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Addressing the unique needs of immigrants  
and refugees: Mainstream Canadian mental  
health and addiction services



# Questions to think about...

- Unpacking Mental Health, Mental Disorder (e.g., Addiction) and Culture
- Why is it important to understand cultural diversity and its relationship to health promotion?
- Limited Canadian research



# Unique needs of immigrants: Examples

- **Loss of validation sources due to displacement**
- **History of trauma (particularly with refugees)**
- **Separation from traditional healing practices,**
- **Acculturation stress,**
- **Language barriers,**
- **Lack of information about available resources,**
- **Stigma associated with mental illness,**
- **Lack of terminology to describe mental-health problems,**
- **Absence of specialized treatment models.**

(Amaro, Arevalo, Gonzalez, Szapocznik, & Iguchi, 2006; Shen, Alden, Sochting & Tsang, 2006).



# Research: Use of mental health services

- Initially a “healthy immigrant effect”-for newly arrived immigrants to Canada,
- The first 10 to 24 months after arrival, may put immigrants at a higher risk for developing mental health & addiction problems (Newbold & Danforth, 2003), linked to acculturation stress.
- Underutilization of mental health services
- Protective factors, or untreated mental health problem?  
(Tiwari & Wang, 2008; Chen & Kazanjian, 2005).



# Culture

- No universally accepted definition
- “Culture is learned, shared and transmitted from one generation to the next and it can be seen in a group’s values, norms, practices, systems of meanings, ways of life, and other social regularities” (Sanders-Thompson, p.133 as quoted in Huff & Kline, 2007).
- Directly/indirectly associated with a health-related behavior and influences the acceptance and adoption of the health education message or activity.
- Operationalized in research as: Race, ethnicity, language, nationality, and even geographic location (Pasick, D’Onofrio, & Otero-Sabogal, 1996).



# Research limitations: Mental health and addiction

- Not accounting for ethnicity, country of origin and culture of research participants.
- Challenges for researchers interested in culture as determinant of health
- Challenges for clinicians to understand how to design and implement culturally sensitive models of care, based on research outcomes
- Vulnerable population-concerns over misuse of research
- Studies are mainly from the US, limited in their application to the Canadian context
- Gap between research and practice

# Potential Barriers to Health

## Promotion

### Cultural Barrier

- Gender, family, age
- Worldview/perceptions of life
- Time orientation
- Primary language spoken
- Religious beliefs & practices
- Social customs, values, and norms
- Traditional health beliefs and practices
- Dietary preferences and practices
- Communication patterns and customs

### Health Care System Barrier

- Access to care
- Financial resources
- Orientation to preventive health services
- Perception of need for health care services
- Health Literacy issues
- Distrust of Western medical practices/procedures
- Cultural insensitivity/competence
- Doctor-patient relationship
- Lack of bilingual and bicultural staff
- etc

(Huff & Kline, 2007)



# Many Terms

- Laden values, assumptions & politics
- Culture, cultural identity, cultural sensitivity, cultural competency, cultural safety, ethnicity, ethnic identity, race, racial identity immigrant(ion), acculturation, multiculturalism, Eurocentricism, ethnocentricism, cultural tailoring, hegemony, power, ideology



# Mental health and Culture

- Paucity of Canadian studies that have taken into account how immigrants' cultural values and practices may contribute to the process of mental health and addiction service utilization.
- Culture not only influences how mental health and illness is perceived but also how symptoms are expressed.
- Stigma and cultural idioms of stress  
(Hilton et al., 2001; Shen, Alden, Sochting & Tsang, 2006)



# Health Behavior Models

- Entirely located within the individual and Eurocentric.
- Cognitive, linear and rational
- Often assume that health-related activities have an end point, i.e., service utilization aimed at reducing symptoms and addressing the problem.
- Pay limited attention to multiple contexts, traditional healing practices and informal support networks
- Do not address how decisions to seek help emerge in the contexts of one's "daily, socially and culturally embedded lives"
- (Hausmann-Muela, Ribera & Nyamongo, 2003; Mackian, 2003, p. 9).



# PEN-3 Model (Airhihenbuwa, 1995)

- Critically examines the dominant health promotion efforts and models of health
- Challenges the Eurocentric biases of individualism and cognitively focused communication in how health has been conceptualized
- Culture is the core of health promotion and disease prevention programs
- Has been used to assess programs such as: cultural eating patterns, cancer screening, and AIDS prevention programs

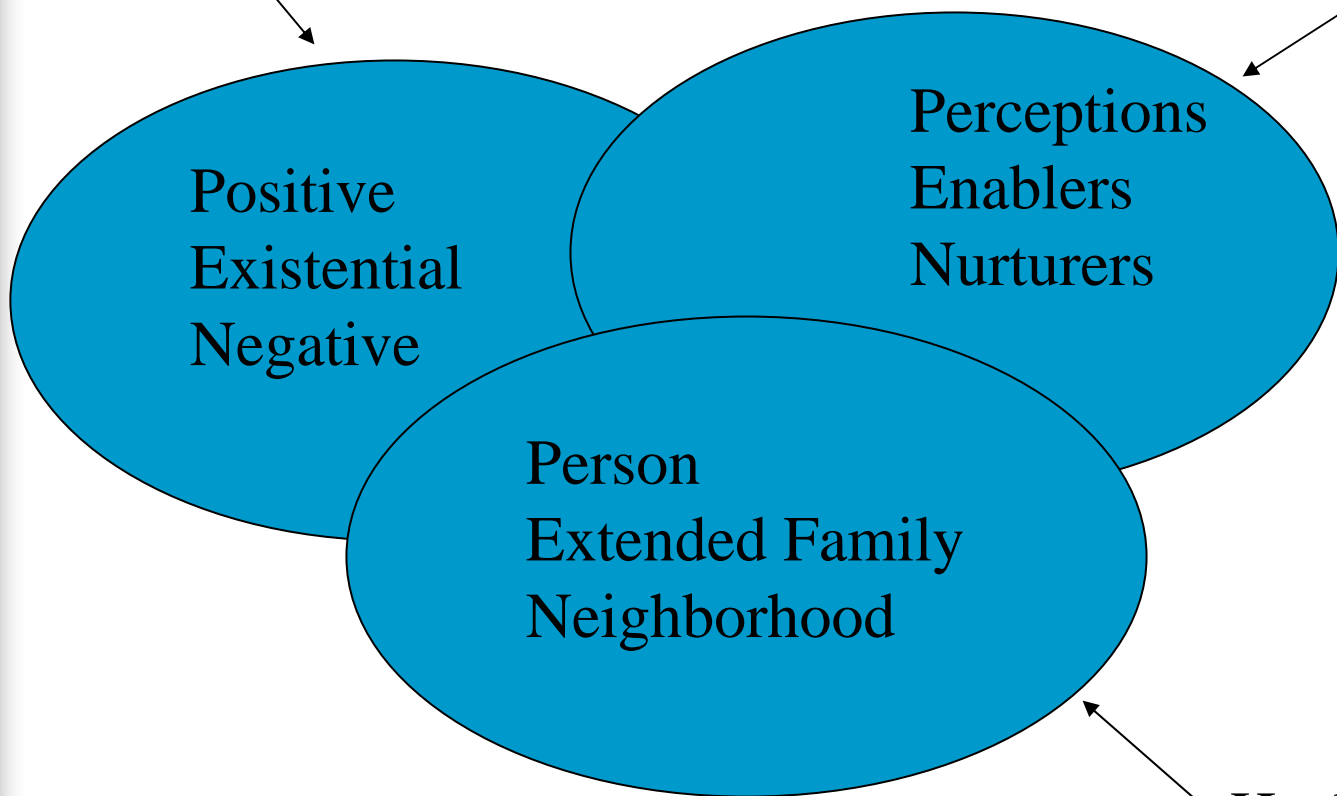
# PEN-3 MODEL

Cultural

Appropriateness of  
Health Behavior

Educational

Diagnosis of Health  
Behavior



Positive  
Existential  
Negative

Perceptions  
Enablers  
Nurturers

Person  
Extended Family  
Neighborhood

Health  
Education



# Health Education

- **P – Person:** improving the health of everyone, empowering individuals to make informed decisions, appropriate to their roles in their families and communities.
- **E - Extended Family:** focus should extend from immediate family to the extended relationships
- **N – Neighbourhood:** community members' involvement

(Airhihenbuwa, 1995)



# Educational Diagnosis of Health Behaviour

- **P – Perceptions:** knowledge, attitudes, values and beliefs that may facilitate or hinder personal, family and community motivation to maintain or change health beliefs and/or practices. (e.g., overweight), begin with "perceived" needs of the community vs. needs assessed by planners.
- **E – Enablers:** cultural, societal, systematic or structural influences/forces that may enhance/create barriers to maintain (e.g., available resources, accessibility, referrals, skills or types of services)
- **N – Nurturers:** degree to which health beliefs, attitudes and practices are influenced, mediated or nurtured by significant others, such as peers, family, kin, religious leaders etc.

(Airhihenbuwa, 1995)



# Cultural Appropriateness

- **P – Positive behaviors:** health beliefs and actions that are known to be beneficial & need to be encouraged
- **E – Existential behaviors:** cultural beliefs/practices/behaviors that are indigenous to a group, and have no harmful health consequences, and therefore do not need to be changed. Programs should address "what is" instead of "what ought to be." Can not blame these for the failure of programs.
- **N – Negative behaviors:** based on health beliefs and actions that are known to be harmful to one's health.

(Airhihenbuwa, 1995)



# PEN-3 MODEL: Strengths

- Critically examines the dominant discourse and theories on health behavior (biomedical, and valorization of European based models)
- Views health as a cultural production
- Health knowledge, beliefs, and actions are produced and interpreted at both micro (individual, family, & community/grassroots) and macro (national and international power and politics) levels.
- The decision making of individuals and families is situated within its proper political, historical, and cultural context
- Centralizes the active role of the cultural community in developing health applications
- Considers the multiple contexts and realities faced
- Encourages and honors the community to identify the health related problems that are critical and meaningful to that community (i.e., the community defines the problem)\*
- Asset-based, vs. seeing culture as a barrier



# Cautions & dilemmas

- We can't assume that each individual of ethno racial minority will necessarily feel connected to that community or cultural values.
- Not recommending a **homogenous/uniform** approach to the phenomenon of culture.
- Debate around as to whether culturally specific health and social services should be a right or a privilege.
- How do we respond to every cultural specificity and would we really want to do that?
- How do we evaluate the “standards” of quality and safety of those paradigms or models of care that don't fit the western paradigms?

(Oxman-Martinez, & Hanley, 2005)



# Need for equitable partnership

- Joint conversations between health researchers, practitioners, policy makers, and community members-bridging the gap
- Structural changes at the level of healthcare
- Community mobilization & empowerment
- Provision of culturally appropriate services
- Outreach, education and prevention  
(Oxman-Martinez, & Hanley, 2005).

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