Cultural Safety in Mental Health Services for Indigenous Peoples

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Welcome to the Network for Aboriginal Mental Health Research (NAMHR) Website

Funded by the Canadian Institutes of Health Research since December 1, 2001, the Network for Aboriginal Mental Health Research (NAMHR) is committed to building capacity for mental health and addictions research and knowledge translation in remote, rural and urban settings by working in close partnership with Aboriginal organizations and communities.

The priority of the Network is to develop research capacity. To that end, the emphasis is on networking and training for existing researchers and conducting a series of pilot projects that provide a basis to seek funding for larger scale projects from other sources including regular CIHR competitions, federal and provincial programs and Aboriginal organizations.

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Outline

• Knowledge, power and empathy

• The place of culture in mental health

• Strategies to address culture in mental health services

• Cultural safety in mental health services

• Knowledge communities and the politics of pluralism

• Person- and people-centred care
A Ritual to Read to Each Other

If you don’t know the kind of person I am and I don’t know the kind of person you are a pattern that others made may prevail in the world and following the wrong god home we may miss our star.

For there is many a small betrayal in the mind, a shrug that lets the fragile sequences break sending with shouts the horrible errors of childhood storming out to play through the broken dike.

And as elephants parade holding each elephant’s tail, but if one wanders the circus won’t find the park, I call it cruel and maybe the root of all cruelty to know what occurs but not recognize the fact.

And so I appeal to a voice, to something shadowy, a remote important region in all who talk: though we could fool each other, we should consider—lest the parade of our mutual life get lost in the dark.

For it is important that awake people be awake, or a breaking line may discourage them back to sleep; the signals we give--yes or no, or maybe—should be clear: the darkness around us is deep.

William Stafford
1914-1993
Radical Alterity and the Limits of Empathy

“Access to the face is straightaway ethical.”

— Emmanuel Levinas

- the face of the other confronts us with their humanity and through that with our own
- the other is at once both the same as us and different; known and also unknown and even partly unknowable
- this demands from us a relationship of respect, hospitality, and responsibility for care

Culture in Mental Health Care

• cultural influences health disparities, exposure to adversity, power and dynamics of care

• therefore need to recognize and respond to cultural differences in —
  • experience of racism, discrimination, structural violence
  • understanding of the problem (need for help) and of paths to wellness
  • language and styles of expression of symptoms, emotions, and distress
  • hierarchy of goals values ("what’s at stake") & sources of resilience

• opportunity to learn and practice one’s culture is a human right and a source of health and well-being


Strategies to Address Culture

• recognition of culture can occur at the levels of system, institution, practitioners and practice
  • ignoring difference/expecting people to adapt to the system ("one-size-fits-all" = fairness or ethnocentric culture-blindness?)
  • use of interpreters, culture-brokers and consultants
  • ethnic matching of patient and practitioner, intervention, service or institution
  • cultural competence of practitioner
  • cultural humility (Mary Tervalon)
  • cultural safety (Irihapeti Ramsden)
### Table 1. Levels of cultural competence

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Institution</th>
<th>Practitioner</th>
<th>Technique</th>
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<tbody>
<tr>
<td><strong>Examples</strong></td>
<td>Organizational cultural competence</td>
<td>Clinical cultural competence</td>
<td>Cultural adaptation of interventions</td>
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<tr>
<td></td>
<td>Institutional policies of equity, anti-racism, cultural diversity awareness</td>
<td>Ethnic matching of clinician and patient</td>
<td>Adjusting style of interaction and communication to patient</td>
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<td></td>
<td>Insuring that administration and staff are representative of ethnocultural</td>
<td>Training of professionals in specific and generic cultural knowledge, skills and attitudes</td>
<td>Matching intervention to patient</td>
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<td></td>
<td>composition of communities served</td>
<td>Referral to other professionals and helpers in the community</td>
<td>Cultural adaptation of interventions</td>
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<td></td>
<td>Engaging communities in policy making, planning, and regulation of services</td>
<td>Use of culture-brokers or mediators</td>
<td>Adoption of new interventions</td>
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<tr>
<td><strong>Benefits</strong></td>
<td>Can organize systems and services in ways that are responsive to needs of</td>
<td>Can facilitate initial trust</td>
<td>Referral to other sources of help or healing</td>
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<td></td>
<td>specific groups</td>
<td>Linguistic match facilitates communication</td>
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<td></td>
<td>Can address issues of power and discrimination, empowering community and</td>
<td>Shared cultural background knowledge facilitates mutual understanding</td>
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<td></td>
<td>resulting in greater equity, safety and trust in institution</td>
<td>Can provide role modeling of successful or resilient individuals from</td>
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<td>Can improve access and acceptability through community relationship to the</td>
<td>similar background</td>
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<td></td>
<td>institution and through design of specific programs</td>
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<tr>
<th>Institution</th>
<th>Practitioner</th>
<th>Technique</th>
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<tr>
<td>If focus is primarily on representativeness of governance and staff, actual delivery of services may be conventional. Institutional policies may not result in actual changes in behaviours of staff. Ethnospecific services may constitute a form of social segregation and fail to transform the general health care system.</td>
<td>Match may be crude or approximate (owing to differences in ethnicity, subculture, social class, education, dialect, etc.). Clinician may not know how to apply their own tacit cultural knowledge to clinical care. Clinicians may be feel typecast, professionally limited or marginalized. Patients may feel singled out, racially categorized, stereotyped. Patients may feel exposed to scrutiny by their own community and may wish for the psychological distance or privacy associated with meeting a cultural ‘outsider’.</td>
<td>Adaptation may be superficial or purely cosmetic. May lose elements essential for efficacy. Culturally-grounded methods may not address issues related to cultural hybridity or culture change. Culture-specific or traditional methods may be socially conservative and do not allow patients opportunity to escape from culturally mediated or rationalized forms of oppression. Interventions may not be familiar or appealing to patients who eschew tradition and value other (“modern”, scientific) approaches.</td>
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Cultural Competence

• Usually defined in terms of outcomes:

  • “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations” (Cross, Bazron, Dennis, & Isaacs, 1989).

  • “the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (Betancourt et al., 2003).

Cultural Competence

- Awareness of own identity, how it affects clinical practice, and its potential meaning to patients
- Language and communication skills
- Knowledge of issues of racism, discrimination, structural violence, power, and position
- Specific cultural knowledge (developmental processes, family structure & process, migration, explanatory models of illness, healing practices)
- Relationship of practitioner and institution to local cultural communities
Cultural Competence

- Awareness of helper’s own identity, how it is seen by others and affects clinical practice

- Language and communication skills (learning to listen; learning to dwell within a language and worldview)

- Knowledge of issues of racism, discrimination, structural violence, power, and position (“structural competence”) 

- Specific cultural knowledge (history, developmental processes, family structure & process, explanatory models of illness, healing practices, values, spirituality)

- Relationship of helper and institution to local cultural communities

Cultural Competence: Advantages

• insists that professionals must acquire specific knowledge and skills to address diversity

• focuses on basic attitudes, knowledge, and skills that can be incorporated into training and accreditation

• aims to provide a general approach that can be applied to every situation

• complemented by developing knowledge of local populations and communities

• encourages thinking about mental health problems in context

• include awareness of cultural roots of professional practice
Cultural Competence: Limitations

• tends to focus on the culture of the other, rather than of the dominant institutions

• may be interpreted superficially; reifying and essentializing culture and stereotyping ethnocultural groups

• treats culture as a property of individuals rather than communities

• fragments culture as a set of traits or variables rather than as an integrated, dynamic system, structure, and set of inter-related social values, roles, institutions, practices, and contexts

• treats negotiation of values and perspectives as a technical issue outside the interpersonal relationships and larger structures of power and domination

• appropriates culture of the other, subsuming it under professional knowledge and thus disempowering the patient and the community
Trauma and how it is transmitted to future generations can help reveal inter-group commonalities about how traumatic events are experienced at individual and family levels, where such legacies are most keenly felt. (MacDonald, p. 1010)

There are several dilemmas with this strategy. As Table 1 outlines, there are profound differences between the kind of trauma experienced and the subsequent

<table>
<thead>
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<th>Table 1. Comparison of Holocaust and Indigenous Historical Trauma.</th>
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<td><strong>Pre-trauma Context</strong></td>
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<td><strong>Types of violence</strong></td>
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<td><strong>Types of loss</strong></td>
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<tr>
<td><strong>Post-trauma context</strong></td>
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<td><strong>Larger social context</strong></td>
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<tr>
<th>Personhood</th>
<th>Self Defined By</th>
<th>Dominant Values</th>
<th>Sources of Resilience &amp; Healing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egocentric</td>
<td>personal history, accomplishments</td>
<td>individualism</td>
<td>self-esteem, competence</td>
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<tr>
<td>Sociocentric</td>
<td>family, clan, community</td>
<td>familism, collectivism</td>
<td>relationships with others</td>
</tr>
<tr>
<td>Ecocentric</td>
<td>environment, ecological relationships</td>
<td>ecological balance, exchange</td>
<td>connection to the land</td>
</tr>
<tr>
<td>Cosmocentric</td>
<td>ancestral lineage</td>
<td>cosmic order</td>
<td>spiritual or religious belief and practice</td>
</tr>
</tbody>
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Cultural Safety

- Understanding historical and contemporary social, economic and political contexts that create health disparities, social inequities, and structural violence
- Building relationships with others based on recognition, respect, and inclusiveness
- Establishing a safe communicative situation, giving space to the other, sharing power and control, learning each other’s language
- Recognizing diverse knowledges and ways of knowing as intrinsic to clinical work and to mental health promotion


Cultural Safety: Advantages

- Goal is to create a safe space for dialogue, knowledge exchange and collaboration

- Awareness of structural violence and its impact on health systems and one’s own identity and position vis-à-vis patients

- Attitudes of respect, humility, interest and concern expressed through dialogue and a collaborative process with patient and family

- Shift in sharing of power and authority in decision making
Cultural Safety: Limitations

- approaches culture and identity in terms of vulnerabilities instead of strengths
- emphasizes practitioners’ capacity to harm rather than to help
- emphasizes colonialism but not other pervasive forms of structural inequality (e.g. globalization, consumer capitalism)
- may displace individual experience in favour of collective narratives
- does not explore dilemmas of minority provider treating privileged patient
- details of implementation and evaluation still limited
From Cultural Competence to Cultural Safety

- Goal is to create a safe space for meeting, dialogue and collaboration

- Awareness of and working through one’s own stereotypes, biases and assumptions

- Awareness of the meaning of one’s identity and position for patients and clients

- Attitudes of respect, humility, interest and concern expressed through dialogue and a collaborative process with patient and family

- Use generic and specific cultural knowledge not to stereotype or assume answers but to guide inquiry

- Assessment, formulation and intervention based on conceptual models of the place of culture in psychopathology, healing and recovery

- Build relationships with community groups, organizations, and institutions not only as resources for professional action but as sources of help, guidance, and political action in their own right
Indigenous Strategies of Resilience

- Connection to land and sense of place as ways of constituting and regulating the ecocentric self
- Recuperation of tradition, language, spirituality, healing as personal and collective resources
- Stories and storytelling as privileged way of knowing and transmitting collective identity
- Political activism as source of collective and individual agency

Guidelines for Training in Cultural Psychiatry

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A position paper developed by the Canadian Psychiatric Association's Section on Transcultural Psychiatry and the Standing Committee on Education and approved by the CPA's Board of Directors on September 28, 2011.

Introduction

Canada is a highly diverse society and Canadian scholars and clinicians have been world leaders in efforts to understand the impact of culture on mental health. However, to date, there have been no national guidelines for the integration of culture in psychiatric education and practice. This paper, prepared by the Section on Transcultural Psychiatry of the Canadian Psychiatric Association (CPA) for the Standing Committee on Education, sets out the rationale, content and pedagogical strategies for training in cultural psychiatry. It is based on a review of literature, experiences with existing training programs and expert consensus. This paper addresses issues relevant to general psychiatry as well as specific populations, including immigrants, refugees and ethnocultural communities as well as First Nations, Inuit and Métis.

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Aboriginal Mental Health

Aboriginal people constitute about four per cent of the Canadian population but bear a disproportionate burden of mental health problems.\(^78\)\(^79\) Although there is wide variation across groups, the higher rates of psychiatric and substance abuse disorders found in many segments of the indigenous population can be linked to the enduring effects of historical social, economic and political policies of forced assimilation, marginalization and discrimination.\(^60\)\(^-\)\(^63\) The Indian Act, the Indian Residential School system and the child welfare system have had profound effects on the mental health of Aboriginal populations.\(^64\)\(^66\) However, Aboriginal individuals, communities and peoples have unique resources and strategies of resilience reflecting culture, language, spirituality and connections to family, community and place.\(^67\)

There is wide recognition of the need for training in cultural competence to respond to the mental health needs of Aboriginal Peoples.\(^68\)\(^69\) Many communities are located in remote regions, posing logistical problems in delivery of care that require consideration of specialized approaches, with close collaboration with community workers, mobile crisis and consultation teams, and telepsychiatry. More than 50 per cent of Aboriginal people live in cities where they may not have access to culturally appropriate services that respect and make use of their linguistic, cultural and spiritual traditions. The National Aboriginal Health Organization, the Aboriginal Nurses Association of Canada, and the First Nations, Inuit and Métis Advisory Committee of the Mental Health Commission of Canada identified cultural safety as an important framework for the development of training programs and institutional changes to improve the quality and appropriateness of mental health care.\(^69\)\(^91\) Cultural safety focuses on the structural inequalities and power imbalances that make clinical encounters unsafe for Aboriginal people.\(^67\)\(^92\)\(^93\)

Recently, the Indigenous Physicians Association of Canada and the RCPSC have developed core curriculum and clinical interviewing training materials for residents.\(^94\)\(^95\) Training involves reading, discussion, role-playing and interaction with trainers from Aboriginal communities, to provide:

1. A basic understanding of the links between historical and current government practices and policies toward First Nations, Inuit and Métis Peoples and the social determinants of health, access to health services and intergenerational health outcomes.

2. Reflection on trainees’ own cultural values and emotional responses to the history, identities and contemporary events involving First Nations, Inuit and Métis.

The curriculum developed for family medicine residents also addresses specific clinical skills relevant to psychiatry, including:

1. Cultural safety in clinical interviewing.

2. Identifying culturally appropriate community resources for treatment.

3. Developing an integrated treatment plan.

Core Competencies and Essential Skills

Cultural competence involves attitudes, knowledge and skills that enable a mental health professional to provide competent, equitable and effective care to meet the diverse needs of all patients.\(^68\) This requires addressing basic cultural issues, including:

1. The clinician’s own identity and relationship to patients from diverse backgrounds.

2. Communication skills and familiarity with how to work with interpreters and culture brokers.

3. Conceptual models of how cultural context and background influence developmental processes, psychopathology, help seeking, coping and adaptation to illness, treatment response, healing, recovery and well-being, as well as moral and ethical issues.

4. Specific knowledge of the particular populations and communities with which the clinician is working.\(^3\)\(^3\)\(^97\)

Acquiring cultural competence requires didactic teaching, mentorship and supervised experience in specific clinical and community settings to address each of these domains. At a minimum, this would include:

1. The opportunity to explore and reflect on one’s own cultural background and identity as a resource and a source of bias, and to address the interpersonal and institutional dynamics of racism, power disparities, social exclusion and acculturative stress as they impact on mental health and clinical work.

2. Basic knowledge of current research and conceptual models in cultural psychiatry, medical anthropology and cross-cultural psychology relevant for understanding social and cultural influences on the mechanisms of psychopathology as well as cultural variations in symptom expression, help seeking, treatment adherence and response.

3. Training in working with medical interpreters and culture brokers as well as immigrant settlement workers, community workers, counsellors, helpers and healers.\(^98\)

4. Familiarity with the values, perspectives and experiences of local communities pertinent to psychiatric care, including ethnocultural groups, immigrants and refugees across all age groups and life-cycle stages (child, youth, adult and elder).
Cultural Adaptation for Mental Health Promotion with Aboriginal Populations

TOOLKIT
Version 1.0

GUIDING PRINCIPLES, CASE STUDIES & RESOURCES
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Responding to Cultural Diversity in Mental Health

The MMHRC provides access to resources to support culturally safe and competent mental health care for Canada's diverse population. Please join us to build a community of practice.

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Notre bulletin pour mars est maintenant
The Division of Social and Transcultural Psychiatry is a network of scholars and clinicians within the Department of Psychiatry, Faculty of Medicine, McGill University, devoted to promoting research, training and consultation in social and cultural psychiatry.

The broad themes of research and training conducted by members of the Division include:

**Social Psychiatry**

- psychiatric epidemiology
- social causes and consequences of psychiatric disorders
- psychiatry in primary care
- social treatments, rehabilitation and prevention strategies
- evaluation of services

**Cultural Psychiatry**

- mental health of indigenous peoples, ethnocultural minorities, immigrants and refugees
- international community mental health
- indigenous healing practices, ethnopsychology and ethnopsychiatry
- cultural critique of Western psychiatric theory and practice
References


