BUILDING BRIDGES 2

A Pathway to Cultural Safety, Relational Practice and Social Inclusion

Final Report

November, 2010

Native Mental Health Association of Canada
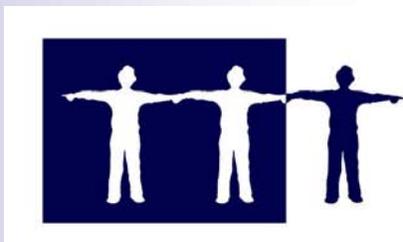
Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

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EXECUTIVE SUMMARY

The Native Mental Health Association of Canada (NMHAC) and the Mood Disorders Society of Canada (MDSC) have a rich history of working collaboratively and sharing their respective expertise in regard to "what works" and "what does not work" in mental health and addictions programs and services. Groundbreaking national initiatives comparing and contrasting similarities and differences between their indigenous and non-indigenous constituents, along with finding common ground and identifying goals for future collaboration, served as the pillars of this unique and effective partnership in Canada.

Aboriginal people and consumers need holistic and relational models of care to develop a sense of belonging and to support their recover y from mental health problems and addictions. These problems do not arise in a vacuum; they emerge within the context of each person's life history, individual strengths and challenges, current life circumstances and stressors, and they are often inter-related. Healing cannot happen unless people feel safe. People feel safe when service providers view them as whole persons rather than disease entities and treat them with compassion, empathy and respect. Unfortunately, mainstream services do not function in a holistic way and current approaches to training health professionals seem to be lacking in this regard.

For Aboriginal people, the concept of cultural safety is central to developing effective models of holistic care and relational practice. Cultural safety focuses on understanding how structural inequities, systems of health care and dominant health practices affect the health status of minority and Indigenous people, and how a critical examination of these can shift attitudes and result in the development of systems and practices of health care that are more supportive of marginalized groups and their specific needs. These concepts are of great value for transforming service delivery models and restoring good ways of providing mental health and addictions services for (and with) Aboriginal people in Canada. As an example, the Western Canada Focus Group report shows how ideas of cultural safety and relational practice can lead to holistic and effective models of service delivery for Aboriginal people.

Our research and extensive national consultation processes, inform us that these concepts speak to us all—Aboriginal, non-Aboriginal, consumer, family member, service provider or policy maker. We all need to critically reflect on our culture: on what it values and devalues, what it believes and assumes, and what these bring to the table and leave behind for mental health and addictions services. The capacity for critical analysis can be learned, and it has been conceptualized as the highest level of health literacy.

In an effort aimed at modifying the status quo and ensuring that the Canadian mental health and addictions systems respond appropriately to the needs of First Nations, Inuit and Métis and

other mental health and addictions consumers and their caregivers, the NMHAC and the MDSC launched *Building Bridges 2: A Pathway to Cultural Safety* project in April, 2009. In keeping with their initial Building Bridges Project (2008/2009), both the NMHAC and the MDSC engaged in dialogue with their respective First Nations, Inuit and Métis communities and provincial Mood Disorders Associations and other provincial and local consumer networks regarding the notion of cultural safety, relational practice, social inclusion and attendant practices that support mental health and well-being.

The two national NGOs have researched and analyzed cultural safety within the context of the Canadian population with specific reference to Aboriginal peoples and mental health consumers. The partners have also collectively developed a comprehensive planning framework on cultural safety and relational practice which will enhance the ability of healthcare providers and others to deal more effectively with major structural and relational issues and barriers facing indigenous and non-indigenous communities.

As part of their Building Bridges 2 initiative, MDSC and the NMHAC collaborated with the First Nations, Inuit and Métis Advisory Committee (FNIM AC) to the Mental Health Commission of Canada (MHCC) in a joint research project to understand best and promising practices that constitute cultural safety and relational practice in the Canadian context. In 2009, they commissioned a total of forty-seven focus groups in Western, Northern and Eastern Canada, a national symposium in Ottawa in 2010, and two research papers, one on social inclusion, the other on cultural safety and relational practice. The focus groups and symposium were designed to capture the voices of those with the most direct experience and knowledge of mental health and addictions services: service providers, service recipients, and family members/caregivers.

The symposium participants emphasized the need to critically analyze the explicit and implicit values and beliefs of the dominant culture, to understand how these underlie decisions about policies and practices that shape health services, and to undertake collective action to "bring others into the circle." In addition, they agreed that individuals need to reflect on their own assumptions and biases and on how these shape their interactions with others. Participants spoke of the need to "walk the talk"—to lead by example, to effect change from the bottom up, to adopt a critical lens of self-reflection and to open oneself to vulnerability. Participants were aboriginal and non-aboriginal, from government, non-government, and indigenous organizations, as well as community members.

In addition, the partners developed a communications tool in the form of a powerful and compelling professionally produced video entitled 'Glimpses of Light', which has already been used extensively in Canada and internationally to stimulate discussion on strategic issues related to cultural safety and relational practice in Canada.

This report also provides an overview of the mental health and well-being of First Nations, Inuit and Métis in Canada in the context of colonial and neo-colonial processes and polices in which mental health and addiction services have been and continue to be provided to First Nations, Inuit and Métis, i.e., why the need for cultural safety. Then we move on to highlight the possibilities, i.e., how cultural safety could be used to create a space for critical reflection and dialogue within the mental health and addictions systems, a dialogue that would lead to action, improved mental well-being for all Aboriginal peoples and Canadian consumers and health equity for all people in Canada. Lastly, we engage with the concept of cultural safety as a means to support *social justice* and the mental well-being of First Nations, Inuit and Métis in Canada.

Concepts of cultural safety and relational practice are particularly valuable for Aboriginal people, because they encourage health care providers, policy makers, and organizations to reflect critically on issues of racialization, institutionalized discrimination, culturalism, and health and health care inequities, and the root causes and conditions that give rise to mental health and addictions issues among Aboriginal populations; and to recognize that peoples' experiences, including health and illness experiences, are shaped by the contextual features of their lives – social, historical, political, cultural, and geographic, as well as by other factors such as age, gender, class, ability, biology and so on. (Cultural Safety research paper).

In response to the major emerging themes contained within this report, a total of 17 major recommendations for future action have been advanced covering the following components:

- Building and Exchanging Knowledge
- Generating System Change through Knowledge Development
- Enhancing Education and Training
- Supporting Good Policy Development
- Supporting Effective Program / Service Development

BUILDING BRIDGES 1 IN PERSPECTIVE

The findings and recommendations from Building Bridges 1 served as a foundation as we moved ahead with the Building Bridges 2 initiative. Research, findings, extensive national consultations, professionally produced video (Glimpses of Light), and recommendations in Building Bridges 2 were studied and examined through lens of cultural safety, relational practice and social inclusion

Findings of Building Bridges 1

This phase of Building Bridges represented a very successful and unique national experiment in health and social policy. The following overall objectives as established at the outset of this particular project were met:

- We articulated the importance of applying population health determinants and spirituality as keys for making meaning of life in Indigenous families/communities as it was, is, and could become;

- Clearly demonstrated that holistic concepts of mental health and well-being are fine working concepts to employ while doing developmental work with Indigenous communities; namely, as (a) tools to promote understanding "what"; (b) tools to explain "how"; (c) tools to explain "why";

- Showed that definitions of mental health are changing and, in fact, are shifting towards a more holistic approach to mental health which affirms Indigenous cultural perceptions of wellness. Balance between the physical, emotional, intellectual and spiritual dimensions of life is a sign of health and wellness and may also be viewed as an indicator of a healthy lifestyle;

- Identified the importance of "walking with our ancestors", knowing their teachings, and living by those teachings as we live today for tomorrow while at the same time living within a framework guided by core values that feature 'community' and the need for 'community of care' where there is safety and feelings of security, nurturance, stimulation, and belief in an optimistic future;

- Demonstrated how the mood disorders movement in Canada can work with Indigenous communities to identify priorities and promote appropriate training for professionals, especially culturally relevant training;

- Explored how Indigenous ways and best/promising practices can be shared with under-serviced communities in rural and remote areas of Canada. People are connected to their communities, but resources are inadequate to support their needs.

- Challenged funding practices and traditions that encourage the creation and maintenance of silos;

◐ Promoted the importance of spirituality and connectedness (belief and belonging) as key factors in prevention, recovery and mental health.

Recommendations from Building Bridges 1

As a result of the Building Bridges 1 Symposium the following seventeen (17) major recommendations were formulated:

1. That elders be selected and honoured for their gifts as educators and healers by their communities, in reshaping mental health services in this country.

2. That Mental Health Resource Teams be promoted and established, particularly in the North, where there are clusters of communities that can be served by a team. Include selected elders in such teams. The potential of the Truth and Reconciliation Commission to re-stimulate trauma, makes these teams particularly important. Members of such teams are to be equally valued; their value is not to be based on their credentials. Mental Health Teams are not to be seen as emergency response teams but as resources for building mental wellness. Consumers are to be included in such teams.

3. That funding be provided for Participatory Action Research (PAR) concurrent with the activities of Mental Health Resource Teams to demonstrate that what is done is effective. PAR is the desired type of research because when it is designed with the input of the people for whom it is done, then it is of benefit to them and knowledge is transferred.

4. That a "College of Elders" be established to investigate how traditional knowledge can be a resource for problem solving in the field of mental health and addictions.

5. That peers and families be respected as important advocates and resources to the mentally ill person and their service providers, and be included in the mental health team.

6. That a process for accreditation of peer support workers be established.

7. That systems be developed which allow the consumer and their family support system to guide and be in control of their own care. Promote collective consumer self-determination from the ground up.

8. That small mutual support groups be established in which people can help themselves, gain self-respect, and learn how to navigate systems and clinical situations.

9. That a new system be created not dominated by psychiatry rather than repair the old system, after first analyzing carefully the value base and deficits of the medical model. It is important to base strategies on a thorough understanding of the problem.

10. That strategies and solutions be community generated, otherwise they won't be embedded.

11. That mental health services be established which are equal in quality and funded as generously as physical health services for all Canadians, including those incarcerated.

12. That the Mental Health Commission of Canada's meetings be dialogical processes in which sufficient time is devoted to problem analysis and practical understanding of the issues.

13. That it is understood that unstructured public consultations are vital for all parties to share insights, to build bridges of understanding between professionals, consumers, peer supporters, family members, and cultural groups. The needs are too great to be addressed solely by experts; community members must be empowered.

14. That the Mental Health Commission of Canada give careful consideration to the First Nations and Inuit Mental Health Advisory Committee (MWAC) plan.

15. That it is formally recognized that quality mental health systems and services are a human right. The federal government should affirm the rights of the mentally ill and provincial/territorial governments should be required to meet a minimum standard of service.

16. That government supports multi ministry approaches to achieve seamless integration of services that will adequately address health determinants (e.g. shelter, food security).

17. That a National Steering Committee be established to develop a comprehensive five-year action planned aimed at collectively dealing with the systemic issues and recommendations emanating from the national symposium.

BUILDING BRIDGES 2: TOWARDS A NATIONAL FRAMEWORK

The Native Mental Health Association of Canada and the Mood Disorders Society of Canada have a rich history of working collaboratively and sharing their respective expertise in regard to "what works" and "what does not work" in mental health and addictions programs and services. Groundbreaking national initiatives comparing and contrasting similarities and differences between their indigenous and non-indigenous constituents, along with finding common ground and identifying goals for future collaboration, served as the pillars of this unique and effective partnership in Canada.

In an effort aimed at modifying the status quo and ensuring that the Canadian mental health and addictions systems respond appropriately to the needs of First Nations, Inuit and Métis and other mental health and addictions consumers and their caregivers, the Native Mental Health Association of Canada (NMHAC) and the Mood Disorders Society of Canada (MDSC) launched *Building Bridges II: A Pathway to Cultural Safety* project in April, 2009. In keeping with their initial Building Bridges Project (2008/2009), both the NMHAC and the MDSC engaged in dialogue with their respective First Nations, Inuit and Métis communities and provincial Mood Disorders Associations and other provincial and local consumer networks regarding the notion of cultural safety, relational practice, social inclusion and attendant practices that support mental health and well-being.

The two national NGOs have collectively developed this comprehensive planning framework on cultural safety that will enhance the ability of healthcare providers and others to deal more effectively with major structural and relational issues and barriers facing indigenous and non-indigenous communities. We are pleased to acknowledge contributions from members of these two non-profit associations and the First Nations & Inuit Health Branch (FNIHB) of Health Canada.

Building Bridges is the creation of the NMHAC) and the MDSC. As part of their Building Bridges 2 initiative, they collaborated with the First Nations, Inuit and Métis Advisory Committee (FNIM AC) to the Mental Health Commission of Canada in a joint research project designed to understand best and promising practices that constitute cultural safety and relational practice in the Canadian context. In 2009/2010, they commissioned forty-seven (47) focus groups in Western and Eastern Canada, hosted a national symposium in Ottawa, and commissioned two research papers, one on social inclusion, and the other on cultural safety. In addition, the partners developed a powerful and compelling DVD that has already been tested in Canada and internationally to stimulate discussion on strategic issues related to cultural safety and relational practice in Canada.

The focus groups and symposium were designed to capture the voices of those with the most direct experience and knowledge of mental health and addictions services: service providers, service recipients, and family members/caregivers. Participants were aboriginal and non-aboriginal, from government, non-government, and indigenous organizations, as well as community members. In addition, the partners developed a communications tool in the form of a powerful and compelling professionally produced video which has already been used extensively in Canada and internationally to stimulate discussion on strategic issues related to cultural safety and relational practice in Canada.

As part of this landmark partnership for improving mental health in Canada, the NMHAC and MDSC commissioned two research papers:

Schedule "A"   Supporting the Mental Wellness of First Nations, Inuit and Métis Peoples in Canada: Cultural Safety

Schedule "B"   Belonging: Social Exclusion, Social Inclusion, Personal Safety and the Experience of Mental Illness

OVERVIEW: CULTURAL SAFETY AND RELATIONAL PRACTICE

Cultural Safety

The cultural safety discussion paper provides a broad context within which the concept of cultural safety can be understood: what it is, how it has evolved, how it relates to cultural competence, why it is needed, and what it brings to mental health and addictions services for FNMI people. The paper also includes a series of recommendations for engaging cultural safety as a concept to work for social justice in mental health and addictions care.

There are both possibilities and challenges involved in using the concepts of cultural safety and cultural competence to support the mental health and well-being of Aboriginal people in Canada. These include:

1. *…colonizing processes that continue to privilege dominant culture perspectives in the construction of the mental health and addictions services, e.g., Aboriginal people tend to not use mainstream health care services, present at advanced stages of disease progression, show "non-compliance" and often drop out before the end of treatment; and*

2. *a recognition of the limitations of 'culturalist' approaches in response to these issues*

The authors, Smye et al, see a particular relevance to engaging the concept of cultural safety in support of the mental health and wellbeing of Aboriginal peoples in Canada because. *… it draws attention to the issues embedded within the social, historical and political context of mental health and addictions care delivery – it is intended to shift attention from the 'culture' of the 'Other' to the culture of [mental] health care and structural inequities and draw attention to and address the power relations that shape [mental] health [and addictions] services and health.*

They show how the term culture can be used (or misused) to explain away discrimination and inequities, and provide a definition of culture which is more inclusive and consistent with the concepts of cultural safety and relational practice, as shown below.

Increasingly, 'culture' is used in health care (and more widely) to explain difference in ways that overlook structural inequities and imply inferiority. "Common applications of the construct of culture may draw on historical and colonial notions of race and in so doing, reinforce longstanding patterns of domination and inequities". For example, higher rates of suicide and substance use are explained as "cultural" problems of particular groups, rather than as consequences of systematic inequities and discrimination. In these "culturalist" explanations, race often operates in tandem with culture as a silent subtext. More insidiously, conflating culture with racialized characteristics, masks discrimination and inequity with more neutral terminology and the perceived "inferiority" of the Other becomes normalized and naturalized.

One of the definitions that we continue to turn to, defines culture as:

"located within a constantly shifting network of meanings enmeshed within historical, social, economic and political relationships and processes. It is not therefore reduced to an easily identifiable set of characteristics, nor is it a politically neutral concept".

Culture is dynamic, it is a relational concept.

As a concept, cultural safety focuses on understanding how structural inequities, systems of health care and dominant health practices affect the health status of minority and Indigenous people, and how a critical examination of these can shift attitudes and result in the development of systems and practices of health care that are more supportive of marginalized groups and their specific needs.

The authors elaborate further on this by saying:

The notion of culture in cultural safety is used to address the relational aspect of Aboriginal peoples' lives, i.e., among people and between people and their contexts, including the broader social, historical and political realities that shape health care experiences of Aboriginal people. The notion of safety assists us to focus on risk and benefit – e.g., we might ask, 'Do strategies and interventions aimed at supporting Aboriginal people to address mental health and addictions issues fit with the unique experiences of Aboriginal people?'; and/or Are Aboriginal people who enter mental health and addictions services effective and safe in those settings given the realities of their everyday lives?'; and/or 'Will the individual and/or family qualify for housing supports given their Aboriginal status?'.

In Canada, there has been a growing realization that mainstream health services, including mental health services and programs, are not effective or accessible for many Aboriginal people. To address this, the authors note that it is important to understand the historical and structural contexts within which these services for Aboriginal people have evolved and to consider culture in ways that directly address issues of racism and inequity. They review the effects of colonization, oppression, discrimination and institutional racism on the mental health and well-being of Aboriginal people; and explain how these forces have shaped and continue to shape the ways that Aboriginal people access and experience health care services, and to influence their health outcomes. For instance, the implementation of assimilationist policies under the *Indian Act* caused the social, political and cultural break-down of many Aboriginal communities and created long-term trauma. These policies included but were not limited to: taking traditional lands, outlawing ceremonial and traditional practices, and coercing Aboriginal families into placing their children in residential schools where the process of assimilation into the dominant society could be undertaken with impunity. The residential school experience

has been particularly devastating to the culture and wellbeing of Aboriginal people in Canada, involving as it did the forced removal of children from their families and communities, harsh punishment for any expression of their culture including speaking their languages and in many cases, rampant abuse and neglect. According to the authors:

Former residential school students endure long-term psychological and social problems that manifest in the loss of individual and collective self-esteem and self-respect, internalized racism, substance use, suicide, a detachment to others, their families and cultural communities. In fact...in addition to a specific cultural impact, many residential school survivors experience symptoms that are characteristic of post-traumatic stress disorder (PTSD), such as "recurrent intrusive memories, nightmares, occasional flashbacks, and quite striking avoidance of anything that might be reminiscent of the Indian residential school experience".

Within the context of the trauma suffered by Aboriginal people in Canada as a consequence of these colonialist and racist policies, Dr. Smye *et al* review what practices work well for promoting mental wellness and healing. Best practices include reconnection with culture and with traditional ways of healing and healing concepts; community-based initiatives and a balanced approach to mental health including treatment, prevention and health promotion strategies; and healing projects that address the historical and inter-generational trauma resulting from the residential school experience.

The authors then discuss what the concept of cultural safety could bring to mental health and addictions services for Aboriginal people in Canada, pointing out that:

...cultural safety cannot be easily defined and "neatly packaged" as a concrete set of standards for practice. In part, this is because using cultural safety in practice settings to draw attention to and prompt critical reflection on politicized knowledge brings an added layer of complexity. For example, grasping the issues that we conceptualize as core to cultural safety, such as the need for health care providers to reflect critically on issues of racialization, institutionalized discrimination, culturalism, and health and healthcare inequities in mental health and addictions services requires layers of understanding that are not necessarily translatable into straightforward "practice guidelines."

Understanding of cultural safety requires health care providers (and policy makers) to engage in dialogue regarding the root causes of inequities in mental health and addictions, which creates the potential for discomfort related to a number of issues, including the call to be accountable and actionable.

Despite these potential challenges, the authors suggest that cultural safety as a concept can add significant value to mental health and addictions services for Aboriginal peoples by: *prompting critical reflection on how the dominant system of health care affects aboriginal peoples, on the values and ideologies that influence mental health and addictions services – and*

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simultaneously reflecting on whether there are new possibilities for conceptualizing and delivery mental health and addictions care.

Cultural safety can be integrated into both practice and policy making, and critical reflection can occur on a number of levels. As examples:

1. *Practitioners can hold up for scrutiny their own and others' knowledge claims, taken-for-granted assumptions and practices and seek ways to engage in dialogue about these in health care delivery settings.*

2. Cultural safety can...*help those who are working in mental health and addictions with Aboriginal people to appreciate how discourses about culture can be (and ought to be) interpreted and mobilized in many different ways for different purposes.* For example, cultural safety can be used in support of legitimate claims for damage from past inequities and abuses, such as the cultural and individual damage that resulted from the residential school experience.

3. *Cultural safety can be used to question what premises and intentions are at the heart of the ongoing calls for "cultural sensitivity" training and programming in mental health and addictions, and to inform education and training curricula.*

4. *Ethical standards can be informed by the concept of cultural safety and these have the potential to, in turn, inform the development of prevention, promotion, and treatment programming in the area of mental health and addictions involving Aboriginal people. Cultural safety, with its focus on shifting the gaze from the 'culture of the Other' onto the 'culture of health care' as the source of the problem, is helpful for examining the extent to which mental health and addictions services for Aboriginal people are founded on Eurocentric and Western biomedical premises that undermine attempts to transform the "best practices" that could more optimally and explicitly benefit Aboriginal people.*

5. At the organizational level, cultural safety is connected to *a ...commitment to recruit Aboriginal and non-Aboriginal staff who are committed to, and can enact, a particular philosophical approach to service delivery.*

6. *At a structural level, cultural safety can be used to draw our attention to those aspects of mental health and addictions policies that do not fit for Aboriginal peoples, and to ask questions about the moral rightness of policy decisions. It can inform the development of a framework to assess whether the values that underlie service delivery (at the organizational level and at the level of provider-client interactions) are aligned with the ways services are organized and delivered.*

The authors point out that the concept of cultural safety is being increasingly endorsed and adopted by a variety of groups in Canada. For example, the Assembly of First Nations and the National Aboriginal Health Organization and a number of medical and nursing associations have endorsed the practice of cultural safety by health care professionals to improve the health status of Aboriginal peoples.

As a result and, with support from Health Canada, the notion of cultural safety is beginning to enter health education, and several frameworks have been developed for medical and nursing curricula to teach competency in cultural safety.

Although there is growing support in Canada for the concept of cultural safety, the authors caution that the term is vulnerable to misinterpretation and possibly misuse, unless there is a clear understanding of the *critical conceptualization of culture that is foundational to the concept of cultural safety.* For example, "culture" in cultural safety may be interpreted as referring only to ethnicity, rather than to culture in a relational sense and to the structural inequities and power imbalances that the "safety" component intends to address. In addition, *cultural safety...requires explicit attention and understanding of several key issues that are at its core – for example, the need for health care providers, policy makers, and organizations to reflect critically on issues of racialization, institutionalized discrimination, culturalism, and health and health care inequities, and the root causes and conditions that give rise to mental health and addictions issues among Aboriginal populations. Without explicit commitment to grapple with these issues – the emphasis on 'culture' in the term 'cultural safety' runs the risk of misinterpretation.* And... *cultural safety can convey that the safety to be ensured is that of the 'cultural Other,' at once further entrenching notions of difference, focusing on individual 'preferences' and turning attention away from the importance of reflexivity on the part of the health care professional.*

These challenges of interpretation have been seen elsewhere and as the idea of cultural safety is taken up by policy makers and health care providers in the field of mental health and addictions, they may occur in Canada as well. However, it is important to note that:

...cultural safety will continue to hold value in the field of mental health and addictions when used to emphasize critical self-reflection; critique of structures, discourses, power relations, and assumptions; and because of its attachment to a social justice agenda. Continued work will be required to better understand how cultural safety can be used to transform the highly politicized and complex terrain of mental health and addictions services while addressing social justice issues of relevance to Aboriginal people and communities.

Relational Practice

In the research discussion paper, Dr. Smye *et al* introduce the idea of *relational practice*, which has been gaining traction in nursing and other health care literature, and which they view as congruent with the concept of cultural safety.

This approach recognizes that peoples' experiences, including health and illness experiences, are shaped by the contextual features of their lives – social, historical, political, cultural, and geographic, as well as by other factors such as age, gender, class, ability, biology and so on. Relational approaches refer to more than respectful, supportive, caring and compassionate relationships etc.; although interpersonal connections are a central feature of excellent relational practice, this view takes into account "how capacities and socio-environmental limitations" influence health and well-being, the illness experience, decision-making and the ways in which people manage their experiences.

Thinking critically about how culture is being discussed and integrated into mental health and addictions services is particularly warranted given the tendency in health care for culture to be used in ways that run the risk of masking social and structural inequities that influence well-being, health and health care and illness and other experiences. In our view, the concept of cultural safety holds promise in this regard because it can orient mental health providers and planners, and funders of mental health and addictions services toward relational understandings of culture, and culturally meaningful services and programs.

In her address to the symposium in Ottawa on cultural safety, Dr. Smye provided some comments that served to clarify the connection between cultural safety and relational practice.

Cultural safety is not a panacea; it is a concept to help us think about and frame things and move to a place of working relationally in this country. I want to underline that relational practice is not simply about inter-personal relationships – being nice and kind, caring and compassionate. It's about understanding ourselves and the care we provide in relationship to the contextual features of our lives, including where we live, how connected or disconnected we are from our past and how we are all deeply connected in many ways.

When I speak relationally I am speaking not just about being nice... how do I convey to the practitioner that there is that reality to everyone? Relational practice calls for vulnerability. That is our challenge, because many people are afraid of being vulnerable. I was taught in a tradition of keeping boundaries very clear, of being careful, not sharing. I would say to you that we have to learn how to shift practice to say it's OK to know and to be known. And we can be safe in that.

OVERVIEW: BELONGING - SOCIAL INCLUSION

A second research paper on social inclusion was prepared for the MDSC and the NMHAC for the Building Bridges 2 project by Barbara Everett, PhD. It includes a review of research literature on social exclusion, inclusion, personal safety and the experience of mental illness, as well as an overview of various government policies aimed at promoting the social inclusion of marginalized people. A summary of the resulting discussion paper – Belonging – appears below. The full report is enclosed as **Schedule "B".**

Belonging: Social Exclusion, Social Inclusion, Personal Safety and the Experience of Mental Illness

Everyone wants to belong but it is clear that many people are denied the opportunities that others have and relegated to the margins of society. People with mental illness call this stigma and discrimination. Others call it social exclusion. Whatever language is chosen, it harms.

Around the world, factors such as the globalization of labour, people fleeing war, disaffected second generation children of immigrants, a widening gap between the rich and poor and 24/7 media reports of riots, bombings and terrorism have awakened mainstream society to the threat that marginalization can pose. What we previously thought "could never happen here" is now understood as all too likely to happen here – and soon.

Social inclusion is the formal name given to a fairly recent set of government policies aimed at including marginalized people more meaningfully in society – not only for their sake – but for the sake of protecting social cohesion and lessening threats to economic progress. Examples of social inclusion policies from the European Union, the United Kingdom, Italy, New Zealand and the Australian Ministry of Social Inclusion indicate just how seriously governments are taking the marginalization of certain groups within their borders. These examples also serve to show that social inclusion policies have widened to include not only ethno-racial minorities and immigrants but also the poor and the disabled, including people with mental illness.

Social inclusion policies are not without their critics who most commonly fear that they fail to state strongly enough that they value diversity or at worst, that they are simply assimilation or colonization dressed up in new language.

If adopted as a new way of thinking, would policies of social inclusion benefit people with mental illness? Certainly, examples of social inclusion mental health policies – those from Scotland are a prime example - indicate that yes, they very well may.

The path to belonging (social inclusion) is rooted in recovery which begins with establishing personal physical, relational and emotional safety aided by finding safe places to belong such as

peer support, the psychiatric survivor movement, or through mechanisms of cultural safety. From this platform of personal safety, people can venture out into the community to establish (or re-establish) meaningful social roles. However, mental health services are often criticized for being siloed and cut off from their own communities and thus, failing to promote their clients' independence and integration into society. Policies of social inclusion, if carefully thought through, may provide openings for the second and necessary aspect of recovery – an opportunity for full participation and a chance to belong – in your community, your province or territory and your nation.

Social inclusion is a complicated set of ideas that requires careful consideration – from all angles. It is clear that in some parts of the world, mainstream society has heard the thunder of deep discontent. They are beginning to recognize the harm that marginalization does to people because the marginalized have struck back. Social inclusion policies, even those with teeth, can only do so much. Powerful historical and cultural forces divide the world while those that unite it are less visible and less commanding. The policies, as reviewed in the enclosed paper, do not speak strongly enough to the preservation of identity and the celebration of difference. Perhaps these ideas are implicit, but comfort for many, will come only from explicit statements and visible actions. Otherwise, social inclusion policies are open to igniting fears that they are really assimilation dressed up in new words. A possible way forward may be to establish the clear distinction between *political integration* (all groups have rights, protections and access to civic engagement) versus *social integration* (acceptance is the only passport to all that society has to offer). Is there something here for people with mental illness and their families? A cautious yes – if the goals of potential social inclusion policies are carefully thought through and clearly articulated.

National Consultations and Focus Groups

Original planning for BB2 called for a series of eleven exploratory focus groups to be conducted in strategic locations across Canada aimed at obtaining qualitative information which will support the development of our national strategy on cultural safety and cultural competence in mental health care in Canada. Recruitment of participants for these focus groups was to consist of aboriginal leaders, mental health care providers, researchers and consumers. Participants were also identified in consultation with leadership in the respective regions of Canada.

As a result of a successful collaborative effort between BB2 and the First Nations, Inuit and Métis Advisory Committee of the Mental Health Commission of Canada, our national qualitative research efforts were expanded from 11 to 41 consultations and focus groups in every region and territory throughout Canada. Two teams of facilitators and recorders conducted these sessions in Western and Eastern Canada.

WESTERN CANADA FOCUS GROUPS

As part of their Building Bridges 2 initiative, the Mood Disorders Society of Canada (MDSC) and the Native Mental Health Association of Canada (NMHAC) collaborated with the First Nations, Inuit and Métis Advisory Committee (FNIM AC) to the Mental Health Commission of Canada (MHCC) in a joint research project to understand best and promising practices that constitute cultural safety and relational practice in the Canadian context. In 2009, they commissioned a total of forty-seven focus groups in Western and Eastern Canada, a national symposium in Ottawa in 2010, and two research papers, one on social inclusion, the other on cultural safety.

The focus groups and symposium were designed to capture the voices of those with the most direct experience and knowledge of mental health and addictions services: service providers, service recipients, and family members/caregivers. Participants were aboriginal and non-aboriginal, from government, non-government, and indigenous organizations, as well as community members.

Research Question

"What will improve practice in mental health and addiction services for all Canadians?" is the central question in this project. To find answers to this question, focus groups were conducted in Western Canada with practitioners and recipients of services, approximately two thirds of them aboriginal, one third non-aboriginal, the majority working in aboriginal-led organizations serving indigenous people. The focus on mainly aboriginal agencies, their staff and clients, was intentional. Historically, health care in Canada has been dominated by the illness and health belief systems of the dominant culture and has disregarded those of Indigenous people for whom health outcomes have been poor. Constructive ways to address these health inequities are a timely priority.

Methodology

The Western focus groups were held in Saskatoon, Winnipeg, Iqaluit, Yellowknife, and Whitehorse in late 2009. A total of 147 people participated. 95 identified themselves as indigenous (22 Inuit and 75 First Nations or Métis), and 50 non-indigenous. Those in provider roles equaled 108 and those with lived experience 39. One in six people reported having gone through their own healing journey, with or without formal assistance, to evolve into care providers themselves.

Discussions were grounded in an overview of the project context. Facilitators explained that the initiative is intended to contribute to the joint efforts of the FNIM AC within the MHCC, the NMHAC, and the MDSC to further the understanding of culturally safe practice in mental health and addictions.

Through a process of circle dialogue and storytelling, participants reflected on their experiences with mental health and addictions services, what was working, what was not working, and what could be improved. Participant concerns led the emergent discussion and spoke to the unique characteristics of group members with respect to their geographical location, the types of services and systems they dealt with, to their challenges, and ways of addressing these. Sessions were audio recorded and transcribed, and resulted in 583 pages of rich material.

Five members of the FNIM AC cultural safety working-group (including the two facilitators) studied the transcripts and shared the process of "making meaning" of the transcribed information, identifying emerging themes and potential framing metaphors.

The first meeting of the working group resulted in a shared vision of the intent and design of this report. Given the complexities of current mental health and addictions challenges, and the multiplicities within society, the group saw the value of the report to inhere in its ability to open a dialogic space between as many people as possible and to invite them to engage, reflect and work together to arrive at new understandings from which fresh solutions can emerge. To achieve this, the approach taken in analyzing the transcripts was an emergent, collaborative one, in which meanings were negotiated in group discussion, patterns sought, and complexities maintained. The group continued to meet, either in person or through teleconference, to deepen their understanding and analysis.

Findings

Six overlapping categories were developed to capture the emerging themes and organize research findings: direct care; interpersonal relations; professional development; ways of knowing; organizational context; and policy:

1. *Direct care* refers to the qualities of the care provider/care recipient relationship. As viewed by participants, the relationship needs to be accessible, inclusive of the disabled, respectful and responsive to the uniqueness of each individual, strengths focused, flexible, trauma informed, acknowledging of grief, and making use of human connection in healing.

2. *Interpersonal relations* refers to the range of relational networks and formal and informal supports in which both the care provider and recipient are embedded, including relationships with families, community members, colleagues, peers, mentors, supervisors, other service providers and agencies. Participants emphasized the importance of reciprocity and dialogue, support for self-care, self-awareness and conscious growth, and the necessity for circles of support for both care provider and care recipient.

3. *Professional development* refers to the informal, non-formal, and formal knowledge and skill development received by professionals in the course of their training to become a mental health practitioner, as well as the multiple life experiences and cultural practices that care providers draw upon in their work. On this topic, participants shared insights about informal, non-formal and formal education/training, mentoring, lived experience,

balance and harmony, and wisdom teachings.

4. *Ways of knowing* refers to the approaches taken to understand, document and make sense of the social world. Themes related to ways of knowing that emerged in the focus groups are best captured by "all my relations", cultural continuity, the power of story, and tensions between Western and Indigenous ways.

5. *Organizational context* refers to workplace norms, policies, resources, agency mandates and professional routines. Participants spoke about organizational norms, centralization vs. decentralization, integration of services, family and community context, and healthy effective organizations.

6. *Policy challenges* refer to government legislation, policies, and funding. Significant challenges identified in the focus groups include the tension between individual and collective rights, between biomedical and complementary approaches, and concerns about the capacity for response to ethical dilemmas.

Conclusions

Conclusions emerged from the findings as well as the process through which the project unfolded. They include: the importance of respecting group process and leadership, guiding principles and practices.

Group Process and Leadership

Group process and leadership were central to this research. We chose to model inclusion, participatory methods and indigenous ways of sharing knowledge both with the focus groups and within the working group. Shared learning from the focus groups combined with the personal and group insights developed through dialogue with the data and each other as researchers led to a new way of understanding mental health and addictions as a human experience.

Principles

Guiding principles that arose from the findings apply to programs, services and the systems supporting policy, program development, and service delivery.

Eighteen principles are identified in the report: (a) honouring humanity and human experience; (b) centrality of connectedness and relationships; (c) valuing and learning from diversity; (d) "Do no further harm"; (e) patience; (f) deep listening; (g) radical acceptance; (h) reconnection; (I) respect; (j) collective healing; (k) community of practice; (l) strengths based; (m) relational attunement; (n) honouring boundaries; (o) recovery model; (p) nature as healer; (q) culture as healer; (r) prayers and ceremony.

Practices

Eight associated practices are key findings from this study; namely, (a) fundamentals first; (b) becoming and honouring human process; (c) silence, nature and "being with" as therapy; (d) culture as therapy; (e) shared living; (f) manage fear; (g) no experts zone; (h) programming with options, multi-year funding and community-driven.

The focus groups and symposium were designed to capture the voices of those with the most direct experience and knowledge of mental health and addictions services; service providers, service recipients, and family members/caregivers. Participants were aboriginal and non-aboriginal, from government, non-government, and indigenous organizations, as well as community members.

While focus group participants testified to the challenges in the current mental health system, they spoke more extensively of what works, how they conceptualize culturally safe practice, and what they want. Following multiple readings of the transcripts, and consistent with the literature (Smye & Browne, 2002), it became apparent that cultural safety is a process that is multiply determined, contextually embedded, and relationally mediated. For the purposes here, cultural safety is described as a relational concept marked by ethical engagement. Cultural safety is action-oriented in that culturally safe practice addresses power dynamics in health care, challenges social and structural inequality and is characterized by interpersonal relationships that take into account the social, political, historical and cultural factors that influence peoples' lives, understanding that health and health care are shaped by these factors. Within this context, six interrelated categories were identified to capture the emerging themes:

1. direct care
2. interpersonal relations
3. professional development
4. ways of knowing
5. organizational context
6. policy

Figure 1 graphically provides one example of how the larger context which includes the natural world, land and physical environment (including human constructed things and systems) works with the socio-political and historical contexts to influence our relational and ethical engagements. The six aspects that will be used to organize findings are captured in the ovals – these are interrelated and contribute to the forces that both enable and constrain relational practice and ethical engagement which rest in the centre of the model.

Figure 1
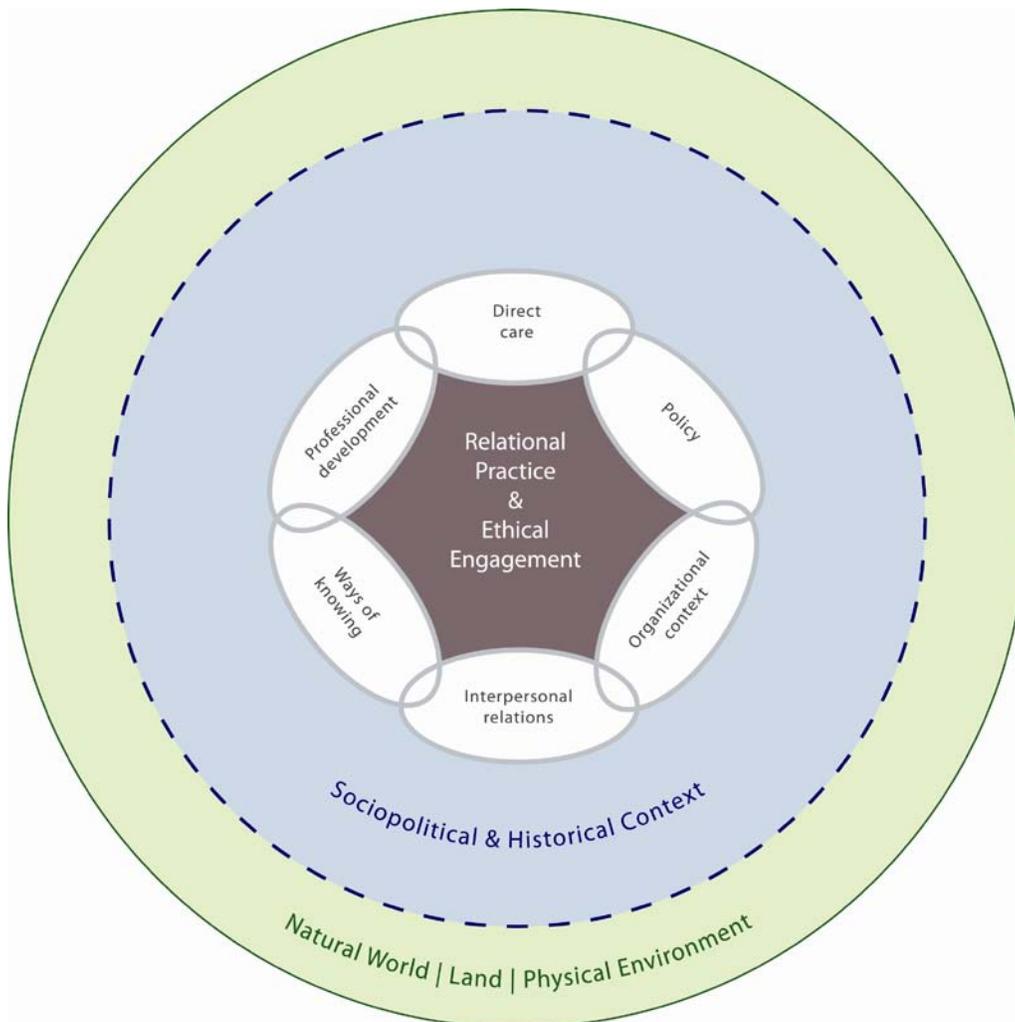
[1] Some of these categories have been drawn from Dr. Jennifer White (2007)'s article Knowing doing and being: A praxis-oriented approach to child and youth care.

What Seems to Work

The Western Canada focus group team identified some examples of what seems to work, to make a positive difference in the lives of community members with mental health and/or addiction challenges.

1. *Wellness Centre (Winnipeg*). This is a multi-purpose Aboriginal community centre in an urban area that offers among other services, healing, educational, and work preparation activities that foster on-going involvement. Everywhere you look, you see things that are familiar to the populations being served. Most people in the centre are indigenous and therefore "like me", signs and names on the directory and offices are familiar, and pictures and sounds in the spaces resonate warmth. Core values of the people are honoured.

2. *Inuit Friendship Centre (Iqaluit).* This is a home away from home for "homeless" Inuit, and others. Food from the land is brought in each day by designated hunters, and is always available for those desiring something to eat. Two senior Inuit people serve as hosts/support/ counsellors and visitors are welcome to make themselves comfortable. The centre has no intake process and no one is there to "dig" for personal information. The centre is warm, relaxing and comfortably furnished. During our visit people were watching TV, reading, talking quietly, and playing checkers and/or cards. Financial support from the Aboriginal Healing Foundation makes this resource available and accessible.

3. *Women's Retreat Centre (Yellowknife).* This centre offers a variety of programs tailored to meet needs of the residents (mostly Inuit). Core staff members are "grads" of the centre's healing program, not people with graduate degrees or conventional equivalents. They share an unfailing belief in the ability of the women to modify themselves. This valued resource is not government funded. The team conducted a focus group with 15 women of this centre. The team discovered that life as a homeless person resembles traditional ways of surviving: through mutual support.

4. *White Buffalo Youth Center (Saskatoon)*. This is a truly unique resource dedicated to serving Aboriginal and other youth. The centre's staff members facilitate engagement of newcomers into a wide range of sports and other activities. Only information necessary to satisfy safety essentials is collected; no personal profiles or inventories are done. Youth are welcomed into an accepting, supportive community that includes legal, dental, medical, educational and personal support services. While this youth centre receives no direct government funding, it does receive indirect government funding through the local school board, the university law school, the health authority etcetera, each of which make services available on site, with the centre providing the work space. The Director spends most of her time writing for grants and searching for donations.

5. *In-House Correctional Program (Yellowknife).* The worker responsible for this program employs what he learned and what worked for him to assist "inmates" to become increasingly self-caring and self-determining. His father and grandfather transmitted to him key aspects of his education and training before he entered the residential school. This proud Aboriginal correctional worker has a strong positive presence and enjoys considerable satisfaction from his work.

People with lived life experience that enjoy health and wellness possess knowledge and skills to assist others like themselves, and have a commitment to them that makes a positive difference.

6. **Dene "Return to the Land" Program (Yellowknife).** This community has invested in "return to the land" programs because they do a great deal to bring the community together. People learn together, work together, develop trusting interdependent relationships and community-building skills while finding ways and means to satisfy shelter needs, supply and prepare food, and so on. When included in the program, people from the "homeless" sector in the town, often provide leadership that is highly valued.

A full copy of the Western Canada focus groups is enclosed as **Schedule "C".**

EASTERN CANADA FOCUS GROUPS

This report summarizes the findings from 14 focus groups held in Eastern Canada between November 2009 and January 2010. Focus groups were conducted in Halifax, Moncton, St. John's, Montreal, North Bay and Sudbury. Participants included Aboriginal and non-Aboriginal consumers, family members/caregivers and service providers. The purpose of the discussions was to further knowledge and understanding of what happens when people attempt to access mental health and/or addictions services, what happens when they succeed in accessing services, what makes them feel safe and comfortable or not with the services, and what actions they take to protect and promote their own mental health. A full copy of the Eastern Canada focus groups is enclosed as **Schedule "D".**

What brings people to mental health and/or addictions services?

There are many reasons why people seek mental health or addiction services. Frequently, help-seeking is precipitated by some sort of crisis. The most frequently mentioned issues were serious depression and substance abuse or substance abuse combined with a mental health problem. Close to one-third of consumers reported a history of physical and/or sexual abuse. A majority of the Aboriginal consumers have been abused and in many cases this abuse was systemic, severe, and institutional in nature, i.e. it occurred over long periods of time in foster care, group homes and residential schools.

What happens when people attempt to access services?

The easiest place to access services so far for me has been jail.
Aboriginal Consumer, Halifax, Nova Scotia

Very few consumers found it easy to access services. Oftentimes, people simply do not know how to access mental health or addictions services. Many find the multitude of services and the differing mandates of organizations very confusing. Because they are unaware of the options, family members often end up taking their loved ones to hospital emergency departments.

When people do get access to services, the services they need are often unavailable, limited in availability or difficult to access for other reasons. In some areas there is a serious shortage of family physicians/general practitioners. Psychiatric services are limited almost everywhere, however, especially with respect to community-based psychiatrists (outside the hospital system) and more so in rural/remote areas and small communities. This means that people needing help are often forced to rely on hospital-based emergency services.

Services for people with concurrent disorders (mental health and addictions) are extremely difficult to access. Non-medical services such as psychotherapy are also difficult to access unless people can get them through work or can afford to pay for them out-of-pocket. Services

for trauma-based issues are sparse; this includes services to treat Post-traumatic Stress Disorder (PTSD) and the inter-generational trauma of Aboriginal people.

> *…the medical system doesn't do well with trauma: childhood sexual abuse or PTSD for any reasons, like vets coming back from Afghanistan… In my opinion, it's because nobody is trained in the system to deal with these types of issues.*
> Service Provider, Halifax, Nova Scotia

> *I was told that residential school trauma has nothing to do with the problems of today – they [mainstream service providers] don't understand the intergenerational trauma.*
> First Nation Services Provider, New Brunswick

Culturally sensitive and safe services are in short supply for newcomers and for Aboriginal people. For those who speak a language other than English or French, supports such as translators and written information in their language are hard to access.

When mental health and/or addictions services are available, consumers and family members often encounter long wait times. The need for more timely access is most acute in rural/remote areas but it still exists in larger cities. Even when people are in crisis, they often experience long waits for service.

> *The only way to get in [to mental health services] is if you threaten to kill yourself. And even then you will have to wait.*
> Consumers, North Bay, Ontario

What happens once people succeed in accessing services?

Unfortunately, it is not uncommon for people to have negative experiences when entering the system of services. Entry points where people most frequently report experiencing poor treatment include crisis services and hospital emergency rooms. Issues identified with entering the system of services include:

- Over-use of police and security guards due to perceptions that people with mental health issues are potentially dangerous.
- Lack of adequate training for police to provide effective support for people in crisis
- Long wait times in environments that do not feel safe or comfortable
- Being turned away when there is a clear need for admission
- Being treated disrespectfully by staff.

A friend of mine went to Emergency – she knew her own symptoms – and they sent her home. Finally she called someone in her building for help and this person called Mobile Crisis Intervention. They put her in cuffs and brought her to hospital, which put her in an isolation room. She lost everything including her apartment and it took her six months to recover.
Consumer, Halifax, Nova Scotia

Once inside the formal mental health or addictions service systems, many consumers have had negative experiences with the system including:

- Being misdiagnosed or having to wait years for an accurate diagnosis.

- Being diagnosed with no consideration of the individual's lived experience and current life context, including his or her culture.

- Being treated like a label rather than a whole person

- Feeling judged and "looked down on".

- Having their complaints ignored or dismissed.

Because we have no focus on the Aboriginal population as a unique and different culture, when they come into the hospital psychiatrists are diagnosing, not in the context of culture, history, family dynamics. People are diagnosed with very serious mental illness and put on heavy medication which may or may not be appropriate.
Aboriginal Service Provider, Sudbury, Ontario

They process people like numbers. If you have cancer they will hold your hand; if you lose your foot they will be there to help you learn to walk again. If you have mental health issues, they just send you out on the street – you get no support.
Aboriginal Consumer, Halifax, Nova Scotia

People who have addictions, are poor or are Aboriginal are especially likely to feel judged and stigmatized and to experience discrimination from mental health service providers.

I'm lucky that I'm not on pills or alcohol but when we First Nations people go for services, they assume we are all alcoholics. One doctor asked me if I ever drink, which I did, occasionally and moderately, and he put in my chart that I was an alcoholic.
Aboriginal Consumer, First Nation, New Brunswick

Participants from every focus group spoke about significant problems with the formal system of services for mental health and addictions. First, models of service provision are too narrowly biomedical in nature and place too much emphasis on psychiatric medications. This is particularly problematic for Aboriginal people, many of whom are still struggling with racism and the lingering effects of colonization including the loss of culture, the residential school experience and intergenerational trauma, all of which they see as the root causes of their mental health and addictions problems.

Everything can't be fixed with a pill.
Consumer, North Bay, Ontario

The lack of connection is the problem with mainstream service providers: they bring a linear perspective to everything they are doing instead of seeing how things are connected. Things are circular – when you're having a problem, there are all sorts of causes for it. The lack of humility of service providers is staggering. There are ways of dealing with problems that are better. There are a lot of problems with the psychiatric drugs. They have bad side-effects and are hard to get off. People need support structures, the medicine wheel. These can affect the mind and body just as much if not more than psychiatric drugs. There's no orthodox description of how these things are curative, but they are.
Aboriginal Consumer/Service Provider, Halifax, Nova Scotia

Second, services are not holistic or recovery oriented, do not recognize the multiple underlying factors that cause illness, and are often experienced as cold and inhumane. This is particularly evident in psychiatric in-patient facilities.

When I was admitted to hospital for anxiety and panic, I was diagnosed with psychosis. All they wanted to do was pump me full of drugs and stick me in a room…I had no sense of being helped there. There was no communication and no one to talk to.
Aboriginal Consumer, Sudbury, Ontario

Third, services are fragmented and uncoordinated. Consumers with multiple needs are often bounced around from one service to another, they have to tell their stories again and again to each new service provider, and there is no continuity of care.

Finally, there is a significant gap between the formal health system and community organizations, such as those that offer self-help and peer support programs. People often stumble across these supports on their own, having failed to receive any information about them from health care providers.

What makes people feel safe?

I just want to be treated with respect.
Consumer, North Bay, Ontario

Many of the focus group participants spoke of feeling safe when they accessed a service provider who was kind, compassionate, accepting and respectful. This creates a sense of trust and helps to make consumers feel cared for and cared about. Consumers also feel safe if they receive information from service providers that can assist them in making their own decisions.

I need someone who… sees me as a person, who explains to me why she is prescribing what she is prescribing, tells me why she is giving me this one rather than that one, talks to me about the side effects.
Consumer, Montreal, Quebec

Coordinated services and continuity of care help to make consumers and family members feel safe. They want service providers to work with them, using a team approach. Participants suggested that mental health and addictions services should be coordinated and that they should also be coordinated with other needed services and supports such as community support programs, housing and income security programs.

For many consumers, support from people who understand their experiences is critical in helping them to feel safe and to begin to recover. A few have received this kind of support within the formal system of services. Most, however, are more apt to get this kind of support from community organizations, especially from those that offer peer support and self-help.

BUILDING BRIDGES 2: A NATIONAL SYMPOSIUM

The final phase of this groundbreaking initiative was to conduct at two-day National Symposium in Ottawa on March 24th and 25th. The overall objective was to develop a framework and series of recommendations aimed at improving culturally and linguistically competent and safe services in mental health care for mental health consumers and Aboriginal peoples. This meeting also served to broaden our knowledge of relational practice and social inclusion and how these two critical elements could be incorporated into our final strategy.

The following list of participants were drawn from a broad and diverse cross-section of Canadians including representatives from our respective Boards, selected thought leaders throughout Canada, consumers, policy makers and leading Canadian researchers.

Farah Mawani	Tina Price	Dr. Ed Connors
Winona Polson-Lahache	Dave Gallson	Ella Amir
Mary Bartram	Terry Adler	Dr. Diane Williams
Dr. Vicki Smye	Tina Holland	Dr. Chris Summerville
Phil Upshall	Richard Chenier	Dr. Brenda Restoule
Robert Allen	Paul Hanki	Dr. Caroline Tait
Dr. Patricia Wiebe	Dr.Normand D'Aragon	Garry Carbonnell
Mona Stott	Dr. Lorna Willians	Bill Mussell
Kathy Langlois	Karen Liberman	Bill Ashdown
Josephine Muxlow	Eric Costen	Beverley Bourget
Dr. Jennifer White	John Fee	Dr. Howard Chodos
Joan Glode		

Symposium Areas of Inquiry

Throughout the Symposium, participants were asked to consider the following key questions and areas of inquiry as we moved towards meeting our objectives:

- What constitutes culturally safe practice and what are the conditions in which such practice could take root/thrive/be supported?

- Do cultural and social institutions need to be restored or reformed in any way in order to accommodate cultural safety? If so, what changes need to be made and what is the best way to approach this?

- What do all of us know that would contribute to advancing excellence in relational practice?

- Do we envision a relationship between social exclusion, peer support and relational practice?

- Who do we need to target?

- What do we need to convince them of?

- What influence do we want to bring to bear?

- What are the webs of relationships that constrain or permit the kind of relational practice we want?

- What would it take to make that flourish?

Independent Analysis of the National Symposium

A full copy of the Symposium Proceedings Summary Report is enclosed as **Schedule "E".**
Bill Mussell arranged for an independent analysis of the Symposium. Viviane Josewski from the University of British Columbia provided the following insightful analysis based on her review of the background material along with the detailed summary notes.

"Walking Together"

This theme speaks to the collective advocacy and activism that is part of social movements. Participants stressed that it is crucial to overcome the dichotomous approach of 'we' versus 'us', to seek commonalities in worldviews and find the join that will create alliances. This will not only promote cultural safety as the outcome in terms of policy, education and practice but make the process of 'change' culturally safe by "not placing the burden of change on the individual". "Walking Together" draws attention to the fact that alliances are not built via policies and agreements but by people and social action. At the very beginning this might take the form of opening up the circle and inviting people into the dialogue to create "pragmatic solidarity" as the first step.

"Building Communities" is about the importance of people's need for belonging as a basic prerequisite for social action and 'walking together'. Participants emphasized that communities are built through mutual supports and engagement with each other. Cultural safety is not something that can be taught through words only but needs to be learned through experience, through active engagement with each other. Thus, cultural safety would mean to seek or create opportunities for people to engage with each other, such as public services and spaces, social networking etc.

Quotes from symposium participants:

"We must deal with these tensions in ways that bring groups into alignment, not opposition with one another."

"Finding the join"

"Part of what has to be taken into consideration is looking at the commonalities in worldviews."

"This has to be a collective process; the challenge is to get ego concerns, our individualism, out of the way to develop alliances with others."

"Educating people one at a time is again individualistic, and we are looking for how to support this collectively. I heard this a.m. the need for solidarity, the need for social action, sharing a common vision that can stand up in solidarity against oppression in all its forms."

"Collective advocacy is critical. We will have a stronger voice if it is a collective one. And we need to not focus on the oppressor, but as change agents, to look collectively at how we would like things to be and put our efforts there, to bring people into the circle with us."

"They may know little about us, but we may be poorly informed about them. We are trying to break the divide between "us" and "them", so rather than convincing them, we need to invite people into the conversation. Ignorant and ill-informed people exist but most try to do their best. Opening the conversation is a good first step."

"Each group started with what will benefit me by being a partner. Each group has to see how the other will be a benefit to them. They have to value what the other group brings to the relationship. But oftentimes the group that has had the power doesn't see the benefit of partnering, so being able to see and value what each brings to the partnership, this creates the grounds for cultural safety."

"It is important that we don't place the burden of change on the individual. Yes, each person has to act and react when the space is culturally unsafe, but we need to build collectives so they can be supported and people don't have to take on the burden of change feeling isolated and alone. The opportunity of coming together like this, allows us to build these kinds of collectives and communities to support each of us in building the change that we want to create. A term came up "peopling up the room" with people who are committed to relational practice and CS, and I really like that term."

"But the excitement part of this is important for me. And some of Paul Farmer's work in Haiti and liberation theology and solidarity. He says it's not enough to bear witness to suffering. That is classically what many academics have done through research, but rather, any time we engage in an activity such as this, we need come up with practical pragmatic ways to move things forward, practical pragmatic ways to mobilize change. I would like to see pragmatic solidarity with people on the ground, people who are doing this every day – like the idea of holistic medicine, which is now mainstream, but came from indigenous philosophy and feminist work. I love the idea of collective activism. That gives me hope."

"When I was growing up, we had a real sense of community – the Minister knew you; the doctor would visit and spend time without concern for the length of visit, everyone went to the same church, the teachers knew the whole community and would come to the house and talk to my parents – there was that opportunity to build relationships and for people to know me as an individual. As I grew older, I noticed withdrawal of public service, away from house calls and a business model imposed."

"I began to appreciate that the life of homeless people in that part of the country resembles traditional survival, the key to which is mutual support."

"They engage newcomers into activities, not creating a file of their problems, no personal profiles; they just take names and contact information for emergencies."

"Social networking needs to be engaged for the latter to share this kind of information. Mind Your Mind is such a fantastic website."

"This is citizen to citizen engagement that informs the whole. You embrace life by living it. Many people have lost that traditional way and by losing it are finding themselves increasingly dependent on someone doing it for them and this is decreasing their quality of life. The main message is to do everything we can as citizens in the interest of the whole community, and get to work. If this means engaging other systems, then this has to be done. For example, in the Commission, most of the Advisory Committee members don't even know the Commissioners. So this is something we could do within the Commission. We could also extend the circle out to the communities."

"We haven't learned in our world how to be caring for the communities we are part of."

"We have to make people feel they belong, and have a voice to contribute to the dialogue and make sure they have that voice in the beginning, not at the end. Without the support, it is difficult to foster a relationship."

More than just words …

This theme is about the importance of other forms of knowledge and ways of learning. Participants persistently emphasized the importance of lived experience and the learning through experience. Learning from experience does not only include one's own experience but also the experiences of others including survivors, elders, ancestors etc. Shared experiences can form the basis for trustful and safe relationship. One fundamental shared experience for all people is the experience of being human. From a cultural safety perspective, our common humanity can be seen as a source of knowledge that needs to be revived as a legitimate and powerful source of wisdom.

Subthemes throughout the symposium included humanity, learning by examples (what works), learning from lived experience.

To walk the talk

"Walking the Talk" is about leading by example and affecting change from the bottom up. To achieve cultural safety the process has to be culturally safe. Advocating for cultural safety when we do not live it is hypocritical and will lead to lip service. This requires adopting a critical lens of self-reflection and openness to make yourself vulnerable.

In this regard symposium subthemes included self-reflection, leading by example and vulnerability.

SUMMARY

Objective 1: Research and Analysis of Cultural Safety

This objective has been accomplished through the development of two research discussion papers on cultural safety and social inclusion, focus group discussions across Canada with Aboriginal and non-Aboriginal consumers, service providers and family members/caregivers, and a national symposium on cultural safety. The project partners have also co-produced a complimentary professional DVD documentary focusing on cultural safety and relational practice entitled: Glimpses of Light.

The first research discussion paper, prepared by Barbara Everett, PhD, is called *Belonging: Social exclusion, social inclusion, personal safety and the experience of mental illness.* The paper provides a review of the research literature on social exclusion, inclusion, personal safety and the experience of mental illness, as well as an overview of various government policies aimed at promoting the social inclusion of marginalized people. The second research discussion paper was prepared by Victoria Smye, PhD, RN, Annette J. Browne, PhD, RN and Viviane Josewski, MHSc. , and it is entitled *Supporting the Mental Wellness of First Nations, Inuit and Métis People in Canada: Cultural Safety– A Research Discussion Paper.* It provides an in-depth overview of cultural safety: what it is, how it has evolved, how it relates to cultural competence, why it is needed, and what it brings to mental health and addictions services for FNIM people. The paper also includes a series of recommendations for engaging cultural safety as a concept to work for social justice in mental health and addictions care.

The focus groups involved discussions with 246 people in eleven cities across Canada including 155 service providers, 86 consumers and five family members. One hundred forty-two (142) of the participants were Aboriginal and 104 were Non-Aboriginal. Discussions revolved primarily around the following questions: why people access mental health and addictions services, how people access the services, what happens when they access services, what makes people feel safe or unsafe when accessing services, and what needs to be improved about existing services, with regard to models of service provision, education and training of service providers and policy directions.

The MDSC and NMHAC convened a two-day symposium in Ottawa, attended by service providers, consumers, representatives from mental health NGOs, representatives from the Mental Health Commission and funders. The participants engaged in structured discussions to grapple with the following questions: what constitutes culturally safe practice and what conditions are required for it to take root and thrive; do cultural and social institutions need to be restored or reformed and if so, how; what do participants know that would contribute to advancing excellence in relational practice; do we envision a relationship between social

exclusion, peer support and relational practice; who do we need to target and what do we need to convince them of?

Key Findings from the Research

A number of common themes have emerged from the research done for Building Bridges 2. A review of these themes and an analysis of their significance and implications for service delivery and policy making appears below, and this has been used to inform the proposed planning framework on cultural safety.

The need to belong

What is evident from the research is that everyone—Aboriginal, non-Aboriginal, consumer, service provider, family member—needs to belong. That is to say, everyone needs to be part of a social group within which they feel safe and at home. This is a fundamental human need and a key determinant of health and well-being. Social isolation and exclusion have been shown to lead to increased rates of premature death, depression, and higher levels of disability from chronic disease, while belonging to a supportive social network makes people feel cared for, valued and esteemed. This has a powerful protective effect on health and mental health. [1] For example, social support and social cohesion serve to reduce the physiological response to stressful circumstances which, if not mitigated, can lead to poor health outcomes. [2]

Many people experience this sense of belonging within a cultural community, within which they forge an individual and cultural identity. Culture has been defined as...*a dynamic and adaptive system of meaning that is learned, shared and transmitted from one generation to the next and is reflected in the values, norms, practices and ways of life and other social interactions.* [3] *It is the foundation of individual and collective identity and its erosion can negatively affect mental health and wellbeing.*[4] *Language is a conveyor of culture* [5] *and the means by which knowledge, skills and cultural values are expressed and maintained.*[6]

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[1] Wilkinson, R. & Marmot, M. (Eds.) (2003) Social determinants of health: The solid facts. Copenhagen: WHO. www.who.dk/document/E81384.pdf
[2] Ibid
[3] Kreuter, M.W. & McClure, S. (2004) The role of culture in health communication. *Annual Review of Public Health.* 25: 439-455. In *Culture and Language as Social Determinants of Health*, 2009-2010, The National Collaborating Centre for Aboriginal Health, University of Northern British Columbia.,
[4] Kirmayer, L.J., Brass, G.M. & Tait, C.L. (2000). The mental health of Aboriginal people: Transformations of Identity and community. *Canadian Journal of Psychiatry*. 45(7):607-616. In *Culture and Language as Social Determinants of Health*, 2009-2010, The National Collaborating Centre for Aboriginal Health, University of Northern British Columbia.
[5] Ibid
[6] *Culture and Language as Social Determinants of Health*, 2009-2010, The National Collaborating Centre for Aboriginal Health, University of Northern British Columbia.

The experience of social exclusion, stigma and discrimination

Unfortunately, people with mental health problems and addictions are often socially excluded, isolated, and subjected to stigma and discrimination. They are viewed as "other" by mainstream society and, as a result, they are rejected, dismissed, disempowered and unheard. As Dr. Everett points out in her discussion paper:

... it is easy to see that many people feel that they don't belong. A personal sense of being excluded, of being different or of not being valued is harmful to the individual and this harm is only increased when the active dimensions of stigma and discrimination enter the mix, meaning that those who do belong (mainstream society) fear or even hate you for being who you are (or, better said, who they think you are) and act in ways to ensure that you have limited opportunities, restricted access to the resources and rights that others enjoy, and little or no opportunity to protest poor treatment or to make your voice heard. People with mental illness and their families know all too well the negative effects of stigma and discrimination and the pain of feeling excluded from their communities.

Unfortunately, stigma and discrimination are often perpetuated by service providers as well, this can deter people from seeking help. Indeed, it can cause further harm to people who are already wounded and vulnerable. This point was made in a powerful way by a number of eastern focus group participants.

We need professionals who treat you like a human being.
Consumer, North Bay, Ontario

They are shown a lot of disrespect and people will not go to the hospital, even if they are very ill, because of the way they are treated. If we had a more humane, respectful system and no stigma from professionals, people would be more likely to go for help.
Family Member, Montreal, Quebec

They process people like numbers. If you have cancer they will hold your hand; if you lose your foot they will be there to help you learn to walk again. If you have mental health issues, they just send you out on the street – you get no support.
Aboriginal Consumer, Halifax, Nova Scotia

Social exclusion plus: the Aboriginal experience

Aboriginal people with mental health and addictions issues are subjected to the same social exclusion, stigma and discrimination experienced by all consumers. When these are combined with racism and racist stereotyping, as they often are, they become a toxic brew of negativity and pain for Aboriginal people seeking help.

> *I'm lucky that I'm not on pills or alcohol; but when we First Nations people go for services, they assume we are all alcoholics. One doctor asked me if I ever drink, which I did, occasionally and moderately, and he put in my chart that I was an alcoholic.*
> Aboriginal Consumer, First Nation, New Brunswick

When people are struggling with multiple challenges, all of which are stigmatized (e.g. mental illness, addiction, being part of a racialized group, being poor), the outcome is apt to be even worse.

> *To be honest with you, I think a lot of it [the way I was treated by the system] has to do with being a person of colour. Within the mental health system, if you go for help and you have any type of drug history, they don't believe you. They don't believe that you really want help.*
> Aboriginal Consumer, Halifax, Nova Scotia

All of this is magnified and confounded by the continuing impact of colonization, including the loss of culture and trans-generational trauma and grief. As the Western Focus Group Report points out:

Historically and currently, Aboriginal people experience trauma related to the undermining of safe family and community connections, loss of land, culture and language. Systemic racism, covert and overt, erodes a positive sense of personal and cultural identity and wellbeing. Similarly, the Cultural Safety Report notes that: *Cultural discontinuity has been strongly linked to the disproportionate problems of Aboriginal communities with depression, addictions, suicide and family violence[7]*

The residential school experience, in particular, has left Aboriginal people with a terrible legacy by creating stress and trauma while damaging cultural identity and cohesion, key factors in support of mental health and wellbeing. As explained in the Cultural Safety paper:
Former residential school students endure long-term psychological and social problems that manifest in the loss of individual and collective self-esteem and self-respect, internalized racism, substance use, suicide, a detachment to others, their families and cultural communities.[8] ..in

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[7] Chandler & LaLonde, 1998; RCAP, 1995 in Smye et al, 2010.

8 Brasfield, 2001; Kirmayer et al., 2003; 2009a; Söchting, Corrado, Cohen, Ley, & Brasfield, 2007.

addition to a specific cultural impact, many residential school survivors experience symptoms that are characteristic of post-traumatic stress disorder (PTSD), such as "recurrent intrusive memories, nightmares, occasional flashbacks, and quite striking avoidance of anything that might be reminiscent of the Indian residential school experience".

What doesn't work: the inadequacy of mainstream services for mental health and addictions

In their present form, most mainstream mental health and addictions services are poorly constructed to meet the complex needs of Aboriginal people with mental health and addictions issues. Indeed, as reported in the *Cultural Safety* paper, Aboriginal people tend not to use mainstream services and when they do, they are often noncompliant with or drop out of treatment altogether. This appears to be due largely to the narrow biomedical perspective of mainstream services, which is based on the values, beliefs and assumptions of the dominant culture; the inherent power imbalances between service providers and consumers which occur as a result of these values, beliefs and assumptions; and closely related to these, the fragmented nature of service provision, i.e. the separation and funding disparities of mental health and addiction services. That is to say, services are provided through distinct, disconnected and differently funded service streams such as physical (medical) health services, medical mental health services, non-medical mental health services, addictions services, peer support and self-help initiatives, basic needs services such as income support and housing, etc. For Aboriginal people, this approach to service provision is counter-intuitive and not suitable for meeting their needs.

The white man's way is to separate things into categories and we see things as part of a whole.
Aboriginal Consumer/Service Provider, Halifax, Nova Scotia

Why are we slicing and dicing our health? …Into mental health, physical health? It's all health. We chop things up and label other people and ourselves, it's not helping anybody and it never has. We need to look at this as a society as a whole....We have to stop thinking of people as broken; we're not cars. My mental, physical, emotional and spiritual health are all connected; we're living the medicine wheel.
Aboriginal Consumer, Halifax, Nova Scotia

Non-Aboriginal consumers also report significant dissatisfaction with mainstream service models. They too want to be seen and treated as whole persons, who have problems that have emerged within the context of a life lived. They do not want to be reduced to a disorder for which the only prescription is some type of psychiatric medication.

Everything can't be fixed with a pill.
Consumer, North Bay, Ontario

When mainstream services are accessed, they may do more harm than good: that is, they often perpetuate stigma and discrimination and re-traumatize consumers. Unfortunately, it seems that disrespect and condescension from service providers are more the rule than the exception, and service providers themselves acknowledge this.

We need professionals who treat you like a human being.
Consumer, North Bay, Ontario

Addictions and mental health services, even health services generally, they are certainly lacking in sensitivity. To be on the receiving end, where you are treated dismissively – the provider knows best, isn't interested in your views – it's desperately condescending.
Service Provider, Halifax, Nova Scotia

In addition, because these services operate in silos, disconnected from other services and supports, many people are unaware of the range of service options and do not know how to navigate the system of care. Due to funding disparities and the lack of coordinated models of care, most consumers will first access medical services. As a result, treatment tends to be limited to medication and/or hospitalization. There is little continuity of care for people seeking other services or supports or even within the mainstream service system.

I don't think the mental health system here has ever understood inter-disciplinary team concept – there is no holistic care – they don't treat the whole person. The psychiatrists are not recovery focused; they don't ask how people are doing with their lives. They just ask "How are you sleeping? How are the meds?" And that's it.
Service Provider, St John's Newfoundland

…every time I saw a new person, it went to zero – I had to retell my story, they had to start a new file, no continuity of care, so no one seems to have the "big picture"; my file was often not forwarded to the new providers, and when it was, it seems the new people don't look at it.
Consumer, Halifax, Nova Scotia

Ironically, despite the limited capacity of mainstream services to meet the needs and support the recovery of consumers (Aboriginal and non-Aboriginal), they are often difficult to access. There are long waiting lists for services and in rural and remote areas, people may have to travel great distances to access services.

The only way to get in [to mental health services] is if you threaten to kill yourself.
...And even then you will have to wait.
Consumers, North Bay, Ontario

Mental health and addictions services are chronically underfunded—the "poor cousins" of health services—due to the ongoing stigmatization of mental health and addictions problems. As a result, mental health service providers are made to feel inferior to their counterparts in the mainstream health system.

The overall system pays some lip service to what we do, but people working in
mental health are at the bottom of the totem pole; we need to be socially included
as care providers also.
Service Provider, Halifax, Nova Scotia

What does work: holistic and relational care

Consumers need holistic and relational models of care to develop a sense of belonging and to support their recovery from mental health problems and addictions. These problems do not arise in a vacuum; they emerge within the context of each person's life history, individual strengths and challenges, current life circumstances and stressors, and they are often inter-related. Healing cannot happen unless people feel safe. People feel safe when service providers view them as whole persons rather than disease entities and treat them with compassion, empathy and respect. Unfortunately, mainstream services do not function in a holistic way and current approaches to training health professionals seem to be lacking in this regard.

The doctors don't understand and they don't see all the linkages and the underlying
factors that cause the problems. When you clear up the pain and suffering you dealt
with, that's when you start to feel better.
Aboriginal Consumer, Sudbury, Ontario

These are communities characterized by disconnection (within the community) and
disconnection between the services and the population they are supposed to serve.
Most indigenous people that have mental health issues have addictions issues, but
we have no way of accessing the mental health issues because we have no way of
accessing the addictions issues.
Participant, Whitehorse

Good ones [service providers] are about inclusion and understanding you are an expert about your own experience. These individuals are certainly trained, but they are not necessarily trained in human interactions, so if they're good, it's usually because of their personality, not their training.
Consumer, St. John's, Newfoundland

For Aboriginal people, the concept of balance is central to understanding why people become ill and how they recover. As the Western Focus Group report points out: *Illness is the result of disconnection and imbalance and therefore healing and recovery is founded on supporting reconnection with self, other, family, community and the natural world. The balance of connections and the personal balance of mind, body, spirit and heart further the capacity for connection.* And, as noted in the Cultural Safety paper: *Traditionally, Aboriginal peoples understand health as a holistic concept, which results from a harmonious balance or equilibrium between different spheres of life, such as the physical, mental, spiritual, and social dimensions "Holism (as Aboriginal peoples use the term) means sensitivity to the interconnectedness of people and nature, of people and their kin and communities, and within each person, of mind, body, emotions and spirit".*

Holistic models of care for mental health and addictions are rare, however, for a variety of reasons:

- inadequate funding for mental health and addictions services generally, due to stigmatization and discrimination;

- funding disparities that favour the biomedical system over alternative approaches (including but not limited to psychotherapy, peer support, self-help and traditional Aboriginal healing approaches) because of the dominant culture's lack of respect for services and supports deemed to be "unscientific";

- the lack of understanding and attention to the broad social determinants of mental wellbeing, within most mainstream models of care. These include culture, socioeconomic status, social support, stress, etc.;

- the artificial distinction in policy and practice between mental health problems and addictions;

- the fragmentation of services and lack of service coordination within the mainstream service system, due to the "siloing" of these services; and

- legislative and jurisdictional issues that restrict the access of Aboriginal people to appropriate services and supports.

Getting to what works: cultural safety, relational practice and complementary approaches

For Aboriginal people, the concept of cultural safety is central to developing effective models of holistic care and relational practice. Cultural safety focuses on understanding how structural inequities, systems of health care and dominant health practices affect the health status of minority and Indigenous people, and how a critical examination of these can shift attitudes and result in the development of systems and practices of health care that are more supportive of marginalized groups and their specific needs. As the authors of the Cultural Safety paper say:

Cultural safety...draws attention to the issues embedded within the social, historical and political context of mental health and addictions care delivery – it is intended to shift attention from the 'culture' of the 'Other' to the culture of [mental] health care and structural inequities and draw attention to and address the power relations that shape [mental] health [and addictions] services and health. ... it is helpful for examining the extent to which mental health and addictions services for Aboriginal people are founded on Eurocentric and Western biomedical premises that undermine attempts to transform the "best practices" that could more optimally and explicitly benefit Aboriginal people.

Relational practice is integral to cultural safety and it is defined as follows:

[Relational practice]...recognizes that peoples' experiences, including health and illness experiences, are shaped by the contextual features of their lives – social, historical, political, cultural, and geographic, as well as by other factors such as age, gender, class, ability, biology and so on. Relational approaches refer to more than respectful, supportive, caring and compassionate relationships etc.; although interpersonal connections are a central feature of excellent relational practice, this view takes into account "how capacities and socio-environmental limitations" influence health and well-being, the illness experience, decision-making and the ways in which people manage their experiences. (Cultural Safety paper)

These concepts are of great value for transforming service delivery models and restoring good ways of providing mental health and addictions services for (and with) Aboriginal people in Canada. As an example, the Western Canada Focus Group report shows how ideas of cultural safety and relational practice can lead to holistic and effective models of service delivery for Aboriginal people.

> *"…and so you know housing is a necessity…and if they need to have psychological help, get them that help, and if they need detoxification, then get them into a treatment program, and if they need further education, you know, go for it, but if they're willing to take on a job, well then, get them one…"*
> Participant, Yellowknife

We have people coming into social work who have very good intentions, they want to be helpers. They are learning that the impact of colonization is still going on, and instead of an approach to healing that 'medicalizes', they learn about social suffering and the power of acknowledging where people are, and that their responses to atrocious things that have happened are pretty normal.
Participant, Yellowknife

We would argue, moreover, that the same concepts are an excellent starting place to undertake a critical examination of mental health and addictions services for non-Aboriginal people, with an emphasis on understanding the values, beliefs and assumptions that underpin these services and influence their outcomes, and with the objective of developing new and better approaches to meet peoples' need and promote healing and recovery. As Dr. Smye said in her address to participants at the Symposium:

Cultural safety... is a concept to help us think about and frame things and move to a place of working relationally in this country. I want to underline that relational practice is not simply about inter-personal relationships – being nice and kind, caring and compassionate. It's about understanding ourselves and the care we provide in relationship to the contextual features of our lives, including where we live, how connected or disconnected we are from our past and how we are all deeply connected in many ways.

When I speak relationally I am speaking not just about being nice... Relational practice calls for vulnerability. That is our challenge, because many people are afraid of being vulnerable. I was taught in a tradition of keeping boundaries very clear, of being careful, not sharing. I would say to you that we have to learn how to shift practice to say it's OK to know and to be known. And we can be safe in that.

These concepts speak to us all—Aboriginal, non-Aboriginal, consumer, family member, service provider or policy maker. We all need to critically reflect on our culture: on what it values and devalues, what it believes and assumes, and what these bring to the table and leave behind for mental health and addictions services. The capacity for critical analysis can be learned, and it has been conceptualized as the highest level of health literacy, as shown below in an excerpt from a report on mental health literacy in Canada.

Critical mental health literacy involves the development of skills to critically analyze and use information to mobilize for social and political action, as well as individual action. Social action can be directed toward changing public policy and modifying social and economic determinants of health. Enhancing critical mental health literacy supports collective empowerment and the development of social capital. Because improving critical mental health literacy exerts influence on determinants of mental health, it can result in benefits to mental health at a population level. Such initiatives are particularly important for marginalized groups suffering from a high

incidence of mental health problems related to social and economic conditions, such as Aboriginal people and immigrant populations.[9]

The symposium participants also emphasized the need to critically analyze the explicit and implicit values and beliefs of the dominant culture, to understand how these underlie decisions about policies and practices that shape health services, and to undertake collective action to "bring others into the circle." In addition, they agreed that individuals need to reflect on their own assumptions and biases and on how these shape their interactions with others. Participants spoke of the need to "walk the talk"—to lead by example, to effect change from the bottom up, to adopt a critical lens of self-reflection and to open oneself to vulnerability.

Creating the best of both worlds

People who have been stigmatized and excluded have been harmed in fundamental ways. They need experiences of safety in order to be able learn, work, engage and participate. Creating personal safety and security is an essential first step in the process of recovery. This includes physical safety, relational safety and emotional safety. (Belonging discussion paper)

For Aboriginal people, it is clear that cultural safety and relational practice are valuable concepts for moving mental health and addictions services in the direction of models of care that meet their needs and within which they feel safe, accepted and supported. For most, this will involve a restoration of healing practices that are grounded in the Aboriginal worldview and that emphasize wholeness and balance. For most, it will also involve autonomy and empowerment in terms of service delivery.

> *What's important too, and I know this from experience…. the services don't have a cultural component. We need to start delivering our own services, and not just using the orthodox way but using a medicine wheel approach with our own ways of doing things. Otherwise, it just becomes the regular psychiatric/mental health system with a brown face. The white man's way is to separate things into categories and we see things as part of a whole.*
> Aboriginal Consumer/Service Provider, Halifax, Nova Scotia

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[9] Bourget, B & Chenier, R. (2007) *Mental Health Literacy in Canada*. Canadian Alliance on Mental Illness and Mental Health, Ottawa, Canada. Dr. D. Nutbeam introduced the concept of health literacy as a set of cognitive skills that develop in stages and reach their highest expression as critical health literacy: Nutbeam, D. (September, 2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International.* 15(3): 259-266.

We would propose further that mainstream services, as currently configured and delivered, do not meet the needs of non-Aboriginal consumers. Non-Aboriginal Canadians need to be viewed as whole persons. They need to feel valued and supported. Their mental health and addictions problems have a history and a context, and they are inter-related. Everyone needs a safe place where healing can take place. Everyone needs to belong.

The western model of healing views mental illness and addictions through a narrowly focused biomedical lens which characterizes these problems as residing within the individual, usually in terms of a brain-based disorder. This perspective is limited, insufficient, and at times, harmful. It is our view that western approaches to healing could benefit significantly by adopting a more holistic approach to health and healing, and the Aboriginal community has a great deal to offer in this regard.

The predominance of the biomedical model is problematic as it leaves little room for indigenous models and perspectives. It is an individualistic, curative rather than holistic approach that often conflicts with the indigenous. Participants called for building complementary approaches to create multiple ways of knowing and multiple pathways to healing and recovery. (Western Canada Focus Group Report)

Our program activities are holistic; a blend of contemporary and traditional services to meet the complex needs of our urban aboriginal population. We like to say we take the best out of both worlds.
Participant, Winnipeg

This work needs to be done at the level of the collective, although it begins with the individual through a process of critical self-reflection; this leads to a critical analysis of the structural inequities and biases inherent to our health care systems and a shared commitment to social action for change. As the Symposium participants put it:

It is crucial to overcome the dichotomous approach of 'we' versus 'us', to seek commonalities in worldviews and find the join that will create alliances. This will not only promote cultural safety as the outcome in terms of policy, education and practice but make the process of change culturally safe by "not placing the burden of change on the individual".
Symposium Participants

Summary of Key Themes

○ Restoring a sense of belonging through social inclusion and support is critical for supporting recovery from mental health and addictions problems; stigma and discrimination result in social exclusion, which exacerbates the problems and deters healing and recovery.

○ Stigma and discrimination from mainstream service providers needs to be addressed.

○ Mainstream mental health and addictions services are often inadequate for and underutilized by Aboriginal people.

○ Cultural continuity is a key factor in promoting the mental health and wellbeing of Aboriginal people and reconnecting with culture has a healing effect.

○ Mainstream services are also inadequate for many non-Aboriginal consumers. The services are underfunded, hard to access, fragmented, and limited in scope. Consumers' experiences with services are often stigmatizing and harmful. Funding is targeted primarily to biomedical approaches, which are insufficient to meet the needs of consumers.

○ Concepts of cultural safety and relational practice are particularly valuable for Aboriginal people, because they encourage *health care providers, policy makers, and organizations to reflect critically on issues of racialization, institutionalized discrimination, culturalism, and health and health care inequities, and the root causes and conditions that give rise to mental health and addictions issues among Aboriginal populations; and to recognize that peoples' experiences, including health and illness experiences, are shaped by the contextual features of their lives – social, historical, political, cultural, and geographic, as well as by other factors such as age, gender, class, ability, biology and so on. (Cultural Safety paper).*

○ These concepts are valuable for non-Aboriginal people as well, because they provide a way to understand why health service systems function as they do and what needs to be changed so that consumers feel safe and supported and healing can take place.

○ Holistic and complementary approaches need to be developed for mental health and addictions care; approaches that take the best from both worlds (western and indigenous).

Objective 2
Development of a comprehensive planning framework on cultural safety

RECOMMENDATIONS AND NEXT STEPS

To further this work, we are proposing the following steps as a planning framework on cultural safety.

Building and Exchanging Knowledge

1. The Eastern and Western reports and a joint summary paper need to be broadly disseminated to inform dialogue and further the work.

2. Plan and implement a follow-up forum to review the results of the eastern and western focus group processes and move the thinking along. Invite funders, policy makers, academics, thought leaders, service providers and consumers. Document the forum to produce a DVD that can be used for educational purposes and to continue a broad-based dialogue.

3. Review and research best practices, including alternative and complementary models of service provision, and identify the key building blocks/components of culturally safe and holistic practices. For example:

   a. Build on the information collected in the focus groups by writing case studies as stories of those agencies that have found "good ways" to provide alternatives and complementary services to mainstream bio-medical models.

   b. Identify best practices for social inclusion and relational practice in western approaches, e.g. the integration of peer support programs into mainstream services. Find out what works, what doesn't work, how it could be improved, and whether these practices are complementary with Aboriginal approaches.

   c. Develop and implement a research project to identify best and holistic ideas and practices within traditional Aboriginal healing approaches and identify ways in which these could be integrated into mainstream service models to serve non-Aboriginal people.

4. Royal Commission on Aboriginal Peoples (RCAP) and Aboriginal Healing Foundation (AHF) Foundational Learning -- Systematically mine RCAP and AHF for foundational learning. Find ways to remind change agents of the richness of Aboriginal perspectives, common sense and good solid recommendations for ways that work and next steps.

5. Create a website or use existing web capability of MHCC to share findings from above initiatives and to provide a forum for on-going dialogue about relational practice and ethical engagement in mental health and addictions.

6. Invest in a more formal knowledge exchange and dialogue with international colleagues working in this area, beginning with Matua Raki, Christchurch, New Zealand.

Generating System Change through Knowledge Development

7. Group Dynamics Paper – Develop a paper that more fully captures the unique ways of working together developed by the FNIM Advisory Committee and the Cultural Safety Working Group as a contribution to describing alternative ways of working together.

8. Presentations and Publications – Invitations to publish or present the work at conferences and other gatherings should be taken and abstracts submitted to competitive processes in order to showcase the work, receive feedback, engage in the exchange of ideas and further develop the knowledge.

9. Audience-specific Short Papers – Develop a series of four to eight page papers building from this core document and targeted towards specific audiences (front line care providers, system managers, educators, policy makers, thought leaders, etc.). Make a case for cultural safety training by showing the direct and indirect benefits for service providers, service users and society as a whole.

Enhancing Education and Training

10. Engage with educational institutions of health care service providers with respect to cultural safety and develop and disseminate education and training materials that: build the critical mental health literacy of care providers, group and system leaders by teaching the critical analysis skills inherent to and necessary for cultural safety; and teach relational practices and ethical engagement in mental health and addictions.

11. Engage with professional associations with regard to developing and integrating standards of practice for cultural safety and relational practice.

12. Provide training directly and through arrangements with training institutions to invest in capacity development throughout the system. Also, take emergent opportunities to build capacity into existing curriculum and training processes.

Supporting Good Policy Development

13. Work collaboratively to develop a lens or series of lenses to use in the analysis of policy propositions to test for cultural safety, supports to relational practice and assurance of ethical engagement between individuals, families, community, and service agencies.

Supporting Effective Program / Service Development

14. Bring key stakeholders together to work collaboratively to develop program and service models as practical and helpful contributions to making the system over one piece at a time (sharing and development of building blocks to a renewed system).

CONCLUSION

By any standard, the Building Bridges 2 initiative has met and in some instances exceeded the original expectations. The following overarching objectives have been met for this Phase Two initiative and will serve as the foundation for an action-oriented agenda as we move forward:

- We have researched and analyzed cultural safety within the context of the Canadian population with specific reference to Aboriginal peoples and mental health consumers.

- We are now equipped to develop a five-year strategic plan on cultural safety which will allow us to deal with major systemic issues and barriers such as labelling and discrimination, colonialism, racism and stigma and discrimination in a planned and progressive manner. The plan will focus on the need to:

    – Develop a national strategic framework for improving culturally and linguistically appropriate services in mental health care for mental health consumers and Aboriginal peoples.

    – Determine how we can ensure meaningful development and delivery of effective and culturally appropriate services for Aboriginal people and mental health consumers in Canada.

    – Determine what kind of forums can be developed in order to address the issue of cultural safety and service delivery and coordinate meaningful responses.

    – Develop national standards for culturally and linguistically appropriate services in mental health care for Aboriginal peoples and mental health consumers.