SERVICE PROVISION BY
Institutions and Identity

BY Cynthia Baker,
Université de Moncton

THERE IS WIDESPREAD AGREEMENT THAT INSTITUTIONS MUST RESPOND TO THE PLURALISM OF CANADIAN SOCIETY (TROPER & WEINFELD, 1999). WHAT IS LESS CLEAR IS HOW THEIR SERVICES SHOULD BE ADJUSTED TO ACCOMMODATE DIVERSE IDENTITIES IN CANADA. THIS HAS RAISED COMPLEX ISSUES IN A WIDE VARIETY OF POLICY DOMAINS. PROVIDING SERVICES TO A DIVERSE POPULATION HAS BEEN DISCUSSED EXTENSIVELY IN THE FIELDS OF EDUCATION, HEALTH AND SOCIAL WORK. CHANGING PERSPECTIVES IN THESE FIELDS HAVE REFLECTED SHIFTS IN THE FEDERAL UNDERSTANDING OF CANADIAN IDENTITY. AN HISTORICAL OVERVIEW OF THE APPROACHES PROPOSED IN THIS LITERATURE IS PRESENTED AND THEIR IMPACT ON THE DIVERSE IDENTITIES OF CANADIANS IS EXAMINED. PERSPECTIVES ARE SITUATED IN THE CONTEXT OF THE EVOLVING NATIONAL VISION OF CANADIAN DIVERSITY.

NATIONAL VISION OF IDENTITY AND DIVERSITY

Prior to the 1960's, Canadian identity was linked to western European culture and to being white (Samuel & Schachhuber, 2000). An explicitly racist immigration policy favoured the entry of white, preferably British-origin, Protestants (Abu-Laban, 1998). Cultural assimilation of immigrants and Aboriginals was promoted (Harper, 1997: Samuel & Schachhuber, 2000).

Following *The Universal Declaration of Human Rights* in 1948, principles of universalism gained ascendancy (Abu-Laban, 1998). The immigration laws of 1967 explicitly stated that there would be no discrimination of race nor colour nor religion and created the universally applicable point system. Equality of opportunity was emphasized, differences among Canadians were downplayed, and a vision of a national identity that transcended ethnicity, race and class was promoted (Harper, 1997).

There was a shift from universalism to an emphasis on differences, following the adoption of the *Official Languages Act* in 1969 and the introduction of the policy of official Multiculturalism in 1971. A vision of Canada as a mosaic within a bilingual framework defined cultural pluralism as the very essence of Canadian identity. Members of all ethnic groups in Canada were encouraged to maintain their cultural heritage (Esses & Gardner, 1996). Although the principle of social justice was an explicit element of the policy, it was largely put into practice through support of cultural programs celebrating cultural diversity (Esses & Gardner, 1996).

By the end of the eighties, demographically, the proportion of foreign-born Canadians from non-European regions and the number of visible minorities had increased significantly (Beaujot, 1999). The focus of multiculturalism was redirected from cultural support to redressing inequities, and combating prejudice, discrimination and racism (Department of Canadian Heritage, 2001).

SERVICES, DIVERSITY AND IDENTITY

Schools in Canada have been designated as the central institution for maintaining or transforming ethnic, racial, linguistic and religious identities. In the health and social work fields, diverse identities affect client access and utilization of services. At the start of the twentieth century, perspectives about Canada's pluralism reflected assimilation biases in each of these fields. By the end of the millennium, many of their practice models were advocating an anti-racist agenda (Harper, 1997; Tsang & George, 1998).

ASSIMILATION BIAS

During the first half of the twentieth century, ethnicity was conceptualized as a temporary phenomenon that could be replaced with a mainstream national identity through schooling (Davidson, 1996). In an historical review of educational services, Harper (1997) concluded that during this period schools in Canada specifically intended to ensure conformity to a narrowly-defined Canadian identity. As most immigrants in Quebec were integrated into the English rather than the French school system before Bill 101 in 1977, this identity reflected Anglo-Saxon culture and Western European values (Harper, 1997). Residential schools for Aboriginal children provided the most extreme examples of school services in Canada with an explicit and aggressive assimilation mission.

The effect of this assimilation mission on diverse identities was mixed. Sociological studies of ethnic persistence indicate that second-generation members of some groups assimilated into the mainstream society as predicted. Some retained an ethnic identity while participating in mainstream institutions and some continued to live much of their lives within ethnic enclaves (Breton, 1964; Herberg, 1989). The negative, long-term effects of the residential schools on the identities of Aboriginal students are still being reported (Royal Commission on aboriginal Peoples, 1996).

Although literature about diversity was sparse in the health and social service fields before the eighties, earlier perspectives focused on deficiencies or inferiorities needing correction, reflecting the biases associated with the assimilation vision of Canadian identities (Tsang & George, 1998). Members of given racial or ethnic groups were variously identified as at-risk for diseases (Padilla, 1981), for deviant social behaviour (Rubingon & Weinberg, 1971) and for social disorganization (Moyniham, 1965). Immigrant status was viewed as potentially pathological, placing the person at risk for mental health problems and for social maladjustment (Tsang & George, 1998).

The deficiency-based perspectives have been discarded and there is no systematic research evaluating their effects on identity. The impact of immigration on health and adjustment, however, continues to be investigated without the implicit inferiority assumptions of the earlier work.

IMPLICIT AND EXPLICIT UNIVERSALISM

Following the Second World War, educational theories reflected principles of universalism (Harper, 1997). Schools were to create a meritocracy, with success based on individual ability and motivation. Equality of opportunity for all students was prescribed and discriminatory practices were condemned (Harper, 1997). A cornerstone belief was that education offers people of different ethnocultural backgrounds a route to social mobility and to full participation in the mainstream society (Davidson, 1996). Recent research data indicate, however, that school services worked better for members of some groups than

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for others. An analysis of 1991 census data revealed that although the educational level of many ethnic group members was at or above the national level, Black / Caribbean and Aboriginal groups ranked substantially below it (Lian & Mathews, 1998). Furthermore, this study revealed that visible minorities have lower incomes than other Canadians have at the same educational level.

In the health and social services literature, an implicit universalism was reflected in a second approach to ethnocultural diversity prior to the eighties. Differences were either simply ignored (Masi, 1988) or there was an insistence that all clients be treated in the same way, whatever their gender, culture, ethnicity or race (Cooper, 1973). This denial of difference was manifested in curricula for health and social service professionals which provided little information on ethnocultural and racial diversity until the end of the eighties (Masi, 1988).

This implicit universalism was problematic for some clients. Intercultural counselling studies, for example, indicate that ethnicity, race and culture influence service providers' interpretations, diagnoses and treatment (Arthur & Januskowski, 2001). The Canadian Task Force on the Mental Health Issues Affecting Immigrants and Refugees (1988) also concluded that racial stereotypes bias client assessment and that a lack of understanding of a patient's culture leads to misdiagnoses.

PROMOTING CULTURAL PLURALISM

During the seventies and eighties, a multicultural education movement emerged that promoted cultural pluralism (Bruno-Jofré & Henley, 1999). Schools began to supplement their curricula with information about the food, festivals and folklore of various cultures (Kehoe & Mansfield, 1993). The major thrust of these initiatives was to support cultural retention and to promote respect for cultural differences (Bruno-Jofré & Henley, 1990).

The contribution of multicultural education to identity is difficult to assess, as evaluation research is scarce. An extensive literature review by Gamlon, Berndorff, Mitsopolous and Demetriou (1994) revealed that most publications about the topic were descriptive. Critiques, however, accumulated arguing that their impact on students' identities was limited (Thomas, 1987; Tator & Henry, 1991).

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Health and social service providers were slower than educators were to respond to the Multiculturalism Policy. By the early eighties, however, a movement calling for multicultural care was initiated and gained momentum (Masi, Mensah, & McLeod, 1993). Its impetus came primarily from front-line service providers and ethnocultural community leaders (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988).

Although the concept of multicultural care included the notions of equity and anti-racism (Masi, McLeod, & Mensah, 1993), the principal emphasis was on respecting *cultural* differences among clients, and language and customs were highlighted. This literature condemned the ad hoc use of unofficial translators and discussed the influence of culture on behaviours, such as dietary customs, rituals related to birth, terminal illness and death, communication styles, time orientation, folk medicines, family structure and gender roles (Kleinman, 1989). Programs were established to train cultural interpreters to act as brokers in interactions between professionals and culturally diverse clients (Cairncross, 1989). Agencies also began to translate educational materials into some of the languages spoken by members of the ethnocultural communities being served (B.C. Multicultural Health Coalition, 1989). Mainstream institutions developed policies permitting clients to practice their own customs. For example, hospitals attempted to respect patients' religious beliefs about food, rituals related to death and dying and customs surrounding childbirth. Information booklets listing customs of various cultures were developed as quick references to be consulted by service providers as needed.

Another attempt to respect cultural differences was the parallel service approach in which culturally specific organizations provided services to their own communities. For instance, Aboriginal service providers began developing programs designed specifically for Aboriginal clients. They incorporated a distinct Aboriginal worldview and traditional healing approaches, such as the healing circle (Morissette, McKenzie, & Morissette (1993).

These initiatives were not systematically evaluated. Critics, however, described the multicultural programs in mainstream institutions as "cook book" responses, based on the false assumption that members of a cultural group uniformly subscribe to easily identifiable sets of beliefs, values and customs (Matsuoka & Sorenson, 1991). They pointed out the non-acknowledgement of linguistic and ethnic differences within populations from the same country of origin, as well as the internal divisions within ethnic groups related to gender,

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class and political orientation. Tenuous funding and difficulties finding qualified personnel were problems associated specifically with parallel organizations (McNicoll & Christensen, 1996).

EQUITY, INCLUSION AND ANTI-RACISM

By the nineties, a new emphasis had emerged in the education, health and social service literature highlighting issues of equity and inclusion. Equity was understood in the sense of a levelled playing field rather than equality of opportunity (McLeod & Krugly-Smolska, 1997). Attention shifted from affirming cultural differences to acknowledging differences in privilege and power. In education, scholars began to make distinctions between multicultural and anti-racist education (Troyna, 1987; Harper, 1997; Dei, 2000). The former was described as seeking to create a greater degree of tolerance among students through positive representations of diverse customs. In contrast, the aim of anti-racist education was to challenge the social construction of race and the overlapping forms of oppression marginalizing some groups. School boards began to develop policies to combat racism and discrimination in schools.

A substantial body of research supports arguments for anti-racist education in Canada. Studies document that visible minority students experience racism in schools throughout the country, regardless of the proportion of visible minorities in the area (Potvin, 1999: Dei, 1994: Kelly, 1998: Baker, Varma, &Tanaka, 2001). Findings, however, regarding the actual effect of anti-racist educational policies in transforming identities are scarce. Studies suggest, however, that there may be a gap between the policy and what happens in practice (Solomon & Levine-Rasky, 1996).

In the health and social services literature, there has been a quest to develop more inclusive counselling approaches (Pederson, 2001). This search was built on earlier cross-cultural counselling models and included an emphasis on the impact of racism on the counselling relationship (Dyche & Zayam, 1995). Tsang and George (1998), for example, have proposed a model that is explicitly committed to an anti-discriminatory and anti-oppression position.

Social workers advocated an anti-racist approach as an alternative to multiculturalism (Christensen, 1995; James, 1996). They argued for interventions that attend to racial experiences, intersecting oppressions, empowerment and the development of critical consciousness.

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At the organizational level, bridging models have been developed to address equity issues. They involve partnerships between mainstream agencies and members of ethnocultural communities. Their goal is to facilitate access to mainstream resources and, at the same time, provide culturally congruent services to diverse clients (Matsuoka & Sorenson, 1991; McNicoll & Christensen, 1991).

As in education, little research has evaluated or compared the effect of the various anti-racism and equity-promoting models on outcomes nor assessed their impact on identities (Tsang & George, 1998). Studies, however, continue to find that, in practice, settings, cultural and racial differences are barriers to access and to the utilization of health and social services (Stephenson, 1995: Roy, Rhéaume, & Hétu, 1998 Browne, 1995; Baker & Cormier-Daigle, 2000; Browne, Fiske & Thomas, 2001).

CONCLUSION

Insufficient evidence is available regarding the impact of multicultural, anti-racist and various service models in education, health and social work. There is a need for comparative studies assessing their effects on students and clients from different ethno-cultural backgrounds living in areas with differing degrees of ethnocultural diversity and in different regions of the country. Studies suggest that there is a gap between formal multicultural and / or anti-racist policies and actual practice. This needs further investigation. In education, more research needs to be conducted examining the actual interaction of diverse groups of parents and students with school services. In the health and social service fields, studies of the factors that impede or facilitate the implementation, in practice, of intercultural and anti-racist policies need to be conducted. Finally, research has demonstrated that racism compromises access to appropriate services. Further research is necessary on the prevention of racism and discrimination in the provision of services.

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