skills can be particularly difficult for those women who were accustomed to relying on a partner to take care of many household decisions. One service provider talked about some of the situations her agency was now observing:

> With the women, lots of depression. Especially the single parents, they come here and were used to a man doing everything for the family. And, and they had no [prior] responsibility for decision-making and anything . They really struggle when they come to Canada and now they are in charge. They are the head of the family; they have to make all the decisions and they have to handle the finances.

> Everything falls on their shoulder. If they have some older male children then I find they don't struggle as bad. But if they don't have older male children then I find it is a really big struggle for them.

In addition to descriptions such as this one, there were others that reflected the diversity among immigrant and refugee women. For example, in other focus group interviews, women talked about their role as activists and professionals in countries of origin.

Whatever the background of the women interviewed, concerns for families in countries of origin represented a common theme throughout the interviews. In some situations participants were able to travel back to visit families and in other situations, not. In the latter situation, women experienced a range of emotions including guilt, homesickness, fear, and anxiety.

Isolation

Living in rural or very small centers

Isolation was one of the major issues identified by all research participants. This was identified even in a region where mental health practitioners appeared to have minimal (if any) experience providing services to immigrant and refugee women. One research participant suggested that there was little contact with immigrant and refugee women in one rural community because isolation caused immigrants and refugees to leave these areas. Some of the factors that exacerbated isolation in rural communities included distance from or lack of a familiar faith or spiritual community, and lack of affordable and accessible public transit system. One service provider, Karen, noted, "Even their religious practices, there aren't places for them to continue with that". She added: "They are

expected to eat our diet. It is a small community. We don't have specialty stores, like a bigger city in Regina or Saskatoon would have". Other comments were:

> Well, it would be hard for them to speak the language, to communicate with the people who work here. For one thing, our work here is organized, it is very time centered. That is a cultural thing we have in this culture and others may not be affected by time in that same way. Getting here is a huge effort in a small community. we don't have public transportation...and other immigrant families may not drive or have vehicles that are reliable ...to even just get here...to me these would be big things.

This practitioner explained that she had learned about settlement and integration issues relating to immigrant and refugee people through work with churches and other community connections, and not from direct mental health work with immigrant and refugee women.

> No, there are...I am aware through other activities like churches and things that have brought immigrant families to the community. They don't stay for any period of time because they want to move to an area where there are common backgrounds.

An aspect of isolation was the importance of "community" to the mental well-being of immigrants and refugees. "Community" could include connection to any sort of community of interest, or professional group. As one immigrant or refugee woman said: "when you come here you have to get your support from friends, or community, churches". Another suggested: "You need to interact with people you have interest with".

There was also a sense that connection to ethno-cultural communities was particularly important to many immigrant and refugee people. One woman commented: "In most cases of course you are looking for people that look like [yourself]". That is, participants seemed to suggest that meeting individuals who had some kind of shared background, shared cultural beliefs and values was important and facilitated the process of community building and integration. Participants did not use the language of multicultural processes but I interpreted their comments to mean that they recognized that all individuals bring values and beliefs to situations and when they met someone they looked for clues about what the other person was bringing to the situation.

The lack of connection to community led to isolation in larger centres but could become even more difficult in areas further away from larger centers such as Saskatoon and Regina. In the larger centres there was at least some (even if minimal for some groups) likelihood of making connections to various kinds of communities. This was less likely in rural communities. There was a suggestion that the exodus of immigrants and refugees from rural and smaller communities was in part due to the lack of ethno-cultural communities in these areas:

> I think one of the biggest issues is that it is a small community, away from a city, away from a common group of communities so if someone is an immigrant from somewhere else they wouldn't have a community for them to kind of fit in and make that transition for them...so think that makes a big problem.

The lack of a critical mass of population and the lack of adequate supports were all raised as issues that had an impact on the mental health of immigrant and refugee women. Mental health service providers reported that they did not have experience working with

immigrant and refugee people because these newcomers did not use services. Immigrant and refugee people had developed relationships through church sponsors and through their association with community groups. However, service providers expressed concerns that more supports were needed.

Isolation and the lack of intimate relationships

Women had varied descriptions about how they lived isolation. Those women who had come as spouses to partners who were international students described the intense isolation because often they had no connections to any other social support networks and did not speak the language. Once these women became involved in community activities and educational programs, they began to feel much better about themselves:

> All time I [was] alone with my daughter, and after I came here [to a particular agency] I feel a little bit better because I saw some people like me and they don't have relatives here like me and you know I feel some calm and some comfort for me.

Other women talked about isolation because of the lack of intimate friendships (non-sexual) with other women:

> I don't have real friend. I have lots of friends but you know I don't have real friend, I don't have close friend. Because everybody like me and they have own problem. They don't have time to spend with me. And here in Canada I have language problem. But l like Canada lots of living. Everything is good, easy, life is easy. But my problem is just alone [being lonely].

Several of the women with whom I spoke were accustomed to having strong relationships with other women and they craved this in Canada. The women in one focus group seemed to be saying that this was what was missing in their lives. Yet, in other focus groups women were able to talk about the connections they had made with other women and noted that this is what helped them in the settlement and integration process. Women from African countries stressed the importance of women in supporting one another, and also of the importance of women finding their own network of support (church, ethno-cultural, women from within the same ethno-cultural community. They suggested that these connections continued to be important to how they experienced life in Canada. It was clear that there were tensions among them but they emphasized that when there was a crisis, they tended to come together and support one another.

Language and literacy

Language barriers have had a significant impact on immigrant and refugee women's mental health. Language was discussed in terms of knowledge of English language proficiency and in terms of accents. Lack of adequate language skills meant that there were women who were at high risk of isolation. These included women who did not venture out because of their low language skills, and who did not ask for help because they feared that others would not understand them and they would not understand others. In addition to language barriers, another barrier that has emerged because of the situation of war in so many countries was the low literacy levels of many recent refugees.

The women who were interviewed and the service providers offered several examples of situations where women were isolated because of language barriers.

Language was viewed as being crucial to the process of social integration. One immigrant/refugee women talked about the isolation facing newcomers whose first language was not English: "many of you who were here they know the language. Many people came and they don't have …any language so how are they going to interact even with people".

The specific situation of refugee women was raised because of a perception of the extremely traumatic situations that women have survived. Participants felt that these women often came with very limited English language skills and were at great risk of isolation because they would not necessarily seek help because of their perception of their low language skills. One participant suggested that refugee women with limited English language skills, and limited social support networks here in Canada, were usually unable to tell their stories. This participant noted that she could identify several refugee women who relied on their children to negotiate life in Canada. Another participant also discussed the challenges facing those with limited language skills. She suggested that low language skills among the parents put great pressure on the entire family system:

> I think there is great pressure on family systems. Children often learn the language quicker so they become the interpreters and so some of those structures break down where the children start to learn much more about their parents' vulnerabilities than they need to know or want to know. Or they gain power in the family in a way that's not consistent with their cultures.

Language combined with other barriers contributed to the exodus from rural communities: "They don't stay for any period of time because they want to move to an

area where there are common backgrounds". Settlement workers consistently raised language barriers as an important factor related to isolation:

> What you say about language is a big problem, even now the immigration is changing. Before was men was the one going to English classes. Now I see more women because they have daycare for them. But even they [are] still at the lowest level. And it is very bad because they aren't able to communicate.

Related to language barriers was the issue of supports that needed to be in place in order to enhance accessibility to programs. While childcare is currently covered for newcomers requiring language instruction, settlement workers reported that when their agencies experienced any budgetary cuts, it was often the daycare that was affected. This had a tremendous impact on immigrant and refugee women's access to programs. One obvious reason was that women would often be the ones who would have to stay at home to take care of children and other family members.

Settlement and other immigrant and refugee serving agencies were generally able to address language barriers. However, this was not as easy for professionals at other agencies. There were different responses among these workers regarding dealing with clients whose first language was not English or who might need interpreters. At one mental health centre, there was confusion about whether or not, or how the agency dealt with clients whose first language was not English, or those with little or no English language proficiency. One research participant suggested that immigrant serving community based agencies were contacted when there was need for interpreter services because the health region did not provide this service. One counselor at a mental health center reported that interpreter services were provided but on an ad hoc basis. Another

counselor from the same health region reported that interpreter services were part of the health region, but that they were provided on a volunteer basis. Staff members with relevant language skills were encouraged to volunteer. That is, there were different understandings about how interpreter services could be accessed in the health region.

Language was cited as an important factor when discussing women's utilization of services. Some participants talked about women's reluctance to seek help because of their language skills. Others suggested that women needed the language skills to name issues. One service provider described the reaction of women when they were able to converse in their first language or in a language in which they felt competent: "And it was amazing how happy those people were that they could come to Canada and find somebody who could speak the language, at least the language they were speaking where they were".

Most participants identified language skills as a crucial element in the settlement and integration processes of all immigrants and refugees. They suggested that these skills were particularly vital to the settlement of immigrant and refugee women within Canadian society because of the multiple roles that women play: parenting, breadwinning, caregiving, community organizing. They were also viewed as essential for women who continue to struggle to achieve equitable places in society.

Several participants talked about how their accents were a barrier to integration. Women who were English speaking and with accents reflecting their countries of origin, talked about they felt about not being understood. A service provider in one agency, commented:

> So I guess when people come here, they...the first adjustment is language. Although for some they think language is not a problem. And it becomes one

> because of their accents, or because of the nuances. That they are not being understood although they have perfect command of the English language in terms of vocabulary and sentence structure and all that. But people aren't understanding them. And that affects how they are respected or how they get jobs. And all those things.

Participants seemed to be raising the lack of Lack of English language skills as an enormous challenge to women's mental health.

Nevertheless, there were other viewpoints about language. One service provider with a long experience of working with immigrant and refugee populations had begun to think that other issues were more important than language:

> We talk about the language barrier, it is not the main barrier. It is there, of course. You need that for communication. But we know now those of us who are not fluent in several languages, you can communicate through pictures, and through body language and expressions. You don't always need the words (though they are important). Making the woman feel secure, self-sufficient, and having confidence, I think is very important. I think with that even without a big vocabulary they can do well.

This participant was not minimizing the importance of language, but rather wanted to emphasize that service providers had not focused sufficiently on the impact of mental health issues on the settlement and integration process of immigrant and refugee women.

The issue of literacy was identified as a relatively recent phenomenon among refugees and immigrants coming within the past 20 years. One service provider working

in a community agency suggested that the newcomers to the province were different from those of earlier years:

> I know we are getting a lot more single parents than we ever used to. There are more clients with higher needs who are coming. Clients who before would have been excluded because they have medical issues, they are now being granted entry in Canada and sometimes with those medical issues they are struggling with psychological issues. At the same time, the adjustment to the new life and the surroundings; there is some culture shock, there is maybe depression, maybe post traumatic stress. There is a multitude of issues surrounding one person now; whereas 5 years ago we had people who came predominantly from European countries who were educated. Used the government assistance for a few months, found jobs, are now business people in our community; they own homes, cars. The settlement for them is a lot easier. The people we are having now are taking longer to [settle] and they need more resources.

This situation has created hurdles for settlement workers and workers at immigrant and refugee serving agencies. Service providers explained that they could no longer make assumptions about literacy levels of newcomers, and had to ensure that the participants in the programs were able to fit into programs without being singled out negatively. In short, it was no longer just about thinking solely in terms of language. Instead, agencies have had to develop programs and services to meet the multiple needs of the current population.

Silence and silencing

Keeping silent about violence

Isolation was identified in discussions regarding the issue of violence. Several immigrant and refugee women talked about the silence among immigrant and refugee families with respect to this issue: "Spousal violence...They try to hide it...A large percentage of people are married"; "I know my friends, they do suffer a lot. They have to keep quiet"; "I know there is violence I know how they react. This is one reason why I don't have many friends. But I know how they treat each other and it's very bad...."; "Some men have a lot of violence. They change because they have been tortured in war. They become something else, they hit. Everyone keep quiet". Silence occurred because of fear of being ostracized from cultural communities, and also fear of having one's culture demonized.

One participant explained that individuals protect themselves through silence. She also suggested that individuals are silent because they have learned to protect their culture from negative feedback:

> The other reason is if I start talking about violence in my life or any other person starts talking about violence in their life right away the cultural community is terrified because they don't want to reinforce the mainstream image of their culture. So we try to stay quiet and try to observe that silence because of the fear of what I call racist gaze. How do you protect yourself and how do you protect your cultures from racist gaze.

One service provider who had particular knowledge of ethno-cultural communities lamented:

> There are real tragedies in the [name of ethno-cultural community] community...people committing suicides and women being beaten up ...all kinds of things like that because there have not been a safe place and a place where women can go to have their needs heard...their concerns heard ...it is a very complex situation and I am not sure where they are getting that sense of community from or where the safe places are to talk ...because of some of the stigma too. And unfortunately as a community too sometimes we do it to ourselves.

This participant added: "There is a real stigma attached to talking to someone outside the family about things that concern the family so a lot of women in the [name of cultural community] community are reluctant to do that". Sometimes the messages have been so powerful that women become part of the force to maintain or protect cultural practices and traditions that are harmful. One service provider cited the example of female genital mutilation. She described a situation in which women were the ones who were defending "with a vengeance" the practice of female genital mutilation.

Participant stories suggested that this silence or silencing has long occurred in women's lives. However, women were generally able to cope because they found ways of helping one another. It was not always easy to find ways to cope in Saskatchewan, largely because of the low immigrant and refugee populations, and the fact that the options for support are therefore more limited than in larger metropolitan centres.

Silence because of stigma related to "mental health"

Many cultures struggle with the stigma of mental health. Immigrant and refugee women live with this stigma and their silence adds another layer to their already isolated lives. Research participants talked about silence related to this stigma and how this posed an enormous barrier to addressing women's mental health needs:

> One is how do you build that capacity within those communities to recognize the need? How do you go there and empower those communities so that they can at least use words in describing what they are going through because of all kinds of stress? And within those communities there are groups that are more vulnerable to distress and to isolation and loneliness. And therefore silencing. Keeping silent is a big huge problem here. Right! As women. And then even among women there are different categories of women. And sure women with more privileges and slightly better relationships within the family may have lesser of those needs than women who are situated on different locations within those communities. So silence is a major problem in those communities.

The stigma of "mental health" meant that women did not disclose having any mental distress for fear of being labelled. In other instances, women did not recognize mental health distress. In many instances, there was intense discomfort with even talking about mental health as an issue. One woman who participated in a focus group commented:

> And also the stigma behind it. You don't go there because then you are labeled. The stigma and the whole idea. That's how many women survive, because it's considered not as important. And then you have stomach problems, traumatic.

> Many times people don't recognize the side effects, unless you are crazy, really crazy.

Research participants continued to stress the importance of connections to ethno-cultural community to the lives of many immigrant and refugee women. Yet these same strong connections could be a barrier to healing. Some immigrant and refugee women suggested that women received strong messages from within their families and from the ethno-cultural communities that mental health issues and other personal issues needed to be kept within the family. This led to further isolation because it was difficult to mobilize collective efforts to address these issues.

Overall, several participants recognized that silence continued to operate as a very powerful barrier to change. Silence occurs because people are protecting themselves and their ethno-cultural communities. In many situations, women fear deportation and withdrawal of sponsorship, and often do not have adequate knowledge of laws and policies so they could make informed decisions.

Racism and discrimination

Racism and workplace discrimination were raised as complex issues that had a negative impact on mental health. Service providers and immigrant and refugee women acknowledged the impact of racism on mental health and were able to give various kinds of examples.

One participant, a professional immigrant woman, suggested that immigrant and refugee women might not use services for fear of their "cultures" being put down:

> A lot of people don't go out for help because as soon as somebody is experience[ing] mental illness among our community, like violence against women and it is right away attributed to the culture. ...But we have not begun to do the work on what happens when our cultures are racialized, how that racialization classes, silences us so we can't, don't talk about violence. Because as soon as we talk about violence against women in our cultural community, right away our culture is seen as more patriarchal, barbaric, or uncivilized and we don't want to do that. We don't want to do that for two reasons. My culture is my source of identity. My attachment to my culture is my basic human right as well as basic human need. So I am really really proud of who I and what my culture is and I don't want anyone to look at my culture in any derogatory ways.

Therefore, the fear of discrimination and racism silences women, and prevents them from identifying need and seeking help.

Other participants identified situations involving workplace racism. One of the examples recounted was about an immigrant woman who had been advised to seek counseling. This woman had little understanding of the counseling process or her right to not seek counseling. The service provider hinted at workplace racism since other individuals involved in workplace conflict situation had not been asked to seek counseling:

> There [were] a number of difficulties...for example, conflict in the workplace...she was the one who was asked ...she did not understand...even though I said to her that she didn't have to come...it felt like a punishment.

This service provider suggested that the client seemed to be treated differently from her workplace colleagues:

> I think about this situation ...I kind of wonder why she was asked to come...and more systemic...was she asked to come because she was from another culture as opposed to.

Even though the client had not named her situation as workplace racism, the service provider in this situation thought that this was indeed a situation involving racism.

Racism and ethnocentrism manifested themselves in many different ways. One of the common systemic issues was that immigrant and refugee people's credentials were not being recognized, an issue which has been raised over and over again in numerous reports and studies (Galabuzi, 2004; Este, 1999). Another concern that was raised by several participants in different ways was that immigrant and refugee women might not use mainstream services because of their perception that practitioners used a lens that did not fit for them and they were concerned that the solutions might not usually be appropriate to their cultural contexts.

One immigrant professional added another dimension when she questioned whether all knowledge was being valued equally:

> My whole pain and grief even before we started to ask. The marginalization of our knowledge we have developed over the years. The skills we have developed over the years. The marginaliz[ation] of our qualitative knowledge which is occurring. When I present the same research I present a research and then somebody with a lighter skin presents a research, they are going to be taken as expert. You know, Judy, that I work very hard to make presentations. I read and do research. And

> yes, I have become passionate and at the end of the presentation a lot of people give me good feedback. It is always reduced to "oh you spoke from your heart ". And it really hurt me because I don't stand up and start talking about here and there and whatever. I have noticed. I read and I research and I go over the world to become more knowledgeable and then bring it back.

That is, this participant suggested that racialized women's knowledge was not given equal value to that of non-racialized women. There were other stories of personal experiences of racism. For instance, one service provider talked about growing up as a racialized person and learning about the racism through the experiences of her parents:

> And even though that immigration experience as a child wasn't something I remembered much. But it was my mother's and father's experience which made an impact on me because they suffered a lot of initial racism types of things for a long time before they were able to settle down in the 60s and 70s … and so it does affect you as you are growing up as a child. And so part of your identity becomes that and learning to deal with those issues …in terms of your parents not necessarily in terms of you.

The service provider also described how she came to understand how others saw her:

> I may not even think of myself as brown because I had an identity that I was just [Citizenship name]….. But I saw that was the perception of other people…was different than mine. And especially when coming to Canada coming [to] a small city like [name of Saskatchewan place], there is a lot of difference living in a big city versus a small city. And you just confront some of these attitudes here. And

that was the first time I actually experienced the differences, when I came here. And then I identified with my mother's experiences even more.

Another service provider noted that agencies needed to get more involved in addressing the issue of racism:

> Well, one thing on my wish list …I think there is a whole issue of racism in our community and the health region has not been very proactive in addressing it, and this has health implications…I think we could play a role in some community education.

Overall, these stories and discussions highlighted the complex realities of women's lives, and demonstrated how various issues intersected: the stigma, fear of being found to have mental illness, experiences of racism. A service provider made this comment:

> Similarly we find all kind of difficulty finding jobs and making our way into the society. On top of all that, if I come for mental health service, so right away there is a diagnostic label on me. What is it along with racism and marginalization, what is it going to do to me in terms of finding a job and being seen as credible. So it is very unfortunate that we live in a very free society but our life is guided 24 hours a day by the fear of being found out.

The concepts of multiple oppressions and of the intersection of oppressions are clearly reflected in the various discussions regarding immigrant and refugee women's lives. In short, racism does not exist in isolation. The issues of racism and discrimination continue to be particularly troublesome because they challenge the very being of who these women are, and makes life an eternal struggle to be strong in order to continue to live and cope with other stressors.

Responses to situations of extreme trauma (post traumatic stress responses, depression)

One of the strongest messages that I received from settlement workers and those employed in immigrant and refugee serving agencies was that they were feeling ill equipped to deal with the emotional distress of newcomers who had come from war affected regions. These service providers talked about the specific issues and needs of refugee women. The service providers identified symptoms of distress that they felt needed the kind of professional intervention that they were unable to provide. These symptoms were described in many different ways. For example, one service provider suggested: "It's the distress. I am sure there is a bit of mental illness, but it is really not illness; it's a distress, coming from sociopolitical conflicts". At least one settlement worker noted that several of their female clients were widows whose husbands had died in war. The service provider suggested that these women were having difficulty coping with the stress of losses and also having to be lone parents in a new culture. Service providers noted that many of the newcomers were coming with multiple issues including low literacy skills, low English language skills, and seemed to be extremely emotionally troubled as a result of the war experiences. Service providers named this post-traumatic stress.

One service provider noted that after very many years working in this sector she has come to realize that the issue of women's mental health was the most important issue to be addressed:

> Making the woman feel secure, self- sufficient, and having confidence I think is very important. I think with that even without a big vocabulary they can do well. When they feel they are really somebody and they are not just from a developing country. They suffered so much and so on.

One of the concerns was that when the discussions about mental health services arose, women were either reluctant or would refuse to use these services. The stigma of using mental health services continued to be a strong theme in these discussions:

> They want you [to make] a referral to a professional counselor to speak to [but] there is a stigma attached to mental health and they sometimes they will just 'no thank you, I'll handle it on my own, or 'I am fine, I will get better'. There is too big stigma attached to mental health.

Service providers explained that there was rarely follow-through by women when referrals were made to other agencies. One service provider talked about the feelings of shame that women may feel as a result of the very traumatic experiences they have lived:

> Some of them feel ashamed of what they experienced because in the Western world they [people from Western countries] don't go through what they [immigrant and refugee women] go through, went through in the developing country. And that makes them feel inferior to the Western world they are coming to. And so we have to have.. I was talking about this on Monday to a woman who came as one of my contact persons for the host [program]. We have been ignoring that. We have been concentrating so much on language, which I am not saying is not important.

The service provider suggested that it was important to validate the feelings of these women, many of whom came as refugees:

> But look at the individual, they have different, they come from different aspects of trauma too, in different ways. Something that we may not think is traumatic, to them it is and you have to recognize that. You cannot say "no, no, no that is not important". In their mind it is and we have to recognize it.

In one focus group interview, one service provider who had strong connections to the immigrant and refugee communities noted that some immigrant and refugee people had very severe mental health concerns that affected their ability to function in a healthy manner. This professional suggested that immigrant and refugee women often went to service providers such as settlement workers, workers at immigrant and refugee serving agencies, and to physicians when they were experiencing emotional distress. The service provided noted that in some cases, some very specific types of intervention were needed:

> But my concern would be ..and ..I am not sure of the numbers but there are some women who are actually very depressed and have other very severe mental health issues and my concern would be that... just assuming that that would be handled there [at community based settlement agencies] is a faulty assumption and there needs to be open lines of communication. They need to be hooked up with an agency like this where people have more skills and more training to do more complex work and I am not sure if that's happening

Participants outlined the complexity of needs of individuals who have experienced and survived extremely traumatic events. Practitioners recognized the importance of strong social and institutional support networks. At the same time, there was recognition

of the impact of trauma on the whole person and that a multi-pronged approach to intervention was necessary. Some service providers were wary of using medication as the sole or primary response to dealing with trauma. All of them recognized the role that professionals with the training and skills in the field of trauma will be able to play. Discussions suggested that it is critical that service providers approach their work using a gender inclusive, anti-oppressive framework to guide them in these interventions.

Final comments regarding issues

Participants' comments reflected that women come from different cultural contexts and so issues are defined differently. Immigrant and refugee women reported that they felt that their cultures were often under scrutiny and their whole identity and sense of self were being judged. Some women had come from backgrounds where they were not accustomed to thinking about the broad definition of health and mental health. Therefore, it was important to begin to have a discussion about language and meaning so that the participants and I could each hear and understand one another.

Critical theory's emphasis on the issue of power is important in being mindful of the ongoing concerns about power and equity especially as this relates to women's experiences. Critical multicultural theory encourages us to consider the various factors that play a role in intercultural contact (for example, language barriers), and then to explore ways of ensuring that these factors are not a further barrier to women's access and using services.

Chapter 7

Data Findings

Understanding under-utilization and how immigrant and refugee women help themselves

Introduction

There were several messages embedded in the literature that I read. One was that immigrant and refugee women were not using traditional mental health services, and therefore their mental health needs were not being met. The second was that as a community we needed to find ways of bridging the gap between the community-based organizations, community sites frequented by immigrant and refugee women, and the existing traditional, mainstream mental health agencies. As a community activist and member of the immigrant community, I was aware that immigrant and refugee women used some formal and informal helping methods. I wanted women to talk about whether they had found a way to bridge the gap between helping methods they used, and/or were familiar with in countries of origin, and what was available to them here in Saskatchewan. That is, were the informal and formal approaches adequate? What else did they need? Could the knowledge of immigrant and refugee women's helping approaches add to existing knowledge dealing with mental health practice and policy? Chapter 7 presents findings based on these discussions.

Western versus and non-Western approaches

During interviews there was awareness among service providers of the different values and beliefs that they and their clients brought to the helping relationships. Service providers recognized that women were coming from different cultural contexts. Some

service providers in traditional or mainstream mental health agencies noted that those immigrant and refugee women who used their services were often those who had some comfort with Western systems: "One of two I can think of are people who have quite good skills of dealing with life and maybe more westernized than other immigrant people that need more kind of basic help".

Another noted:

> I see some of the immigrant women. Most people are seen as individuals. There have been some in group who I think their understanding of English was excellent. And they had some experience in the culture here before coming into group. So I think with one individual, I think we were quite prepared in terms of the nuances of how group might work even though she was not in a group before (therapy group). But she got that, having been in a classroom here in Canada. So I think the services are relevant but I don't think we are necessarily set up to meet a woman who is just arriving.

A similar situation was reported by another service provider: "I have worked with women from other countries...not English speaking women...but I am remembering one in particular who was married to a White Canadian...and so there wasn't so much of a stretch...it was okay". That is, if women had been in Canada for a while, or had gone to school in Canada, or had some connections such as Canadian-born spouses, friends, relatives, then the transition to using services was easier than for those women who did not have those experiences and supports to assist them. Mental health service providers often talked not just about how to provide service to immigrant and refugee women, but more about how to respond to those women who may have needs but who did not usually

appear at mental health agencies; or those who came from social, economic, political, and cultural contexts that were very different from the Saskatchewan contexts. That is, service providers wanted to think about getting themselves more ready to work with populations with whom they had little professional experience, because they too could see an evolving population.

Service providers and immigrant/refugee women discussed the need to recognize the diversity of backgrounds and that some "bridging" work would have to be done with immigrant and refugee women. That is, not all women would be ready to use existing services because they would not be familiar with mental health services in the way in which they were delivered, and might be intimidated because of a range of different factors. One service provider mused about how some newcomers might respond to existing services: "I cannot imagine a typical Sudanese woman coming to a woman's group". An immigrant and refugee women tried to express these challenges when she noted that the new systems might be "alien" to some newcomers:

> And sometimes too among our people, these services are available but they are not tailored towards our people's needs. And to the method or the way the way they do our program. For example a typical example a family, they come with 6 kids. They are from a remote area.

Some immigrant and refugee women talked about the process of settlement, and suggested that immigrants and refugees who have been here for a longer period of time needed to remember to reach out to newcomers.

Client readiness

Client readiness was a strong theme in these conversations. Some service providers noted that many immigrant and refugee women were not ready to use the systems when they first arrived:

> My experience too is the same. Working with individuals I am thinking have been here for a period of time. Now they could have used services; could have used services when they first came but for some reasons they didn't use services. That might have just been because of the barriers. So it's always too bad when you see someone and they have been dealing with an issue for a long period of time and couldn't use the service at a different point in their lives. But there are other considerations there too.

Client readiness was also connected to the comfort with using services and systems that might be different from those in countries of origin. Individuals might begin using services only after a period of settlement, and comfort with systems and services in their new country. In situations where women were relatively new to the country and were coming from cultural environments where helping systems and approaches were quite different, the fit with existing mental health systems was the least comfortable. The discussions with service providers suggest that we need to look at needs and try to determine where women might fit along a continuum.

Relevance of programs and services

Service provider perceptions

None of the service providers thought that their services (Appendix A) were developed in a way that was adequately responsive to the needs of immigrant and refugee women. Mental health service providers all reported that generic services were available to all members of the public. Overall, agencies were using a broad range of social work interventions and models to fulfill their mandates: individual counseling, group work, public education, and community development approaches. Service providers reported that they had generic skills, and that many of them had good knowledge of issues of trauma. However, service providers questioned whether the programs and services responded to the needs of immigrant and refugee women. There were frequent comments that echoed this participant's belief, " I am not sure we are doing much and I think there is lots that could be done".

One service provider was quite adamant that her agency had little or no experience working with immigrant and refugee women and could hardly imagine the agency providing services to this population: "Well, the first thing is that it would be hard to even think about that if we aren't seeing immigrant families here and thinking that we need to have services here to keep them".

Service providers raised other concerns: attitudes to time, relevance of programs and services, perception of relevance of services and programs. They suggested that Western societies tended to be very time focused with respect to service delivery. One service provider suggested that " we would need to change so we would have to stop being so time focused...start to think of adapting our world view". Other service providers

recognized that the current models of practice were inappropriate and that there would need to be a complete rethinking about how we work. One practitioner talked about her experiences with trying to work with immigrant and refugee populations:

> One of the other things....it's been a bit of a challenge to be able to do work with clients that have wanted to access service. I book service hour after hour...it does not make sense to them [immigrant/refugee families or clients] to come here. [They say] why not come to my house...it's been a bit of a challenge....to have a bit more space in my calendar to do it...because of my schedule at that time, ...coming to my office is not a helpful approach..

Service providers spoke about their perceptions of what kinds of programs might be helpful for immigrant and refugee women. They suggested that immigrant and refugee women's mental health needs were complex, interrelated to the needs of their children and families, and that the availability of services to other family members was an important factor in addressing women's mental health. The participation of their children and other family members in community programs allowed women to make various kinds of community connections, which was an important factor in community building (and addressing isolation).

Service providers agreed that reluctance to use mental health services was not unique to immigrant and refugee populations. At least one mental health agency was aware that some immigrant and refugee women were using their services: "The caseload is just kind of being spread out right now because I do have two women who would fall under that category with my current caseload here". A concern was that the broad concept of "mental health" services was quite an alien one to many newcomers and that the term

carried a strong stigma. Several participants (immigrant and refugee women and service providers) questioned whether different language (with respect to talking about mental health services) needed to be explored since the current one had such a stigma. Service providers noted that many newcomers were coming from situations where community (including extended family, family, friends, neighbours) played significant roles with respect to caregiving and healing, and that the current clinic models might be unfamiliar to these populations.

> I don't think this is an easy solution. but to some ways, get to getting people where they feel safe...if that is within their cultural centres...giving information about services, about how we view mental health...a lot of people don't have that in their vocabulary. It's foreign to them. It's not something they have ever reached for from their family. How do you get that information out there? I don't know.

The notion that the current adult community mental health approach was inadequate and sometimes irrelevant was raised in many different ways. For example, one service provider described using a community development approach and suggested: "I think it was far more effective than this micro treatment. It also looked at larger issues such as political, social, economic issues". This service provider talked having been involved in a study:

> In fact, in the needs assessment, only 7% of the needs expressed was to see a clinician in their office. And our whole (and I have spoken about this many times) our whole mental health office is set up to do that. And 93% of the people I spoke to did not want that.

That is, there were concerns that the current clinic model might be inadequate not only for immigrant and refugee women, but also for other members of the community. This service provider suggested that what was needed was a paradigm shift. However, she recognized that neither the workers who were protecting turf nor the senior decision makers were ready to make that shift. She had her own goals:

> My goal is first of all is not to go that path of creating victim...constructing victim out of anybody who has been harmed...who has suffered harm...I see that as an invention of the patriarchal system which is very disconnected in terms of mind and body, run by men who don't have a good concept of connectedness with themselves or with others and this is what they invented and we have suffered from it ever sense. So what do you do as an alternative? First of all we work with people to access their own strengths and you always facilitate those strengths way before they come into this place.

This service provider also referred to Prochaska's and DiClemente's Wheel of Change in which they suggest that only 80% of clients are actually ready for change.

Many of these service providers talked about their understanding of the importance of family, and family and community support. They talked about the fact that many immigrant and refugee women seek help at community-based organizations rather than at mental health centres. The overriding concern was always how to get immigrant and refugee women to the centres. This also led to the question of whether services should be taken elsewhere, that is, whether the same clinic model should be moved to another location.

Service providers commented, in many different ways, that the current model of service delivery was not adequate for the majority of the population; that it focused on micro issues and did little to address root concerns. For those professionals who were committed to a strengths-based, feminist approach to practice, working in their current sites was not empowering: "So as a [mental health professional] if we were dreaming about what it would look like … I will turn it on its ear without a doubt…without a doubt".

The big question was how to do this work, how differently might one's practice look? The following quotation reflects some of the struggles that service providers shared:

> My own question would be for my own self …if I am working with a woman…would I be supporting her…I would be…but would I be….it may be all of it…educating her about what happens here or supporting her own thoughts and ideas about what she has lived with…that would be big for me because I would want to know what to do with that…you want to have a good relationship with them.

Another service provider struggled with the idea of ghettoizing clients. She suggested that not all immigrant and refugee women needed to see a "specialist" if the issues were "legitimate mental health issues". In a discussion about how the agency planned to deal with one case, she suggested:

> I am not sure whether that is going to be an immigrant and refugee issue or whether that's a mental health issue so it is important that we think with a broad mind about these things…and [ensure that] these needs are met. Some of them are not related to being an immigrant and refugee person.

She suggested that sometimes immigrant and refugee clients might not self-identify or name immigrant status as an "issue" but that this might emerge later on during a counseling session: "And if their experiences are related to the immigrant experience which is very broad, that will emerge. However, it may be that is not their issue and it may never emerge...you never know".

Service providers were critical about their practice and generally felt that decision makers needed to explore ways of responding to the mental health needs of immigrant and refugee women. Their perceptions were that their agencies were not adequate or appropriate and that significant changes needed to occur.

Perceptions of immigrant and refugee women: then and now

The common comment from immigrant and refugee women themselves was that the term mental health was very negative and there was a strong stigma attached to it. During one of the interviews, when we were talking about defining mental health, the women (immigrant and refugee) all burst into fits of laughter and began speaking at the same time. This was a signal to me about how strongly they felt about this topic: "Oh, to be honest, the moment I think about mental health, I was thinking about someone walking the streets"; "it seems so big to us. If I come out in the open and say I have a mental problem. It really means a lot to Black people who come from [name of country]".

One of the most telling interviews involved a focus group with a group of immigrant and refugee women. Like their response to the term "mental health" there were loud outbursts of laughter when women asked about ways of getting help in countries of origin, and then about ways of getting help in Canada.

> Back home, I can say back home this kind of stuff you are asking ..this kind of thing is hard to see because always you have people surrounding you....you can talk to them. Maybe it is just for the support from family and friends.

Other women talked about how women would deal with situations of violence or domestic discord:

> Because you have very much you have relatives, mom, aunty, sister. So sometimes you leave the house, where you living with your husband, just to take time out to calm yourself. You can leave your house and go to your people. They will help you with your kids. Or you know. So there is help back home. Here there is nobody you will go to. Sometimes you are ashamed to say because people will say "oh she and her husband can't leave me alone.....they abusing her. Back home we don't know what they call abuse. So here you will be ashamed to say it.

These women explained that they would often return to their parents' home when there was domestic discord or family violence, and that this could also serve to embarrass their spouses. It was not usually necessary to explain the problems: "If you leave your house and go to your parents. They will say you went to spend time. They not going to say see the man abuse you".

The message from some immigrant and refugee women was there was a strong network of support in their countries of origin. Extended family and neighbours could be depended on to provide emotional and other kinds of support. For some immigrant and refugee women coming from African countries, the idea that they would actually need to think about issues on their own in African countries, seemed to be an alien and comic

concept. The idea too that they would need to go and seek help was foreign because help was always present:

> The help is also.. everybody's there ..because everybody is there. You don't …I think about the mental health because it ..there is a lot of sense of community. Because people are…it is something for granted. It is not something we have to learn. Because we just..it is there in the community.

> Back home things are different actually. The social systems are different, the work environment is different. The weather which is a big problem is different. So all those together they might make things really …and easy for everyone . You really don't think you have a problem. Because even if it is a problem it [is] already solved. Helped by someone. So those conditions together, environment, the system is quite different from here. Definitely the family, extended family, closer family and friends, and even the coworkers when you work ….they are different from the coworkers here.

Women talked about their values and beliefs and how these affected how they lived with one another. For example, they talked about the fact that children belonged to the community and there was a community responsibility to care for children:

> You can carry the child for nine months, but you know what? That child is ours. There is no way, I don't remember anybody calling, picking up the phone saying I am going to call Mrs. …I am going to come and help her to bath your baby. No, people will line up to come and bath the baby because they will say she is our child. They will come. They say she is our child.

Another woman talked about how much this kind of support is taken for granted:

> As I am thinking imagine how much we owe our people back home. If we had to pay them an hour. You go to pay a counsellor for an hour. Imagine how much you will be paying your neighbour. If you really think about it, we owe them a lot. And most of the time a thank you doesn't really come as often as it should. Because we all just take it for granted. I am going to the market. Without even taking the baby to your neighbour, you just pass by to your neighbour's place. You are going to the market, and you tell them the baby sleeping in the house. And it is automatically your neighbour's responsibility. The baby is sleeping in the house. That is all.

Neighbours, family, and community provided support in raising children and passing on cultural values and traditions. That is, women did not have to perform these tasks on their own. They would get help when they were being challenged by the behaviours of their children:

> And if your children are getting out of hand, your neighbours are always there. A lady three or four houses back. You go to that lady [you say] "my children [are] behaving, help me. This is what it is". The lady comes to your house, and talks to the children. Or you say, for this week you will be living at that lady's house. That is the kind of counseling.

In other situations community members would teach pubescent girls:

> Girls are getting of age, getting mature. The girl is getting her period. You put that girls in seclusion for a month or two. And all the ladies they come and talk to the children and teach them the way of life.

One woman explained that she had only begun to appreciate the values of these traditions and supports since living in Canada:

> So when girls start having periods for the first time if they have a elder, they make a celebration. I thought at that time it was nonsense. But it is actually a way of counseling and preparing and someone comes and talks to her, the girl. Tells how how she is supposed to be doing, taking care of herself. The same thing if a woman is being prepared the same thing in marriage. It is not in a professional sense but in a community sense.

Immigrant and refugee women talked about the difference between living in countries of origin and living in Canada. They talked about the different climate, their busy schedules and about the fact that these factors made it difficult to take care of one another and build community in the same way as they had done in the past:

> Here to whom you can talk? And even if you have like our community or other [ancestry named] people because we all involved, we are all busy even if you have the time you need that time to do some things for your kids, for yourself, for others. So it is quite different.

Another extremely informative comment came from a woman who shared her views about why women did not seek help from formal helping services in Canada. She suggested that in countries of origin some practices had become so much a part of the norm that women had learnt to cope with them. When they came to Canada and those same practices were challenged, they were somewhat jolted because they had not perceived them as problematic:

Because she was already saying that sometimes the problem is not a problem ...is not a problem there. It is only when you come [to Canada] that's when you realize, 'Oh, that's a problem? So when he does this to me, he is abusing me?'. You know...so when you are there, it is kind of no more but when you come here it's like this..and it is a big problem. Maybe that's the other reason why we don't access the services, because we don't feel they are necessary yet. You know, we can be going through some issues: he was saying such bad words to me yesterday and...but he has said that and before and before and I am used to it. Now, I don't take it seriously. But here, oh, he said that to me yesterday, that's abuse, that's abuse. I am calling the line. You have no right to talk to me like that, who do you think you are ? So that's one of the reasons we may not access the services that we think we need to.

Because you come here and you are being told 'Oh you have a right to do this and you have the right to do this. You are being made aware that this is wrong and this is right but there we also knew this is done and this is not done but even when we were doing this. To this degree it is acceptable but when it goes beyond, then it is not acceptable. But here, we are told that if he hasn't done dishes in a week then that's abuse. Then you say, oh I am having problems. At home, that kind of stuff. It is really different. We look at how big the issues are. And maybe because we have endurance we are thinking it is not that big yet to call on him. It is not that big yet to seek help. I am still doing okay. That's an inside to why we won't access those services when we really should

Some immigrant and refugee women felt that they knew how to get information about services but did not think that would be the case for everyone. They felt that agencies would need to think about reaching out more proactively to immigrant and refugee women: "And the services don't say: 'and hey we are here please come to me'. We have to go and look for them. You have to look for them". The immigrant and refugee women who were interviewed had strong ideas about what worked for them and what else they needed. They accepted that they had come from countries where they had strong social support networks and where the church, faith, and spiritual communities played an important role in providing emotional support. They felt that it was particularly important to maintain their values regarding community relationships here in Canada. One woman suggested that she had shared her "[country of origin] ways of support with [Canadian] friends and felt good about this. Women talked about discovering their strengths and realizing that they had the capacity to cope with issues that arose:

> With the few problems I have had, I have been able to make use of friends. The first few years I was here the telephone bills were quite high. As time goes by you learn to adapt. Through adapting, comes I don't know if you can say, perseverance. Maybe through adapting comes not caring to some extent. Because you say, my mother is not here, my sister is not here; it is going to cost me so much to call. Is it really such a big problem? It is not really a big problem. Maybe it is not as big as I think it is. Then you learn to deal with the problems and you are fine.

In short, women had built their social support networks and they also developed various coping skills. Social support networks included members from ethno-cultural communities, from their church communities, and from the wider community. The church

and faith communities, as well as their spirituality were significant sources of support for many immigrant and refugee women. Few women had used traditional mainstream mental health services and most admitted that there was a stigma attached to "mental health".

Chapter 8

Data findings

Accessibility and agency capacity

Introduction

The previous chapter dealt with perceptions about the relevance of services to the mental health needs of immigrant and refugee women. The other questions that I felt needed to be asked were about agency accessibility and about the capacity of the agencies to respond to the needs. Accessibility refers to the manner in which services and programs are delivered and whether there are barriers that might limit or make it difficult for immigrant and refugee women to use services. Accessibility factors that were raised included availability of childcare, transportation, mechanisms to address language barriers, and the way in which services and programs were delivered. I defined capacity in terms of agency resources: professional knowledge, skills and readiness, ability to provide supports such as transportation and childcare, ability and readiness to make shift in program models and delivery approaches. Through the discussions with immigrant and refugee women and service providers, I was able to identify some broad themes relevant to these areas.

The question about accessibility raised concerns about whether immigrant and refugee women would be comfortable entering these existing programs and services. None of the mental health service providers felt that their services were particularly welcoming to immigrant and refugee populations, or to immigrant and refugee women specifically. Their concerns ranged from the expectations that immigrant and refugee women would have to adapt to time limited and time focused counseling session; to

concerns about whether the actual programs might "fit" for immigrant and refugee women (and that this time limited focus was not always appropriate); to concerns that there would need to be some changes to the ways in which services and programs were currently organized and delivered; to suggestions that agencies would need to be proactive and reach out intentionally to immigrant and refugee populations. This might mean having dialogue, and developing partnerships with community based immigrant and refugee serving agencies.

With respect to language used to name the agency, service providers pointed out that there had already been evolution in language: from Adult Mental Health to Adult Community Mental Health to Adult Mental Health and Addiction Services. Some interviewees suggested that further change would make these services more welcoming not only to immigrant and refugee people, but to other members of the public. A recommendation for change was to drop the term "mental" completely from the title of Adult Community Mental Health Services.

Capacity

Knowledge, skills, and actual experience with working with immigrant and refugee women

There were healthy contradictions in the responses. That is, there was a range of responses to this issue, and a willingness to deep returning to the issues with different perspectives. At several of the agencies, individual staff had worked with immigrant and refugee people (including women). However, these may have occurred years ago, with different kinds of immigrant populations (through the years, there have been different

waves of immigrants). In some cases, service providers were unaware of the experience that existed among their colleagues or team. In other situations, practitioners had had very sporadic professional contact with immigrant and refugee people and did not feel they could claim competency and experience.

Service providers discussed whether one had to be an immigrant and refugee person to work with immigrant and refugee people. One service provider suggested that she and other professionals had professional capacity on which they could continue to build:

> I think we build capacity. I don't think you necessarily have to be an immigrant woman to work with immigrant people and sometimes we get really caught up in that and that does us a disservice. All of us should feel that we have capacity.

This service provider further stated:

> All of us should feel that we have capacity. That was certainly one of the things I discovered in the research that I was doing. I actually did a survey of all the counselors and psych nurses at that time. I think the literature would support that.

Another focus group participant added to the conversation:

> But there is no denying the lived experience either. But then again, depending again, if you are a good counselor, then that is what you are going to also try to bring in or refer people to... if somehow that's necessary.

Service providers were open to reflecting on what might be best practices in doing this work with immigrant and refugee women, and discussed this issue from different angles.

When service providers were involved in work with immigrant and refugee populations, as volunteers, this involvement would eventually have an impact on the work of the mental health agency:

> I don't think there is any doubt that my involvement in the refugee communities, and my church work, my volunteer work, and that history that has generated and expanded has influenced how I have nudged people here and who I have talked to about what. And who is aware of our agency that as a potential resource that maybe they might not have considered before.

At one agency where some recent work had been done with immigrant and refugee families through involvement in a project, agency staff felt that they were beginning to ask questions, build knowledge and skills, but that they were at the infancy stage of doing this work:

> Where I think we are ahead of the game [is]...we are asking the question: what would be respectful? How can we meet people's needs? No, we aren't dedicating everyone to do home visits ...this [work] isn't a fifty minute [work].
>
> Those are in house things we have been invited to consider. Nobody said to me you can't do that.

One worker suggested that if she had been asked the question about agency capacity prior to that project, she would have been more confident about responding positively about her skills and knowledge in doing the work, than now following their program. Participation in that program opened her eyes to the enormity of the work, the unknown, the complexity of the work, the way in which the work was different from what was traditionally done:

> And I think our capacity to hold the truth of all the different cultures, my experience is: it is so much easier when people go along with what [I propose]. I am accustomed to people going along with [me or my ideas], but having to stop and listen and let people have their voice and their [ideas]. As we kind of wait between two systems to find a common ground, I find myself ...I am going to have to build capacity on that; it isn't quick. And, you know how we are a quick society to have this done and finished. Not [that] that is always a bad thing.

Overall, these service providers recognized the challenge faced by their agencies since doing work differently might require more or different staffing. This was so because they had begun to think that they needed to do more home visits, and perhaps some community development work and more work in the community. At the same time, they were aware of the pressures that would be put on an agency whose primary focus had been "counseling", usually about 50-60 minutes per client: "When we see it and recognize it, it places an extra on the agency. What will be one hour becomes two hours. It is a staffing issue. We need two people to see as many people".

Service providers' perceptions emphasized that they needed to build/enhance their skills in order to address the mental health needs of this population:

> I think things like that question is kind of complex in that on the one hand you can have capacity. I personally haven't had training in diversity although I have my work experience a little around Aboriginal women. But again, not a hell of a lot. I think that mostly what I have learned have been in books but not specifically in training the trainer. I know also that I don't know some of the things about systems

very well. I may have some learned capacity from experience but I know there is more I could have if I did focus in on that. So I think it is kind of complex.

Actually doing the work with immigrant and refugee women seemed to be an important piece in building capacity. Capacity according to these workers also meant having theoretical knowledge, current knowledge, and being able to keep up with new and emerging issues, based on the needs of new and emerging populations.

One service provider introduced another dimension:

> A lot of people have a certain sensitivity or a general awareness of how to work well in cross cultural, intercultural situations. I think a lot of people are doing that and doing a good job. But the research also suggested that people who are ....where there is a more complex presentation, and perhaps language barriers and cultural barriers if you want to call them that, very different world views, different way of looking at mental health and all of the layers of that, it does require very specific training and I think that it's important to have someone with the skills that's available. I think a lot of us will continue to do the general kind of work. We need someone who is very well trained and skilled to provide that kind of expertise. There may be some psychiatrists and maybe some psychologists but I don't think that a lot of the programs put emphasis on that.

This service provider acknowledged that practitioners might have helpful generic skills, but suggested that immigrant and refugee women would also benefit from professionals who have specific expertise in the area of working with this population.

As mentioned earlier, mental health practitioners were generally confident that they had good generic professional knowledge and skills in the area of trauma, violence

and abuse, and in other counseling areas. However, repeatedly, they felt that what was weak was the "cultural" piece:

> I think the counselors here have lots of expertise...they have that clinical skill pretty nicely developed and in many different ways with people with adults...the piece we don't have is the culturally sensitive piece... whatever that is.

> When I think about the women and domestic violence I think there is a whole piece to understand the culture and domestic violence, our capacity as well as workers. I think that, you know, we all may need a bit more fine tuning on the work, that cultural piece. When I think about inviting women in the area of domestic violence from other cultures on domestic I would have to do some thinking about how I would approach that.

One knowledge gap that was identified by one mental health agency was that workers did not have a grasp of the immigration system and were somewhat limited to assist clients who were struggling with issues that were related to immigrant or refugee status:

> It would be helpful if we had an in-service from someone who knows how to do this [and] to bring everyone up to [par with respect to information related to immigration policies]. We likely won't do that, as a result our capacity is limited.

Generally, capacity included the knowledge, and skills to work with immigrant and refugee women. Service providers suggested that they had some knowledge and generic skills but their limited work interaction with immigrant and refugee women meant that they had little opportunity to develop knowledge and skills from direct practice with this population. They also felt that there were gaps in their knowledge in areas such as

immigration and settlement policies and these gaps limited their ability to provide anadequate response to some clients.

Agency capacity to address the issue of violence

One of the specific mental health questions that I asked service providers was about the issue of violence. I wondered whether the service providers could talk about their knowledge of the situation of violence among immigrant and refugee communities, and how their agencies had been responding.

Those service providers with closer connections with immigrant and refugee communities (because of them being from immigrant and /or refugee backgrounds, or because of volunteer work) were able to share stories about domestic violence. These individuals talked about family violence, silence about violence, and the depression within many of the immigrant and refugee communities.

Overall, comments about how mental health practitioners were addressing the issue of violence supported what I had been thinking: we are unsure and still learning. "We are not reaching out…breaking any sort of invisible silence of violence in other cultures". Practitioners were certainly convinced that there needed to be focused discussions within the community and among service providers regarding this topic:

> I think there would need to be a concerted effort around that. …there needs to be conversations. There are probably agencies in the community who know about this …I don't know if we are the ones to be doing this work…I think we do this work…we should make ourselves available.

The challenge was always how to begin. As one practitioner asked, "So how would we present this?" In that regard, the issue of "culture" again surfaced:

> As a worker, I need to understand the cultural perspective of violence...domestic violence, our sort of take on this, as opposed to...here is how we view [violence], come into our group, this is how we deal with domestic abuse in Canada. I think the work has to be different.

This theme of "culture" continued to appear at other points. Service providers named some of the situations that would be challenging: "I cannot imagine a typical Sudanese woman coming to a woman's group". The following exchange between these service providers reflects what they viewed as other challenges:

> Comment: I think that's when we get really [thinking]..I think [of] the ethical concerns and the requirements to report and the legal concerns...I think we are looking at a different standard of what is acceptable.
>
> Response: And isn't that heresy! It's like..like we have to we have to ...to somehow convince these people that they are doing wrong...you know...That's not going to work.
>
> Other response: We act as thought we have convinced all those people who are Canadian born that they are doing wrong.

Child protection legislation and policies were important considerations when discussing the issue of reporting and bridging the gaps among different cultural contexts. Some mental health service providers who had some experience working with immigrant and refugee families noted that it was difficult to implement current legislation and policies for populations that had no familiarity or understanding about Canadian policies

and legislation: "If a woman says she has done something towards her children, would we have the requirements to report? We won't have confidence that we would be reporting to someone who is culturally sensitive in any way".

One service provider facetiously questioned: "So are we going soft on violence...like it's ok to be violent? Is that the line?"

Working more closely with immigrant and refugee families had enhanced these workers' understanding of the gaps and about immigrant and refugee women's understanding of the issue of violence. They were not sure about how to deal with the issues but were clearer that current standards could not be rigidly applied.

> Building my capacity to tolerate being caught between this agency that was created to protect children and another way of being in the world, which does not mean that we just want to be violent to children, to people.

Another practitioner named other challenges:

> I think one of the huge challenges is that we have in our culture and particularly in our professional culture, developed a gender analysis that informs the work we do and that sort of makes sense to us. And we understand the power imbalance and how we are trying change that. And the gender roles, and historically and protecting women. I think that the risk, one of the risks, is that we are going to want to bring people from a very different culture up to our speed in 20 minutes.

Service providers in the agency that had done recent work with immigrant and refugee families had some instructive comments: "I don't know...I hadn't thought about this before doing this work so I think that this is the richness of the work...it demands of

me that I think about it more differently". There was a level of enthusiasm that was infused with a strong sense that they should not stop the flow or try to contain it:

> I think it's a huge job...I don't think we can contain it...if we don't do community stuff whether with DCRE [Department of Community Resources and Employment] or within our community here in this office, as individuals, we couldn't hold the responsibility of knowing some of the things we know and making some of the decisions ...every time about how you would do this...and ethically... I think we need to figure out some ways to talk about it with the other people.

At the same time, these workers understood that they were still learning and were not sure that they were ready to talk with others:

> I think that is the challenge that we have been given ...how [to have] conversations within our community...I would much rather have the conversations here rather than take it out.too soon....I think there is room here to talk about this and grapple with [it].

A common response was that the programs and services, in their present form, were not necessarily appropriate for addressing the needs of this population:

> Some of the programs we offer just aren't on target with what the issues are that they may...immigrant and refugee families may have. Some of our groups are geared to people who ...life's pretty good...and you are wanting to reflect a bit on other things ...I don't know exactly if marriage prep would fall into something that immigrant and refugee families would [be interested in], but I don't think so we

structure, develop programs for good reasons, around what the demand is; they wouldn't all be of interest.

There was no resistance to considering how to address the mental health needs of immigrant and refugee women, but more of a sense of how complex the work would be.

The response of a service provider in one of the smaller centres was less enthusiastic, not because of unwillingness to consider the issue but rather because of how unreal it seemed that the agency would even begin to see immigrant and refugee families coming through their doors: "So it would take a huge leap to go there". The worker added:

> Well, the first thing is that it would be hard to even think about that if we aren't seeing immigrant families here and thinking that we need to have services here to keep them. So that would be the first thing. We would need them here, we couldn't focus on something that might never happen here

Like the service providers in the larger centres, the service provider in one smaller centre suggested that there would need to be some preparatory work because: "This would be so foreign …there would need to be some sort of liaison person".

Certainly one of the challenges raised was how to provide the resources to do work in the way that would be most appropriate for immigrant and refugee women. Service providers generally suggested that they needed to work with individuals and agencies that already had some relationship with immigrant and refugee populations. One agency had already been talking about hiring a staff person who was a relatively recent newcomer to Canada:

> We have been chatting a bit of how that is going to be shaped. I think because she has these great connections in the community with different agencies it would be a

real opportune time to be able to have our service become more outreach because I think what often needs to happen to make it more friendly, because we need to go where people are more safe or more comfortable.

Several of the service providers recognized that there would be immigrant and refugee women who were coming from regions where values, beliefs, legislation, and policies (that is processes and structures) would be very different from those of the Saskatchewan and Canadian contexts. Most service providers wanted to learn and explore how to respond to the issue of violence and to learn about the different contexts and attitudes. Immigrant and refugee women tended to be less optimistic about the willingness of the service providers to be open. Most immigrant and refugee women who were interviewed believed that service providers were limited in their capacity to provide service to them, and of the capacity of the agencies and they would not necessarily use a service that did not seem to meet their needs. As discussed earlier, much of their reluctance stemmed from the stigma of mental health, but women also seemed to be talking about the ethnocentricity among service providers and the racism since they and their cultures would be judged if they exposed themselves. Another reason for the reluctance related to the perception that service providers in mainstream agencies did not have the knowledge and understanding of their issues, cultures, and backgrounds.

Accessibility

Childcare, transportation, language, and other supports

Service providers acknowledged that many users of their services required various kinds of support services such as childcare, transportation, language or interpreter

services: "Regularly we have people who can't make it to group because of childcare". All of the agencies suggested that there was no "formal" mechanism to address transportation or childcare needs. However, the agencies could talk about informal ways of helping women and their families to access the agencies. Service providers at mental health agencies noted that agencies seemed to have bus tickets that could be given out on request, and that individual workers tried to find ways of addressing barriers faced by women and their families when they were trying to access programs and services: "We have some small capacity to support that childcare stuff...it isn't come on down...bring your kids...which is what you need"; "I think we mostly do things on an ad hoc basis"; "Again, if we have something specific, a one to one situation, personal service contracts, if you know ahead, someone to help out with money that way...done on an individual basis". In short, agencies' staff members were resourceful and tried to ensure that clients had access to services. Nevertheless, this was all informally done:

> If you buy something, we reimburse, informally, so that we can get the money....but we haven't had a formal system...I think we have some openness again to...if we set up a system and have ideas, for it to happen...but there is no formal [system].

This might prove more difficult for some immigrant serving agencies. Settlement agencies had more capacity to assist with transportation and childcare but these were subject to budget and funder constraints.

Service providers all raised the issue of language barriers. Karen, a service provider in a rural community felt that that her agency could not guarantee that there would be interpreter services readily available: ".I couldn't right off say if you were from

an oriental language [for example] that it would be easy to find … I cannot guarantee or that one would be available in a reasonable [timely] way". This seemed easier in the larger urban centres but the lack of awareness among staff about how interpreter services were set up meant that immigrant and refugee families were not always benefiting to the maximum. That is, not all service providers were aware that there were interpreter services attached to their own health region.

Generally speaking, all service providers were aware that one way to ensure that immigrant and refugee women use community services was to address any barriers or access issues. Nevertheless, actually addressing these barriers was reliant on the attitudes of managers and workers at the particular agencies. For example, at smaller agencies in particular, directors and managers who were strong community organizers and advocates canvassed a variety of resources for help. Overall, both workers and managers at small community agencies spent a lot of time fundraising and searching for resources to provide the kinds of supports that they felt were necessary.

Providing an attractive and welcoming service

There were general concerns that the generic services would not necessarily be welcoming and attractive to immigrant and refugee women. Service providers thought that their agencies had some responsibility to find a way to reach out to immigrant and refugee populations: "We would have to do a lot more"; "Work hard to recruit women coming from different cultures"; "Unless the woman makes an effort to come to our group…we aren't doing anything". Another concern related to the way in which services have been delivered. One service provider in an agency that had been involved in a project with

immigrant and refugee families said that she was now receiving requests for service because of the relationships that had been built:

> One of the other things.... it's been a bit of a challenge to be able to do work with clients that have wanted to access service. I book service hour after hour...it does not make sense to them to come here...[they say] why not come to my house...it's been a bit of a challenge....to have a bit more space in my calendar to do it.

That is, even when some relationships had been made, the recognition was that the traditional clinic model was not necessarily an approach that fit for immigrant and refugee women. The issue of time was continually referred to and/or alluded to as a potential issue: "It (the traditional counseling approach) is very time centered. That is a cultural thing we have in this culture and others may not be affected by time in that same way".

Other comments also suggested that immigrant and refugee women might not be comfortable using the existing services. Others were more adamant: "The group program is really full of barriers for immigrants and refugees and we haven't addressed that....so I don't think we are doing very well...we haven't...I don't think we are doing very well". Another participant suggested:

> I don't think by but by how the services are organized, I don't think this would be a place where they would come anyway. Even if there were families here ..I think it would be kind of hard for them to come into this agency.

Service providers identified other issues such as the scheduling of groups and other programs and services: "There is a cost attached. There is a ...we do have after-hours programming but ... a lot of it so people who have new jobs are much more likely to need something during the day". Workers suggested that often programs and services were

scheduled to meet the needs of service providers and not the individuals and families: "In some ways it speaks to the way we frame the work we do...we see ourselves as ...therapeutic or whatever . We do this during the week".

Service providers identified accessibility in terms of the factors that facilitated the process to attract and welcome immigrants and refugees to traditional mainstream mental health agencies. These would include factors such as transportation and childcare as well as the issue of the way in which services are delivered, the location, and the times of services. Overall, service providers suggested that the current model of delivery might not fit for many immigrant and refugee women and was perhaps a major factor explaining why women did not use services. Chapter 9 includes discussion about the recommendations made by service providers about the ways in which services can be better developed or delivered.

How does the process of developing services and programs get started?

A related theme to the above discussions was the question of how programs and services would get started. For example, one service provider had no recent recollection of her agency being asked to provide services in the area of domestic violence specifically for immigrant and refugee people. Another worker in the same agency remembered conversations several years earlier, but with no follow-up. Another noted: "Just to go back, I just wanted to say that in my experience I don't think I ever recall us being asked to do anything specific to immigrant or refugee populations...in the area of violence". Service providers suggested that agencies needed to do more outreach in the community:

"Just putting a sign up: we are doing a group for refugee and immigrant women for family violence...just come up...I think it has to be more than that".

Service providers also noted that getting ready to do this work with immigrant and refugee women involved preparing both service providers and immigrant and refugee women. This meant that service providers needed to begin to talk more intentionally with immigrant and refugee serving agencies about what they are hearing and observing. It also meant service providers "finetuning" their facilitation and intervention skills.

> It's true...I am thinking we do need to be talking to agencies ....about what they know their folks are saying.

> We would need to have conversations with other agencies...to get ourselves ready to do that work...how [we need] to be recognized with other communities that we are a resource.

However, more than anything else, service providers felt that the getting ready stage would need to involve teamwork between service providers and immigrant and refugee women since they were both learning about how, and preparing to address the issues:

> Basic education for people facilitating and I think also for the women who are involved...I would think they would need some kind of understanding of what is going to be addressed and sort of maybe develop their own ideas if this is s something they are living in ...whether it's the parent or not...I think it is something they have to be willing to be part of ...for us to also understand where we are coming from.

Other workers stressed that agencies could not expect that all immigrant and refugee women would necessarily be ready to fit into existing groups. That is, in some cases, there would need to be some bridging work: "I think so much work would have to go in...I don't know...the work would have to go in before hand because...I don't know why I feel that there would be barriers for some of these women". Another participant added:

> Where we are coming in having pre knowledge of what violence is, the do's and don'ts of all of that and I feel they may not have that. And to present a group might look like.a bit...I am not saying they aren't all educated...but not....not even the basics being there.

With respect to accessibility and capacity, service providers in mainstream mental health agencies reported that they had limited experience providing services to immigrant and refugee women. They knew they had knowledge of issues such as trauma but felt that the sporadic contact with immigrant and refugee women gave them limited opportunity to develop the knowledge and skills necessary to work with the immigrant and refugee women who were coming from what service providers would define as non-traditional source countries. Service providers brainstormed about ways of reaching out and providing service to immigrant and refugee women. They discussed some of the barriers to accessibility and suggested that addressing the barriers to access in a more formal manner would enhance accessibility. Several immigrant and refugee women expressed lack of faith in the ability of the service providers to help them. They did not necessarily identify barriers to their using services in terms of transportation and childcare, but rather in terms of their perception of the knowledge or lack of knowledge of the issues that they lived, in terms of the stigma of mental health, and consequently, in terms of the where and

how services were located and delivered. In addition, immigrant and refugee women did not express their needs in terms of mental health services but rather in terms of support, the need for sites where they could meet other women and share stories, and in terms of being able to go to agencies where they could find practitioners who came from similar ethnocultural backgrounds. While women talked about non-formal services they used, they also recognized that there would be times they would need more formal services. What was important was knowing that there were practitioners who were competent and able to address their needs when they needed them.

A consideration of the concept of multicultural processes would lead one us to begin to explore the different cultural contexts from which immigrant and refugee people come. This would mean awareness of issues such as language, kinds of helping approaches, family backgrounds and cultures, and attitudes to women. It would also mean an awareness of issues that occur within Canada as women begin to create home. What are the different values and beliefs that intersect, what are women's experiences within the home, community, workplace, and in other areas of their lives? The discussions with practitioners suggested that they had been able to reflect on the relevance of these ideas to the topic of service development and delivery. However, practitioners would also have to be reflect on stereotypes and to remain committed to recognizing diversity among and within groups.

Chapter 9

Data findings

Recommendations for other models or ways of providing programs and services

Introduction

The recommendations made by service providers and immigrant and refugee women suggested that there needs to be a multidimensional approach to mental health service provision. The benefits of using a critical multicultural theoretical framework in the analysis of the findings is that I have been able to listen to participants and learn about their values and beliefs on a variety of issues, but more specifically on the topic of mental health. Figure 1, *Multicultural Processes,* which is presented on page 216, illustrates several key factors which make up this concept of multicultural processes. Chapters five to nine provides details about women's experiences within community and about the relevance of values and beliefs to how services and programs are developed and delivered. Figure 2 *Multicultural structures* (located on page 240) describes some of the responses (policies, programs, services) which may be developed in response to the findings related to multicultural processes. The list of responses suggest that practitioners and policy makers may recognize the various options if they also recognize the diversity of experiences, and that diversity of experiences will mean diversity of responses. Again, this is consistent with Baubock's catalyst, that existing systems will have to change.

There were some common themes among the recommendations:

- Taking the services and programs out to communities;

- Encouraging more collaborative and partnership work between immigrant and refugee serving agencies and mainstream mental health agencies;
- Learning from lessons of working with Aboriginal communities.
- Proactively recruiting individuals with the knowledge and skills to address the needs of immigrant and refugee women; also recruiting individuals from within the immigrant and refugee communities.
- Exploration of ways of working with the family as a whole, especially in areas such as violence against women and children.
- Turning the system on its head.

Taking the services and programs out to communities

As stated throughout this dissertation, few immigrant and refugee women actually use traditional or mainstream mental health services. Mental health agencies were a resource that appears to be underutilized, despite the fact that mental health service providers have certain knowledge and skills that may be useful or relevant to immigrant and refugee women's needs. This does not mean that immigrant and refugee women do not use any kind of resources to take care of their mental health needs. In fact, the responses of the women interviewed, as well as responses of service providers suggested that there were many resources that were being used: settlement agencies, immigrant and refugee serving agencies, faith and spirituality communities, organizations, friends, other community resources. One of the recommendations of many participants was that mental health service providers needed to go to the sites frequented by immigrant and refugee

women. In that way, mental health practitioners would be a resource to other sectors and agencies.

The following sections describe some of these sites and include recommendations about how to bridge the gaps between immigrant and refugee women and mental health service providers.

Faith Communities

One of the service providers, Melanie, suggested: "And that is another aspect, the faith of the people, we have to recognize the faith of the people. No matter what religion they come from, I think our faith is a stability that everybody carries with them". Other service providers had similar comments:

> I believe there is need for mental health services. I mean that there is, is a whole more distress in the lives of immigrants and refugees. But I do not believe the prevalence of mental illness is greater in these communities than anywhere else. They [immigrant and refugee women] have been very creative in building enclaves of support and doing like turning to things like turning to spirituality and all that to decrease the impact of this distress. So there is an enormous degree of resilience, despite the fact that there is distress.

Several immigrant and refugee women made similar comments. What I heard was that faith and spirituality were extremely important aspects of women's lives. This was one of the most important elements that helped them to cope:

> I have seen the difference of people not having the tight support system and those [that] have had. I can compare those two people. And then having association with

the Church community, association. But it depends too. Even if you belong to all those places, do you feel you are a part of them: belongingness, association to any women's groups? But you have to feel at home, you have to belong there.

Even while women were identifying the importance of faith and spirituality communities, they were not naïvely thinking that every connection would be positive. Therefore women also spoke about the need for genuine and positive support: "For one thing what survive me here is the strong social support network, whether from the church [or] from friends. And you then you surround yourself with positive people"; "I am the same thing, when you come here you have to get your support from friends, or community, churches, whoever will come around you to help you to be yourself, then it would be good".

Reliance on "Church", "faith communities", or "spirituality" was a dominant theme in women's lives and across many ethno-cultures:

> If we have problem now…we have gone around and said- family, friends, community. To be honest with you, with all these people in this room, this is our social support; we will say this is the social support networks. Let's say, you don't have me, where else can you go? The church is very big. That's one thing I can say if we have problem. Here the church is one of the major sources of help. Because back home if we have issues, the first person you think about is the family, and if the family is not meeting you, then you can involve the church. Here you can call family on the phone. But it is not the same, it is different, you have your community. It depends if you are free to speak to that person. The church is there. Then the church depending on how free you are with the pastor. The church is

quite within reach. I don't remember any professional services back home that somebody will go to for mental health. When you get to be mental health people, you go to the psych ward.

One woman explained that sometimes women would not go for help from within their own ethno-cultural community because of confidentiality issues, but would go to their faith or spiritual leaders, or someone in the church who is slightly removed from the ethno-cultural community:

> And it depends...even though we are all ... [name of continent], how comfortable is [Patricia with] me. So [Patricia] will [be] thinking, well, I am having issue with my husband at home. Will I be comfortable talking to [Lorraine]? And to [Sylvia] without the whole world knowing what I am going through? [Patricia] will end up staying in that house and be killed. In other words, sometimes [Patricia] will prefer going to the White person that she knows in church that more or less will look at her as a human being and whatever she says with her is confidential.

Faith communities and spirituality were not new resources for women but were obviously long integrated into women's ways of helping themselves. During interviews therefore, the conversations with different participants could include discussion about spiritual healers, pastors, church leaders, or any other kind of faith or spiritual leaders, reflecting the range of cultural pasts and traditions.

Immigrant and refugee serving agencies as well as other community based services

Another site identified as being frequented by immigrant and refugee women were community based settlement and integration services and other non-profit agencies.

Mental health service providers accepted that this was occurring: "I think places like Open Door Society and some of the other NGOs also do some of the front line stuff". Several participants recommended that mental health service providers begin to provide services within these agencies in a more formalized way. According to service providers, the idea would be to:

> Bring services to where people feel more comfortable. Service to clients doesn't have to be specialized services but still it is more accessible than coming here. [The] majority [area in Saskatchewan named] are immigrants, and if we could go over to them; see what is needed. But I like the idea. It is more accessible there than coming there.

Particular reference was made to taking services to settlement agencies since these agencies served very large numbers of immigrant and refugee people (particularly refugee people). This could take many forms. It could mean hiring mental health professionals at settlement and immigrant and refugee serving agencies. One serving provider in an immigrant and refugee serving agency suggested:

> And he or she should be one of the staff of this agency .... This person should help, should be introduce them to the proper places, proper area of treatment. It would be better if we had one psychiatrist, and if that person should be male or female. But we need that kind [of staff on-site]. Because it is very important for the new arrivals. So this is one of my suggestions. This agency would be able to hire such a person. It would be better, because in some cases they need psychiatrist, some advisor for the new arrivals. So it needs long time to make appointment with the psychiatrist or specialist.

This service provider and others suggested that immigrant and refugee serving agencies often needed to have a professional on site to respond to immediate situations and crises, or act as a consultant to other staff members. Participants noted that the waiting period for seeing mental health professionals was usually lengthy, and that more often than not, the agencies and clients would have benefited from immediate consultation from a mental health practitioner. Participants added that it was particularly difficult to get early appointments with psychiatrists. The suggestion to have on-site consultation seemed to fit with the perception that there had already been a level of trust built within the boundaries of settlement and immigrant and refugee serving agencies. These relationships would facilitate the development of relationships with mental health practitioners. Agencies generally tried to be flexible with respect to serving the populations so that even after some immigrants might have exhausted "eligibility" determined by funders, agencies would still try to respond to their needs.

Another suggestion was that mental health practitioners could operate as itinerant workers and be a resource to settlement and community based agencies. There was general recognition that immigrant and refugee women might be reluctant to seek services at mental health centres, but that several have already been using community based organizations for support. Service providers thought it would be easier for mainstream service providers to gain trust if they were on site at these places that were familiar to many immigrant and refugee women: "To add to that I see that consistency is very important; having the same person there because it takes a long time for people to gain trust and open up and share your feelings". One service provider noted that within more

recent years there had been discussions among agencies about having a mental health practitioner assigned to work with these agencies:

> We talked about what can be done and the idea at that time just died because everybody realized ...about funding. But the idea was to have somebody, social worker, whoever, psychologist who would be available to the agencies and who may not have an office in any of the agencies, but would travel from one place to another [agencies would know that] that person would be at that agency on that particular day, people get to know the person.

At least one service provider remembered that that kind of service used to be exist:

> That sort of thing did happen 20 years ago, probably on a small scale, funding back there was not the same as it was back then....I remember being approached to work in that kind of itinerant role ...I think that was spearheaded by the Open Door Society or some agency like that. I don't know whatever happened to that program, if funding was discontinued. It has been explored.

Mental health service providers in one focus group suggested that there were other professionals who were interacting with immigrant and refugee women and some attempts should be made to work with these professionals. For example, many newcomers see physicians. This was supported by immigrant and refugee women who talked about the supportive role of their physicians. A suggestion was that mental health practitioners could collaborate more closely with professionals like the physicians: "I think that it is people like the physician who may be actually frontline in that respect. And I wonder if some of the work that we need to do involves those front line workers".

The conclusion of many of the participants in this study is that immigrant and refugee women were not using traditional mental health services and programs and therefore, every effort should be made to take services to the people. This could take many forms: itinerant mental health practitioners, community educators, community developers, and consultants. In short, "mental health work" with immigrant and refugee women would take on different forms from what is currently conceptualized and delivered. That is, when service providers talked about taking services out to communities, there was a suggestion that service delivery should go beyond the confines of the traditional "mainstream" clinics or offices. "Communities" could include sites where ethno-cultural communities were, immigrant and refugee serving agencies where immigrant and refugee women formed new "family" relationships; and other sites where immigrant and refugee had built relationships. In order to make these changes happen, practitioners from traditional mainstream agencies were being asked to work more closely with immigrant and refugee serving agencies and with service providers in immigrant and refugee serving agencies. They were also being asked to work collaboratively with practitioners such as physicians and other health practitioners to whom immigrant and refugee women were already going.

Encouraging more collaborative and partnership work between immigrant and refugee people, immigrant and refugee serving agencies, and mainstream mental health agencies

Service providers from the various sectors (immigrant and refugee serving agencies, community agencies, and mental health agencies) spoke about the need to do more collaborative and partnership work with one another. Practitioners felt that a

community consultant role or community partnership building role would therefore be beneficial:

> If we could have someone who could make connections with community groups on an ongoing basis; somebody who would be able to go to [names of agencies] with the ESL programs, [go to] more of a variety of groups and we could be more visible and see people over there or over there.

In some areas, refugees were being housed in specific housing complexes and several participants wondered about developing services on site at these locations. One service provider noted:

> While I am not always happy about how people are ghettoized and put into one area or two or three areas, sometimes when you are offering programming that makes it easy because you can go to a certain housing complex.

It seemed that collaborative work between the school sector and the settlement agencies had already begun and service providers were enthusiastic and committed to continuing on this path. Mental health practitioners at one location felt that this was an area where they needed to get more involved:

> I don't think this is an easy solution but to some ways get to getting people where they feel safe. If that is within their cultural centres, giving information about services, about how we view mental health. A lot of people don't have that in their vocabulary. It [is] foreign to them; it's not something they have ever reached for from their family. How, how do you get that information out there? I don't know.

Collaborative work with settlement agencies and immigrant and refugee agencies could help with capacity building among mental health practitioners, and could be a way

to ensure that immigrant and refugee women receive professional help: "So maybe one of the things we should be thinking about is how Open Door has certainly got more expertise about settlement than we do and maybe we should be blending our services and resources there a little earlier".

Other practitioners had similar comments:

> If our staff, some of our staff might work with people in other agencies to provide programming and service whatever. I think that we could have talked about that in general terms with other programs more broadly but maybe in this way this is a way to build our capacity as social workers, and to be aware where people are, with other folks who maybe have a clearer sense of what the needs are

More collaborative and partnership work also meant working with and learning with immigrant and refugee women. This would include having a dialogue about values and beliefs that all the different players bring together in their process of interaction. As one service provider said,

> We do live in a global world and even our theories and our whole understanding of psychological health is based on Western theories and Western world view and Western way of looking ways of looking at things. I taught a life skills course [name of location] for a number of years and I learned so much from them because the psychological theories that we talk about and describe and are taught are so Western, how we view things about adolescents and things like that. It was wonderful to have their input to hear how that applied to their understanding. It's very interesting and very complex.

Immigrant and refugee women recognized that there needed to be greater dialogue and collaboration with practitioners and service providers who worked in the mental health field. They were willing to share their own knowledge about traditions, beliefs, and values relevant to their own ethno culture. They also noted that this kind of collaboration and dialogue would go a long way to enhance the delivery of mental health services and programs. They noted that the recruitment and retention of immigrants and refugees to the mental health arena would be tremendously beneficial to the mental health sector since these individuals could build bridges, help to raise awareness of the mental health needs and issues of this population, and build capacity within the agency.

Learning from working with Aboriginal communities

One of the interesting recommendations related to learning from the lessons of working with Aboriginal communities. Those service providers who had worked with Aboriginal communities kept returning to share examples of initiatives, programs, approaches that they felt worked and would work with immigrant and refugee communities. The major discussion related to the format: that community development and community support programs such as community kitchen programs, Kokum (grandmothers) groups were examples of approaches that worked. That is, developing programs that were based on mutual aid approaches, where women could come together in some kind of activity (cooking, sewing, craft), offered tremendous opportunities for women to come together, learn from one another, and support one another. The role of the mental health practitioner was to be the professional who would provide consistent

support, be available for individual support and counseling, or simply be part of the group that was driven by participants.

Practitioners knew that they had valuable knowledge and skills that could be helpful to the women; they would make themselves available as resources. They could offer direct intervention and support to individuals when it was appropriate to do so. In other instances they could make referrals, or get involved in lobbying or other advocacy work. Practitioners could also do community education: "Do more community education which is a small piece of the work here. Just watching the Aboriginal people attend and watching and light bulbs go on. Empathy developing and compassion". Therefore the roles varied. For example, this community education could address issues such as the impact of racism on mental health:

> I think there is a whole issue of racism in our community and the health region has not been very proactive in addressing it, and this has health implications. I think we could play a role in some community education.

Somewhat related to this was the comment made by at least one immigrant or refugee woman who suggested that there was a great deal of education and awareness work being done regarding cultural awareness of Aboriginal history and traditions. Presenters from within Aboriginal communities were making presentations to various groups about history and traditions and a recommendation was that similar presentations could be done by immigrant and refugee presenters. Participants realized that some presentations were already being done but felt that more needed to be done in this area.

There has been some recognition of the history of exclusion, marginalization, and oppression of Aboriginal peoples. This is the population that is often recognized as the

"Other" in Saskatchewan. Chapter 2 included some discussions about the history of Aboriginal peoples in order to highlight this history and to emphasize that there has already been experience with colonization and oppression and that there are lessons to be learned from working with this population. The experiences of racism and discrimination lived by Aboriginal, First Nations, and Metis people in Saskatchewan are unique and distinct. Yet, there are several reasons why awareness and understanding of this history is important when considering how to address the mental health and well being needs of immigrant and refugee women. First, it is important for newcomers to understand the history of the country to which they are now coming, and particularly the place of indigenous people in this history. Another reason is that while the experiences of racism, discrimination, and colonization as experienced by Aboriginal people are unique, there are lessons to be learned about the impact of assimilation and colonization on the mental health and well being of people. There has been some experience with trying to address the issues of diversity, racism, ethnocentrism. In addition, there has been some recognition that the current systems do not necessarily respond to the needs of Aboriginal people. I believe that some of the approaches (community development, community work, with relevant supports) that have been attempted with Aboriginal communities in Saskatchewan will be beneficial to other communities but particularly to immigrant and refugee women.

Proactively recruiting individuals with the knowledge and skills to address the needs of immigrant and refugee women

Participants recommended recruiting individuals with specific knowledge and skills to work with immigrant and refugee women. This could include non-immigrant or non-refugee professionals. It also included engaging individuals from within the immigrant and refugee communities to make presentations, and hiring immigrant and refugee people to work within the mental health arena. One step in addressing this was to ensure that immigrant and refugee people pursue educational opportunities in this field because as one woman said, "we need our own people who we will trust to take the training". Related to this was ensuring that attention be paid to ensuring that the process of registration for professional associations be user friendly for foreign trained newcomers with the relevant knowledge, skills, and experience. Another related aspect is that agencies begin to explore whether newcomers might come with knowledge, skills, and experience outside of the traditional criteria for registration, and that consideration be given to recruitment of these individuals since they might be able to make invaluable contributions to the multicultural health settings.

Several participants talked about integrating a community development approach and that the recruitment of individuals from within the immigrant and refugee communities would help in terms of gaining access to these communities. Having an "insider" (practitioners from within the immigrant and refugee communities) would have advantages of entering the community, and helping in the preparation phase prior to

entering communities. These individuals could help with community building or partnership work. One service provider speculated:

> If we had a certain amount of resources....I don't know what would fit there, whether a full time position or something like that, the equivalent. If we could have someone who could make connections with community groups on an ongoing basis, somebody who would be able to go to [community agencies named] with the ESL programs...more of a variety of groups and we could be more visible and see people over there.

A community development approach was seen as key to addressing women's mental health needs: "Because it is different work, it's different work than [what we usually do; it's [about] community, it's building community, out there and in here as well". Another practitioner expressed this community development in another way:

> The metaphor I use is that our job is to jog with people. We don't jog ahead of them [ ] or behind them. We jog with them. When they turn right left we turn left with them. When. Our job is not to turn them [to the right or to the left]. And it's an art to not be behind or ahead.

That is, many of the recommendations kept returning to the idea of building relationships and community building. Some service providers suggested that a logical step would be to have a diverse workforce to help in this process.

An identified benefit to hiring immigrant and refugee people was that these individuals could serve as role models, could generate trust and confidence, and could help bridge the gap between the different communities. One service provider speculated that there could be major benefits to hiring mental health practitioner from within the

immigrant and refugee communities because women might then feel more encouraged to use the services. This was confirmed by other immigrant and refugee women.

Exploration of ways of working with the family as a whole, especially in areas such as violence against women and children

One practitioner noted that she observed that many immigrant and refugee women were very family centered and wanted to be involved as a family. She suggested that this required a different way of providing services and that the families she met wanted to participate voluntarily:

> With my experience with the youth often they aren't with family. Correct me if I am wrong, but with the immigrants and refugees, it has been very much been the attachment to the family. So that right there is very different. The parent very much wants to be involved, and with this population [Aboriginal]...there isn't ...that's different too.

The well-being of children was identified as being very strongly connected to the mental health of immigrant and refugee women. While this might not be specific only to immigrant and refugee communities, it seems very evident with immigrant and refugee families. This practitioner felt that there were advantages to doing this kind of family work, and that working with one part of the family only has its disadvantages: "I would think the work would need to be done with the entire family because if one is moving this way and the rest aren't ...then it's like....how would that look?"

Another recommendation was that practitioners in the mental health field might explore working more closely in the schools. One practitioner said:

> I think one of the things we could be doing, is doing programming in some of the schools. I think that there are ways of doing some prevention work in the schools with the younger, the adolescent focus kids who have immigrated and take the programming out.

With respect to the issue of violence against women, immigrant and refugee women shared stories of situations when service providers were not helpful because they did not have adequate understanding and awareness of the particular community. All of the examples given by immigrant and refugee women were very connected to the notion that current intervention approaches were not adequate or appropriate. One of the immigrant/refugee women concluded:

> Again, the reason why our people don't go for help, I will tell you is because of the stigma. Me going to help from the White man. What can they offer me? No, the White man don't like me; he is only using me. So that the government can pay him or her money to deal with my issue.

In other stories the participants discussed how intervention with respect to the issue of violence was not well handled. The stories generally involved situations in which immigrant and refugee women recognized that there was a problem but they felt that practitioners seemed to be too quick to recommend that the woman leave her spouse.

In short, participants were suggesting that service providers needed to understand the importance of the family as a whole. There was understanding of the impact of violence and of issues of power. Service provided said they needed to consider different ways of addressing issues of power and abuse of power. Some women recognized that they were living within situations that others might define as abusive, but they had

generally come to terms with what they were living with, and how they would cope. They spoke about how there would be intervention by other women and members of ethnocultural communities when it was deemed by these to be necessary.

Turning the system on its head

One of the main observations that I made was that research participants focused on two primary sets of issues: women's experiences with settlement and integration issues; and refugee women's experiences with war and extreme trauma. Practitioners made a genuine effort to engage in critical reflection of their work. Several wanted to do the same work they had always done, but only in a different location. Other practitioners seemed to want to do the same work, but would add some new components to their work. Some felt that work with immigrant and refugee populations was quite different and were unsure of how else it could look. These recommendations have been discussed in this chapter and at other points during this dissertation. The final recommendation is one made by several of the immigrant and refugee women, and very clearly by one practitioner: this involved a recommendation to turn the current mental health system on its head.

One woman suggested that the entire system needed to be redesigned and that immigrant and refugee women should be part of the redesign process. The redesign would involve ensuring a system that had an ethnoculturally diverse workforce, taking services out to communities, and focusing on the issues that had a negative impact on women's mental health. Participants suggested that mental health clinics were not always the most appropriate resources for immigrant and refugee women. One recommendation from a practitioner was that one should not wait until there was a major crisis but that work with

women should start long before that: "So what do you do as an alternative? First of all we work with people to access their own strengths and you always facilitate those strengths way before they come into this place". Several participants had noted that they would use services when they were desperate. They recognized that they would have been experiencing some stress long before that, but would try to cope for as long as possible. Therefore, a big piece of the work that could be done would be prevention work to minimize the potential downward spiraling of women's lives. Thus, listening to women, and responding to their identified needs are important steps in addressing women's mental health needs. This would not necessarily occur within existing mental health settings but more within the settings already frequented by women.

Chapter 10

Analysis and conclusion

Introduction

The final chapter provides conclusions and recommendations based on the analysis of the data findings that were presented in the previous 5 chapters. This current research has added to my own understanding of how women get help to address their mental health and well-being needs. The research revealed that immigrant and refugee women have their own traditional ways of helping themselves and that here in Saskatchewan, they have found a way to use helping approaches that make sense for them. These include the use of community organizations, friends, family, faith communities, and spirituality. One way of responding to this information is to assume that women are coping, they are doing fine, and therefore mental health practitioners need not get involved. My response is to use the findings of this research to make recommendations regarding how professionals can support the existing helping systems that women use, and/or how they can provide service to a group that has not traditionally viewed mental health services as a resource for them. I also hope the findings of this research will have an impact on the way in which mental health programs and services are developed and delivered in this province, and perhaps elsewhere.

This final chapter builds on the recommendations made in the previous chapter. The theoretical framework has allowed me to ensure that particular elements are considered: application of critical theory, integrating gender inclusive analysis, integrating feminist analysis, and integrating an anti-oppressive perspective. In addition, I believe that strengths-based and empowerment approaches have allowed me to remember to focus on

the strengths of a segment of the population whose courage and resiliency can offer lessons to many other populations.

Chapter 3 provided an overview of the theoretical framework, critical multicultural theory, which has been used in the development of this analysis. The theoretical framework recognizes some of the tasks for critical theorists: engaging in philosophical discussions about human life and relationships; maintaining commitment to anti-oppressive and justice perspectives; integrating theory and practice; maintaining a commitment to social transformation, and engaging in action to achieve this. That is, critical theorists are committed to a process of ongoing reflection that would lead to social transformation.

Bronner expressed this commitment:

> Critical theory was always based on a commitment to freedom and the need for ongoing revision in order to confront new questions posed by new historical circumstances. Critical theory is perhaps best understood as what Theodor Adorno termed a "force-field," a problem-complex, composed of certain intersecting concepts. (Bronner, 1994, p. 322)

Bronner (1994) noted that critical theorists had hoped that this perspective would help inform anti-oppressive work. He wrote that critical theory had lost some of its allure and that it failed to "restore the connection between theory and practice" (p. 322). He concluded that one way to restore critical theory was to build solidarity with the disempowered, reaffirm "its forgotten materialist component and [reinvest] it with a practical interest in public affairs" (p. 322). Bronner also added that critical theory "must prove willing to confront power and offer criteria for judging how one response to

exploitation or oppression might work better for the exploited and oppressed than another" (p. 326). That is, as he noted, "critical theory must anchor itself in the structural imbalances of power defining the manifold contexts wherein subjectivity is put into practice" (p. 326).

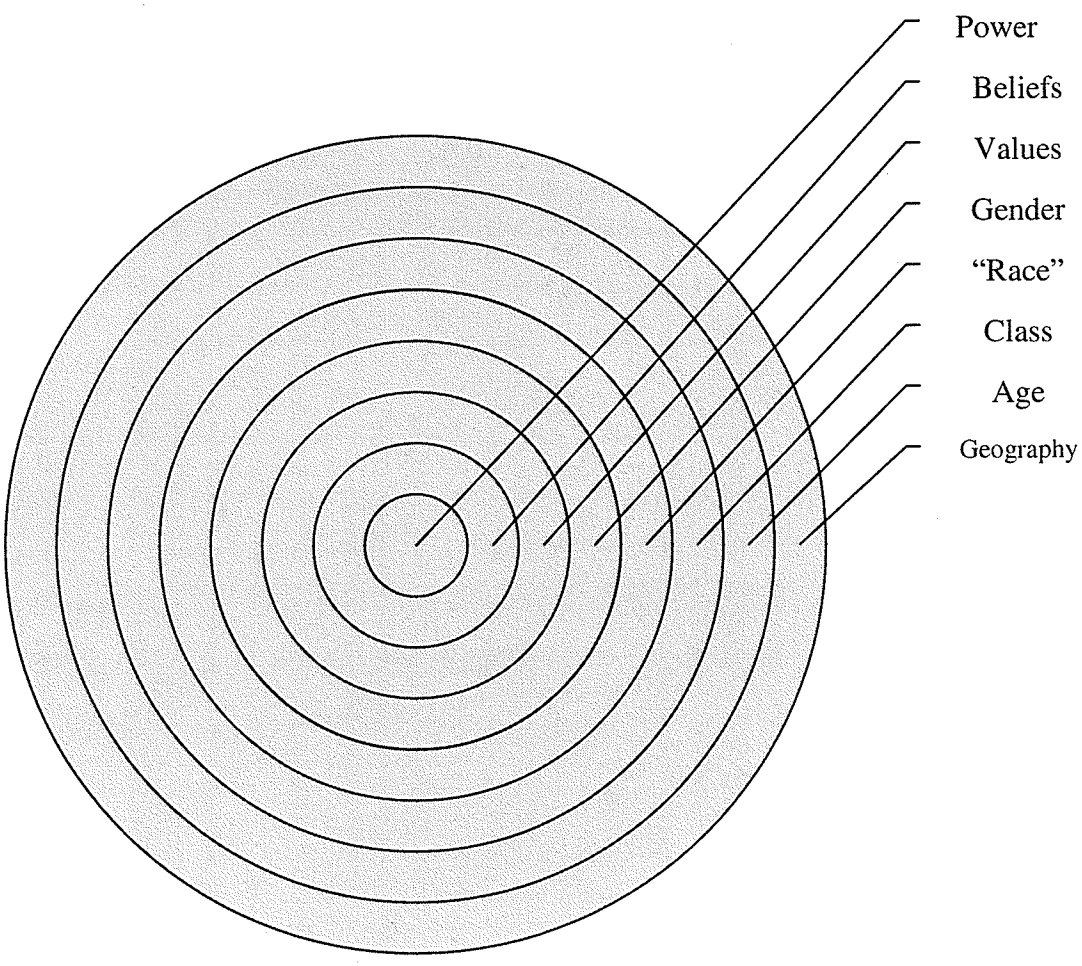
An important emphasis of this analysis is its focus on identifying issues related to power and equity. Another is on the recommendations to bring about change. Baubock's catalyst model has been useful to me as I began to explore ways of enhancing responses to immigrant and refugee women's mental health needs because it led me to think about how immigrant and refugee women's presence in Saskatchewan could have an impact on current mental health services and programs. That is, a recognition that change will occur as a result of immigrant and refugee women's presence in Saskatchewan, and also that this change could benefit the wider population.

The analysis will be organized using the concepts of multicultural processes and multicultural structures. The concept of multicultural processes recognizes the relevance of values and beliefs in the world, and their impact on the lives of people. The concept also recognizes the impact of globalization, travel, migration, and the reality of a dynamic world that is ever changing. The application of this concept in the analysis of the data provides opportunity to develop a critical understanding of the lives of immigrant and refugee women through exploration of the diverse factors that have an impact on their lives, and through acknowledgment of the changing and evolving dynamics within which they live. The concept of multicultural structures focuses on the policies, structures, legislation and other mechanisms that frame the context within which individuals live. Of

particular importance within this dissertation is a study of how the structures respond to the mental health needs that have been identified.

Overall there are several ways in which this theoretical framework can be help to mental health practitioners and policymakers. Figures 1 provides an illustration of elements of multicultural processes. Some elements are identified within the circles. I have made a decision to place some elements closer to the core of the circle (power, values, beliefs) because these play such a key role in this theoretical framework. As practitioners and researchers identify other elements, as society changes, additional circles can be added. Some elements may be placed at different points on the schema depending on what is happening at any given moment. Nevertheless, these are all intersecting elements and the main point is to be able to identify the elements that are intersecting. Figure 2, Multicultural Structures, also identifies a range of elements essential to this concept. I have chosen to put "counseling" at the edge, because I want to illustrate that there is a broad range of activities that can be done, prior to or in addition to the traditional counseling. By placing it at the edge, I have decentered it, allowing other interventions and approaches to have a more central place. Again, similar to the case of multicultural processes, practitioners can begin to add new elements as they explore new approaches and ways of intervention.

Figure 1- Multicultural Processes



Multicultural processes

Understanding the diversity among women

The service providers who participated in the interviews came from settlement, immigrant and refugee serving, and mental health agencies (health region agencies and other counseling agencies). Several of the service providers (especially those employed in settlement and immigrant and refugee serving agencies) were themselves immigrant or refugee women. The immigrant and refugee women who were interviewed came from a broad range of country backgrounds: African countries, Latin American countries, Middle Eastern countries, and South Asian countries. Women's lives were dominated by their caretaking roles. Many have had to cope with various experiences of sex discrimination, as well as violence including domestic violence, rape and sexual violence. They have had to deal with settlement and integration issues that all immigrant and refugee people may experience: language barriers, credentialing issues, isolation, racism and discrimination. Women described how they experienced these issues differently based on the roles and social status in communities, families, and workplaces.

Gingrich (2003) identified the importance of diversity when she discussed how "[h]omogenization processes" (p. 10) occur at all levels and involves the tendency to place individuals into one of two categories (dichotomizing) without recognition of the complex nature of issues, and the diversity among and within groups. The research highlighted the importance of recognizing diversity and complexity. The composition of the participants in the study is a relatively good representation of the current newcomer population trends in Saskatchewan. Each participant had a unique story, based on the dominant values and traditions of their countries of origin, reasons for migration, their family backgrounds,

their age, their educational and professional backgrounds, and their own unique personalities. Therefore, women came from a wide range of cultural contexts and their stories exposed the dynamic nature of their lives.

It would have been easy to make an assumption that each woman represented a particular country and that we could then make assumptions about the experiences of women from that particular country. However, while there were some common themes, for example, the importance of extended family and community to the lives of women coming from African countries, it was important to listen to the individual stories and to recognize the interrelationship between community traditions, values, and beliefs, and the individual life stories of participants. Focus group interviews provided opportunity for the participants to speak to one another, to share their thoughts about similarities of experiences, and their own individual uniqueness. One example was an exchange involving women from the Middle East. Several of the women talked about how much they craved having strong friendships with other women. One woman in this focus group insisted that she did not need those kinds of friendships, again reflecting the unique personalities of each individual woman.

As indicated in Chapter 6, I had not expected that service providers would have been unclear about who was being identified as an immigrant. Many of the service providers wanted to state the limitations of their own practice with respect to seeing immigrant and refugee women as clients. They noted that their current client population did not necessarily reflect the growing diversity within the province. Their perception was that their clients traditionally came from European and Western backgrounds. Service providers generally believed that they were ill prepared to address the needs of newcomers

from non-traditional, non-European, and non-Western backgrounds. Their perception of who the newcomers were did not fully reflect the reality of the lives and backgrounds of many of the newcomers, mainly because service providers did not always fully acknowledge the diversity among women, and the impact of globalization and travel on the lives of these women.

Again, this is reflective of the "homogenization" that Gingrich talks about, and the tendency to set people into one of two camps. In this case, the practitioners would often recognize that there were individuals who came from cultures that were predominantly Westernized, and they put all others into an "Other" camp. Several of the comments, while coming from well-meaning practitioners, could also be interpreted to be racist in essence. Nevertheless, in most of the situations, what I heard was that practitioners wanted to acknowledge that there were realities different from theirs and that they wanted to find ways of accommodating and working with these different realities and cultures. These situations were somewhat different from those comments that seemed to assume that different meant less than. One contribution of critical multicultural theory is the naming of diversity in culture, values, and beliefs and the recognition that individuals bring these elements of diversity to every interaction or meeting. Therefore, practitioners are challenged to consider their own cultural backgrounds, values, and beliefs, as well as their assumptions about others, and then begin to explore ways of working with individuals coming from backgrounds that are different from theirs. In addition, practitioners are reminded to remember to consider the relevance of factors such as ancestry, "race", and gender.

As already noted, the racialized immigrant and refugee population in Saskatchewan is small but certainly developing. Service providers were generally accustomed to working within a dominant Eurocentric culture. The "minority" populations with whom service providers have had most contact have been largely Aboriginal, First Nations, and Metis. Contact with racialized immigrants and refugees has been minimal. The comments from service providers about racialized immigrants and refugees tended to be expressed in "othering" terms. In some instances, comments seemed to be sparked by ignorance about newcomers from developing countries and from non-source countries. In other instances they seemed to be influenced by ethnocentrist attitudes; and in others a belief that the cultures were different and that little attempts had been made to develop services and programs in a way that were most appropriate to the slowly evolving multicultural population.

I believe that there is a deep seated racism within Saskatchewan. This is a significant aspect of Saskatchewan (the case). Chapter 2 provided some brief discussion about the history of Aboriginal peoples in this province. That chapter described the evolution of immigration in Canada and Saskatchewan and described racism within immigration policies. Such literature did not always receive adequate showcasing. For example, the history of Blacks in Canada and Saskatchewan was not always accurately or adequately represented. Even more importantly, the history of oppression of Aboriginal peoples did not receive recognition. Instead, the contributions of the early settlers of European ancestry have traditionally received a dominant place in Saskatchewan's history. The marginalization and oppression of the "Other" while now recognized and

acknowledged, still continue because of the privileging and dominance of Eurocentric perspectives. This is evident in many of the comments by practitioners.

My analysis is that this is one of the characteristics specific to places where the dominant population is numerically of European ancestry, where ethnic and cultural diversity (beyond the diversity within this Eurocentric culture) has been slow to evolve, and where the racialized population is still numerically small and seemingly invisible. Nevertheless, I believe that many of the service providers who participated in the interviews were willing to explore, be confronted, and learn about anti-racist approaches to working with immigrant and refugee women. My analysis is that the service providers who did not (or who refused to) participate were those whose racism was more deeply set, and who did not appear to be open to reflecting on attitudes and on ways of providing best responses to immigrant and refugee women.

I raised the concept of citizenship in Chapter 2 because of my conclusion that as we continue to evolve as a multicultural society, we are going to have to address the issue of citizenship. Who is a citizen, who is truly a citizen? What is the responsibility of societies and communities to change and evolve in order to meet the needs of newcomers? This research suggested to me that our thinking in terms of dichotomies, us and the "Other" is about an assumption that the citizen is the one who manages to become easily integrated into a Eurocentric way of living and being, or into the dominant culture's way of being. However, Baubock's model as well as writings on anti-oppressive, anti-discriminatory practice suggest that the entire system needs to change or evolve. It can no longer remain the same. That our conception of citizenship must therefore change.

In many ways, globalization, colonization, electronic media, and travel have already been changing the world, and have led to varied manifestations of Western influences in many of the countries from which immigrant and refugee women are now arriving. The research revealed that immigrant and refugee women are influenced by a wide range of cultural traditions. The description of these traditions suggests that those countries that we might have assumed to be non-Western are themselves influenced by multiple traditions, including Western ones. For example, women coming from Middle Eastern countries suggested that professionals such as psychologists were becoming more recognized than in previous years because several had studied in North American settings and returned to their countries of origin to practice. In addition, factors such as living in urban or rural areas, class, occupation, and educational background are important in understanding the lives of immigrant and refugee women. This was repeatedly raised by women who emphasized that the experiences of women living in rural areas was different from those living in urban areas, especially as this related to access to and utilization of helping services.

In short, immigrant and refugee women have their own unique stories based on country of origin experiences and other life experiences and factors. These experiences are themselves influenced by macro political, social, and economic forces, and by other characteristics such as ethnicity, age, religion, family status and background, individual personality, economic background, social status, class, geographical location (including urban, rural, or remote), educational and professional background, and age.

Immigrant and refugee women in Saskatchewan

Service providers reported that at different times in its history, the province had welcomed waves of immigrants and refugees from various source countries. This allowed some sporadic contact, but did not give mental health practitioners much confidence in their skills with dealing with populations from non-European, non-Western cultural backgrounds. Service providers in rural areas recognized that immigrants and refugees preferred to settle in larger centres. This is consistent with information recorded in the literature review (Lamba, Mulder, & Wilkinson, 2000).

In Saskatchewan, communities with industrial activity attracted immigrants. For example, Wynyard, an Eastern Saskatchewan town community of 2000 at one time attracted a fairly large number of newcomers because of the Lilydale Processing Plant (www.quilllakes.com/wynyard). An observation made during the research was that some immigrants had purchased property and had moved to farming communities. Most of these appear to be individuals of European ancestry who seem to be making easy connections with other members of host communities. Again, this movement appears to be connected to the possibilities of farming which is another form of self employment (See Lamba, Mulder, & Wilkinson, 2000, regarding the high percentage of self-employment among immigrants in Saskatchewan.) That is, there continues to be a correlation between employment and settlement places of choice. The fact that many of the immigrant and refugee workers seemed to have relocated to Alberta suggests that financial rewards may be a primary goal for these individuals.

One reason for this may be that newcomers are not only taking care of those family members living in Canada but also those living in countries of origin and in

refugee camps. Immigrants and refugee people will continue to move in search of employment and they also move to places where they could raise families and build a sense of home. One aspect of retention is the availability of and access to support services. This is challenging for places like Saskatchewan where the immigrant and refugee populations have been particularly small, and where industrial growth is much slower than its neighbour's (Alberta's). These factors and others such as stigma and the attitudes toward mental health services have contributed to the low utilization of mental health services by immigrant and refugee women, and to the lack of opportunity for mental health service providers to build capacity to work with this population.

Understanding the contexts of immigrant and refugee women's lives

The 1988 Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees reported stories of immigrant and refugee people's experiences with respect to addressing their mental health issues. This next comment from the executive summary of that report captures the essence of that study's findings about the issues: "In Canada, negative public attitudes, separation from family and community, inability to speak English or French, and failure to find suitable employment are among the most powerful predictors of emotional distress among migrants (Executive summary)" (http://ceris.metropolis.net/Virtual%20Library/health/candian_taskforce/canadian2.html). The findings from my study reiterated these concerns and added some other aspects:

- That globalization has exposed the interrelationship between and among countries, that technology and travel have made communication between countries easier, and that immigrants and refugees are more aware of what

is going on in other countries. That is, television and radio have brought vivid pictures and stories of what is happening in other countries into homes in Canada; immigrants and refugees receive messages about fair and unfair trading practices through various media, and they learn about the impact of trade agreements on the lives of people in developing countries.

- That immigrant and refugee women who continue to play caregiving roles in families and communities, are particularly affected by stories coming from outside of Canada because technology and media have brought stories and news from abroad into homes in Canada.
- That violence against women and children continues to be an issue within immigrant and refugee communities living in Saskatchewan.
- That low literacy and language levels (resulting largely because of war, unrest, sex discrimination, and poverty) have become a major barrier to refugee women's full participation in their communities and in the programs in which they can potentially become involved. Thus, language and literacy skills are interrelated to the mental well-being of immigrant and refugee women.

Service providers talked about their perceptions of the very traumatic experiences that immigrant and refugee women have survived. The discussions related to two dimensions: one to broad issues of settlement and integration that have an impact on immigrant and refugee women's mental health; and another about the extremely traumatic experiences of refugee women coming from war affected regions, countries in turmoil, situations of violence, and poverty. Some women come to Canada as landed immigrants

but also lived through experiences very similar to those of refugee women. The issue of coming from war affected countries, and from countries where there was extreme violence, was a very important consideration when trying to understand the lived experiences of immigrant women and refugee women, and how these might have an impact on the mental health and well-being of newcomers.

The word "racism" was not often used by participants, even when it seemed to be under discussion (I have discussed my own analysis of service providers's attitudes earlier in this chapter). Those women who lived under an Apartheid regime had particular understanding of the impact of racism on their lives, and the triggers for them might be different from those who have not lived under such extreme regimes. When it was named, the message was that racism reaches the core of the person, and has the potential to destroy the person.

As I listened to practitioners talk about their interest in finding ways of responding to immigrant and refugee women's mental health needs, my assessment was that there was a lot of heart and commitment to doing this work. There was also theoretical knowledge of how to do anti-oppressive work. However, having been entrenched in a system based on Western traditions, values, and beliefs, practitioners were not always aware of the extent to which Western ways of doing and thinking were still privileged over other ways. Service providers discussed different ways of responding to immigrant and refugee women, but the dominant discussion about this often returned to the traditional clinic model, whether this meant encouraging immigrant and refugee women to use existing services, or taking the traditional clinic model out to agencies and community.

Understanding values and beliefs

Immigrant and refugee women spoke about the values and beliefs that were dominant in their countries of origin, and how each lived these experiences was based on a range of factors including age, educational background, professional background, rural or urban background, and economic status. These "potentially salient ethnographic, demographic, status or affiliation identities" (Pederson, 1999, p. 3) together influenced the different life stories. Some examples of values included respect for elders or seniors. This seemed to be one of those values that crossed ethno-cultures and country boundaries.

There were strong values about treating one another with dignity and respect. A shared value was the commitment that many of the women had about taking care of extended family, and their concerns for the welfare of extended family in countries of origin. Globalization, technology, media (including the telephone, television, internet, newspapers), and travel, all had an important impact on the ways in which women stayed connected with those other homelands. They were very aware of what was happening in these other countries and continued to feel pain, grief, and sometimes guilt because of the stories they heard. In short, stories of poverty, family crises, earthquakes, floods, wars, violence, and civil unrest continue to come almost daily to the eyes and ears of immigrant and refugee women in Saskatchewan, making the world a smaller place, and reminding many of us about how interconnected the world is. The geographic location of the province

While there is a great deal of literature that talks about women and caregiving in general (Neysmith, 1991; Baines, Evans, & Neysmith, 1991; Collins, 1998; Wood, 2001), the phenomenon of feeling pressured to help relatives "back home" has its own

significance for immigrant and refugee women. These pressures have their own unique meaning because of the distance from family and friends in countries of origin, and because of socioeconomic and political conditions of those countries. Many immigrant and refugee women are aware of the turmoil, poverty, and lack of opportunity that they often left behind. So while they have chosen to make Canada their home, their emotional ties to their homeland and often their connections to family members and friends in those countries, have an impact on their mental health and well-being. As already noted, travel, electronic media, including the internet and television, all contribute to enhancing communication across oceans, and maintaining the strong ties to other countries. Immigrant and refugee women have varied access to technology and travel that would help to maintain these ties. In addition to differential experiences with accessibility, some immigrant and refugee women may not have the financial resources to travel and be physically present with relatives and family in times of need and crisis. For example, inability to attend family funerals and be present in times of mourning adds another level of stress. The stress of constantly hearing about families living in crisis, as discussed in an earlier chapter, can be particularly painful because of the sense of helplessness and sometimes guilt.

Immigrant and refugee women's lives are characterized by an ethic of caregiving throughout their lives. This caregiving takes place in countries of origin, on the flight to Canada, and here in Canada. One of the challenges of taking on caregiving roles is that there is little room for immigrant and refugee women (like many other women), to take care of their own needs. Ferguson (1991), Reitsma-Street (1991), and Aronson (1991) have all discussed how women caregive throughout the life cycle. Immigrant and refugee

women would benefit from support in order to cope with their multiple roles, and in order to take care of themselves.

Since immigrant and refugee women do not always have the kinds of support networks in Canada that they might have had in countries of origin, caregiving might be even more stressful. The women's stories suggested that they had some support networks but did not always reach out because they knew that others had to face their own personal stresses. The discussions of the immigrant and refugee women reflected the extent to which their relationships with others, the daily interactions in their lives, and the process of settlement and integration have an impact on their mental health and well-being. Their sense of self and their identities are all interconnected with these other factors.

Values and beliefs about mental health

The interviews with immigrant and refugee women led to a shift in my own thinking and language. This included a movement away from the language and concept of "mental health", and instead, to a focus on "mental health and well-being". For many of the immigrant and refugee women who were interviewed, the term "mental health" still had very negative, stigmatizing meaning with a strong biopsychological foundation. Traditional mainstream mental health services were associated with negative meaning.

This stigma, which partly led to reluctance to use traditional mainstream mental health services, is not specific to immigrant and refugee women. In their 1988 study, the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees made similar remarks when they spoke about public attitude to using formal mental health services:

> People who are troubled often avoid formal mental health services, turning instead to family physicians or to family service counsellors, public health nurses, the staff of multicultural or ethnic community organizations, or second-language teachers. For example, of all contacts between majority culture patients and family physicians, 15 to 20 per cent involve a mental health problem. Although no data about the way immigrants and refugees use the health care system have appeared, there is no reason to believe that the proportion of time and effort taken up by psychiatric problems is any less than it is among the majority of Canadians. (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988)

The Canadian Task Force study also reported that only a small percentage of the population of individuals with severe mental health problems actually used the formal mental health system. This underutilization appeared to be even greater among immigrant and refugee populations:

> At most, only 20 per cent of people with mental disorders who need care actually receive it somewhere in the formal mental health system. While underutilization of services is a general problem, immigrants and refugees resist mental health care even more than majority culture Canadians. Ethnic groups in Canada avoid the mental health system because they feel that barriers impeding access to appropriate services are often insurmountable. They also feel that, even if they sometimes succeed in overcoming barriers, the treatment they receive is inappropriate or ineffective. These feelings are not confined to small communities or to recent arrivals. Large cultural groups who have been in Canada for generations also feel

disenfranchised from care. (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988)

The immigrant and refugee women who participated in the interviews understood what constituted their mental health and well-being and defined this in terms of how they lived and experienced all aspects of their lives, and how this impacted on their health. The experiences of being "woman" in countries of origin and in Canada, coupled with what this means as immigrant and refugee women experience migration, settlement, and integration are particularly important when considering the mental health and well-being of immigrant and refugee women. Their ability to celebrate their cultures, their identities, their music; their ability to realize their talents and potentials, their ability to live in equitable societies were all aspects of their mental well-being. Along with this is their realization that if these aspects are ignored or not achieved, the impact could have long-term negative health outcomes which could have been avoided. For this reason, women suggested that while they had not been using traditional mainstream services that they would like to know that these services were available to them when they reached a state of extreme crisis.

Several countries of the world have recognized the importance of considering the concept of mental health and well-being which has been defined by WHO as: "fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens" (WHO, 2005). Several of these countries have developed strategies to reflect this conceptualization that include a focus on goals such as addressing stigma, and access to primary health care (WHO Europe, 2005; Scottish Executive Health, National Programme

for Improving Mental Health and Well-being). In Australia, one initiative within the government's Department of Health and Ageing is a Program of Assistance for the Survivors of Torture and Trauma (Australian Government, Department of Health and Ageing, *Mental health and Well-being*, accessed at www.health.gov.au/internet/wcms/Publishing.nsf/Content/).

Immigrant and refugee women living in Saskatchewan conceptualize mental health in a way that reflects their tendency to approach their world in a very holistic manner. Their conceptualization is better understood by talking about mental health and well-being. They identified a range of issues as relevant to their mental health needs, and recognized how important it was for them to live in environments that were safe and committed to social inclusion. They also recognized the connectedness of the world and acknowledged their connections to other countries and how much what was occurring in other countries was relevant to their mental health and well-being. Conceptualizations of mental health and well-being, as already explored in various European countries, can be used to advance conceptualization of mental health and well-being in Canada and particularly in Saskatchewan that will be more relevant to immigrant and refugee women.

The research interviewees continually suggested that it was important to talk with immigrant and refugee women and with those who have worked and lived closely with women from the immigrant and refugee communities. Mullaly (2002) talked about the challenges facing practitioners because they are often unaware of the extent to which their own experience and culture influence their work:

> Feminist, post-colonialist theorists, and black liberation philosophers, among others, have identified a different form of oppression- cultural imperialism. This

> form of oppression comes about when the dominant group universalizes its experience and culture and uses them as the norm. Through a process of ethnocentrism the dominant group, most often without realizing it, projects its experience and culture as representative of all humanity (Mullaly, 2002, p. 46).

Therefore even when we think we are aware of the issues of oppression and are committed to an anti-oppressive perspective, our Western values and beliefs dominate and lead us to developing structures that do nothing to bring about social transformation. As such the systems and structures do not evolve to meet the needs of immigrant and refugee women.

The conclusion of this research is that a conceptualization of immigrant and refugee women's mental health is best expressed through the concept of mental health and well-being, as reflected in the discussions with immigrant and refugee women. This conceptualization of mental health and well-being will provide opportunity to develop an awareness of the importance of identifying the elements that will promote good mental health, the barriers to good health, the elements to address in policy and practice that will counter these barriers (prevention), and the range of mental health needs among immigrant and refugee women. That is, the conceptualization of mental health and well-being presents a more holistic approach to immigrant and refugee women's needs. The provision of opportunities or a forum to learn from and learn with immigrant and refugee women is vital in achieving such outcomes.

Overall, the research consistently revealed that the term "mental health and well-being" seemed to better speak to the reality of women's lives and to how they would conceptualize the integration of the "mental". One of the comments that I heard from these women was that they were coping and that they would go to a mental health practitioner

only when things got desperate. This may not be very different from the bulk of the non-immigrant, non-refugee populations. While many of the experiences can be extremely traumatic, or relationships may be extremely troublesome, women have become accustomed to surviving and taking care of themselves and others.

Refugee women

While immigrant and refugee women all experience traumatic experiences, we have to recognize the unique experiences of refugee women whose lives have been so full of pain and turmoil. As research participants noted, many of the more recent refugees are arriving with language and literacy issues, have suffered many losses, are often ill prepared for being heads of households and lone parents, have survived horrific violence, and these experiences have lasted for several years.

Some research participants suggested that refugee women may perceive their experiences to be so different that they may not want to participate in existing groups because they are ashamed, or they fear that mental health service providers will have no understanding of their lives. As one woman said, "you have to explain too much". Women continue to caregive and to go about their lives without great expectations that they can be helped, or without any awareness that they have mental health needs. If they have heard about mental health centres and if they understand that they are resources, the stigma of "mental health" may be a barrier to their reaching out for help, and their own conceptualization of their needs may not fit with their perceptions of what the existing centers offer. Fear of the unknown, trust issues, fear of authority figures, lack of faith in

mainstream, non-refugee, Euro-Canadians mental health practitioners to help might be additional barriers.

Service providers from traditional mainstream agencies generally felt they did not have a strong knowledge of the cultures of many of the immigrant and refugee people who were now arriving. My own assessment was that the "cultural" piece related to their actual experience with working with refugee populations from backgrounds that they perceived to be significantly different from theirs. That is, they had theoretical knowledge of what the issues were, they had strong generic counseling skills including skills in working with survivors of trauma and violence, they had a willingness to learn and to build cultural sensitivity, but they had little experience with actually working with a wide range of refugee populations. So "having the cultural piece" was also about knowing and understanding the different cultural contexts from which refugee women came, and knowing and understanding the values and beliefs of refugee women. Another challenge would be to be aware of the diversity among refugee women because of the tendency to see all refugee women in terms of oppressed women or women living in subordinate positions. A particularly significant aspect of "having the cultural piece" involved actual experience interacting and working with refugee women.

Workers in settlement agencies identified what they saw as emotional needs (post traumatic stress responses) among survivors of trauma and violence. These workers had daily interaction with refugee women and generally had the "cultural piece" that mental health service providers were reporting that they did not have. It seemed to me that more intentional partnership between immigrant and refugee serving agencies and mental health practitioners would benefit both sectors (immigrant serving agencies and mental health

agencies). This type of partnership would go a long way to address the mental health and well-being needs of this population.

As noted in the research findings, and in the literature review, women may come from systems that are non-Western, have a mix of Western and non-Western traditions, may be dominated by Western traditions. Therefore, it may be easier for some to enter Canada, and the settlement and integration journey may be easier for these than for others. It follows that there needs to be a range of options including specific intervention to address trauma issues. For example, in one focus group interview, service providers were able to describe how one woman had been able to access and use their services without difficulty because she had spent some time in an educational system in Canada. This had served as a bridging mechanism. In another interview, women talked about the disconnect for refugee women who had lived in refugee camps for a long time, and that it would be difficult for these women to begin using mental health services immediately. That is, services need to reflect these varying circumstances, and need to be developed in a way that would make sense and would respond to women's needs. Again, doing work in community, at sites already frequented by refugee women, may help to build some bridges. Collaboration and partnership work with settlement and refugee serving agencies and groups would be a logical step for mental health practitioners. Some of this work may not take the form of "counseling" in the way it would be traditionally done, but may involve other approaches such as education work, group work, community development approaches.

Conclusions regarding multicultural processes

A challenge in defining and understanding the population is to be mindful of the diversity within and among immigrant and refugee populations. I drew on anti-oppressive perspectives on the topic of identities to help in the analysis of the issue of identifying the population:

> Postmodernism helps the anti-oppressive social worker develop a new politics of solidarity- one that pursues the idea of fractured identities where differences within particular oppressed groups 'are always given attention, contextualized with reference to their specific geographical location in the world, their class position, and their place within the structures of race and ethnicity...age, sexuality, and difference of ability (P. Leonard, 1995: 7) (Mullaly, 2002, p. 25).

Therefore, while there are merits in reviewing literature about particular ethno-cultural communities, it is also important to listen to the individual stories to understand where they fit within broad socio-economic and political contexts. By the end of the data collection process, I realized that I was asking about immigrant and refugee women's mental health and well-being, and refugee women's mental health and well-being. That is, I came away with more clarity about the similarities among immigrant and refugee women and about the unique characteristics of refugee women.

Through integration of the theoretical framework in the analysis, I concluded that even while I talked about diversity, I still had not adequately understood how the breadth of this term. For example, I realized that there were women who themselves did not consider that they had "mental health needs" because they knew how to find, access, and use resources around them. That is, there were women who did not feel that their status as

having come as an immigrant was a barrier to full integration, or posed difficulty beyond what the average person born in Canada experienced. In addition, there were women who were able to talk about having lived in many other places and countries, and for whom the migration process was not particularly daunting.

A focus on the concept of multicultural processes helped me to formulate certain questions: What are the values and beliefs that mental health practitioners and service providers bring to helping situations when interacting with or discussing the needs of immigrant and refugee women? What are the assumptions? The data findings have served to provide answers to these questions. Following analysis, I have concluded that interactions involve a coming together of individuals operating within a context of globalization. It is not as easy to talk about Western and non-Western traditions as easily as one might have done in the past. Therefore, practitioners have to be cautious about assuming that all immigrant and refugee women coming from developing countries are all coming from places with non-Western traditions of helping. There was some realization of the diversity among immigrant and refugee women. For example, service providers in mental health and counseling agencies talked about their work with immigrants from European backgrounds. When they talked about women coming from non-traditional source countries, they did not always name diversity factors such as class and social status in Canada and educational background which would make women's experiences different. One comment that several immigrant and refugee women who had lived in Canada for several years made was that when they returned to countries of origin, they were able to see the changes that had occurred with respect to getting help in countries of origin. Several suggested that psychology and counseling had become recognized professions and

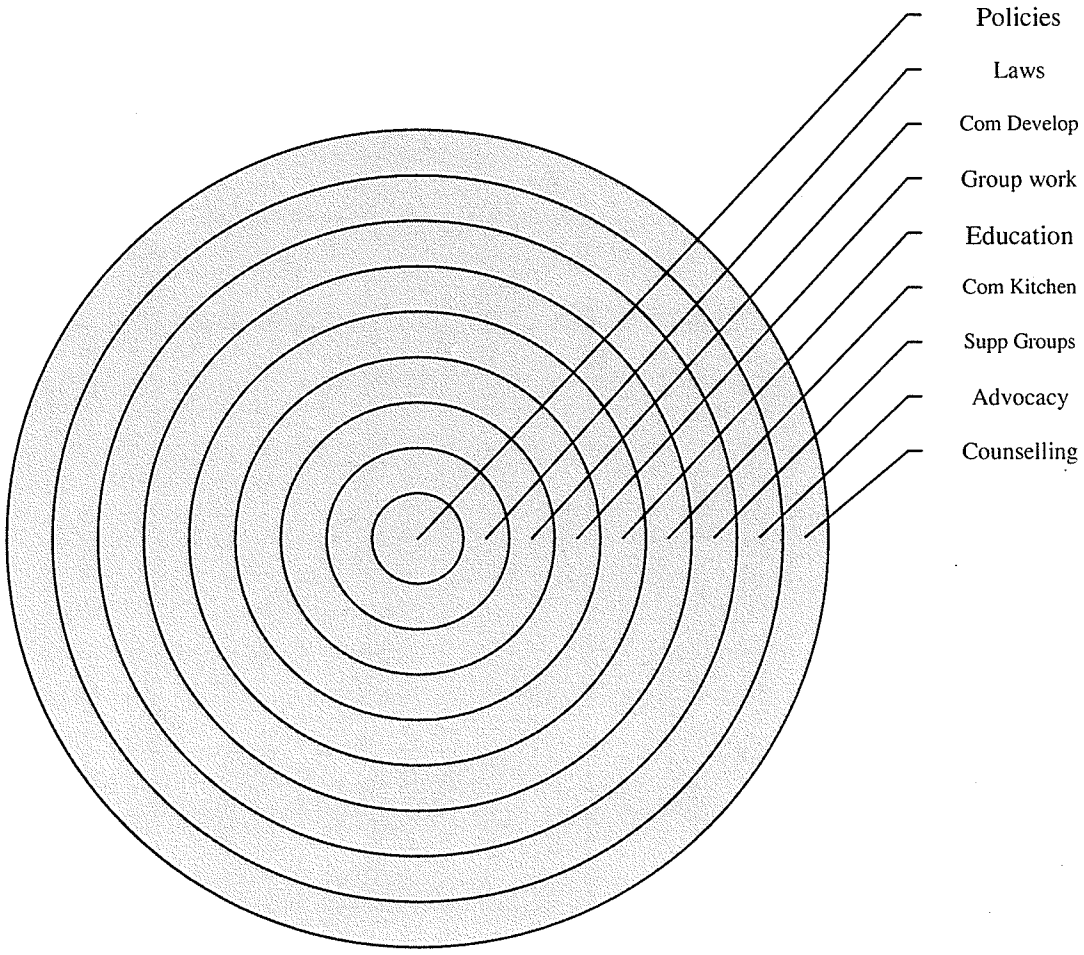
that young people in those countries were not as reluctant to use professional helpers. At the same time, participants seemed to be suggesting that women in urban centres were the ones who had access to these services and who were using professional services. One might also speculate that this clientele might be middle class. In short, participants acknowledged the changes that were occurring in their countries of origin. That is, cultures are not static, but that rates of change are varied within country boundaries.

I have continued to rely on anti-racist, anti-discriminatory, and anti-oppressive frameworks. These frameworks have reminded me that stories are not to be used to further "other", demonize and disrepute non-Western cultures, and cultures of developing countries. I used anti-oppressive and discriminatory perspectives to question whether I was considering all aspects of oppression and discrimination, and to keep returning to the task of critical theorists- to focus on justice and equity. Feminist perspectives assist with remembering to hear the unique stories of women, and to recognize the different accounts of women's unequal status in many countries of the world. This is an important aspect in the development of approaches for working with multicultural communities.

As expressed earlier, when I started looking at critical multicultural theory, I wanted to find a way to name the population under study (immigrant and refugee women), and the complex issues facing multicultural populations in Saskatchewan. I wanted to explore new ways of addressing immigrant and refugee women's mental health needs. Above all, I wanted to ensure that we maintain a justice, anti-oppressive perspective. That is, my primary focus has been on maintaining a critical perspective in the way that Bronner has proposed. This concluding chapter will continue to explore the role of service providers and agencies in facilitating the healing from these traumatic experiences. The

next section of this chapter will continue to focus on the structures needed to address women's mental health and well-being needs.

Figure 2- Multicultural Structures



Multicultural structures

The concept of multicultural structures will be used to do an analysis of the relevance of policies, legislation, regulations, and action to addressing the mental health needs of immigrant and refugee women. The review of the issues affecting the mental health and well-being of immigrant women and refugee women has described a wide range of issues including those relating to settlement and integration issues; and those relating to refugee women's experiences of extreme trauma.

The immigrant and refugee women who were interviewed generally explained that the term 'mental health' still held a strong stigma for them, and that its meaning seemed to be limited to a very medical conceptualization. Their own conceptualization of mental health and well being, as discussed earlier, was much broader, and therefore the conceptualization of how one would address mental health and well-being were also broad. Service providers also suggested that there needed to be different approaches to addressing the needs of immigrant and refugee women. There was some acceptance of the diversity among women and that there needed to be a range of options to meet the diverse needs. Most women had little experience with using formal mental health systems in countries of origin. This was similar to their experiences in Saskatchewan. The most prevalent helping approaches had been faith communities, families, extended family, and friends.

The findings suggest that in Saskatchewan, many immigrant and refugee women use ethnocultural organizations and immigrant and refugee serving agencies as well as other community agencies and services for support and to assist with settlement and integration. They also rely on some friends and family, and on faith communities. Women

did not have access to extended family support in the way they were accustomed to in countries of origin. Therefore, they did not have the same support buffers that would enable them to cope with stresses and emotional pain. Several women talked about how the telephone calls were a source of support but that the longer they stayed in Saskatchewan, the more these kinds of calls decreased as they learned to cope on their own.

A logical approach would be to ensure that the relationships between immigrant and refugee serving agencies and the mainstream mental health sector be formalized. Another approach would be to build relationships with other sites used by immigrant and refugee women. This would provide opportunity for service providers from the different sectors to come together to exchange information and develop mechanisms for program or service delivery. Some recommendations about how this might be done have been provided in the previous chapter.

I found Baubock's concept of a catalyst model of multiculturalism a useful one to consider when exploring helping models and approaches. Baubock's model recognizes that entire systems can change with multicultural contact. The first conclusion that I have made is that we need to recognize the specific needs of refugee women coming from war affected regions. The stories of refugee women are often about surviving and fleeing situations of extreme trauma and violence. These experiences have a major impact on the mental health and well-being of these women. All the newcomers (migrants) share similar experiences of settlement and integration. These issues have been described in an earlier chapter. Women experience these changes differently depending on individual life stories, and individual cultural backgrounds. It is important to consider how their unique

experiences as women affect their mental health and well-being. Women have been using other resources and mental health practitioner may need to begin to work with these resources and offer themselves as resources (some of these resources have been identified in the previous chapter).

The findings from the research interviews also revealed that while mental health agencies had built some competency in dealing with immigrants of European ancestry and backgrounds (acquired through years of practice), there was less familiarity with working with individuals from non-European countries. One reason for this was that the immigrant population prior to the 1970s had been coming primarily from European countries and so professionals had developed knowledge and skills appropriate to this population. Another reason was that immigrant and refugee women were not using the services in large numbers and so practitioners were still in the early stages of building knowledge and skills to work with this population.

Mental health practitioners will have to begin to think about the role they can play with respect to public education, or education outreach, facilitating work on the issue of violence against women, impact of racism on mental health, and other issues that are relevant to immigrant women and refugee women's mental health and well-being. That is, mental health practitioners have certain knowledge and expertise and they can work more collaboratively with other resources and systems to bring about change.

Another way of responding to the mental health and well-being needs of immigrant women and refugee women is to consider what have been women's traditional ways of helping one another and to seek to develop systems that make sense for women. Community kitchens, women's drop-in programs, support groups, activity groups such as

sewing groups and craft programs are examples of support programs and approaches that may be helpful. A mutual aid approach allows practitioners to draw on the strengths of women who have survived extremely difficult situations, and who can come together to learn from one another, and to support one another. This is consistent with empowerment practice, which recognizes working with individuals, helping individuals to connect with others in a group setting, and then working at a more macro level. The role of the mental health practitioner in these settings would include being a resource to these groups, providing individual intervention when necessary, and making referrals.

Several participants described initiatives and projects that had been attempted in the past. That is, there had been attempts to explore different approaches and models of service delivery but these did not continue because of lack of funding, lack of resources, or simply because other managers and administrators might have come along and not seen these as significant enough to keep them. Many of these new approaches have continued to be viewed as initiatives and have not been integrated into the core of mental health services and programs. As I listened to women talk about community and family meetings to confront an individual or individuals and the role of community in the lives of women, I also realized that the recommendation of one practitioner to explore use of wraparound models would make tremendous sense for many newcomers because this is about bringing together resources in partnership with the individual, developing a support network or "blanket" similar to what many women have traditionally used or had, and helping to build community.

Addressing human rights issues and bringing about change

On a macro level, there are several policy documents that state a commitment to equity for all women. These include the international Convention on the Elimination of All Forms of Discrimination against Women, and national and provincial policies such as Canadian Charter of Rights and Freedoms, and the Saskatchewan Human Rights Code. In general, women coming from developing countries come from contexts where many grassroots women have minimal, if any, understanding of these documents, of what are defined as human rights issues; and minimal awareness of the mechanisms to fight against human rights abuses. They often have little faith in governments to uphold these documents or to protect them from various kinds of gender based discrimination. This was evident from some of the comments from women who reported that they would not report incidents of violence against them in countries of origin because they did not think police would deal them with these issues. However, there were other mechanisms such as family meetings, community meetings, community shaming, which were sometimes helpful. Some women reported that at least one ethno-cultural community in Saskatchewan was using similar approaches to address some of the domestic problems being experienced here in Canada. These stories suggested that there were elders and individuals in these communities who would take a lead in these forms of intervention.

The situations of violence and the culture that formed the contexts of women's lives in countries of origin continue to exist in varying forms here in Saskatchewan. The findings suggest that the issue of violence against women will have to be addressed on many fronts: with men, with women, and collectively. Participants discussed how cultural traditions and expectations have been a barrier to change. Both women and men have

worked to maintain these traditions and so all sectors of the immigrant and refugee communities will have to be engaged in this process of change. There are currently several initiatives to address this issue. These have come following years of community action, mobilizing, and education. For example, the Global Gathering Place and Family Service Saskatoon have been begun work on a men's group that includes a focus on violence against women. This project is based in Saskatoon. The Saskatoon Open Door Society and the Department of Community Resources together have been running a women's support and have included the topic of violence within their weekly discussions.

Nevertheless, even while women in many countries are unaware of human rights policies, the literature reminds us that there are strong anti-violence, liberation, women's movements occurring within these same countries. Therefore, there is resistance. The literature has noted that women often felt that they have benefited from being in Canada because of the laws that exist to protect them. At the same time, an observation that was repeatedly made during the interviews in this dissertation research was about the lack of knowledge about laws and human rights, and that this information needed to be given not just during the first few weeks after arrival into Canada, but repeatedly after that. Simultaneously, I heard about the strength and power of tradition. In doing this analysis, I reflected on Bronner's comments that:

> Struggle is always embedded in tradition; its presence from injustices inherited from the past as well as anticipation regarding their amelioration in the future. Proponents of the new are always situation in time. Tradition is, for this reason, inescapable. It becomes manifest in the values inspiring their enterprise; it appears in the questions they ask and the assumptions they make. (Bronner, 1994, p. 330)

While many women recognized that they were living in a country where there would be some commitment to protecting their human rights, there was still a tendency to protect tradition, and often the very traditions that disempowered them. The messages to remain silent and the pressure to preserve and protect cultures mean that harmful traditions and practices continue to survive in countries of origin and in Canada. Silence and silencing are relevant to many other issues. That is, once we do not speak out about issues, the problems persist unchallenged. The risk is that immigrant and refugee women will suffer in silence, and may feel various levels of depression which may be treated with medication but the root cause of which remains in place. Service providers acknowledged the need to educate and lobby for change, and recognized the need to ensure safety for women.

These issues lead to tensions that have an impact on women's mental health and well-being. Agencies such as the Status of Women Canada have served as a "watchdog" and mechanism to ensure that women's equality rights are protected. At a time when immigration to Saskatchewan is being encouraged, and when women are coming from regions where women's equality rights are still on shaky ground, agencies such as Status of Women of Canada have a particularly important role to play through funding of research and action aimed at ensuring that the rights of all women are protected. Nevertheless, cuts to Status of Women funding in the fall of 2006 suggest that the federal government has little understanding of the impact of globalization and that global migration will inevitably change the overall picture of women's status in Canada. That is, Canada will need to continue to build awareness of the issues of women's equality rights, and has a key role to play in speaking out about what is happening globally to women,

since events occurring elsewhere will have an impact on this country and other more developed countries that are receiving migrants.

The case for diversity in the workforce

One of the comments that I heard from women was that they did not always have faith in the Canadian-born practitioners. They would like to see more diversity within agencies so that they could trust they would be understood. A few mainstream agencies in the province had already begun (ever so slowly) to make some changes, explore new initiatives, hire individuals with diverse backgrounds and with a sensitivity to working with ethnoculturally diverse populations. When mental health agency staff included individuals who had come to Canada as immigrants or refugees, or individuals who had particular connections to the immigrant and refugee communities, often those individuals influenced that agency's work with immigrant and refugee populations. These individuals were called upon to provide services (usually counseling) because they were perceived to have most relevant knowledge and skills. Nevertheless, these changes were so slow that they have had little impact on how the agency was perceived by immigrant and refugee women. As well, these changes are in their early stages of inception and so agencies have to be encouraged to continue on this path.

The mental health agencies where there was most promise were those agencies where there were practitioners who had migrated from different countries or who had worked in different countries. Because of their relationship with their ethnocultural communities and because of their knowledge of the communities, these individuals were able to share knowledge about cultural practices and traditions, act as consultants within

the agencies, and could provide direct service when appropriate. During focus group interviews these service providers brought a perspective that added richness to the discussions. They were also able to give both insider/outsider perspectives. For example, one practitioner explained why women tend to be reluctant to use services:

> A lot of people don't go out for help because as soon as somebody is experience[ing] mental illness among our community, like violence against women and it is right away attributed to the culture. ...But we have not begun to do the work on what happens when our cultures are racialized, how that racialization classes, silences us so we can't, don't talk about violence.

Another talked about the violence occurring within one ethnocultural community, and about the reasons why there might be silence:

> There are real tragedies in the [name of ethno-cultural community] community...people committing suicides and women being beaten up ...all kinds of things like that because there have not been a safe place and a place where women can go to have their needs heard...their concerns heard ...it is a very complex situation and I am not sure where they are getting that sense of community from or where the safe places are to talk ...because of some of the stigma too.

That is, these practitioners brought new issues to their agency "table", were able to share ideas about values and beliefs within various ethnocultural communities, and could help to engage in dialogue about the complexity of this work.

In all the cases, these individuals had brought with them a sensitivity and commitment to issues facing immigrants and refugees and the agencies were benefiting from the richness of the multicultural contact within their agencies. This also demonstrated the links between multicultural processes and multicultural structures: that multicultural structures can evolve in response to multicultural processes when agencies are open to learning and change. While it was important to recruit individuals from diverse ethnocultural backgrounds, it is also important to note that several of the agencies were gifted with Canadian-born individuals whose sensitivity, awareness, and willingness to continue to learn amazed me.

The focus on immigrant and refugee women-integrating gender and feminist analysis

A particularly difficult aspect of this research was to keep remembering to focus on the target population- "women". The immigrant and refugee population in Saskatchewan is relatively small and often it seemed to make sense to talk about the population as a whole, rather than what seemed to be a segment of a group that was already small. Some service providers like mental health service providers were not seeing immigrant or refugee people at all, so the questions about immigrant and refugee women kept moving back to "immigrants and refugees". I realized that this was acceptable as long as I remembered to include questions that allowed the participants to identify the specific experiences of women. This invariably allowed women to have a central place in the study. I believe that this is important because failure to do this will result in generic questions being asked that do not prod research participants to talk about the unique experiences of women. This is consistent with feminist perspectives.

Maintaining anti-racist, anti-oppressive perspective

Mental health practitioners come from a Eurocentric, Western, middle class background. They enter these situations with eyes of privilege and with assumptions of what is. I had the privilege of coming to Canada with some unique experiences and these have enhanced my own awareness that women from all over the globe have long been involved in struggles for equity. When I attended the End of Decade World Conference of Women in Nairobi, Kenya in 1985, I listened to women from all over the world, including the so-called developing countries, talk about injustice and inequity. I have continued to be involved in these international women's conferences and continue to see women from developing countries take the microphones to make powerful speeches about equity issues. So I am very aware of the need to walk with other women and to avoid disempowering them by making assumptions about their own understanding of oppression.

This research highlighted the importance of considering the concept of the intersection of oppressions. The interviews and literature together highlighted the diversity among women and that racialized women have additional layers of oppression with which they have to deal. I believe that women have learned to survive because they understand the roles they are expected to play, and the contexts within which these roles occur, and they have learned to survive. Yet, the stories of physical symptoms may also be symptoms of mental distress. Sometimes women too get overwhelmed with the daily task of surviving and coping. Another important issue was about anger. I believe that when we do not address the hurts that women experience that they may attempt to bury them.

However, anger may still appear in different ways and we have to begin to have dialogue with women about how they express anger.

The final comment is about the issue of depression. I heard the issue of depression raised many times by immigrant women, refugee women, and service providers. One of the very telling comments was that women would use medication for depression but when they went back to countries of origin, they stopped taking the medication, and were fine. Women were reporting that when they returned to Canada, they would need to resume taking medication. Several women suggested that the medication was not necessarily helpful. They felt it was a quick, band-aid solution and did not deal with root causes. I also heard that there were many situations where women seemed to be "depressed" and that this "depression" was not addressed. Depression groups might not fit for all women but women needed to be connected to some form of group or assistance that could be a bridge to other services that might become relevant some time in the future. That is, one concern would be the need to address situations of mental illness. Several practitioners suggested that greater collaboration needs to take place with physicians since refugee women and immigrant women would go to see these professionals.

A related concern was that women were not necessarily self-identifying when there was depression or they might be having extreme responses to extremely traumatic experiences. While women might not self-identify, their behaviours within the family, communities, among friends, and at the workplace might be troublesome for themselves and others. For example, employers might misread depression or withdrawal for lack of motivation, laziness, or professional incompetence. Employees might not recognize that their responses to past events were having such a negative impact on their workplace

performance. Friends and community members might misunderstand responses to racism and other kinds of hurt as anger and negativity. Intervention with immigrant and refugee women and with refugee women must take into account these complex realities. The integration of an empowerment approach offers possibilities to practitioners wanting to address these issues without engaging in oppressive behaviours.

Empowerment practice

The aspect of empowerment is a crucial topic on which to end this dissertation because I will be ending with a discussion about power and how we work with immigrant and refugee women, and with refugee women so that they can be empowered to live in equitable societies, and move toward the goals they set for themselves. An empowerment perspective recognizes that individuals who have survived oppressive conditions and situations, often have not had the luxury of thinking critically about their situation.

With respect to women's empowerment, and the process of gaining power, the literature has identified several important elements. One that is particularly key is the development of knowledge and skills for critical thinking and action. That is, empowerment practitioners are committed to processes that recognize the importance of sharing knowledge and the importance of ensuring that we all develop the critical thinking skills to allow us to make decisions about how we live in the world, about the kind of world in which we want to live.

Ingram (1990) pointed this out when he discussed how individuals can learn to accept their lives as a way of coping. Mullaly (2002) and Bishop (1994) have discussed internalized oppression and suggested that these are all approaches to coping. Therefore,

consciousness-raising, education, awareness, group work are all approaches that would be helpful in this process of building knowledge and the development of critical thinking skills. These activities may be done in group settings which will afford a sense of security and comfort. In other situations, individuals may not yet recognize the need for or want to enter group activities so they would benefit from individual work, or perhaps other media such as print and public education. Practitioners must continue to be aware of literacy and language issues and ensure that they accommodate these barriers. That is, practitioners must continue to explore working at different levels and always with recognition of the diversity among this group, and of the fact that many of these women who have learned to survive may not have had the luxury to stop and reflect on their world. Practitioners must be ready to walk alongside these women and be ready to challenge women respectfully, learn from them, and listen to how they can be part of the process to transform a world that has been terribly hurt.

If empowerment is about ensuring that power is not taken away from women, then it is also important to consider what kinds of structures would best fit for immigrant and refugee women, and for refugee women. If, as some practitioners and immigrant and refugee women suggested, women have had their own ways of helping themselves, how can practitioners provide service or play a role, without creating victims out of these women. A model for mental health and well-being that can shift away from relying essentially on a clinical model that helps those who attend individual or therapeutic group sessions, to one where the focus is more on strengthening community, that sees the shifts the focus or core of the model to the community and to an empowerment model may be most relevant in addressing immigrant and refugee women and refugee women's mental

health and well-being needs.

This holistic approach has been partly recognized by practitioners and policymakers working with individuals living with mental illness. For example, psychiatric rehabilitation services provide housing and other support needs. However, there is less concrete recognition of those who have not been given a label or "diagnosis". This rethinking of the way in which mental health services are delivered is relevant not only for newcomer populations, but to the Saskatchewan population as a whole. As the literature on empowerment and on anti-oppressive perspectives have noted, work at the individual level is an essential component of healing. Much of the work done at adult community mental health centres and at other agencies have relied essentially on a traditional "clinic" model. That is, philosophically, few agencies have shifted to believing that the work has to be multidimensional and that the "counseling" aspect should only be a small piece of the work that is done. This is the essential piece of paradigm shift that needs to take place before the agencies can be truly responsive in addressing the mental health and well-being needs of immigrant and refugee women in Saskatchewan. Those that do recognize the need for this shift are challenged by the reality that "counseling" and "counseling clients" bring in dollars to their agencies and play a major role in their financial survival.

Limitations of the study

A limitation of this study is the small number of participants who were interviewed. For example, I would have liked to have held focus group interviews with individuals representing a wider range of ethno-cultural backgrounds. Nevertheless, I

believe that the diversity of the participants helps to provide a relatively balanced picture of the different voices of immigrant and refugee women. This dissertation will add to existing research that focuses on the experiences of immigrant and refugee people in Saskatchewan (and specifically about immigrant and refugee women). I would anticipate that I will continue to do further research in this area.

Another challenge was maintaining a focus on "women" when the population as a whole is so small and when the needs of the immigrant and refugee population as a whole (men and women) were not addressed or inadequately addressed. Another equally significant challenge was that the immigrant and refugee population as a whole is small and it is difficult to focus on one segment only (women only). It seemed excluding to focus on the experiences of women since the mental health needs of men were equally ignored. As I engaged in conversations with the research participants, I often had to remember to ask specific questions that would provide information about the unique experiences of women. I continued to realize that women's voices would not be heard if we did not consistently think about gender inclusive analysis or reflect in a more integrated manner. Therefore, the focus on women does not mean that men's experiences are being ignored, but that particular attention is being paid to giving expression to their unique experiences. The theoretical framework allowed me to ask the questions that would help me to be critical and to reflect a gender inclusive approach, and to maintain a commitment to an anti-oppressive, justice-oriented approach.

Final comments

I had lived in Saskatchewan for about 4 years before I realized that there were settlement agencies such as the Open Door Societies. I was aware of the ethno-cultural associations because they would organize various kinds of cultural celebrations and events. I was aware of the AfroCaribbean-Canadian Association and of women's organizations such as the Congress of Black Women and the Immigrant Women of Saskatchewan because these reached out to women. I had long been involved in the women's movement and knew what to look and ask for (regarding women's organizations) when I moved into the province. I have come to realize that many immigrant and refugee women have limited or no relationship with organizations. There is some likelihood that women will become involved in activities of ethno-cultural organizations, and for many, these types of organizations offer some social support. On a personal level, my association with the Congress of Black Women and with the Saskatchewan Caribbean-Canadian Association helped to minimize some of the isolation I felt during my first few years in this province of Saskatchewan.

This academic journey to focus on the topic of immigrant and refugee women's mental health needs in Saskatchewan began with my Master's thesis work: *The issue of isolation as it affects Black women of Caribbean ancestry living in Saskatchewan.* In retrospect, I know that I hoped this work would help me to make sense of my own journey as an immigrant woman. I also hoped that the research would make a contribution to the small, but growing literature on immigrant and refugee women's experiences of settlement and integration in Saskatchewan. I wanted to find out what we needed to do as social work practitioners to make the process of settlement and integration an easier one. Another

milestone in this academic journey was my involvement in research focusing on the topic of post-traumatic stress responses among immigrant, refugee, and racialized women. This latter research added to my own understanding of the kinds of traumatic experiences that many immigrant and refugee women live. This was my first realization that women were not using traditional mental health centres, despite the tremendous pain many were living. As I continue to do volunteer work with immigrant and refugee communities I have been struck by the coping capacities of women in the midst of memories and experiences of pain and trauma. Women continue to play significant care-taking roles in their homes, families, and communities. These roles could be locally focused (Saskatchewan), or they could involve long-distance caregiving (taking care of others in other countries). This research has enhanced my own understanding of the complex lives of immigrant and refugee women.

The research has brought together the voices of immigrant and refugee women and services providers to build understanding of the different conceptualizations of mental health, and about ways of developing and enhancing models and programs to meet the mental health needs of this population. The dissertation has identified the kinds of help women require here in Canada, the kinds of help that are available to them, the ways in which they now get help, the gaps that exist, and ways of developing/enhancing service and support to immigrant and refugee women. The voices of service providers, their understanding of the mental health needs of this population, their own challenges with respect to providing service, and their recommendations for change have also been presented in the dissertation.

A final comment is about the survivor spirits of the immigrant women and refugee women whom I interviewed. It was a privilege to be present throughout the interviews and to listen to the laughter and sense of humour of the participants. I believe that as a host community, Saskatchewan has a lot to learn from this population. These are women who have lived and survived all sorts of experiences, and we need to remember to give the messages that highlight women's resilience and spirit, and celebrate women's strength, and spirit of survival.

Finally, it took women a long time to get where they are today. Healing will take a long time: this is slow, rebuilding work and that it requires time to build relationships. Short-term, one-time projects will not have the kind of long term impact that is required to build strong, healthy communities. What is required is a long-term commitment to ensuring immigrant and refugee women's mental health and well-being needs are met. As the province continues to welcome newcomers, mental health practitioners have a role to play in working with immigrant and refugee women as they continue on their journey to build home and community. They also have a tremendous role in reaching out to refugee women as they proceed on their healing journeys.

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Appendix A

Description of mental health services in Saskatchewan

Government of Saskatchewan: Saskatchewan Health

Mental Health Services

The Government of Saskatchewan supports the delivery of mental health services through its health regions. The goal of Saskatchewan Health is "to promote, preserve and restore the mental health of the population (Government of Saskatchewan, 2003). Health region boards deliver the various programs and services. The health regions include:

- Prairie North Health Region
- Heartland Health Region
- Parkland Health Region
- Regina-Qu'Appelle Health Region
- Saskatoon Health Region
- Cypress Health Region
- Sun Country Health Region
- Sunrise Health Region

The mental health program has four program components:

- Child and Youth Services
- Adult Community Services
- Inpatient Care Services
- Psychiatric Rehabilitation Services.

These services are regulated by the standards and guidelines of the Mental Health Services Act and Regulations and are available to all segments of the population.

Child and Youth Services

Child and Youth mental health services recognize the broad range of needs among children and youth. Services include:

- assessment, consultation and referral services
- more specific programming in such areas as treatment services related to eating disorders, sexual abuse (for sexually abused children and youth, and for sex offenders), sexually intrusive children, and attention deficient hyperactivity assessment.
- suicide intervention and prevention
- trauma response is also provided.
- parenting and family therapy services.

Other services include inpatient services (limited to 6 beds at the Royal University Hospital in Saskatoon). A limited number of community-based organizations are supported by the health regions to provide services to children and youth.

Adult Community Services

Adult Community Services provide a wide range of services and programs (excluding inpatient and psychiatric rehabilitation services):

- Clinical and consulting services including diagnosis, treatment, counselling, support, and forensic assessment of individuals who are being dealt with through the justice system.

- Crisis intervention services, marriage counselling, individual counselling, violence intervention programs, family therapy, intake, assessments, referrals, problem gambling support services, and promotion, prevention and education services.
- The Alternatives to Violence program are available to perpetrators of partner violence.
- The Sex Offender Treatment Groups are delivered to perpetrators of sexual abuse. In the Saskatoon Health Region, once offending partners appear for services, their spouses are contacted and support services offered. These have included a women's support group which is now being reviewed. This agency has been referring women to other agencies where there are still domestic abuse programs.

A few community- based organizations are supported by the health regions to provide services to adults.

In-patient care services

According to the Saskatchewan Health, the goal of inpatient services is to work with individuals so that they can live independently. Inpatient Care Services provide diagnostic and treatment services to individuals living with various kinds of mental illnesses. Services include the following:

- 24-hour on call psychiatrist
- 24-hour nursing service
- Consultation (involuntary admissions)
- Specialized treatment service
- Adolescent unit

- Day treatment
- Crisis management
- Counselling for individuals and families
- Nursing consultation to other units
- Medical and psychosocial assessments
- Behaviour management programs
- Psycho-educational groups and programs
- Case management
- Assessment for long-term care placement (Saskatchewan Health-Mental Health Services Inpatient, accessed at http:// www.health.gov.sk.ca/ps_mental_health_inpatient

The above services are provided at

- Battlefords Union Hospital
- Moose Jaw Union Hospital
- Prince Albert Victoria Hospital
- Regina General Hospital
- Saskatoon City Hospital
- Saskatoon Royal University Hospital
- Swift Current Regional Hospital
- Weyburn Mental Health Centre
- Yorkton Mental Health Centre (Saskatchewan Health-Mental Health Services Inpatient, accessed at http:// www.health.gov.sk.ca/ps_mental_health_inpatient

Psychiatric Rehabilitation Services

Psychiatric Rehabilitation Services provide services to individuals living with long-term mental illnesses. These services include:

- Long-term case management services. These may include various kinds of housing support (group and approved homes, independent living).
- Day activity and recreational programs
- Family respite and education
- Crisis management.

Clients receive rehabilitation through:

- Intake, orientation and assessment
- Case management
- Residential services
- Prevocational/vocational
- Shared management
- 24-hour emergency response
- Coordinating councils
- Family education and support education
- Family support and rehabilitation programs which are provided through contractual services.

According to Saskatchewan Health, several community based organizations deliver vocational and prevocational services to rehabilitation clients. These are available at:

- Portage Vocational Services, North Battleford

- Canadian Mental Health Association (CMHA)- North Battleford, Kindersley, Swift Current, Prince Albert, Regina, Weyburn, Saskatoon, Yorkton
- Moose Jaw/Thunder Creek Rehabilitation Services-Moose Jaw
- Self Help and Recreational Education (SHARE)-Prince
- Nipawin Oasis Community Centre
- Phoenix Residential Society- Regina
- Crocus Co-op- Saskatoon
- Smile- Estevan (Saskatchewan Health-Mental Health Services Psychiatry, accessed at http:// www.health.gov.sk.ca/ps_mental_health_rehab.html

Other mental health serving agencies (community based organizations)

Family Service Canada and its Saskatchewan member agencies

Family Service Canada is a national voluntary organization whose mission statement is "Strong Families in a Caring Society". The organization focuses on strengthening families and communities and also engages in advocacy to achieve this goal. The organization acts as a clearing house that provides information and consultation to member organizations, engages in public awareness on social issues, in social action and advocacy in collaboration and partnership with member and other groups, provides a range of activities regarding family life education (including providing a certification program for family life educators, plays a lead role in the Families and Schools Together program, and takes a lead in National Family Week celebrations. One of the major contributions of the organization is the delivery of the Family Service Employee Assistance Program to employees and their families, as well as to employers.

There are several member organizations in Saskatchewan:

- Catholic Family Services of the Battlefords Inc.
- Catholic Family Services of Prince Albert Inc.
- Catholic Family Services of Regina
- Catholic Family Services of Saskatoon
- Family Service Regina
- Family Service Saskatoon (operating since 1931)
- Minahik Waskahigan Community and School
- Moose Jaw Family Service Bureau

In addition, SIGN (Society for the Involvement of Good Neighbours) is an affiliated

agency that operates in Yorkton. Most of these agencies existed for many years before the inception of the national organization (Family Service Canada) in 1982. These agencies all strive to be inclusive and respond to the needs of all members of the community. Services and programs include family life education programs, counselling, young parent services, family violence services, group programs, art for youth programs, a volunteer program, and adolescent-parent support programs.

The organizations all state a principle of delivering services to all segments of the population regardless of ancestry, religious belief, sexual orientation, age or financial status. Family Service Saskatoon has reached out to disadvantaged youth in the Saskatoon region. Their art for youth program has attracted Aboriginal youth who have played a key role in their performing arts events. This agency partnered with International Women of Saskatoon (formerly Immigrant Women of Saskatchewan, Saskatoon Chapter) in the summer 2004 and began developing the Moving Forward program which focused on working with immigrant and refugee families who had experienced war and violence. More recently Family Saskatoon has partnered with the Global Gathering Place to deliver groups to newcomer families who want to learn about life in Canada.

Community Clinics/the Community Health Co-operative Federation

There are 5 community clinics that are part of the Community Health Co-operative Federation. The co-operatives were created in 1962 at a time when there was a strike by doctors in response to the provincial government's attempts to introduce a universal health care system. The federation boasts of being "among the oldest and most highly evolved primary care centres in North America" (Canadian Co-operative Association, 2005, p. 1).

The federation advocates for "progressive reform in health policy and of consumer-sponsored alternatives in the planning, organization, financing, and delivery of health services" (Canadian Co-operative, 2005, p.2). The co-operative emphasizes prevention and education, as well as remuneration of professionals through a salary (rather than a fee for service) (Canadian Cooperative, 2005).

The services are designed to meet the needs of their specific populations in the different communities. The clinics provide:

- Professional practitioner services from physicians, primary care nurses, psychiatric nurses, occupational therapists, nutritionists, optometrists, pharmacists, counselors, health educators foot care specialists, and physical therapists.
- Health promotion, community development, laboratory and X-ray services.
- 24-hour emergency call services

The community clinic model is committed to interdisciplinary approaches and with integrated and co-ordinate service delivery (Community Health Services (Saskatoon) Association).

The Saskatoon Community Clinic

The Saskatoon Community Clinic Foundation was founded in January 1968. The foundation was formerly called the Saskatoon Community Health Foundation. The foundation funds a number of various activities including research, equipment, parenting, conferences, and renovations. The agency provides a wide range of programs and services including the following:

- Awasis KidsFirst Home Visiting Program
- Professional services including counseling, pharmacy services, occupational therapy, nutrition, nursing, community mental health nursing, physical therapy, family physician care
- Diagnostic services that would include laboratory, ECG, X-Ray
- Diabetes education, parenting classes, health information centre,
- A Seniors group program, an Aboriginal seniors' program
- A community kitchen program

The agency believes that health services should be universal, accessible, comprehensive, portable, and public administered. The agency is committed to the elimination of social and economic factors such as racism and poverty; and to addressing environmental influences on health and well-being. Advocacy and social action to address these concerns are an inherent part of the work of this agency. Work at the primary health care Westside Clinic with Aboriginal seniors and outreach to families in the Saskatoon core neighbourhood, reflect a commitment to universal, accessible, equitable health care. The focus on addressing poverty (as evidenced by advocacy work in this area), and on the development of services for people living with chronic diseases are also examples of community outreach work.

Regina community clinic

Community Health Services (Regina) Association Ltd. is a non-profit charitable health care co-operative founded in 1962. The association manages the Regina Community Clinic which provides primary health care services with its focus on

"diagnosis and treatment, disease prevention, and patient education" (Regina Community Clinic). The agency provides:

- Professional services such as counseling, optometry, nutrition, exercise specialist, blood glucose monitoring, and 24-hour emergency call services
- Diagnostic services such as laboratory, X-Rays
- Community daycare and toddler services
- Patient education including menopause resource centre

Prince Albert Co-operative Health Centre

Dr. O.K. Hjertaas was the first doctor to provide services at the Prince Albert Services Cooperative which later came to be known as the Prince Albert Co-operative Health Centre. The centre provides an array of services:

- Professional services including general medical practice, dentistry, nursing services, internal medicine, surgery including orthopedic surgery, counseling including nutrition counseling, physical therapy, urology, radiology, and acupuncture.
- Diagnostic services such as laboratory, X-Rays, ultrasound.
- ISKWEW provides support services for women who have been victims of abuse.
- Health promotion and prevention
- Health education
- Translation services for Aboriginal patients.

Wynyard Community Clinic

The Wynyard Community Clinic officially opened as a primary health care site in 2003. The integrated professional team includes public health and home care practitioners, community pharmacists, physicians, and a primary care nurse practitioner. The clinic focuses on "disease prevention, health promotion, early intervention, treatment, and follow-up care" (Wynyard welcomes primary health care team, 2003).

Lloydminister and District Co-operative Health Services Ltd.

This agency provides a comprehensive range of services to clients. These include medical and counseling services. The agency has about 338 members and 8 full-time positions.

Private Practice

In addition to these community-based organizations, various counselling and support agencies provide a range of counselling and support services to individuals and families. The professionals in this agency are private practitioners

Appendix B

Demographic Profile of Immigrant and Refugee Women Participants

	Age	Country	Marital status	Children	Yrs in Canada	Yrs in sask	Occupational status	Educational background	Personal experience needing help to address mental health	Personal experience using mental health
1	44	Congolese	Widow	6	4	4	Student	College	No	No
2	38	Sudanese	Single	0	5	5	Environmentalist Forester	Bsc, msc	No	No
3	36	Sudan	Single	1	6	6	Esl teacher, Community worker, student	Graduate degree	yes	No
4	29	Ghana	single	0	6	6	Student	Degree	No	No
5	41	Uganda	Married	6	8	8	Caregiver	Grade 11	No	No
6	31	Zambia	Single	0	7	7	Human resources	Degree	Small degree	No
7	47	Liberia	Single	3	10	10	Dietary aide	Grade 12	No	No
8	42	Iran	Married	1	16	12	Teacher, principal	Ed degree	No	No
9	65	Chile	Separated	2	29	23	Surveyor helper	Secondary	Yes	Yes
10	45	Guatemala	Widow	1	14	14	Secretary, computer programmer, early childhood educator	Certificate	Yes	Yes
12	-	Zambia	Married	3	16	5	Medical doctor	University	No	No
13	54	Zimbabwe	Divorced	3	23	23	R.N	University	Yes	Yes
14	47	Malawi	Married	0	8	3 ½	Teacher	Graduate	No	no
15	60	Zimbabwe	Other	2	33	28	Nurse	University	No	no
16	43	Iran	Married	1	13	13	Teacher	Graduate degree	Yes	no
17	30	Iraq	Single	0	8 mths	8 mths	Student	Grade 10	No	No
18	21	Afghanistan	Single	0	3	3	Student	High school	No	no
19	26	Afghanistan	Single	0	3	3	Student	Grade 4	No	No
20	20	India	Married	2	3	3	Seamstress	High school	No	no
21		Bangladesh	Married	1	30	30	Activist, social worker	Graduate degree	yes	no
22	47	Iran	Married	1	9	9	Research consultant	University degree	No	no
23	51	Indonesia	Married	2	20	20	Homemaker, clerical worker	Commerce education	No	NO
24	51	Greece	Divorced	1	20	5	Professor	University education	Yes	yes

Appendix C

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For service providers (focus group interviews)

Interview Guide

1. How are the programs and services at your agency relevant to the mental health needs of immigrant and refugee women?
2. How would you describe your agency's capacity (for example, financial and human resources, professional development and training background, experience) to address the mental health needs of immigrant and refugee women?
3. In what ways are the mental health services and programs accessible (addressing barriers or needs such as transportation, childcare, language, location of services, appropriateness of policies, models and practices) to immigrant and refugee women?
4. In what ways might the agency's programs and services not be accessible to immigrant and refugee women?
5. What would you recommend to enhance accessibility issues?
6. Is there anything you would like to ask or add?

Appendix D

ALL DOCUMENTATION TO BE PRINTED ON UNIVERSITY LETTERHEAD

For service providers (individual interviews)

Interview guide

1. How would you describe your awareness of the mental health issues affecting immigrant and refugee women in Saskatchewan?
2. How has your work changed or evolved to respond to the growing immigrant and refugee population in Saskatchewan? (how would you describe your knowledge and skills, how have you acquired the knowledge and skills)?
3. How would you describe the capacity of your agency to address the mental health needs of immigrant and refugee women?
4. In what ways are the mental health services and programs of your agency accessible to immigrant and refugee women living in Saskatchewan?
5. What would you recommend to enhance accessibility issues?
6. What would you recommend to enhance your knowledge and skills?
7. Is there anything else you would like to ask or add?

Appendix E

ALL DOCUMENTATION TO BE PRINTED ON UNIVERSITY LETTERHEAD

For immigrant and refugee women- Focus group

Interview Guide

1. How would you define the mental health needs of immigrant and refugee women living in Saskatchewan?
2. Describe the help (professional, non-professional, other) that women use in your country of origin to take care of their mental health needs (for example, if they are feeling extremely stress, traumatized, are in situations of violence)?
3. Are there different kinds of help that women of different backgrounds (for example, urban/rural, age, class) might use in your country of origin?
4. Describe why women might not use help (professional or non-professional, other) in your country of origin if their mental health were threatened (for example, if they were feeling extremely stress, traumatized, in situations of violence)?
5. What do you know about the different kinds of services that are available to respond to the mental health of immigrant and refugee women from different backgrounds (for example, urban/rural, age, class, refugee camps, war affected countries) here in Saskatchewan?
6. What are the different kinds of help (professional, non-professional, other) that immigrant and refugee women of different backgrounds (for example, urban/rural, age, class, refugee camps, war affected countries) might use here in Saskatchewan?

7. What might be some reasons why immigrant and refugee women from different backgrounds (for example, urban/rural, age, class, refugee camps, war affected countries) would not use help (professional, non-professional, other) in Saskatchewan?
8. What kinds of help would you like to see available to immigrant and refugee women of different backgrounds (for example, urban/rural, age, class, refugee camps, war affected countries) to address their mental health needs here in Saskatchewan?
9. What recommendations would you make to enhance accessibility of mental health services to immigrant and refugee women here in Saskatchewan?
10. Is there anything you would like to add or ask?

Appendix F

ALL DOCUMENTATION TO BE PRINTED ON UNIVERSITY LETTERHEAD

For individual immigrant and refugee women

Interview guide

1. How would you define the mental health needs of immigrant and refugee women who are now living in Saskatchewan (what affects your mental well-being)?
2. Describe the kinds of help (professional, non-professional, other) that you have used in your country of origin to address mental health needs (for example, when you were feeling extremely stress, traumatized, in situations of violence)?
3. What were the factors that made you reluctant to use help (professional, non-professional, other) in your country of origin when your mental health was threatened (for example, when you were feeling extremely stress, traumatized, in situations of violence)?
4. Are you aware of mental health services and other help that are available to you here in Saskatchewan?
5. What are the factors that might make you (make you) reluctant to use help (professional, non-professional, other) in Saskatchewan if your mental health were threatened?
6. What recommendations would you make to existing kinds of services (helping approaches) so they can better meet the needs of immigrant and refugee women?
7. Is there anything you would like to add or ask?

Appendix G

ALL DOCUMENTATION TO BE PRINTED ON UNIVERSITY LETTERHEAD

Sample letter of introduction to agency managers

Dear...,

I am a student enrolled in a doctoral program (Social Work) at the University of Manitoba. I am planning on conducting research to study the mental health needs of immigrant and refugee women living in Saskatchewan. The purpose of the study is to explore how mental health policies, helping models and practices can be developed or enhanced to address these needs. This research is being done as partial fulfillment of the requirements of the Doctor of Philosophy degree.

I will be meeting with immigrant women and services providers from a broad range of backgrounds. I would like to invite staff from your agency to participate in this study, and to share their knowledge and experience as service providers. I will be conducting individual interviews and focus groups with human service providers. I am anticipating that individual interviews will last approximately one hour, and that focus groups will last approximately one and a half hours. I would also like to invite you to share information about this study with immigrant and refugee women with whom your agency or staff may be in contact. I have attached copies of letters of introduction that you may share with agency staff or with immigrant and refuge women.

I will be contacting you in the next few weeks to discuss the study. If you have any questions, please do not hesitate to call me at ( ) .

Sincerely,

Judy White

Appendix H

ALL DOCUMENTATION TO BE PRINTED ON UNIVERSITY LETTERHEAD

Sample letter of introduction inviting immigrant and refugee women to call regarding individual interviews and/or focus group interviews

To Whom It May Concern:

I am a student enrolled in a doctoral program (Social Work) at the University of Manitoba. I am conducting research to study the mental health needs of immigrant and refugee women living in Saskatchewan. The purpose of the study is to explore how mental health policies, helping models and practices can be developed or enhanced to address these needs. This research is being done as partial fulfillment of the requirements of the Doctor of Philosophy degree.

I will be meeting with immigrant women and services providers from a broad range of backgrounds. I would like to invite you to participate in this study, and to share your knowledge and experience as an immigrant/refugee woman. I will be conducting individual interviews and focus groups. Individual interviews will last approximately one hour. Focus groups will last approximately two and a half hours.

If you would like further details about the research study, or if you would like to participate in the study, please call me ( )

Sincerely,

Judy White

Appendix I

ALL DOCUMENTATION TO BE PRINTED ON UNIVERSITY LETTERHEAD

Sample letter of introduction inviting service providers to call regarding individual interviews and/or focus groups

To Whom It May Concern:

I am a student enrolled in a doctoral program (Social Work) at the University of Manitoba. I am conducting research to study the mental health needs of immigrant and refugee women living in Saskatchewan. The purpose of the study is to explore how mental health policies, helping models and practices can be developed or enhanced to address these needs. This research is being done as partial fulfillment of the requirements of the Doctor of Philosophy degree.

I will be meeting with immigrant women and services providers from a broad range of backgrounds. I would like to invite you to participate in this study, and to share your knowledge and experience as a mental health service provider. I will be conducting individual interviews and focus groups. Individual interviews will last approximately one hour. Focus groups will last approximately two and a half hours.

If you would like further details about the research study, or if you would like to participate in the study, please call me (_) .

Sincerely,

Judy White

Appendix J

ALL DOCUMENTATION TO BE PRINTED ON UNIVERSITY LETTERHEAD

Sample letters of introduction to immigrant and refugee women regarding individual interviews and/or focus groups. Researcher will follow up with phone call

Dear…,

I am a student enrolled in a doctoral program (Social Work) at the University of Manitoba. I am conducting research to study the mental health needs of immigrant and refugee women living in Saskatchewan. The purpose of the study is to explore how mental health policies, helping models and practices can be developed or enhanced to address these needs. This research is being done as partial fulfillment of the requirements of the Doctor of Philosophy degree.

I will be meeting with immigrant women and services providers from a broad range of backgrounds. I would like to invite you to participate in this study, and to share your knowledge and experience as an immigrant/refugee woman. I will be conducting individual interviews and focus groups. Individual interviews will last approximately one hour. Focus groups will last approximately two and a half hours.

I will be contacting you in the next few weeks to discuss the study. If you have any questions, please do not hesitate to call me at (.) :

Sincerely,

Judy White

Appendix K

Letter of invitation

September 1, 2005.

You are invited to participate in a research study that is intended to improve programs and services to address the mental well-being of immigrant and refugee women. If you are interested in this study, please call me at .

Judy White

Appendix L

ALL DOCUMENTATION TO BE PRINTED ON UNIVERSITY LETTERHEAD

Consent Form (individual interviews)

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Title: Enhancing and developing policies, models and practices to address the mental health needs of immigrant and refugee women in Saskatchewan

Purpose: Despite a growing body of literature relating to the settlement and integration experiences facing immigrant and refugee women living in Canada, there is still a suggestion that the mental health needs of this population are inadequately addressed. The study aims at studying current mental health models and practices in Saskatchewan in order to generate ideas for developing and enhancing practices and models to meet the mental health needs of immigrant and refugee women.

Procedure: You are invited to participate in an individual interview that will be approximately one hour. The interview will include about seven questions. The interview

will be audio taped and transcribed. Once the tapes have been transcribed, I will send a copy of the transcript so that you can peruse to determine whether the transcript accurately represents your views. You will be asked to sign and return in a self addressed envelope.

Risk: I do not anticipate that there will be any risks to you. Nevertheless, should the questions evoke any negative emotional responses, please do not hesitate to let me know. I will make every effort to ensure that you receive the appropriate support services if necessary.

Confidentiality and Anonymity: Information you share will be kept confidential by the researcher. Every effort will be made to provide anonymity. The information collected during interviews will be incorporated anonymously into the final report. I will be using pseudonyms to protect your identity. However, given the small immigrant and refugee population size and the small population in Saskatchewan, I cannot guarantee anonymity. The tapes will be transcribed by a professional who will also be required to respect confidentiality. The audiotapes and transcripts will be stored in a secure and locked cabinet, and will be destroyed after three years.

Voluntary Participation: Participation in this study is completely voluntary. You may decline participation or withdraw from the study at any time (even after signing the letter of consent) without penalty.

Feedback: Summary of findings will be available to you on request.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate in the study. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

This research has been approved by the University of Manitoba Research Ethics Board. If you have any concerns or complaints about this study you may contact any of the above-named persons or the Human Ethics Secretariat at 1(204)474-7122, or email _____. A copy of this consent form has been given to you to keep for your records and reference.

_____

Participant's Signature Date

_____

Research and/or Delegate's Signature Date

Judy White

Appendix M

ALL DOCUMENTATION TO BE PRINTED ON UNIVERSITY LETTERHEAD

Consent Form (focus group interviews)

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Title: Enhancing and developing policies, models and practices to address the mental health needs of immigrant and refugee women in Saskatchewan

Purpose: Despite a growing body of literature relating to the settlement and integration experiences facing immigrant and refugee women living in Canada, there is still a suggestion that the mental health needs of this population are inadequately addressed. This study aims at studying current mental health models and practices in Saskatchewan in order to generate ideas for developing/enhancing practices and models to meet the mental health needs of immigrant and refugee women.

Procedure: You are invited to participate in an individual interview that will be approximately one hour. The interview will include about seven questions. The interview

will be audio taped and transcribed. Once the tapes have been transcribed, I will send a copy of the transcript so that you can peruse to determine whether the transcript accurately represents your views. You will be asked to sign and return in a self addressed envelope.

Risk: I do not anticipate that there will be any risks to you. Nevertheless, should the questions evoke any negative emotional responses, please do not hesitate to let me know. I will make every effort to ensure that you receive the appropriate support services if necessary.

Confidentiality and Anonymity: Information you share will be kept confidential by the researcher. We request that participants do the same. Every effort will be made to provide anonymity. The information collected during interviews will be incorporated anonymously into the final report. I will be using pseudonyms to protect your identity. However, given the small population in Saskatchewan, I cannot guarantee anonymity. The tapes will be transcribed by a professional who will also be required to respect confidentiality. The audio-tapes and transcripts will be stored in a secure and locked cabinet, and will be destroyed after five years.

Voluntary Participation: Participation in this study is completely voluntary. You may decline participation or withdraw from the study at any time (even after signing the letter of consent) without penalty.

Feedback: Summary of findings will be available to you on request.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate in the study. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

This research has been approved by the University of Manitoba Research Ethics Board. If you have any concerns or complaints about this study you may contact any of the above-named persons or the Human Ethics Secretariat at 1(204)474-7122, or email _____. A copy of this consent form has been given to you to keep for your records and reference.

_____

Participant's Signature Date

_____

Research and/or Delegate's Signature Date

Judy White