Health Canada Santé Canada

Immigrant Women and Substance Use

Current Issues, Programs and Recommendations

Canada

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Current Issues, Programs and Recommendations

Monograph Prepared For:

Office of Alcohol, Drugs and Dependency Issues
Population Health Directorate
Health Canada

canada's drug strategy

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I INTRODUCTION

Only in recent years have we begun to understand the special needs of women in relation to substance abuse prevention, education and treatment. Less is known about the issues of immigrant and refugee women and women of colour in relation to substance use. This project was undertaken in response to a recommendation from **Working Together: A National Workshop for Action on Women and Substance Use**, February 22-24, 1994, sponsored by Health Canada:

> "... [to] undertake research on the specific needs of immigrant and refugee women and women of colour" (p.20).

The central research questions asked in this project were:

- What is currently known about immigrant women (see below for a working definition) and substance use in Canada?
- What programs, or program components, currently exist to address substance use among immigrant women? How well do these work?
- What areas require further investigation?

The purpose of this monograph is to make the findings of this study accessible to the public.

1. Who are "immigrant women" for the purpose of this study?

The term "immigrant women" can encompass women from a variety of backgrounds and life situations. For the purpose of this project the following working definition was provided: "immigrant women who have chosen to leave their homes and settle in Canada; refugee women who have come to Canada because of persecution in their country of origin; in-settlement women who have lived in Canada for several decades but have not integrated into the mainstream; and women who, though born in Canada, maintain strong identification with an ethnic racial or linguistic group, such that they have not integrated with the mainstream". The Health Canada definition for this project excludes Aboriginal women from the category of racial minority women.

Immigrant, refugee, and racial and ethnic minority women are far from being a homogeneous group. In addition to seemingly obvious differences as skin colour, immigration status and country of origin, many other factors (such as ethnic and racial self-identification, age at immigration, participation in ethnocultural community activities, mother tongue and second language skills, religious and class location within the ethnocultural group, marital status, existence and age of dependents, level of education, type of employment, political orientation, experience with discrimination and

racism in Canada and elsewhere) all contribute to each woman's unique identity and to the way that she lives and experiences her culture. All of these factors also impact on the status of each woman in Canadian society.

In seeking to identify common barriers and propose solutions, we have attempted to remain alert to the tendency to generalize about the situation and health needs of this diverse group included in the definition "immigrant women". Therefore, we will occasionally use other terms, including "refugee women"; "racial and ethnic minority women"; "women of colour and white women"; "official language speakers and non-official language speakers"; "Anglo/French and non-Anglo/French"; "Canadian-born and non-Canadian born"; etc., to distinguish some important sub-groups within that category. Please refer to the review of literature, Section III for a more detailed discussion about the term "immigrant women" and how it has been used in this study.

2. From what perspective can we understand the health promotion needs of immigrant women in relation to substance use?

Immigrant, refugee, and racial and ethnic minority women form an increasingly large percentage of the Canadian "mosaic"; up to 42% of Canadian women are neither French nor British in origin; and one in ten women in Canada is of colour (Statistics Canada, 1991).

Many studies have emphasized that their situation is one of continuing inequality in relation to other women in this country, or even in relation to immigrant, refugee, and racial minority men. This inequality is especially visible on the economic plane, with enormous differences in income and very limited employment opportunities for many immigrant women, especially those from African, Latin American, Asian, and Southern European origins (Boyd, 1992; Elliott and Fleras, 1992).

Assessing and meeting the health promotion needs of many immigrant, refugee, and racial and ethnic minority women may be especially complex, in comparison to other women in Canada and in the context of certain realities. Some of these are:

- difficulty in speaking Canada's official languages;
- separation from family and social networks;
- traumatizing experiences of refugee women prior to migration, such as torture
- stress related to migration itself,
- lowering of socioeconomic status after migration; and

- racial discrimination in the society and within the health services system (see, for example, Bodnar and Reimer, 1979; Bolaria and Li, 1988; Boyd, 1992; Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Carole, 1991; Das Gupta, 1994; The Equity in Strategic Health Planning Working Group, n.d.; Freire, 1989; Ng, 1988).

Partly because of the factors identified above, many immigrant, refugee and racial and ethnic minority women have important health needs to which traditional health services and institutions have not always responded successfully. On the other hand, there are also many non-traditional services (such as immigrant women's centres, multicultural health networks, etc.) which could offer support to women who experience cultural, racial, linguistic, gender, and/or social barriers in accessing the 'mainstream' health services, especially those located in major urban centres (see, for example, Cuenco and Estable, 1986; Isaac, 1989).

Immigrant, refugee and racial and ethnic minority women also face similar barriers that all women face in relation to substance use issues, which may impede their access to both "mainstream" and "alternative" health services and programs. These barriers include:

- denial that such problems exist;
- societal attitudes that blame and ostracize women;
- inadequate and inappropriate treatment approaches;
- lack of necessary support systems such as childcare- and
- lack of access to information and supportive counselling (see, for example, Finkelstein, 1990- 1994; Lundy, 1993- McCrady and Raytek, 1993; Nadeau, 1987).

For this study, we have framed our questions about immigrant, refugee, ethnic and racial minority women's health promotion needs in relation to substance use, in the context of the issues and barriers mentioned above.

II METHOD

How do we find out what is currently known? There is little accessible research on the general health promotion needs of immigrant women in Canada. We began this research using a combination of conceptual frameworks (community-based, feminist, and anti-racist) to understand the issues and analyze literature and programs. This process allows people to identify issues from their own perspectives, taking this as the starting point for building knowledge about needs and programs. Appropriate programs and services for immigrant women cannot be developed without the knowledge that women and ethnocultural communities have about their own needs and services.

Community-based research also means that we were committed to participation at every stage from the communities that will be affected by, or use, the results of the research. The Canadian Ethnocultural Council (a national organization representing 37 ethnocultural groups across Canada), with involvement from the Canadian Ethnocultural Women's Network, was an active partner in this project.

The following methods were used:

- **Literature review** of published and community-based literature: with emphasis on Canadian literature and search for reliable incidence data.

- **Sample selection** across the country of settlement, ethnocultural and immigrant women's organization- health, community health, and treatment facilities; and some women's organizations, using a combination of source lists from many nonprofit and community groups and networks.

- **National telephone survey** using four different survey instruments translated into English, French and Spanish, contacting a total of 375 individuals and completing a total of 281 interviews.

- **Consultation session with the Canadian Ethnocultural Women's Network** with participation of 32 women from over 20 member organizations. Participants in the Consultation were also surveyed using a two-page written check-list, returned by 25 of the women.

- **Analysis of survey, interview, and consultation data** which are summarized in this report.

- **Development of recommendations** in consultation with the Canadian Ethnocultural Women's Network and the Health Canada Project Team.

III ISSUES FROM THE LITERATURE

What has been written about immigrant women and substance use in Canada? The literature reviewed for this project included over 200 documents from a range of sources including research studies, scholarly articles, community profiles, needs assessments, survey reports, and education material. The following summarizes the main issues identified in the literature with regard to immigrant women and substance use.

1. Who are "Immigrant Women"?

The popular stereotype reflected in the media and many government programs is that "immigrant women" comprise a homogeneous group with some superficial variations in language and dress, and that all "immigrant women" are different from "Canadian

women" in some significant ways. In fact, the group of "immigrant women" in Canada is strikingly diverse, as is the group of "Canadian women". All immigrant women do not share the same history, nor do they all live the Canadian reality in the same way.

Definitions of the groups included in this study vary considerably and different authors offer a range of different terms and descriptions. The literature by and about immigrant refugee and racial minority women tends to emphasize that in addition to seemingly obvious differences such as skin colour, immigration status and country of origin, many other factors contribute to each woman's identity and have an impact on her location within Canadian society (such as ethnic and racial self-identification, age at immigration, participation in ethnocultural community activities, mother tongue and second language skills, religious and class location within the ethnocultural group, marital status, existence and age of dependents, level of education, type of employment, political orientation, experience with discrimination and racism in Canada and elsewhere).

Given all the possible definitions, how are we to understand what the health promotion issues are for "immigrant women"? How are their lives different from those of "4 non-immigrant women" in relation to substance use? What concepts can help to explain their lived experience, in relation to substance use? We turned to the literature for help.

2. What research has been done on immigrant/ethnic minority women and substance use, from a health promotion perspective?

We were almost unable to find valid, useful and reliable information specific to the issue of immigrant women and substance use in Canada. There are very few published research reports about substance use that examine the fact of immigration or the characteristics of immigrant groups as variables. We found few studies that examined how gender may affect substance use patterns for women and men who are immigrants. Neither did we find many reports linking substance use, immigrant women and health promotion. There are, however, many articles describing and comparing the substance use patterns of different "ethnic", "cultural", "racial" and "national" groups.

The U.S. and international/cross-cultural literature cannot readily be applied to the situation of immigrant women in Canada for the following reasons: important differences in the populations of each nation; different ways that "ethnic" and "racial" groups are defined; different economic and social locations for the same "ethnic" and "racial" groups in different nations different methods and tools used in different studies; differences between the health behaviour of individuals in their home country and that of migrants in a host society, and many untested assumptions about ethnic, racial, linguistic groups and/or women.

Important national Canadian surveys on which the few available published studies on immigrant and/or ethnic minority women have been based, may not be as valid or reliable for this section of the population due to the following: sampling problems; interviews conducted only in official languages; and some confusion in the definitions of "ethnic" and "immigrant". Most authors in the Canadian substance use literature have

underestimated the importance of addressing both the concept of "ethnic group" and the ways that ethnic self-identification may or may not impact on specific health behaviours of immigrant women in Canada.

A lack of careful analysis about ethnic identification and the role of ethnicity in health behaviour and health promotion may have led some authors who write about substance use to present conclusions that do not appear to be well supported by research. Rather, they seem to be based on untested assumptions and stereotypes about immigrant women and their communities.

There are some interesting insights and findings within the feminist and woman oriented literature about substance use. However, most of this literature appears to ignore the fact that immigrant women are also female.

The multicultural health literature, especially the more recent work, also offers some interesting insights about health, immigration, and ethnicity in Canada. However, few of these authors focus on substance use, while fewer examine the specific situation of women.

Some of the community-based literature that offers "ethnic profiling" does not appear to be based on careful research; it underestimates or ignores issues such as class, gender, language, and race, which impact differently on members of the same "national" or "ethnic" group, and it may suffer from many of the same conceptual problems and stereotypes as other literature.

Some of the community-based literature and studies that document the barriers immigrant women face while becoming full and equal members of Canadian society (e.g., racism, sexism, lack of childcare, poverty, cultural stereotyping, and lack of access to language courses and/or interpretation to permit communication) offer interesting insights that could be applied to substance use issues, although direct mention of substance use issues is extremely rare.

The above confirms that it is essential to ask immigrant women in Canada, their organizations, and those who work directly with immigrant women, how they see the issue of substance use; if they consider it a priority for health promotion and what measures should be taken to address it. As Sabloff and Birchmore Timney (1988) suggested almost a decade ago, "A crucial next step is to take our inquiry directly to the different ethnic communities - that is, to the consumers themselves" (p.43).

IV SUBSTANCE USE AND IMMIGRANT WOMEN - PERCEPTIONS AND ISSUES

The following is an overview of the main issues which emerged from the analysis of the telephone surveys, key informant interviews and the consultation held with the Canadian Ethnocultural Council Women's Network. The information collected from these interviews varied considerably since informants were purposefully drawn from a range of different settings with diverse program goals. Although there were many common themes, there were also some differences in the way that the issues were perceived, both within and across different settings (such as health promotion and education, treatment and prevention, settlement and immigrant services).

The findings are summarized under eleven different questions. The quotations under each question are from key informant interviews.

1. How can the government support health promotion among immigrant women, refugee women, and women of colour?

> "Sometimes, I feel very sad about my community. The funders might say: since you don't have a drug problem, you are not a problem for us. It's not that: the problems are more hidden things. So we don't get resources, and for other people there is more funds in the substance use. But the hidden problems are more serious, psychiatric problems are more serious. I like to look at this holistically. I want to help before it becomes a psychiatric illness".

It is generally understood that health promotion is a long-term challenge with results that may be measurable only after many years of consistent work within a community. Yet the health promotion needs of women in general and immigrant, refugee, and racial minority women in particular have not been assessed carefully. Detailed needs assessments should be undertaken prior to the setting of government funding priorities for immigrant communities in the areas of health care and health promotion.

In relation to program development, there was a strong consensus that programs will work only if they are community driven with integrated and efficient community outreach components. Informants also questioned whether it was realistic to expect the development of alternative, community-based and culturally-sensitive health promotion programs for immigrant and minority women, given the current structures and pre-existing inequalities within the Canadian health care system.

It is essential that health programs addressing the needs of immigrant women consider women both as individuals as well as members of families and communities, and take into account their responsibilities as caregivers. On the other hand, the definition of "community" in itself was seen as a challenge by many who asked: "Who is the "immigrant community"? Who is "ethnic"? Who is "mainstream"? Who is "Canadian"?"

2. Where does substance use fit within the priorities for health promotion among immigrant women?

> "Prevention, addiction and substance abuse is only one part. There are other more basic things, like immigrant women going for physical checkups, which is real prevention; like women over 40 doing mammograms, pap smears, those kind of things. Looking at sexuality, contraception, AIDS prevention is an issue. There are so many more things that people could be preventing if they knew."

Most people working directly with immigrant women did not identify substance use, misuse, or abuse as priorities for health promotion programs. A few were interested in the issue of illegal drug use by youth, often motivated by concerns about their own children as well as in ways to handle or reduce spouses' alcohol consumption. A small number of informants felt that prevention and education specific to prescription drug misuse and tobacco were important for immigrant women's health.

Rather than focusing exclusively on substance use education or abuse prevention, many informants suggested developing health promotion programs to help immigrant women deal with stress and depression. There was also concern that women received help only when they were in crisis - ending up in psychiatric facilities when this could have been prevented.

3. What conditions and situations pose a special challenge to immigrant women's health?

There are many more pressing issues affecting immigrant women's health than substance use or misuse. Stress and depression caused by racism, job discrimination, poverty, nutrition and diet contraception and reproductive health, routine preventive health care, and other health issues need to be addressed more urgently and/or in conjunction with substance use issues.

4. What special stresses do immigrant women experience that might impact on their health?

There was consistent acknowledgement of the strength and successful coping skills displayed by immigrant women, despite the stress of immigration and the experience of racism and discrimination in this country.

Workers in immigrant services were very concerned about the amount of stress immigrant women experience. Most frequently mentioned stressors were as follows: racism; lack of language knowledge; unemployment and consequent poverty; lack of recognition of qualifications, experiences and skills; lack of support systems; consequences of the refugee experience, including sexual torture and exposure to violence; relocating to another country; lack of childcare; cultural barriers; not knowing the whereabouts of family members; having lost family members prior to arrival; coping with a different climate; and generational conflicts with teenagers. All these factors may lead to depression, especially if compounded by isolation and a lack of family and friends.

5. Is there a substance use problem among immigrant women?

A slightly disconcerting, if not totally unexpected finding was that the majority of informants had little or no direct knowledge of substance use problems among immigrant women. Very few of the key informants had actually served or referred any immigrant women with substance use problems (including those informants working in substance abuse treatment services that were billed as offering multilingual services to women, community health centres, addiction clinics, settlement agencies and women's organizations). The few who actually had come across immigrant women with substance use problems had worked with a very small number of women (often two or three in total over a period of several years). These women were described as having been in Canada for a long time and were generally able to participate in programs delivered in one of the official languages.

However, some respondents offered opinions on the issue even though they appeared to lack contact or practical experience in helping immigrant women.

Many informants felt that there might be a "hidden" substance abuse problem among immigrant women. Several informants, especially those working directly with immigrant women, considered that women's lack of economic resources was "Protecting" them from abusing substances, except for prescription drugs which were often paid for through provincial drug plans.

6. What issues were raised in relation to alcohol?

Although some suspected there might be a hidden problem, only a few respondents had ever actually served or referred an immigrant woman who was misusing or abusing alcohol.

7. What issues were raised in relation to tobacco?

The general perception was that immigrant women smoked less than either Canadian-born women or immigrant men (confirming other survey data), although several informants did know women who smoked cigarettes.

A number of informants suggested there might be a lack of information about the effects of second hand smoke among immigrant communities. (This may be more of a problem in Canada than many other parts of the world because winter forces us to hold many social gatherings and other activities indoors). Others questioned the assumption that immigrant men smoke in the presence of their wives or children to a greater extent than Canadian men.

8. What issues were raised in relation to illegal drugs?

Very few informants had encountered (in their professional or personal lives) an immigrant woman with an illegal drug problem. Those who had, felt this issue was part of a whole pattern of largely inner-city poverty. Due to poverty, young immigrant women and single mothers might have to find housing in a type of neighbourhood where they would not have lived in their home countries. Some of them were being offered protection and friendship by local men who used street drugs. Some of these women were forced into the sex trade and used substances to cope.

9. What issues were raised in relation to prescription drugs and medications?

The use of medication and/or prescription drugs was mentioned with greater frequency than any other type of substance use or abuse by all informants. Informants themselves often distinguished between use of alcohol and illegal drugs, and misuse of prescription drugs. There was much concern that there might be a serious problem in this area, especially since it might not be identified as a problem by the women themselves, their families, their communities, and most alarmingly, by doctors who treated the women.

It might be difficult to detect and address the misuse of over-the-counter and prescription medications among immigrant women because these substances are seen as legitimate (offered by prescribing doctors and pharmacists). Immigrant women who have difficulty communicating in English or French might be hesitant or unable to ask about the effects and side effects of the drugs they take and might not know that some could be addictive.

10. What issues were raised in relation to young immigrant women?

The consultation with members of the Canadian Ethnocultural Council Women's Network included a special workshop with young immigrant and ethnocultural minority women who identified substance use and abuse as a priority issue. Many of the issues that affect young women in general may be compounded for young immigrant women. The issues included:

- culture shock;
- peer pressure and a social atmosphere in Canada supporting substance use;
- information, outreach and health policies (including those that targeted ethnocultural communities) that did not focus on youth;
- gender blindness in youth programming ("youth" groups almost exclusively male) which masks the reality of young women's lives and contributes to the lack of services and programs for them;
- family responsibilities that might make it difficult for young women to participate in programs;
- a lack of female role models in leadership positions including community-based prevention programs;
- racial stereotypes and bias in information material on illicit drugs, alcohol and tobacco;
- immigrant parents unaware of the "warning signs" of their child's potential drug abuse until they became involved in a crisis (i.e., trouble with the law);
- normal inter-generational conflicts complicated by communication problems between parents and children (parents lack official language, children lose mother tongue);
- loss of status or class position of parents and entire families after immigration to am Canada;
- unemployment, underemployment and poverty; and
- racism and other difficulties parents had in protecting their children from discrimination.

11. What role do immigrant women's cultures play in relation to possibly different patterns of substance use and access to services?

Many informants suggested that immigrant women's cultures, religions, and/or traditional values kept them from using or abusing some or all substances, especially in comparison with men. Many of those with minimal or no experience working with immigrant women also suggested that the "immigrant woman's culture" explained differences in the way that immigrant women used or abused substances, compared to non-immigrant women.

Some informants identified common issues for all women facing substance use problems or seeking treatment in Canada, regardless of their cultural origin. The issue of cultural differences was turned around by other informants. They identified the "mainstream" culture and the insensitivity of service providers or program staff as the main barrier, not the assumed culture of the immigrant woman in need of services.

Assumptions were sometimes made about immigrant women's preferences for a specific treatment approach without asking the women themselves why they did not use certain settings or felt uncomfortable with certain approaches. Many of the service providers attributed the reason for women not using the service to the women's culture, rather than to barriers created by the services or the 'mainstream' culture.

Some informants assumed that important cultural differences between immigrant women and all other women were strong enough to influence substance use patterns. These patterns remained intact for long periods of time after immigration, were transmitted to children and grandchildren, or remained relatively untouched by "mainstream" norms. These different behaviours were then thought to be exhibited with little variation by all individuals who self-identified as belonging to a particular ethnic community, or were identified by others (due to their language, skin colour, or religion, for example) as being members of a particular, non-mainstream ethnic group.

Other informants contrasted the cultural norms and values of recent newcomers with those of individuals who had been in Canada for a long time, and/or they recognized the social stratification of people belonging to different "cultural" groups as affecting the way that their problems were assessed or addressed. These informants operated with a more dynamic and fluid interpretation of the idea of "culture" and its impact on various conditions of immigrant women's lives, including patterns of substance use, misuse, and abuse.

V REFERRAL PATTERNS, ACCESS AND BARRIERS IN CURRENT SERVICE DELIVERY

- If immigrant women are experiencing problems with substance use, where are they going for help?
- Can immigrant women who need help with substance use problems get help?
- What barriers keep them from having equal access to health promotion programs or activities?

"I'm working on an outreach basis. I'm counselling clients. I might be able to help them as outpatients, but if there is a problem, a drinking problem that goes beyond that, outpatient counselling is not enough. There is no residential treatment program where I could refer a client. I would like to have at least one counsellor in a treatment program somewhere that I could refer to."

Mainstream health organizations faced with a non-English or non-French speaking immigrant woman tend to refer them to a settlement or immigrant aid organization. Since settlement workers and women within the ethnocultural communities generally do not have the expertise or resources to deal with substance use issues, immigrant women were referred back to mainstream health workers. How many women get lost in this services "ping-pong" game? Nobody seems to have a clear idea.

The almost total absence of any appropriate services or programs is further complicated by misinformation about what exists, leading to incomplete and inappropriate referrals. This was especially notable in relation to services or programs in non-official languages. In some urban centres, including those with high concentrations of immigrant populations such as Toronto or Vancouver, a number of programs and services were mentioned repeatedly as places where immigrant women with substance problems could be served in their own language. Direct contact with these settings almost always revealed that services were not, in fact available in any language other than an official language or, less frequently, that there were some programs in a non-official language, but they were for men only.

The specialized health support services that non-profit or volunteer immigrant settlement organizations and/or ethnocultural groups were able to provide are frequently overestimated. Direct contact with many agencies or services mentioned as a place to refer immigrant women with substance problems "within their own community" revealed that they seldom had the resources or expertise to address substance use issues at all, much less the specialized expertise needed to work effectively with women.

Many immigrant women who need help dealing with substance use problems may not find it easy to get what they need. Many will receive no help or information at all; others may get some assistance in a language with which they are not familiar, a few may get help from people who speak their language but who are inexperienced in the area of substance use or addictions; others may be offered assistance from a perspective that does not take into account their cultural reality and/or their specific needs as women.

This gap in services was remarkable and seemed to be almost invisible to many otherwise committed professional people who appeared to care about women's health. There seemed to be a great readiness to pass on immigrant women to other services without ever verifying whether these other services were available or able to meet their needs.

What barriers make it difficult for immigrant women to access health promotion programs or services?

- language differences and the lack of services in a language other than English or French;
- inadequate interpretation services for women who are not fluent in an official language;
- untested assumptions about immigrant women's cultures or needs;
- lack of childcare;
- intake or referral requirements that inhibit immigrant women's access (e.g., insisting on self-referrals by women or having to go through detox first);
- individual and systemic racism within the health system;
- inappropriate or inadequate outreach strategies (such as public meetings or information written in official languages only);
- the structure of health service delivery in Canada;
- a medically oriented health care system and sexism within the system that tends to dismiss women's complaints and over-medicate women;
- a lack of woman-oriented treatment approaches to health;
- inaccessible service locations; and
- inappropriate or inadequate assessment tools (e.g., available only in English or French, not cross-culturally tested or with embedded racism or stereotypes, not tested in the Canadian environment and relying on high levels of literacy).

VI DESCRIPTION OF EXISTING PROGRAMS AND ACTIVITIES

> "Immigrant and refugee women more likely are coming to talk about the social determinants of health, social impact issues, and then speak about substance use. For example, the topic of a workshop could be: stress in the workplace. Do we use tobacco? Do we use alcohol to deal with the stress? It is very important to see the context in which it is done and which issues are addressed. We have to be very careful; we want to address the real issues, they are not the use, but what the social issues are around us."

One important objective of this study was to discover the effectiveness of programs addressing substance use issues for immigrant refugee, and women of colour. Given the nature of community-based programs for ethnocultural and racial minority groups and the women within those groups, it was not surprising that we were unable to locate programs that met the requirements for a formal evaluation (i.e., have clearly formulated goals, stable and sufficient resources to have permitted consistent operation over time, appropriate empirical data collected in an objective manner over time, etc.). In addition, regional variations in population, services available and patterns of substance use would make it difficult to compare the effectiveness of different types of services across locations.

Rather than having an evaluative focus, the program-related information was collected with the intent of providing as detailed a description as possible of programs and program components, including such elements as target group, risk factors, specific activities, and any outcomes available.

Sixteen different settings across Canada were identified that are attempting to address the issue of substance use and immigrant women in some way. Most focused on prevention or education rather than treatment. The majority had women as a specific target group. A few were geared to both genders but were particularly aware of women's issues or needs within another specialized target group (seniors, youth).

The programs were selected to illustrate a variety of different entry points into the issue of substance use among immigrant women across the country (e.g., within settlement services and immigrant women's programs, community programs, community health centres, shelters and women's treatment facilities, senior and youth programs, and pregnancy outreach programs).

Common Elements

Despite considerable diversity in approach, target group and resources available, it was possible to identify some common elements among the programs. These were elements that informants considered to be important and likely to lead to some success. They include the following:

- providing services in the language of the women;
- modelling inclusiveness through hiring staff from diverse linguistic, racial and ethnic backgrounds;
- using informal methods for delivery of information; researching demographic realities of the community being served and targeted; addressing substance use in the context of other health promotion issues;
- emphasizing self-esteem and self-management as the main health promotion goals for immigrant women;
- carefully identifying community needs before implementing programs; using a range of methods for outreach and publicity;
- using a range of methods for delivery (including groups held in an agency, workers going to groups where women already meet, individual counselling, home visits, etc.); and
- attention to infrastructure, recognizing the barriers that keep many women from attending programs (childcare available on-site, transportation, interpretation).

In addition, the majority of informants in the described programs (as well as the majority of all informants interviewed in this research) were of the opinion that:

- immigrant women in general are less likely to use alcohol or illegal drugs than either immigrant men or Canadian women;
- their substance misuse problems are to be found in the area of prescription medications;
- they are mostly interested in other substance use issues in relation to problems being experienced by their spouses or children; and
- the inability to communicate in an official language creates a significant barrier for most immigrant women who might need to access any health related services.

VII SUGGESTIONS FOR PROGRAM DEVELOPMENT

> "The first thing is to develop a framework a philosophy of working, understand why the issue is there. Then do a very serious needs analysis, talk to the women, listen to the women, and then begin to develop long term strategies. Stop patching. Go to the government say this is the issue, have it documented objectively, say this is a long term strategy."

Although few informants had worked in the specialized area of substance use with immigrant women, many made suggestions about ways that education, prevention, and/or treatment services for immigrant women could be developed, based on related experiences with immigrant women's health or in, the area of women and substance use.

The following section presents a summary of suggestions regarding the effectiveness of programs and activities. Opinions about the usefulness of many approaches and methods varied considerably. This variance illustrates why "recipe" approaches, in which one type of program is applied to all immigrant women, may not be as effective as more flexible approaches. Inconsistent results from the same approach also illustrate the importance of assessing the context in which programs are designed, resourced, staffed, implemented and evaluated.

1. How should programs for immigrant women be organized and structured?

> "What is needed, as well as awareness and sensitivity and a different atmosphere, is a diversity of staff, so that you can show that people there are like people who are coming in for services; pictures on the wall, showing that you are representative of more than one culture or race; an approach and tools you use in counselling that draw from a range of cultures, that kind of thing. And strong awareness that language is a barriers."

Many of the informants with expertise in delivering services and programs to immigrant women recognized that how programs were organized and structured influenced whether or not immigrant women would use or benefit from them. Based on their experience in delivering health promotion, education and/or women's programs with immigrants, the following practical suggestions were offered:

- locating programs close to where immigrant women live and in places they frequent;
- flexible approaches to home visits (some informants have positive experiences, others negative);
- economic and other incentives for participation;

- flexible intake procedures that are accessible to women and open to their advocates;
- program delivery in the languages preferred by immigrant women; and
- cultural interpretation to facilitate program access where other language options are not feasible.

2. What should be the focus and content of health promotion programs for immigrant women?

> "People have knowledge and experience and are able to facilitate the circulation of their knowledge. People know what's wrong in their lives. They are in pain. On that basis, they then can be supported in their intentions to change. This outlook changes the whole perspective, social and political."

Several informants emphasized that the only successful health promotion programs for immigrant women were those with a woman-centred and anti-racist approach. These must be developed by immigrant women themselves in collaboration with the health system and service providers.

Alternative Health Models

Programs which incorporate alternative visions of health and health care have a greater chance of succeeding with immigrant women. On the other hand, there was also recognition that "mainstream" service providers or agencies may not have enough knowledge in this area to implement any real alternatives at this stage. A few informants emphasized that it was important in all work with immigrant women to maintain considerable flexibility and to be open to repeated experimentation in program delivery.

Group and Individual Services

Informants had very different experiences and degrees of success in both group programs and individual services. Some informants seemed to have had no problem getting immigrant women out for social activities and meetings and considered group activities to be an essential element of any health promotion program. Others were equally convinced that immigrant women would never participate in group activities and should be served on an individual basis or through more diffuse methods.

Program planners must guard against making incorrect assumptions about people from the same background or linguistic community, expecting that they will automatically trust each other and feel comfortable in a group together.

Advocacy

Advocacy was mentioned frequently as an essential element in any program for immigrant women, and health promotion programs were no exception. This may take the form of advocating on behalf of an individual woman, or it may be part of an effort to improve the situation of a group of women or an entire community.

Program Content

> "Self-esteem would be the most important issue in promoting the health of immigrant woman. It is the most powerful weapon that a woman has to rebuild her rights, within the family and outside of it. Among immigrant women, this is a very common factor, the lack of language, the loss of her economic status, leads to a reduction of women's self esteem of about 80%".

The following aspects are considered crucial in designing any program for immigrant women that addresses substance use:

- self-esteem, empowerment, social and economic justice need to be a primary focus;
- starting from where women are at is fundamental to build on their experiences and knowledge;
- offering a choice of programs, including those for immigrant women only, to ensure that women have an opportunity to talk freely about their experiences as immigrants; and
- placing an indirect focus on substance use since this has not been identified yet as a health priority by immigrant women and their organizations.

3. How can existing services be made accessible to immigrant women?

> "I want buddies. I want them to stop hiring white mainstream blue-eyed Canadians to become multicultural workers and hire the people in the communities that have the expertise and the knowledge. I want people who have lived this experience. They have to be working together with us. They are hiring more. There are a lot of qualified immigrant people and make sure that you have money for cultural interpretation. Everybody should have this money in their budget ... If you have substance abuse information that's only written in English and French, how can you reach people? If only in two languages, how is it going to help?"

Ensuring that existing services are accessible is equally or more important than developing new programs or services for immigrant women.

Staffing

Many informants suggested ways that access could be improved in terms of who should provide services. Informants working with immigrant women frequently mentioned that access to services would be greatly improved when institutions, agencies and community centres hire more staff from different linguistic and ethno/racial backgrounds.

Training

What training or education would support successful provision of health promotion services to immigrant women? In addition to having diverse and multi-lingual staff, many informants mentioned sensitization to cross-cultural and immigrant women's issues, including anti-racism, as an essential program element.

Outreach

There were different views about the best way to inform immigrant women about services, programs, and how to reach out to their communities. Some informants felt that the same strategies and approaches that worked with Canadian-born women (the more traditional methods, such as advertising in the newspaper, on TV., etc.) would also work with immigrant women if the language barrier was lifted. Others suggested very different outreach and education strategies depending on the specific situation of the community being targeted. However, few informants were able to provide much detail on how outreach and education strategies would differ for immigrant women.

Community Liaison

Beyond outreach to individual potential clients, a few informants were trying to work more closely with immigrant serving agencies, immigrant women's groups, and/or shelters or other specialized women's treatment services. Some had been successful with this approach; others had not.

4. What material is available to help disseminate information about substance use to immigrant women?

Many informants recognized the need for effective dissemination of accurate information about substance use, misuse and abuse using methods and materials that were relevant and accessible to immigrant women. The majority of informants who worked with immigrant women emphasized that offering information and services in the language of the women was the most efficient way of communicating to non-official-language speakers.

Assessing Accessibility of Services Prior to Reaching Out

Many informants, especially those from the immigrant serving community, pointed out that providing knowledge and information about services was insufficient if the seances themselves remain inaccessible to immigrant women. Some informants were concerned that many mainstream services add-on multilingual outreach strategies without considering what would happen if a non-English speaking woman 'knocks on their door' for help, and there is nobody who could speak with her.

VIII CONCLUSION

This study confirms that little is known about substance use and immigrant, refugee, racial and ethnic minority women in Canada. Unfortunately, reliable national data is not available at this time. However, a few regional and local studies have looked in a systematic way at substance use among women in the immigrant and racial and ethnic minority populations.

The few programs and activities aiming to improve the health of immigrant women appear to be limited in scope and of generally short duration. Although some immigrant, ethnic and racial minority women's organizations recognize that substance use is a potential area for health promotion activities, priority is consistently given to other areas which impact on immigrant women's health and are considered far more urgent. These areas include poverty, economic and social marginalization, racism, childcare, reproductive health, violence, workplace health hazards, and issues of self-esteem and human rights.

Although many of these areas might be linked to substance use, the connection is not primary in the analysis that immigrant women make of their own situations. In addition, the main barriers that immigrant women face to access health services and health promotion programs are consistently identified as the following:

- language differences;
- lack of interpretation services;
- lack of knowledge about their own rights and ability to use the system;
- lack of knowledge about the services available;
- lack of knowledge on the part of service providers about the realities of immigrant women's lives;
- sexism; and
- prejudice, stereotyping and racism within the health and social service system.

One disturbing finding from this study was the extent to which immigrant women with substance use problems are ignored by every level of the service providing community, including those immigrant and health service organizations with a special interest in women. Even many of the service providers committed to ensuring woman-sensitive addictions and other types of counselling seem to remain unaware that there is a lack of woman-oriented services or facilities accessible to immigrant women. It is as if immigrant women were not ’women’ for the purpose of most women’s health promotion programs.

The "ping-pong" pattern of referrals back and forth from the "mainstream" to the "immigrant services" that has been described in this report ensures that many immigrant women will not be picked up by any service or program until they are in severe crisis. The desperation of women and their families who may have to deal with these problems on their own is not recorded or entered into the official knowledge upon which health programming decisions are made. In particular, this pattern of referrals contributes to few immigrant women being able to benefit from the considerable gains that have been made in recent years in understanding, treating and preventing substance use problems from a woman’s perspective.

In relation to substance use problems and despite the lack of concrete data, there is considerable anecdotal evidence that prescription drug use/misuse may be the most critical area for attention at this point. This finding is not unexpected given that national data indicate that Canadian women use prescription drugs more than Canadian men. National data also suggest that this may be an issue for seniors. Since the senior immigrant population has a greater percentage of non-official-language speakers, the group of senior immigrant women may require special attention.

Inappropriate prescription medication use is linked to the prescriber while many physicians over prescribe and/or prescribe inappropriately for women. If women, in general, have limited access to supportive doctors who won’t over prescribe, then immigrant women who speak no official language have even less access. As suggested by groups for other sectors of the Canadian female population, this study suggests that education in this area must also focus on the medical profession.

In relation to tobacco use, the national data suggest that women born outside of Canada tend to smoke less than Canadian-born women. The anecdotal evidence also suggests that immigrant women may have very diverse use patterns. This extreme variance should be examined with great care, taking into consideration both the attitude towards and the prevalence of tobacco use in women’s countries of origin and current Canadian conditions (such as cost) which may impact on changing use patterns.

Smoking among immigrant women should not be ignored in health promotion planning, regardless of whether immigrant women smoke considerably less than non-immigrant women Prevention strategies could begin by identifying the factors that make women born outside of Canada less likely to smoke than Canadian-born women and assessing how these factors could contribute to the development of prevention strategies across the entire population. In

addition, special attention should be paid to changes in tobacco advertising that might reflect industry awareness of an "untapped market" among immigrant women, so that effective responses can be developed.

In relation to alcohol, the anecdotal evidence seems to indicate that there may be a considerable but "hidden" problem, especially among older immigrant females that have lived in Canada over twenty years. Based on the small number of figures collected by various treatment and referral services, the problem is well hidden indeed; immigrant women are almost invisible within the network of prevention and treatment settings across the country. Is this due to a lower rate of alcohol problems among all the immigrant, refugee, racial and ethnic minority female population? Cultural or other factors that affect all non-Canadian born, non-white, non-Anglo/French women in a similar way, keeping them from using existing services? To alternative methods for coping with alcohol problems among non-Canadian born, non-white, non-Anglo/French individuals? To inappropriate or insensitive treatment approaches? To a lack of access to treatment services for women in general? To language barriers or cultural differences? To systemic racism and cultural stereotyping? These questions merit much more serious investigation.

Illegal drugs are not perceived to be a problem among immigrant women with two exceptions. First, the link with extreme marginalization, poverty, and prostitution in inner cities was identified. Immigrant women in this situation would benefit from the type of programs available to reach out to other sex trade workers with attention being paid to issues of accessibility, cultural relevance and language in any such programs. Second, the concerns about younger immigrant women and immigrant women’s Canadian-born daughters are similar to those mentioned regarding tobacco; as use patterns begin to resemble more closely Canadian women’s use patterns, the issue of illegal drug use may become more prominent. It is also important to keep in mind that national data does not suggest that there is a major illegal drug problem in Canada, and this should help keep the focus of such strategies in perspective.

Despite the difficulties and barriers documented in the study, it is encouraging that a number of program activities throughout the country are addressing substance use issues for immigrant women. Most of these activities focus on education and prevention with a wide health promotion mandate, rather than directly addressing substance use only. A range of strategies are being tried for outreach and delivery of information to a small number of target groups but to date, have produced only mixed results.

At the same time there are certain factors that hinder the development of activities to meet the health promotion needs of immigrant women in this area. These factors include:

- a lack of knowledge of immigrant women’s realities;
- misinformation, untested assumptions, and sexist beliefs about women from different ethnic groups;
- cultural stereotypes about the substance use patterns of different ethnic groups;

- inappropriate staffing; and
- a lack of long-term resourcing for health promotion programs.

Programs with a comprehensive framework within which to understand the health promotion needs of immigrant refugee, and racial and ethnic minority women, take into consideration the economic and social factors which impact on health (including class differences, racism, gender inequalities) and offer interesting models for activities that may be reaching immigrant women more effectively. The connection between program philosophy and effectiveness deserves much more careful consideration.

Few, if any, comprehensive needs assessments that examine the health promotion needs of immigrant, refugee, and racial and ethnic minority women in any region, especially in relation to substance use, have been carried out. Many programs, therefore, may be floundering or focusing inappropriately on issues or needs which are not a priority for the women they are trying to reach. Without comprehensive community-based assessments and active participation from the people being "targeted", it is possible that the activities being undertaken by the many enthusiastic and sincere service providers will not have the intended effect. This area also requires much more careful examination.

Finally, in carrying out this study we were reminded of the wealth of knowledge and expertise that exists among immigrant, refugee, and ethnic and racial minority women in this country which should inform health promotion efforts directed at all women in Canada.

IX RECOMMENDATIONS

The above report includes a number of detailed suggestions made by a range of informants across the country regarding health promotion strategies and accessibility of health services for immigrant, refugee, and racial and ethnic minority women who might have a substance us problem. They will not be repeated here. Our intention in formulating the following recommendations is to focus on a few areas that emerged as a priority in research, information, education and program development.

1. Research

1.1 That research be undertaken on the patterns of and factors associated with substance use among all women in Canada is required. This will ensure that education prevention and intervention services respond to the specific and diverse needs of immigrant refugee, racial and ethnic minority women. It is essential that this research be undertaken in close consultation with immigrant women’s organizations with expertise in the area of health services; involve data collection at the local (community) regional and national level; use the tools that can be

understood by those women being investigated who do not speak an official language; and incorporate methods to facilitate the participation of socially marginalized individuals and groups.

1.2 That research be undertaken to assess the extent to which current health promotion strategies and programs pertaining to tobacco, other drugs or alcohol use have been effective in reaching and changing the behaviour of immigrant refugee and racial and ethnic minority women while paying special attention to those who do not speak an official language.

1.3 That research be undertaken to assess the specific barriers that keep immigrant, refugee and racial and ethnic minority women from accessing existing health promotion, substance use intervention and prevention programs.

1.4 That available national survey data and smaller scale studies describing the substance use patterns of immigrant and ethnic minority women be critically reviewed for limitations (such as validity of assumptions, definition of ethnic, immigrant, and linguistic groups, sample size and representativeness) affecting the validity and reliability of findings as applied to immigrant, refugee and racial and ethnic minority women, and non-official language speakers, before they are used as a basis for program development.

1.5 That community profiles, articles and other documents describing the substance use patterns of immigrant racial or ethnic minority individuals, be critically reviewed for limitations affecting the confidence with which the results can be extrapolated and projected to the entire group being described. Additionally, they should also be carefully reviewed for bias, racism, and cultural stereotyping before they are used as a basis for program development.

1.6 That research be undertaken on the pattern and context of substance use of younger immigrants and sons and daughters of immigrant parents in order to examine factors related to their substance use. These factors could include the transmission of Canadian patterns of values around substance use, peer pressure, integration, changing parent/child roles, cultural and linguistic differences, the impact of ethnic-self identification, labelling, and cultural stereotyping and racism.

2. Information and Education

2.1 That print and audiovisual materials in non-official languages be developed and distributed in consultation with organized immigrant refugee and racial and ethnic minority women who have expertise in health issues. These materials should be gender-sensitive, non-racist, culturally appropriate, and reflect the needs and realities of women in the different regions of Canada.

2.2 That partnerships be developed with the Canadian Medical Association, faculties of medicine, provincial regulatory bodies and organized groups of immigrant refugee and racial and ethnic minority women with expertise in health issues. These partnerships would contribute to the development of an education and prevention campaign directed at sensitizing physicians to the issue of over and inappropriate prescribing for women, especially older women, non-official language speakers and immigrant, refugee, racial and ethnic minority women.

2.3 That print and audiovisual materials be developed to address the information and education needs of all young women, including non-official language speakers, young immigrant, refugee, racial and ethnic minority women and daughters of immigrant parents.

3. Program Development

3.1 That community needs be carefully assessed prior to the development of health promotion programming. This should include the assessment of barriers that prevent non-official language speakers and immigrant, refugee, and racial and ethnic minority women from accessing existing health services or programs.

3.2 That new health promotion programs take into account that long-term comprehensive interventions are required for behaviour change and improved health in all people, including immigrant, refugee, and racial and ethnic minority women.

3.3 That existing programs designed for ethnic or racial and ethnic minority youth as well as those for racial or ethnic minority seniors, be assessed for appropriateness and accessibility by all women.

3.4 That substance use intervention programs advertising or listing services in non-official languages carefully review the extent to which these services reflect community linguistic needs, as well as the extent of their actual use by and availability to non-official language speaking women.

3.5 That substance use prevention and intervention services make special efforts to recruit qualified staff from minority ethnic, racial, and linguistic groups to provide culturally appropriate service to all clients. Personnel should be able to provide linguistically appropriate services to women who prefer to be served in a non-official language.

3.6 That substance use prevention and intervention services, especially women's services, be reviewed regarding the content and conceptual frameworks of their programs. This will allow racial, ethnic, cultural, religious and gender bias and stereotyping to be identified and removed.

3.7 That existing barriers which have been repeatedly documented in previous research as contributing to immigrant people's marginalization and consequent lack of equal access to services and opportunities (in particular, the lack of services in non-official languages and the lack of accessible, well-trained cultural interpreters in mainstream services and programs), be taken into serious consideration in the development and implementation of any new health promotion programs for non-official language speakers, immigrant, refugee, and racial and ethnic minority women.

3.8 That all levels of government and their agencies take concrete steps to address the health promotion priorities that immigrant, refugee, racial and ethnic minority women have identified over the last decade: poverty, racism, lack of child care, unequal access to health services, and social marginalization.

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