CULTURAL COMPETENCY:

A PATH TO DELIVER HEALTHCARE TO ETHNIC MINORITY AND ABORIGINAL POPULATIONS

by

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MNRES, University of Northern British Columbia, 2003

PRACTICUM REPORT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENT FOR THE DEGREE OF
MASTER IN SOCIAL WORK

THE UNIVERSITY OF NORTHERN BRITISH COLUMBIA

April 2011

Abstract

An understanding of traditional world views and cultural imperatives by social workers and healthcare practitioners is an important step for mental wellness and empowerment. Community mental health workers/social workers face challenges working with street-involved mentally ill populations with addictions. These populations frequently visit hospitals. It is important to document and understand the unique positions of clients in order to assist and provide culturally competent healthcare. Therefore it is important that social workers and other mental health workers learn about traditional and cultural values in relation to health and mental illness. Cultural competence along with adequate resources can enhance the function of people with mental illness. Continuous work towards the process of suitable housing and cultural practices could enhance the functioning of mentally ill populations.

Acknowledgements

I would like to extend my sincere thanks to Dr. Glen Schmidt, my academic supervisor for his insight, constant support, and guidance in developing this practicum report.

Thanks are also owing to my other committee members, Joanna Pierce, and my practicum supervisor Kristine Henning, for her valuable guidance and support during my practicum at the hospital.

Special thanks to my wife Mina Bhandari, sons Parakram and Subha, for their constant support, encouragement, and incredible patience.

And last, I would like to share my sincere thanks with all of my coworkers on the psychiatric unit where I completed my practicum. Your dedication to promoting mental wellness for patients with serious mental health issues was inspiring to me during my practicum tenure. I also must thank all the patients on the unit whose lived experience, stories, and courage give me the strength and desire to work with those who struggle with mental illness.

Table of Contents

Chapter 1: Introduction

This practicum report examines the importance of cultural competency and aims to focus on cultural competency in work with mental health populations, particularly Aboriginal populations. There is a lack of empirical research that examines the effectiveness of social work interventions focused on cultural competency (Wong, et al., 2003). In this report I will highlight how decisions made by health professionals or social workers may affect patients' world views and daily living, especially if we do not understand patients in their respective social-cultural context.

In order to address this issue, I have given an example of an elderly minority person of Asian background diagnosed with schizophrenia. This topic is particularly important to me as I too belong to a minority group, and would like to examine whether or not patients' interests are incorporated correctly during discharge planning in hospitals. The case example will be used to illustrate the importance of cultural competency in social work practice.

I developed this report based on my practicum at the psychiatric unit of the University Hospital of Northern British Columbia (UHNBC), as well as through my personal community mental health work experience. I was also able to learn the value of cultural competency in multicultural Canada; specifically in the hospital setting. Understanding the cultural background of a client helps to meet the client's best interests and provide client-centered services. My position as a member of a visible minority group and my community mental health work experience has helped me to develop a cultural competence management strategy for mental health clients.

Cultural competency has become important in social work. For the purpose of this report, cultural competency in health care describes the "ability of systems to provide care to patients with diverse values, beliefs, and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt, Green, & Carrillo, 2002, p. 2).

As Canada establishes itself as an ethnically and racially diverse nation, there is a dire need that health care and social service providers understand patients' world views, perspectives, values, and behaviours about mental health, and patients' overall sense of well-being. Understanding diverse populations' views is important as Canadian populations are increasingly heterogeneous (Al-Krenawi & Graham, 2003). The literature discusses about service disparities due to the lack of diversity of service providers in hospital environments; thus cultural competency has been seen as an effective strategy in health care systems, to reduce disparities and provide patient-centered intervention (Betancourt, Green, & Carrillo, 2002; Livingston, et al., 2008). Research has focused on cultural contexts to help clients understand their lived experience (Livingston et al., 2008).

This report aims to understand clients' views, their world and belief systems, to provide culturally suitable health care to ethnic minority communities. In this report, I provide two different scenarios which illustrate Eastern society and Western society as case examples. Cultural competency involves a human understanding of social and cultural connection, in which patients' needs can be met. This is only possible when social workers and health care practitioners are culturally competent.

Chapter 2: Literature Review

The notion of cultural competency has experienced tremendous growth among social workers and health professionals over the past decade; immigrant movement to Canada over recent decades has been enormous. This tendency shows that the Canadian population has become increasingly heterogeneous (Al-Krenawi & Graham, 2003). Openness and recognition of multiculturalism by the government of Canada is in fact attracting people of many ethnic backgrounds from all over the world (Suh, 2004); as a result, rapid diversification of the population, in terms of race and ethnicity, is an unprecedented socio-demographic phenomenon in Canada (Al-Krenawi & Graham, 2003). The unknown and ambiguous nature of future Canadian Immigration policies makes it very challenging for Canada to be adequately prepared for racially and ethnically diverse populations, and thus, many human service needs, including health care, will face limitations or inappropriate cultural interventions for populations (Min, 2005). It is therefore very important to acknowledge multiculturalism in order to appropriately serve diverse and disfranchised people. It is particularly important for mental health patients/clients, as they are the most vulnerable populations due to inadequate client-centered cultural practices.

Mullaly (2002, as cited in Heinonen and Spearman, 2006) criticizes cultural practice in Canada. In Canada, "multiculturalism ideology only focuses to gather ethnic people and celebrate cultural festivals" (p. 100). This is a demonstration to the world that Canada has an essence of multiculturalism, and we value this ideology. However, this idea does not pay attention to people who are heavily discriminated against and not able to find appropriate

medical care, due to a lack of cultural competence among health practitioners (Heinonen & Spearman, 2006; Hyde, 2004).

Under the auspices of multicultural development, community activities such as cultural awareness, outreach, and service delivery systems in health care are important (Hyde, 2004). Transparent and true practical recognition of multiculturalism development is essential in preventing oppression and racism. Understanding the cultural values of others involves cultural awareness, openness, ability, and flexibility (Suh, 2004); it ultimately helps in communication and understanding different ethnic groups and their needs (Schultz, 2004).

There is a strong correlation between mental health and addiction; as a result, there is an ongoing debilitation of mental health conditions and a person may ultimately be hospitalized in an acute psychiatric ward (CMHA, 1997; Health Canada, 2002; McBratney, 2007). Brady (1984) contends that there are times when mental illness symptoms overlap and even mask each other, making treatment and diagnosis difficult. In our society, alcohol and drug use have many negative connotations. Many people are perceived to be lacking willpower or motivation. Furthermore, mental illnesses and addictions have a tremendous impact on the families, friends, colleagues, and society as a whole.

Often, people with a mental illness or addiction are blamed for their conditions, and many believe that mental illnesses and addictions are human weakness, a behavioural choice, or an inherent character flaw. This type of thinking needs to be changed (McBratney, 2007). Brady (1984) states that mental health and drug use affect each other and each disorder is predisposed to relapse into another disease.

A man with schizophrenia who smokes marijuana is less likely to take his prescribed medication. Several population-based and clinical studies have confirmed the high

prevalence of co-existing mental health disorders and substance abuse. Approximately, one in three adults who are mentally ill also have substance use problems (CMHA, 1997). Further, it is estimated that at least 50 percent of people who have a mental illness, abuse illegal drugs or alcohol, compared with 15 percent of the general population. In British Columbia, 55 percent of mental health service users had substance use issues accompanying their first episode of mental illness (B.C. Partners for Mental Health and Addictions information, 2003).

During my community mental health work experience and practicum at the hospital psychiatric unit, I found that drug use can worsen intense paranoia and patients are sometimes admitted to the hospital after smoking marijuana or using other illicit drugs. This is because they are not able to separate the behaviours and the interacting effects of chemical dependency and mental illnesses. People with mental illnesses should be treated with respect so that they feel like members of a community: they need compassion and support for better treatment. This can be accomplished through learning about others' cultural and social backgrounds.

Culturally-competent social work practice ensures effective access and treatment for the population. Suh (2004) states that the understanding of cultural values of others involves cultural awareness, openness, ability, and flexibility. The importance of cultural competence practice focuses on the need for a general sensitivity to cultural factors that may influence clients (Hyde, 2004; Suh 2004).

Multiculturalism exhibits social change and empowerment through the cultural interventions and cultural respect of different ethnicities. Clients can be best served by social workers with knowledge and experience (Heinonen & Spearman, 2006; Hyde, 2004). It helps

to connect and build the clients' networks within their communities, and assists in linkage to the relevant professionals (Hyde, 2004).

Understanding cultural phenomena connects cultural values and respect for clients. The National Association of Social Workers (NASW) Code of Ethics (2001) speaks of culture: "It implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group." Thus, culture identifies the internal essence of the society. Similarly, the Canadian Association of Social Workers (CASW) Code of Ethics advocates for respect of diversity, different ethnic belief systems, and lifestyles of individuals, families, groups, communities, and nations without prejudice, specifically on gender, language, sexual orientation, socio-economic status, political affiliation, age, race, and religion (CASW, 2005). Thus, within the Code of Ethics perimeter, the CASW Code of Ethics implies respect of world views and rights.

Turner (2002) states that, in society, everyone has different views. In fact, knowledge and education help us to see and perceive real situations regarding society's values and pictures. It is not necessary that a person's interpretation should be the same as another person's. Every person from any cultural background has their own unique values and experiences. Therefore

> … human service workers and other health practitioners need to understand experiences that people have and the situations in which they find themselves through their own lens and then provide support that is necessary to empower clients. Empowerment improves a client's situation so that clients perceive the treatment as meaningful. (p. 57)

Conversely, in real practical situations, it is a challenging task. It is more critical when people have egocentric thoughts. Egocentric thoughts produce more harm than good (Turner, 2002). In this situation, human service professionals need to understand clients' values, cultural backgrounds, and empathize with their situations in order to provide treatment of equality, while eliminating disparity.

Social scientists define culture as a social structure that includes values, beliefs, and expectations (Heinonen & Spearman, 2006). It is the identification of human beings and how they view their world through their own lens. If a person's identity and values are not recognized by the service provider, cultural competency seems feeble, and intervention does not occur on behalf of patients/clients (Hyde, 2004). Nobles (1986) further argues that culture is an integrated pattern of behaviour, which is shared by a group of people that includes ideology, thoughts, beliefs, speech, action, and artifacts, and is passed from one generation to the next through various ceremonies, rituals, and traditions. Thus, understanding culture helps to know more about the clients in order to interpret their reality.

Lu (1999) contends that "culturally competent services thus can be defined as a set of congruent behaviours, knowledge, skills, attitudes, and policies that work effectively in cross-cultural situations between a system, agency, or the clinician and the patient/family" (cited in Schultz, 2004, p. 232). The Canadian Association of Social Workers' Code of Ethics states that "a social worker shall identify, document, and advocate the elimination of discrimination" (CASW, 1994, p. 24).

Heinonen and Spearman (2006) argue that racism plays an important role in preventing opportunities for disenfranchised people. The authors state that discrimination over colour, language, or ethnicity would be the obstacles. In order to offer appropriate

treatment to mental health clients, social workers and health care practitioners need to understand a client's past experience, cultural background, and the environment in which he or she was living. In this regard, it is important to consider an emic perspective (insider's view) to understand particular cultural or ethno-racial groups (Al-Krenawi & Graham, 2003). Ethno-cultural values and beliefs ultimately influence how a client is helped.

Heinonen and Spearman (2006) further propose an emic approach that helps to understand a client's view. It provides the client with an opportunity to think about and understand his or her situation. Only then will the client be able to understand whether the treatment he or she receives is helpful or not. The authors clearly illustrated the application of an emic approach and the helping process with an Asian family living in Canada.

An Asian family with an elderly member is in a hospital recovering from a severe stroke. The hospital social worker is responsible for discharge planning. Our knowledge and past experience tell us that elderly people are highly respected and valued and families are willing to take care of elderly sick people in their own home. We need to take account of the client's past experience; however, we also hold open the possibility that the family cannot care for the elderly. It is the health practitioners' or human service providers' responsibility to ask the family about the elderly member's past story and how they perceive the situation. This intervention will help to determine the course of action. (Heinonen & Spearman, 2006, p. 135)

In social work practice, social workers should draw on the client's experience and knowledge, understand the client's relationship with members and relatives, and share knowledge with the health care practitioners to provide optimal benefits to the recipients (Hepworth, Rooney, & Larsen, 1997). This is an essential and strategic role of a social

worker to help a client's situation appropriately. The authors also argue that not understanding client's cultural values may affect his or her living situations and benefits. Failure to understand a client's experience or knowledge may have negative impacts on service delivery. I experienced this in my community mental health work: A person of Asian background was affected when the hospital decided to discharge him to the community, without understanding cultural aspects of the client that affected his rights and self-determination.

My Experience with Community Mental Health: Are Client-Centered Health Care Services Practiced?

During my work experience at the Northern Health Authority, in a community recovery mental health resource, I came across an elderly mental health client of Asian background who came to Canada ten years ago. His daughter sponsored her parents. In Canada, he lived in a remote northern community of British Columbia with limited access to his culture and social structure. He was an educated person, suffering from mental illness. He was transferred from his hometown to the mental health recovery center in Prince George. I was the only worker of colour and he always liked to talk or share things with me, partly because of our similar cultural backgrounds and the language through which I could communicate with him.

My country of origin (Nepal) probably brought him closer to me as he was quite familiar with the Nepalese culture. None of the health care workers and professionals understood his situation, expression, body language, and overall cultural background. His case worker from remote northern British Columbia found the recovery center to provide suitable mental health treatment for him. The mental health recovery center administration

did not note anything unusual from his family's concerns or lack of family visits; as a result, he was completely detached from his wife and family. He told me a couple of times that "I am not married." He interpreted his perceived abandonment as a part of his culture, saying that "I am not married" because he felt that no family members were around him and that his family ignored him. It was easier for me to understand his interpretation and the language he expressed from his cultural perspective about his loneliness and how he defined loneliness as meaning "unmarried."

In Eastern societies, family members live together. He probably did not see anyone who understood him in the mental health recovery care facility. One day, he had been admitted in the UHNBC for physical illness. The hospital internal medicine unit (IMU) team discharged him to a new facility in Prince George. The mental health recovery center management attempted to liaise with his family before moving him to the new facility, but the result was negative. In this situation, he was basically isolated, felt helpless due to feeling abandoned by his family, and disconnected from his cultural essence in the long term care facility. He couldn't have access to his culture or familial connection. He lacked community access and social services as per his cultural background and health care system. I visited him one day. He called me by my name ("Kulraj"). I enquired about his health and living situation. He expressed in Hindi, pointing to his body and told me "you can see my situation." It seemed he was not happy staying in a big crowd without cultural familiarity, programs, and services.

At the mental health recovery center, I shared my time with him singing Hindi songs, showed him favourite movie artists and singers, and his cultural ceremonies on *You Tube*. He

was really happy, smiling, impressed, and recalled his memories. I also took him to his Temple in town, where he enjoyed having feasts.

Inclusion of this person's situation illustrates the value of cultural competence in healthcare which allows me to see a larger gap between the familial and cultural aspect connecting to mental health clients like him. As a result, many patients have been abandoned and isolated from the culturally competent services in health care systems. There are many examples at the mental health recovery center in which the patients are completely abandoned by their families.

What is Culture?

The definition of culture has been addressed by social scientists and anthropologists very closely. Social scientists state that "culture includes a shared but not necessarily identical home country, region, or group, customs, language, beliefs, traditions, and world view, which are expressed in everyday life" (Heinonen & Spearman, 2006, p. 131). On the other hand, anthropologists have addressed culture similarly to the above statement, where culture is defined as "that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society" (Heinonen & Spearman, 2006, p. 131). Therefore, culture is a full range of learned human behaviour.

Heinonen and Spearman have similar views to the anthropologist's point of view in that "culture is dynamic, changing over time and place" (2006, p. 131). Culture is a "continuous process of renegotiation grounded in specific times and places and affected by other social processes" (Morrissey, 1997, as cited in Heinonen & Spearman, 2006, p. 132). Nevertheless, culture is a life-tool for human beings, which has a strong sense of connection

to his or her family and surroundings. It is not ingrained from birth, nor is it a biological outgrowth. Thus,

> An individual's cultural background will affect the specific way in which he (or she) sees the environment and by which the individual might show his or her feelings, emotions, distress, or conflicts in behaviour, thoughts or an actions. Therefore, culture will influence the experiences of mental disorders and how they might be presented. (Andrews, Goldner, Parikh, & Bilsker, 2000, p. 46)

We as social workers or health care practitioners need to understand our clients' world views because every society has a distinct culture that forms its identity and value system. Culture is stagnant and somehow influenced by other cultures and societies. It is very important to understand cultural orientation and cultural sensitivity during intervention. Clients' cultural factors can strongly affect how they behave and how they interpret and understand problems; thus, clients are central to social work intervention (Heinenon & Spearman, 2006).

Cultural Competency

Social workers seek to understand a client in the context of a person-in-environment (Heinonen & Spearman, 2006). This framework emphasizes the relationship between environment and individual; thus it allows us to understand the influence of the environment on the individual, and his or her ability to influence the environment. Those individuals whom society values have an easier time in achieving a balance between their psychosocial capacities and the demands of their environments, whereas those devalued by society often experience problems in social functioning and environmental support systems. This fundamental balancing and non-balancing mechanism produces different levels of social

groups, which possess different levels of power and prestige, and where the dominant groups are at liberty to define the overall social status quo (Appleby, Colon, & Hamilton, 2007).

Yan (2005) talks about how social workers' own ingrained cultural values might exert a negative impacts on clients; therefore, social workers are expected to maintain a high level of cultural self-awareness of their own cultural background in order to respect clients' values and needs. He further adds that the discourse on cultural awareness helps to filter the influence of social workers' cultures, which can be blocked from affecting their engagement with clients from different cultures.

Livingston et al. (2008) also support Yan's conceptual meaning of self-awareness but emphasize a high engagement and dedication of mental health workers. They argue that cultural competency is a process that requires time, dedication, reflection, and full participation of clinical and mental health workers. They add that cultural competency requires knowledge and respect of another culture's values, beliefs, customs, and traditions. It is necessary to have knowledge, respect, and value for one's own culture before one can truly respect and value another culture. In an effort to become culturally competent, mental health professionals must become self-aware, develop knowledge of other cultures, and acquire skills that will enable them to conduct successful interventions (Livingston et al., 2008).

Vonk (2001) argues that cultural competency is becoming an increasingly popular philosophy in pluralistic societies, in which the professionals are trained and educated in a mono-cultural tradition. Greene et al. (1998, as cited in Vonk, 2001) identify the importance of cultural competence in the field of social work. They state that cultural competency has three frameworks: knowledge, attitudes, and skills. *Knowledge* "refers to the information

needed to develop an accurate understanding of the client's life experiences and life patterns" (p. 48). *Attitude* refers to the social worker's self-awareness of assumptions, values, and biases. These are part of a social worker's own culture and world view and how he or she understands the world view of the client who belongs to a different culture. *Skill* refers the development of practice skills that are tailored to meet the needs of a client from a different culture, including cross-culture communication skills.

Vonk elaborates on Yan's views about the importance of cultural self-awareness, stating that attitudinal components are related to the social worker's self-awareness of assumptions, values, and biases that are a part of his or her own culture and world view. Therefore, it is important to understand the world view of the client who is a member of a different cultural group or culture. Thus, self-awareness helps social workers to develop skills that are tailored to meet the needs of a client from a different culture, including cross-cultural communication skills. McPhatter (1997), as cited in Vonk (2001), adds that: "cultural competence denotes the ability to transform knowledge and culture awareness into health and /or psychosocial interventions that support and sustain healthy client-system functioning within the appropriate cultural context" (p. 261). The concept of cultural competence is an active process of learning and practicing over time between two actors: the social worker and the client (Vonk, 2001).

Culture is defined as "the sum of total" or "totality" of "ways of life" or "life patterns." (Wong et al., 2003, p. 150). Culture is the "sum total of life patterns passed on from generation to generation within a group of people and includes institutions, language, religious ideals, habits of thinking, artistic expressions, and patterns of social and interpersonal relationships" (Lum, 1999, p. 2).

The definition of culture relates to both material and non-material culture. Material culture entails hospitals, social service agencies, retirement villages, and personal computers and nonmaterial culture, which focus primarily on our abstract creations, ideas, rules, and patterns of communication. The non-material cultures are norms and values, (Appleby, Colon, & Hamilton, 2007). "All aspects of non-material culture are passed from one generation to the next primarily through written and oral exchange. Indeed, human language and human culture, in the broad sense of the terms, are intimately linked" (Appleby, Colon, & Hamilton, 2007, p. 21).

Cultural meaning further elaborates on the life story of the individual or family. A cultural story refers to an ethnic or cultural group's origin, migration, and identity. Within the family, it is used to tell where one's ancestors came from, what kind of people they were, what issues are important to the family, what good and bad things have happened over time, and what lessons have been learned from those experiences. At the etic level, a cultural story tells the group's collective story of how to cope with life and how to respond to pain and trouble. It teaches people about how to thrive in a multicultural society and what children should be taught so that they can sustain their ethnic and cultural story (Dhooper & Moore, 2001).

Similarly, Asamoah (1996) urges that, in order to provide culturally competent services, there are two approaches that must be considered: the studying of specific cultures (emic), and the identification of transcultural principles relevant to helping situations across cultures (etic). These two approaches are essential in developing multicultural understandings and counselling strategies.

Etic and emic approaches are the communication approaches of research orientation to understand the culture of specific groups or communities (Creswell, 2007; Sherman & Reid, 1994). According to Heinonen and Spearman (2006), an emic approach refers to an insider's view, which provides the opportunity for the client (participant) to think about and understand his or her situation. In other words, when insider views are explored from the outsider (outside knowledge), the social worker (researcher) needs to relate the insider's situation to his/her surroundings. In this way, it helps to locate insider views and position and the factors affected in the community. Then, the client (participant) is able to understand the situation that will be helpful or not. Thus, the social worker should draw from the clients' experiences and knowledge and let them realize and perceive their situations. This is an essential and strategic step in order to intervene in clients' situations appropriately.

The cultural portrait of the group or community incorporates the views of clients (emic) and social worker (etic) (Creswell, 2007). During intervention, there has been controversy in how the approach affects intervention (data collection). Patton (2002) argues that an etic (outsider) perspective controls participant (insider) views because of a higher level of ideas. He also says that the contrast in views and knowledge of the etic (outsider) with emic (insider), the question of power imbalance between them is raised. As a result, social workers knowledge and views affect participants' views and thoughts and discontinue the relationship between these two actors.

Thus, the values and beliefs of two actors should be addressed in such a way that the social worker's knowledge and background should not impede the clients' (participant) views and beliefs. Sherman and Reid (1994) further contend that etic is an external approach (i.e., social worker's perspectives which are influenced from the outside culture, research

knowledge, and the process of study). This type of study is a comparative approach where the researcher analyses information through a different lens amongst the interested group. The authors add that an emic is a domestic communication approach which is more subjective. In order words, an emic approach is a life experience and belief of the targeted populations (client) or individuals to be helped. It reflects the reality of the community or individual that will be the target of the intervention. In social science, an emic approach is an important aspect that will expose oppression and help to develop policies to ameliorate social injustice.

Views between these two components (emic and etic) can become challenging during intervention, especially in multidisciplinary settings where the service is carried out by different interest groups such as nurses, social workers, medical practitioners, teachers, and leaders. The position of emic and etic is ambiguous on the team. It appears that lack of clarity might be due to a power and knowledge imbalance as different interest groups have different perspectives. For example, views of nurses and views of social workers are different during intervention (data collection). Nurses examine or interview through a medical lens, while social workers focus on both social and environmental factors. Heinonen and Spearman (2006) state that the emic approach helps to understand participants' inner feelings, empower knowledge, and deal with situations according to their knowledge. In social work practice, understanding the cultural background is significantly important as it gives the social worker (researcher) understanding of the clients' (participant) identities, values, and beliefs. Knowing clients' cultural identity helps to bring them closer to the researcher and eventually the client (participant) perceives service outcomes more positively and meaningfully. Therefore, it is important to gather information from the participants and the surrounding

environments, events, and objects from the field work to relate these factors to the participants' expressions and beliefs. Then a social worker will be able to identify and analyze the meaning of the participant's expressions. Capturing all events during intervention is therefore a very important consideration in finding the best client-centered social work practice.

There are many factors which determine the health conditions and well-being of a person. A person's family and social network, financial needs and obligations, employment, safety, and comfortable accommodation are some of the urgent needs that affect a person's health. Similarly, the National Health and Medical Research Council of Australia (2005) has documented the importance of cultural competency in health care. It states:

> …impact of settlement and acculturation varies widely depending on their experience and situation. In addition, there are many determinants of health and wellbeing from factors outside of the health system, such as housing, employment, education, spirituality and social connections to the life of the community. As a result, the health and wellbeing of culturally and linguistically diverse communities depend on a complex balance of social, economic, environmental and individual risk and protective factors. (2005, p. 3)

Nobles (1986) defines culture as "an integrated pattern of behavior shared amongst a group of people that includes ideology, thoughts, beliefs, speech, action, and artifacts and is passed from one generation to the next through ceremonies, rituals, and traditions" (as cited in Livingston et al., 2008, p. 2).

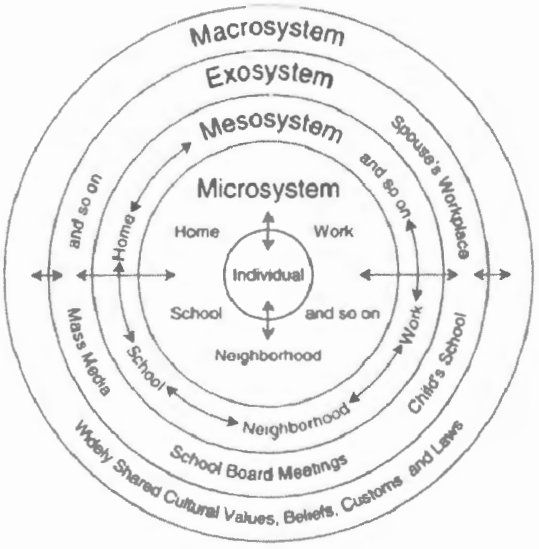
Livingston et al. (2008) discuss culture and link it to the ecological context. The authors state:

> … any organism's ecological context also provides a material and ideological context, which reinforces and affirms an organism's propensity to exist and, thus, is conducive to the survival of a specific group of people. Therefore, culture itself is alive and is an extension of a group of peoples' experimental reality. Culture is an entity rich with images, symbols, and belief systems that signal to the individual, on both a conscious and unconscious level, the morals and traditions of one's nature and role of a culture and how it impacts human behaviour. (p. 3)

There is a need to reevaluate our understanding of cultural competency and to provide a conceptual framework. Thus, social workers, clinicians, counselors, and mental health professionals can shift their thinking from the surface level of understanding of differences to a deeper appreciation of culture and ethnic differences (Livingston et al., 2008). The holistic idea of cultural competency is the reflection of the assessment of the nature and role of culture, and how it impacts human behaviour. Human behaviour is directly connected with one's surrounding environment and one's role with or in that environment.

The ecological system theory developed by Bronfenbrenner (1979) also incorporates *Development in Context* or *Human Ecology*. The ecological theory is based on four perspectives: microsystem, mesosystem, exosystem, and macrosystem (Bronfenbrenner, 1979), which encompass bi-directional influences within and between the systems. According to the author, the microsystem looks at the roles and characteristics of an individual's development, whereas the mesosystem looks at a person's interaction in development. The mesosystem illustrates that individuals do not interact directly, but it affects the individual's development; whereas, the macrosystem explores cultural values that affect an individual's development.

In addition to these, a new concept called chronosystem was added within the periphery of the ecological concept. The chronosystem deals with environmental events and life transitions over the period of one's life. Various social scientists have common ground on ecological system theory. They believe that the ecological system theory was a useful framework for the design of intervention approaches addressing complex problems of individual or family settings (Corcoran, Franklin, & Bennett, 2002; Schweiger & Brien, 2005). These social scientists focused mainly on child issues in relation to the mesosystem and exosystem. Therefore, ecological systems theory provides a multi-faceted approach to dealing with individual and family problems. The following graphic shows the reciprocal interaction of a person within the system, as developed by Urie Bronfenbrenner.



Individual within the system. (Model developed by Urie Bronfenbrenner.)

The ecological perspective considers how the individual develops in interaction with the immediate environment, as well as how the aspects of the larger context influence the

individual and his or her immediate environments (Poria & Pike, 2005). Ecological systems theory is the interaction and interdependence between individuals and nature/environment, as well as between people and events and how the individual interacts within the immediate environments (Heinonen & Spearman, 2006; Poria & Pike, 2005). Thus, this theory explores interpersonal relationships of individual and family as well as social and environmental forces that give rise to a crisis situation or event.

The ecological theory incorporates the life model of social work (Heinonen & Spearman, 2006). Human beings need many things to be able to fit into the social environment. When fitting into the environment, they come across many challenges. "Human needs and problems are generated by transactions between persons and their environment, and through the process of continuous reciprocal adaptation, humans change and are changed by their physical and social environment" (Dubois & Miley, 1992, as cited in Heinonen & Spearman, 2006, p. 183). Structural social work often encompasses how people fit into our society and how all things within the system (as a whole) affect one another. In short, it often means looking at the bigger picture and how all things work together systematically (Heinonen & Spearman, 2006; Mullaly, 2002).

For example, a child who is not doing well in school might not have one reason, but in fact, many. There may be family problems experienced at home, peer pressure at school, special needs within the school curriculum and/or societal issues around the individual's body image/sexual identity. Much like the ecological systems approach, structural social work looks at the many things that could have an effect on the issue.

Culture and Mental Illness

Harrison and Carver (2007) define culture as:

> … the totality of the beliefs, ideas, knowledge, myths, norms, practices, and values of a group of people who share a common set of experiences (e.g., corporate culture, feminist culture, police culture). Everyone has a culture or set of cultures. Culture can change over a person's lifetime and people can belong to more than one culture at one time. Sometimes this can produce an internal conflict. For example, a lawyer, who belongs to a legal culture but who is also a social activist and belongs to an activist culture, may sometimes disagree with laws he or she has to work within. (p. 442)

There is a diversity of opinions and theories about what causes mental illness. Mental illness is a disorder in the brain due to a chemical imbalance that causes a person to function differently. Mental illness is caused by brain injury or genetic problems. There is often stigma attached to the mentally ill person.

Aboriginal Perspective on Mental Illness

The Aboriginal perspective on mental illness is different from that of mainstream society. Their traditional knowledge allows for a wide range of concepts of mental health illness. Aboriginals believe that a poor relationship with environments and physical and emotional health are causing mental distress and ultimately degrade mental health (Kirmayer, et al., 1994). Aboriginal people believe that, due to the breakdown of interconnectedness between a person and environment, mental illness and distress are manifested (McCormick, 2000; Moran 1997). Therefore, there is a need to consider the Aboriginal perspective of mental illness which needs to be respected in order to practice appropriately and culturally, and to provide suitable mental health services.

The ecological perspective of understanding mental illness helps to recognize inclusive underlying problems of mental health. It requires recognition of the intergenerational traumas and effects of colonization. The promising steps to resolve the

historical traumas of Aboriginal people need culturally competent approach. It helps to generate positive aspects of life that build community and individual capacity.

Aboriginal peoples' understandings of mental illness are culturally determined. Such is the hegemony of mainstream views of mental illness that many in the mainstream are blind to this fact and its implications. There is no language for "mental health" in traditional Aboriginal languages. The Aboriginal world view highlights concepts of wholeness, balance, the importance of relationships with family, community, ancestors, and the natural environment. An individual's identity, status, and place in the world are tied to the family, and to one's ancestors' traditional territory and the community. Each of these elements have implications for the design and delivery of healing programs. Aboriginal people understand that Western therapeutic intervention and practices have not authorized their world views, experiences, and needs. Aboriginal people want to exercise their own judgment and understanding about what makes people healthy, and to use their own skills to solve health and social problems (Aboriginal Healing Foundation, 2006). Thus, providing culturally-relevant care helps to incorporate the Aboriginal world view which may lead to better treatment outcomes for Aboriginal people (Hart, 2003).

From an Aboriginal perspective, mental wellness is holistic. Holism includes consideration of physical, emotional, cognitive, and spiritual health, with particular attention to congruence between the mind and body encompassed by the spirit. Individual well-being is strongly connected to family and community wellness. This way of viewing mental health is very different from the Western perspective, (Aboriginal Healing Foundation, 2006).

Aboriginal mental health is relational; strength and security are derived from family and community. It is a concept embedded in context, and embodied in group traditions, laws,

customs, and everyday practices that foster and maintain health in every dimension. The community was the main vehicle for achieving social cohesion and individual and family well-being in Aboriginal societies, prior to contact. No one was left alone or beyond the circle of communal identification and affiliation. When a crisis arose, all community members were responsible for its resolution. This shared responsibility was, in a sense, a psychological shield protecting members of a society from helplessness and demoralization. The community worked to nurture its members and to create accepting, genuine, and empathetic interpersonal relations (Mussell, 2006).

Summary

The notion of multiculturalism demonstrates social change and empowerment, through cultural intervention. It requires the recognition of different ethnic groups, their views, values, and culture, and ultimately helps to prevent oppression and racism. Interventions should view and utilize an emic point of view, as it helps to understand the client's situation and position. Cultural competence is a process that requires time, dedication, reflection, and the full participation of social workers and health care professionals to gain a better understanding of their clients.

Aboriginal traditional knowledge allows for a range of concepts of mental illness. The Aboriginal tradition believes that, the interconnectedness between a person and the environment is important to avoid and prevent mental illness and distress. Thus, when Aboriginal people lose their sense of community, social support, and shared meanings in life, the results are psychological and emotional problems. Their views of wholeness, balance, and relationship with family and community have implications for the design and delivery of healing for mental wellness.

The following chapter discusses my practicum placement at the University Hospital of Northern British Columbia in the psychiatric unit, as well as my personal community mental health work experience.

Chapter 3: Practicum Placement and My Experience

My practicum placement was primarily in an adult (in-patient) acute psychiatric unit at the University Hospital of Northern British Columbia (UHNBC), Prince George, Canada. This practicum report will not include patient names, but rather the views and belief systems I came to understand. I also spent time with the Patients Liaison Worker Program (PLWP), Quick Response Program (QRP), other social workers in the Internal Medicine Unit (IMU) and Family Medicine Unit (FMU). Last but not least, I have engaged intensively with my practicum supervisor, Kristine Henning, at the adult psychiatric unit during my practicum.

The adult psychiatric unit is comprised of two programs: the general inpatient program and the psychiatric intensive care unit (PICU). The general inpatient program applies to all patients requiring psychiatric treatment and care, who do not meet admission criteria for other specialized units (e.g., psychiatric intensive care, adolescent, geriatric). All inpatient programs should be designated to admit involuntary patients under the Mental Health Act. "The general inpatient program provides concurrent, multidisciplinary assessment, and treatment for people with psychiatric disorders as one component of continuum care" (Best Practices for BC's Mental Health Reform, 2002, p. 3).

The inpatient program is heavily dependent on the other services and programs available in the community. Other patient populations that present special challenges in a general unit include those with eating disorders, head injuries, mental handicaps, as well as forensic patients. Once patients can be managed in a less restrictive environment, they are discharged, unless it can be demonstrated that remaining in hospital leads to better clinical outcomes (Best Practices for B.C's Mental Health Reform, 2002).

In the psychiatric intensive care unit (PICU), there is a 24- hour computer surveillance facility to ensure that high risk patients are less likely to attempt self-harm. The PICU is also for those patients who are highly paranoid and are at risk of harming themselves or others. A nurse monitors those patients through computer surveillance. "The psychiatric intensive care (PICU) is a secured locked unit for patients requiring the highest level of observation and containment" (Best Practices for BC's Mental Health Reform, 2002, p. 4). In UHNBC, the PICU is intended to provide constant clinical assessment, observation, and treatment for severely ill and aggressive patients, who may pose harm to themselves or others. Patients' daily progress notes are discussed every morning during round meetings where social workers, psychiatric doctors, student doctors, student social workers, team leader, and nurses engage. With the decision of the psychiatrist, the PICU patients transfer to the general inpatient unit. Discharge planning starts at the time of admission.

There are 20 general beds in the adult psychiatric unit (personal communication, Kristine Henning, May 19th, 2010). On the floor, there is a dining room, a recreation room, and a small common room where a treadmill is kept for the exercise purposes of the patients. There is a public and hospital phone for patients to use. An occupational therapy position has recently been discontinued, due to budget constraints. As a result, patients do not have the opportunity to work at improving their daily living skills (personal communication, Kristine Henning, May 26th, 2010). The psychiatric unit also provides stress management classes and verbal support groups; both classes run five days a week.

The stress management group is run by a nurse who gives tools and techniques used to cope with and manage stress. This is a lecture-type class and participants receive notes and tasks to complete homework. On the other hand, the verbal support group uses a non-medical

social interaction group approach in which generally four to six participants can take part in the session. These participants typically suffer from depression, post traumatic disorder, borderline personality disorder, and bipolar disorder. The psychiatric unit management allows patients to participate in both sessions throughout the day. Patient names are displayed every morning on the notice board which is kept in the hallway.

I achieved my learning objectives through active participation in meetings, daily communication with my practicum supervisor, Kristine Henning, consultations with health care professionals, and face-to-face interactions and consultations with patients, mental health and addiction community representatives, and case managers in discharge planning.

The UHNBC provides special social work service to Aboriginal populations that are pertinent to Aboriginal culture, language, and health care benefits and information. The Patient Liaison Worker helps to communicate with the patient's family, band, and case managers, and provides appropriate information and services to them. Essentially, the patient liaison worker program (PLWP) is designed to provide support to the Aboriginal people of northern British Columbia, as well as the adjoining territories and provinces of British Columbia. PLWP is connected with all hospital units, such as the maternity, surgical, renal, internal medicine unit, family medicine unit, intensive care unit, pediatric unit, rehabilitation unit, and emergency. PLWP provides non-insured health benefits including social and cultural therapeutic interventions to the Aboriginal people and their families. This program also provides patient escort services to immediate patient members in the community. A personal hygiene starter kit is also available at PLWP for patients needing it. The Patients Liaison Worker Program runs in collaboration with the Carrier Sekani Family Services and Northern Health authorities.

I have learned the importance of the Aboriginal peoples' social connections, family bonds, and ethnic and cultural values when patients come from remote areas to UHNBC. The liaison workers provide health information, therapeutic intervention, and support to patients and their family.

Language is a big piece of cultural competency in the hospital environment. Many Aboriginal patients, especially the elders, do not understand the medical terminology that English speaking health care providers use. Liaison workers help to simplify medical language and convey messages to patients and their family members appropriately. Speaking the patients' mother tongue helps to implement care plans more quickly and easily. This approach will help to establish trust between the two parties, in a friendly environment.

I have observed Aboriginal peoples' approach and communication in the emergency, internal medicine unit (IMU), family medicine unit (FMU), surgical, and maternity unit. Aboriginal liaison workers follow the admission chart of admitted Aboriginal people. It is a crucial part of the liaison worker's role, as, once she finds Aboriginal patients; she can connect them and their families to services and other social and community networks. This is the important part of intervention, which helps to understand patients' world views. I have observed that Aboriginal people are very open, in most cases they communicate simply and very congruently. Cultural competency is also a process of understanding language, beliefs, and values of others (Appleby, Colon, & Hamilton, 2007), as it helps to connect to the patients more easily.

During my days with the liaison worker, I started my job at 08:00, and I approached or connected with Aboriginal patients in the hospital through the admission lists. Then, I gathered information about their home town, reserve, and the band to which they belonged.

This normally helps to locate the patients in the community and provides a context for their background. The Liaison worker approaches patients and warmly greets and touches them. "Aboriginal people believe that God is the protector for them and that nobody is above God" (personal communication, June Moise, May 17, 2010).

Many Aboriginal people believe in a creation-based form of spirituality which has, at its center, the symbol of the sacred circle. This is not true for all Aboriginal people but many subscribe to this belief. The circle represents a harmonious relationship with nature (living and non-living things) who they believe are relatives. Moreover, nature is connected and equal because, in a circle, there is no beginning and no end. Mother Earth is often referred to as a Medicine Wheel, because she is circular and turns in a circle (Thunderbird, 2010).

Similarly, Hart (2003) states that the Medicine Wheel helps wellness, balance, connectedness, harmony, growth, and healing for the Aborignal people. The Medicine Wheel focuses on four areas of human kind: physical, emotional, mental, and spiritual health. The Medicine Wheel "reflects the cosmic order and unity of all things in the universe" (Heinenon & Spearman, 2006, p. 241). Significantly, the Medicine Wheel is a symbol of understanding many issues and viewpoints. It exhibits several key and interrelated concepts familiar to various Aboriginal approaches to helping. These concepts include wholeness, balance, relationships, harmony, growth, and healing (Aboriginal Healing Foundation, 2006; Hart 2003, Heinenon & Spearman, 2006). The Medicine Wheel helps a person to achieve wholeness, balance, connectedness/relationships, and harmony with his or her environment.

Aboriginal people believe in transaction and interface in the ecosystem. "Transaction is a connection and interlink between person and the person's environment, where they live" (Heinonen & Spearman, 2006, p. 258). According to this principle, interface is a focal point

where systems come together and contact each other. In this regard we can also imagine that Aboriginal people believe in ecosystem practices which are connected to the theory of ecology. It is a concept of an ecological niche where every person has a role to fulfill. The theory of balancing society is, in fact, fulfilling the notion of connectedness of Aboriginal beliefs in the Medicine Wheel (Heinenon & Spearman, 2006).

Verbal Support Group: A Gateway to Understanding Patients' World Views and Belief Systems

Previously, I mentioned the verbal support group in the adult psychiatric unit, which is facilitated by a social worker handling four to six patients, and one nurse assisting the social worker. It is a group session for social interaction, and usually runs for one hour. Patients have the opportunity to openly vent about their feelings, life experiences, hospital care, treatment plan, and post-discharge plans in the community. This verbal group has some guidelines about respect toward others and confidentiality. Participants need to respect each other. Participants cannot disclose other participants' personal matters, feelings, views, and group interactions outside. After the end of the session, social workers chart, using SYNAPSE (electronic charting), a Northern Health Authority information and record keeping system), the important conversation pieces for each patient who participated in the verbal support group.

In verbal support group sessions, patients share their life experiences, family matters, personal mental health issues and problems, mental health support groups, and mental health resources. I had an opportunity to run this group after one week of observing sessions. Patients can gain experience by sharing and discussing life experiences. The verbal support

group is a session for empowerment, as it helps group members to learn from each other through discussion and sharing experiences.

In my tenure with the psychiatric unit, I found that the verbal group is a place where participants (patients) share world views and life experiences, discuss obstacles in the health care system, identify stigma about being in the psychiatric unit, and exchange cultural and social ideas. As social workers, this gives us the opportunity to understand participants' views (emic). The verbal support group is primarily a social interaction group, in which participants share life experiences with the group. The facilitator does not write or record whatever has been expressed by the group, for the purpose of respecting confidentiality and privacy. However, their views and experiences definitely help to access services for the patients if needed. Addressing their concerns and views helps to develop a suitable discharge plan. Encompassing the patients' needs, interests, and views in their care plan after discharge represents culturally-competent service to the oppressed group. Verbal groups enhance an opportunity to advocate on behalf of patients appropriately, providing culturally competent intervention.

The adult psychiatric unit of the University Hospital of Northern British Columbia has multidisciplinary health care professionals. The multidisciplinary team includes a psychiatrist, a resident doctor, medical students, nurses (registered nurses and psychiatric registered nurses), and a psychiatric social worker.

The psychiatric social worker has many responsibilities which include discharge planning, liaison with government, social and mental health community resources, and family members. In addition, the psychiatric social worker also facilitates the verbal support group on a daily basis, provides psychosocial assessment, and arranges conference call

meetings between hospitals, remote community mental health organizations, and other social services organizations and their families for emotional and other supports.

Practicum Learning Objectives

I achieved the following learning objectives in my practicum placement:

1. Completed a literature review which included cultural competency and multiculturalism, culture and mental illness, and Aboriginal perspectives on mental illness.

2. Gained a deep understanding of the importance of cultural competence in social work practice.

3. Increased my knowledge of current procedures and social work practice in hospital, particularly in the psychiatric unit.

4. Increased my understanding of the role of a psychiatric social worker within adult acute psychiatry.

5. Identified the social worker's challenges in a hospital environment.

6. Illustrated a case example that entails the importance of culturally-competent social work practice during discharge planning.

7. Identified various problems and issues for street involved mental health patients after discharge.

8. Proposed recommendations for the health authority to practice culturally appropriate health care services.

Summary

My practicum placement was in an adult acute psychiatric unit at the University Hospital of Northern British Columbia. This unit provides 20 general psychiatric beds and four psychiatric intensive care units. The unit is operated by a multidisciplinary team that includes psychiatrists, social workers, and nurses. The social worker's main duties include a discharge planning, psycho-social assessment, the arranging of case conferences between community agencies and family members, providing social and emotional support, and facilitation of a verbal support group. In addition, the psychiatric social worker must know or ask about support systems.

The unit runs two programs for the patients: stress management and the verbal support group. Stress management is basically a lecture class for the participants, whereas the verbal support group (run by a social worker with the presence of one nurse) is a social interaction group involving four to six participants. The verbal support group provides an opportunity to share and discuss participants' views and belief systems, life experiences, feelings revolving around the psychiatric unit, hospital management, and their post-discharge plans. It is my impression that the verbal group allows the social worker to acquire knowledge about participants' views toward the health care system, values, and cultural belief systems. This interaction process helps to understand participants' experiences, in order to provide client-centered intervention. The following chapter covers clinical observation and consultation and provides a case example to illustrate social work application.

Chapter 4: Clinical Consultation and Observation

The objective of this report is to evaluate cultural competency in the health care system. The broad idea of this statement will encompass intervention or clinical practice in hospital settings, primarily in the psychiatric unit and other hospital wards where I observed or consulted /intervened with ethnic minority patients including Aboriginal people.

Intervention is a process that meets stated goals to provide the best service plans. Hepworth et al. (2006) state that intervention is a process that needs to be discussed with clients and provide a brief overview of the situation in order to elicit the clients' reactions and to obtain their consent. From a social work perspective, Heinonen and Spearman (2006) add that, during intervention, the "social worker and/or client take initiation to resolve the problem. Generally intervention flows from the assessment and from the goals that have been established. Intervention emphasizes treatment-direct action by a social worker to alleviate a problem" (p. 313). The authors further indicate that intervention has two elements for treatment and prevention. Moreover, they state that there are two kinds of prevention: primary prevention and secondary prevention. "Primary prevention is an attempt to keep a problem from occurring in the first place, while secondary aims to stop the development of new problems while working on an existing one" (p. 159). However, for the secondary prevention approach, it is my understanding, developed from knowledge gained through working with the community mental health field, that secondary prevention involves consistent care and close contact with clients. This intervention helps to reduce relapse in people with mental disorders. After de-institutionalizing, many mental health clients are

faced with a lack of culturally appropriate mental health group homes and access to mental health networks.

While exercising social work practice and intervention, our values and work ethics are primarily based on "humanitarian and egalitarian ideals" (Heinonen & Spearman, 2006, p. 34). In fact, in this new era, we as human beings need to display a caring disposition if we aim to fulfill our responsibility and work ethic to help vulnerable populations in a democratic way. We need to voice peoples' needs to provide them service as they wish or require, based on their cultural perspectives.

Thus, within the framework of these two fundamental ideals, social work intervention emphasizes and is characterized by the following values, which are applied to practice:

- the right of every person to be safe from harmful and abusive environments;
- the importance of the acceptance and intrinsic worth, integrity, respect, and dignity of every human being;
- the right to self-determination;
- the right to social justice, which includes the elimination of oppression, domination, subordination, and exploitation;
- the individual and collective empowerment of people who are vulnerable, oppressed , or living in poverty;
- a commitment to individuality, self-realization, growth, healing, and well-being of people, resources, services, and opportunities for the benefit of one another and humanity;
- the belief that people's culture should be respected. (Heinenon & Spearman, 2006, p. 35)

All the above values revolve around peoples' rights and responsibilities. While serving clients, our intervention practices should be within the framework of the above principles, in order to meet the criteria of culturally-competent practice.

The main role of a social worker is to work actively in patient discharge planning, and to investigate family and social networks, social welfare avenues, and housing (if applicable) for the patients. Prior to discharge, it was my responsibility to contact family, friends, community mental health services, case managers, counsellors, and local and provincial mental health resources in order to provide mental health treatment on a regular basis. I had debriefings with my practicum supervisor on a regular basis about health care, housing issues, and the importance of cultural competency. Post-discharge discussions and consultations, and housing issues were reviewed with my field supervisor.

In the adult psychiatric unit, I found a few patients, who were known to me from community mental health work, with problems with finding housing after being discharged. Those patients were street-involved, street drug users, and non-compliant with medications. They were not connected to the case managers or did not attempt to connect. I also noticed that some people did not want to connect or establish communication with their case manager. These people frequently visit the hospital and are admitted several times in a year when they relapse (personal communication, Kristine Henning, June 9, 2010).

Practicum Activities: Method (Information Collection)

During my practicum, information was collected through interactions with patients and health care providers on a daily basis. After each interaction, I documented patient needs, concerns, and treatment planning in a journal, which was kept in a secure place for analysis. All aspects of documentation were not recorded. I have not disclosed patients' names and

personal identifies in this report. I targeted Aboriginal populations from the psychiatric and other units wherever patients are available. Upon the completion of the practicum, I read and analyzed all the journal entries maintained throughout the placement, and destroyed the journal to further protect identity.

In order to explore cultural competency in health care, on a daily basis, I attended rounds meetings with multidisciplinary teams, which include social workers, unit team leader, nurses, psychiatrist, and medical student doctors. These rounds meetings discuss new admissions, reasons for admission, daily clinical updates (progress reports) of admitted patients, and discharge planning.

Since my concentration in this report is cultural competency in health care, I have observed how health care professionals address or consider patients' views, concerns, and needs while they are in the hospital. Within the concept of cultural competency, I have noted daily patient concerns and needs. I have constantly engaged and consulted with my practicum supervisor. During the meetings, I addressed and discussed issues around cultural competency. She provided valuable feedback regarding my practice and made suggestions on how I could perform better social work practice interventions. During my tenure, there was one mid-term evaluation with my practicum supervisor and academic supervisor, and one final evaluation with a committee that includes a practicum supervisor, academic supervisor, and a committee member. I discovered the challenges in implementing culturally appropriate health care practices.

Observation and Consultation

The population of Prince George is predominantly Caucasian; however, Aboriginal people comprise 9 percent (BC Stats, 2006). Due to its regional health service facilities,

Prince George attracts remote and isolated populations for better health care access. Many Aboriginal people come to Prince George seeking medical help.

A young Aboriginal man, age 21, was admitted to the psychiatric unit voluntarily. He might have mental health and addiction problems. Since his childhood, he may have been raised in foster homes and in group homes. He completely missed love and care from parents. He may have little contact with his mother; may have never met his biological father. He lacks parental love and emotion as a result of his childhood. He has been living on his own, and literally spends his nights on the streets, in shelters, or on the couch with his friends when fortunate enough to do so.

This young man is typical of many mentally ill people who are on drugs and alcohol and remain in homeless situations. Many of them do not have the mental health community connections or may experience long waitlists for the community service providers. These vulnerable populations do not comply with psychotropic medications due to addiction with street drugs; as a result, repeated admission to the adult psychiatric unit can be seen or observed.

Implications of the Practicum Tenure: Knowledge from Interaction

A young man came to see me and referred to me as a "brother." He had been admitted into the psychiatric unit a number of times. Him referring me as a "brother" was partly due to his culture where Aboriginal people address others in a respectful way. Using "brother" was a part of his custom of greeting another person in his community (personal communication, June Moise, PLWP, May 12, 2010).

I checked the young man's housing situation, his connection with community mental health teams, social networks, and medical benefits. In the past, he was referred to the

Community Assertive Team (ACT) from the Community Outreach and Assertive Service Team (COAST), but did not connect with the ACT team.

> The "ACT is a self-contained mental health program made up of a multidisciplinary mental health staff, including peer support specialists, who work as a team to provide the majority of treatment, rehabilitation, and support services clients need to achieve their goals. (Leer, 2008, p. 53)

Similarly, the COAST provides outreach and assertive service to the person with serious mental illness. The goal is to keep the client in the community functioning at their optimal level. I asked him about his status in those agencies, but he was reluctant to see them.

Lack of communication or a regular monitoring system with a young man like this is a big community service gap after discharge. This is one of the biggest problems among the street dependent mental health patients and it results from a lack of front line workers and long waitlists for community mental health agencies (personal communication, Kristine Henning, June 7, 2010).

Long waitlists and a lack of connection with appropriate community mental health teams/bodies ultimately result in frustration and dull the motivation to see professionals. This young man had similar problems. He did not know or did not want to connect with the mental health care professionals. He was missing a cultural connection and social network, which would otherwise help him to develop motivation and seek continuous care.

Patient Autonomy

Many mental health patients in the psychiatric unit want to be discharged quickly; however, they may lack the ability to make the right decisions. I have seen many situations in the psychiatric unit where patients wanted to leave the unit or get discharged as soon as

possible. The young man had the same tendency, although he was a voluntary patient and can leave the hospital whenever he wishes to do so.

Social workers should focus our practice in decision making on the client's behalf. In this regard, my responsibility was to locate the areas where the young man actually would receive benefits. His case involved investigating his personal support, family network, income, housing, and liaison to mental health community networks for his continuing care after discharge.

Most of the street-dependent mental health populations don't have the above access. The young man approached me and requested pain-killing medicine, which he stated helps him alleviate the pain he gained from an ice skating injury, and he wanted to get discharged as soon as possible. This is a frequent problem with mental health patients. I found in many cases that drug-addicted people on the street seek pain killing drugs to help cope with pain. This tendency could be even more detrimental, as many people trade and sell such prescribed drugs for street drugs on the streets.

This young man had no other hopes for permanent living, or empowering and dignifying his living situation. He somehow wanted to be discharged from the psychiatric unit. I consulted with the ACT team for his post-discharge plans about housing and connection with community mental health teams. There was a long waiting list situation and, on the other hand, he had minimal interest in connecting with community mental health teams. He assumed that he doesn't have any issues with mental health, rather just the issues of pain he acquired as a result of his skating injury:

> Mental health is as important as physical health to the overall well-being of individuals, societies and countries. Yet only a small minority of the 450 million

> people suffering from a mental or behavioral disorder are receiving treatment. Advances in neuroscience and behavioral medicine have shown that, like many physical illnesses, mental and behavioral disorders are the result of a complex interaction between biological, psychological and social factors. While there is still much to be learned, we already have the knowledge and power to reduce the burden of mental and behavioral disorders worldwide. (World Health Organization, 2001, p. 1)

The young man also fits in the above idea of the World Health Organization (WHO) report. Social work's responsibility in this scenario is to comply with the "Ethical Responsibilities to Society," Section 8 of sub-section 8.2.1 (CASW, 2005, p. 24). It clearly advocates social action for people who have issues with the ability to decide for themselves. However, there seems to be an ethical challenge in social work practice when informed consent for mentally challenged clients is involved. Section 1.6.3 states that there "is a provision without informed consent to exercise provincial/territorial legislation, standards of practice and workplace polices" (CASW, 2005, p. 9), if the client seemed self-harmful or a threat to others. Section 4.1.4 illustrates that the social worker can "appropriately challenge work to improve policies, procedures, practices and service provisions that are in anyway oppressive, disempowering or culturally inappropriate" (CASW, 2005, p. 16).

If we respect Section 4.1.4, then it is our responsibility to find a culturally-appropriate continuum care for the young man or elderly person in the community. Social work implications for the previously mentioned elderly Asian case did not justify Section 4.1.4, as this vulnerable person has no ability to decide for himself. The discharge plan for this person may reflect incompetent cultural practice.

Challenges for Social Workers in the Hospital

The social worker fulfills responsibilities relating to the specific needs of the individual patient and their families in regard to discharge planning, liaison with community resources, and consulting with other staff and community agencies. In addition, social workers also help to obtain psychosocial information in order to provide client-centered treatment planning to teams (Van Hook, 2003).

Heinonen and Spearman (2006) proposed a bio-psychosocial model for mental health client care and intervention. According to them, it is a holistic approach that entails the ecological model. However, it is seen that street-dependent mental health populations do not frequently follow referral processes or mental health community resources; as a result, their metal status deteriorates. During consultation with my field supervisor, she expressed concern about inadequate frontline workers/life skills workers and case managers in the Prince George community, and, as a result, mental health clients are admitted to the psychiatric unit regularly (personal communication, Kristine Henning, June 2, 2010). There is a lack of community resources and complications in the referral process (Van Hook, 2003), and, as a result, patients might fall off the medication track and regular consultation with health care provider or case managers.

In my work experience I have noticed that many mental health clients are non-compliant with their medications, or that they do not want to regularly see their case manager or psychiatrist. Mental health clients may abstain from taking their medications or they believe that reducing psychotropic drugs help them. This often leads to relapse, and these people habitually attend the hospital. Psychosocial issues and social problems are seen as the most significant and powerful predictors of the length of hospital stay rather than the

Diagnostic Related Groups (DRGs) (Keefer, Duder, & Lechman, 2001, citied in Van Hook, 2003).

The social worker is responsible for respecting the dignity and autonomy of clients to empower their lives. There is wide agreement about the basic values in social work. Based on respect for the inherent worth and dignity of all people, social work should promote the rights to individual self-determination and participation in society. Social workers should challenge discrimination, recognize diversity, and work to overcome social exclusion. These values are substantially constant across different societies and throughout the history of social work (Asquith, Clark, & Waterhouse, 2005).

Social work core values in discharge planning could not always be met due to the medical environment, limited access, or restricted social worker authority in hospital. This may be the reason the elderly man that I referred to, was discharged without knowing his cultural background and desire to live in Prince George community. How and on what grounds was he discharged to an assisted living care center? This happened partly because the elderly man was helpless and unable to express his views to the health professionals. When I visited him in June 2010 in a new care facility to enquire about his health and other conditions, he expressed in his cultural way: "you can see how I am doing" in the language of Hindi. I could understand his feelings and emotions. He was frustrated staying there because he did not have a cultural context to relate to.

Family responsibility in many Eastern and Aboriginal cultures is critical to social identity. When parents or grandparents are not able to talk or communicate, the offspring usually advocate on behalf of their parents or grandparents. This avenue was completely disconnected for him. Therefore, the patient's language and cultural understanding are

important elements that determine effective intervention and cultural competency. Without understanding these aspects, the UHNBC discharged the elderly person to an extended resident care facility.

Social work literature has addressed the challenges of "everyday clinical experiences" in hospitals with mental health populations (Bergmans et al., 2009, p. 421). It is important to document and understand the unique positions of both the health care providers and the clients in order to assist the social worker to better navigate the complicated personal, social, and system issues related to intervention and advocacy for these vulnerable populations (Bergmans, et al., 2009). Bergmans et al. also identified huge challenges due to a lack of access to mental health community resources. The study revealed that the hospital psychiatric unit was not seen as a solution, and the lack of community-based interface was identified as problematic, because patients are sent home many times and admitted to the psychiatric unit when relapsing. These populations more often return to the hospital. Lack of communication, support, housing, medications, and regular monitoring systems are factors which cause them to voluntarily visit the hospital for admission. My consultation with Kristine Henning also highlighted this problem. She stated that many patients often return to the psychiatric unit because of lack of housing and a medication monitoring system (personal communication, Kristine Henning, July 2, 2010).

Summary

Patient information, health care and social needs, and views were collected on a daily basis through my interaction with the patients. All information was documented in a journal, destroyed in order to protect patient confidentiality, after completion of this report. Long waitlists and a lack of connection with community mental health teams exacerbated the

symptoms of mental illness, resulting in many mentally ill; street-involved homeless patients repeatedly visiting the hospital after being discharged. A continuum of care is required to reduce hospital visits and maintain daily living styles. The following chapter discusses the Aboriginal perceptions of mental illness. A cultural approach to healing intervention helps to provide mental wellness and reduce addiction (Heinonen & Spearman, 2006; McCormick, 2000).

Chapter 5: Discussion

Learning about other cultures is a step toward achieving cross-cultural competence: it can be achieved by reading books, participating in cultural ceremonies, events, and studying art. Connecting with individuals and groups of different cultures is an avenue for learning the social values and customs of a particular group (Livingston et al., 2008). Recognizing, respecting, and understanding other cultures and related health beliefs lays a foundation to build healing alliances with clients (NASW, 2001). Thus, social workers and health care practitioners are responsible for self-reflection regarding the impact of their own cultural beliefs on their professional and personal life.

During my practicum tenure with the UHNBC, I had good communication with two families in the family medicine unit (FMU) and the internal medicine unit (IMU). I approached them in a very sincere manner and let them know that some of their ceremonies and events were known to me. Thus, I was able to create a comfort zone for myself and the patient in the family meeting, so that patients would recognize my perceptions, knowledge, and belief systems towards Aboriginal people. As outsiders, we have to plan like an anthropologist to intervene or approach people of different ethnic backgrounds. Sometimes connecting with individuals and groups may be uncomfortable even if we know the client's culture. Therefore, social workers, counsellors, clinicians, and human service professionals need to become anthropologists, immersing themselves into the setting of language, customs, and world views different from their own (Livingston et al., 2008).

Mental Illness and Addiction in Aboriginal People

Assimilation and oppression by mainstream society has led to contemporary social problems faced by many Aboriginal people and their communities (Garrett & Pichette, 2000). Intergenerational trauma has been found to be a major problem; as a result, many Aboriginal people depend on alcohol and illegal substances in order to cope with difficulties and manage past traumas (Assembly of First Nations, 1994). Aboriginal people have different ways of seeing or viewing their world than mainstream society (McCormick, 1997). Therefore, it is important to understand the root cause of mental health problems and addiction to provide a culturally competent intervention. It is a necessity to understand Aboriginal belief systems which help to manage addiction and heal mental health problems (Assembly of First Nations, 1994). Consequently, problems can be alleviated by providing appropriate intervention strategies.

Understanding addiction problems involves a broad background of Aboriginal interconnectedness, their culture and belief systems, their trauma from residential schools, and how these factors are impacting their life (Aboriginal Healing Foundation, 2006; Moran, 1997). Interconnectedness can be viewed as the individual's connection to the world where he or she lives (Heinonen & Spearman, 2006). Interconnectedness connects families, friends, and communities as a whole (McCormick, 1994). The Medicine Wheel is a symbol of wholeness for some Aboriginal people, where their belief systems are tied (Aboriginal Healing Foundation, 2006; Heinonen & Spearman, 2006; NAHO, 2007). It represents spiritual ties that bind human beings to one another and to their world (Bell, 1991, as cited in McCormick, 1994). The Medicine Wheel is the essence of mental health healing practices that will make intervention easier and effective for the Aboriginal people. Spiritual healing

provides treatment for the intergenerational trauma and helps to provide strength to cope with stresses and traumas (Assembly of First Nations, 1994).

Many Aboriginal people are dependent on alcohol and drugs and suffer from lack of self-esteem, autonomy, and mental illnesses due to the negative impacts of residential schools, and the loss of traditional ways of life (Aboriginal Healing Foundation, 2006; Corrado & Cohen, 2003; Moran, 1997). Intergenerational or multi-generational trauma occurs when the effects of trauma are not resolved in one generation. When trauma is ignored and there is no support for dealing with it, the trauma will be transferred from one generation onto the next (Assembly of First Nations, 1994). A great deal of literature relates the current issues of mental and physical illness to intergenerational trauma (Archibald, 2006; Corrado & Cohen, 2003; Moran, 1997). Many Aboriginal people are using drugs and alcohol to cope with the hardship of trauma; as a result, their physical and mental health is heavily impacted.

Similarly, Aboriginal people are currently suffering from higher mortality rates from illicit drug use and mental health related conditions, and frequent movement from rural and urban areas poses a further threat of stress and depression (Archibald, 2006; Assembly of First Nations, 1994). The vulnerability of this population is complex, as Aboriginal people do not feel comfortable within the health care system or do not have access to non-Aboriginal services (Assembly of First Nations, 1994). Additionally, they are more vulnerable due to isolation, and have limited access; as a result, service delivery systems are ineffective and unreliable.

Similarly, Heinonen and Spearman (2006) further contend that Aboriginal people are not getting appropriate access to addiction and health care services. Furthermore, a lack of cultural competency is not tailoring delivery to meet Aboriginal peoples' social, cultural, and

linguistic needs (Nova Scotia Department of Health, 2005). It is therefore essential to acknowledge cultural and belief systems to provide culturally competent mental health services for Aboriginal people.

Importance of Aboriginal Culture for Mental Health

After the destruction of Aboriginal peoples' economy, family values, and religious beliefs, a large social gap developed between the dominant white society and the Aboriginal people. Ultimately, the Aboriginal people relied on spirituality to heal and recover from their problems. This was a way to establish well-being for Aboriginal people. Aboriginal people use mental health treatment through their healing processes to recover from personal and social problems (Assembly of First Nations, 1994). Understanding these traditional values involves interpersonal communication, and a relationship between health care practitioners and ethnically different patients, in order to build cultural competence (Suh, 2004).

Thus, health care practitioners need to understand the etiology of addiction and its illness, and also how clients understand the problem of addiction. We need to consider the language of addiction and how clients interpret this. Aboriginal people believe that addiction and its problems are due to disconnections, imbalances, and disharmonies (Malloch, 1989, as cited in Heinonen & Spearman, 2006).

To cope with and handle these imbalances and disharmonies, Aboriginal people consider the healing process as a journey that one has to practice on a daily basis throughout life. One of the Aboriginal sayings, *mino-pimatisiwin* (meaning "the good life" in Cree), also highlights the idea of healing for the whole family and community (Heinonen & Spearman, 2006, p. 244). This faith refers to the Aboriginal perspective of seeing family problems as a community concern, not just as a family problem. It can be said that Aboriginal people do not

see person or unit problems; however, they consider an individual problems as community problems. "*Mino-pimatisiwin* believes in self-actualization that we as human beings have to grow toward *mino-pimatisiwin*. This concept believes that human growth and development takes place through our actions" (Heinonen & Spearman, 2006, p. 245).

Krischenbaum (2004) also admits that life and culture are an endless process of creativity, even if only in small ways. Human beings, including all living creatures, are driven to grow and strive for optimal health, and require resiliency in the face of cultural diversity. Thus, knowing the cultural diversity of Aboriginal people can help to develop competence and provide resilience, so that mentally ill people do feel empowered and can cope with hardship in culturally diverse situations.

Aboriginal people believe that helping and healing are connected. On the other hand, they also believe that human problems are related to disconnections, imbalances, and disharmony within the society (Heinonen & Spearman, 2006). Such impressions of Aboriginal people need to be considered in order to provide optimal health-care. Furthermore, cultural competence has been significantly important and a required characteristic in interactions with ethnically different populations, such as relationships between physicians and patients, psychologists and patients, teachers and students, and social workers and care recipients (Shu, 2004).

Addiction is prominent in many Aboriginal people due to lack of awareness and education about the health related issues, as well as stigma and shame associated with mental illness (Min, 2005). Thus, cultural competency requires:

> … knowledge of cultural norms, acculturation, and language difference; the ability to differentiate between individual and culturally linked attributes, the initiative to seek

> out needed information so that evaluations are not biased, and services are culturally appropriate, and an understanding of the way that cultural differences may reveal themselves in the assessment process. (Hepworth et al., 2006, p. 183).

Thus, recognition and familiarization of culture in this regard is a crucial part to managing mental health, addictions, and disparities.

Culture brings discipline and ways to help build hope and empowerment. It provides a different way of doing things in life. For example, in a *powwow*, you have drums, you have dance, you have physical exercise, and you have a sense of belonging. These are the times that bring people together, and in these places, drugs and alcohol are not tolerated (Hart, 2003). McCormick (2000) contends that many Aboriginal Elders and healers believe that reconnections to culture, community, and spirituality are healing approaches for Aboriginal people.

The trauma may be eased by incorporating culturally appropriate treatment practices into public health care for the Aboriginal people. These practices will provide moral strength and support, and empower Aboriginal people, which will ultimately enhance their mental, physical, and emotional health conditions and help to decrease intergenerational trauma and substance use (McCormick, 1994).

The Medicine Wheel: Cultural Approach for Mental Wellness

Aboriginal people have their own values, traditions, and culture. They have different perspectives on healing methods. Intervention, care giving, and social service methodologies allow the service providers to think critically about the ways they practice and how their own assumptions can hinder the success of their work (Turner, 2002). Inclusive service providers attempt to look past their personal assumptions: this allows them to work with realities and

experiences differing from their own (Turner, 2002). In order to accomplish this and acknowledge the experiences of self and others, service providers and health care professionals must understand different concepts and world views in order to successfully engage in the process of connecting with Aboriginal beliefs, values, and experiences (Archibald, 2006). The inclusive approach to social work may have Aboriginal world views in mind; however, it still consists of Western theory and does not include traditional Aboriginal healing methods (Turner, 2002).

In order to provide culturally competent treatment for Aboriginal people, some specialists recommend a combination of Western and traditional approaches to promote individual and community wellness. Dr. Gary Chaimowitz works with remote Aboriginal communities in the James Bay area, in Ontario. He promotes the wellness approach, as opposed to the model of addiction and mental illness, as he believes health is more than the absence of illness (Chaimowitz, 2000).

Hart asserts a traditional Aboriginal approach to social work about the life and goodness, believes in "seeking m*ino-pimatasiwin* (The Good Life)" (2003, p. 104). This approach of intervention for Aboriginal people also entails the preservation of traditional beliefs for frail Aboriginal communities. This approach to healing relies heavily on the principles of the Medicine Wheel, which is an ancient symbol of the universe, used to help people understand what they cannot see (Hart, 2003). In the same way, Heinonen and Spearman (2006) also support the traditional values of Aboriginal people and how these values work for their wellness. According to the authors, an Aboriginal approach to social work is focused on *mino-pimatasiwin* (p. 256). Aboriginal people believe that helping and healing are connected (Assembly of First Nations, 1994). Health care professionals need to

acknowledge and understand the tie between the earth and Aboriginal culture. Aboriginal people believe that there is a disconnection between the environment and Aboriginal people and that, in addition, human problems are related to disconnections, imbalances, and disharmonies. Aboriginal peoples' cultural beliefs are interlinked in such a way that they are fully relying on the environment; they value and respect the earth as a mother and the sky as a father (Hart, 2003).

Disconnections, imbalances, and disharmonies are the result of colonization and residential schooling systems (Assembly of First Nations, 1994; Moran, 1997). Most of the Aboriginal children were taken away from their families to be assimilated into a strict environment to learn English; as a result, their family value system, culture, food, and other ritual rights were heavily impacted by the dominant society (Moran, 1997). Those people are now suffering from severe mental health and addiction problems, including psychological and emotional stress due to intergenerational trauma (Assembly of First Nations, 1994). Social workers and health care practitioners need to understand the longitudinal impact on Aboriginal people's health, and provide services according to those beliefs and reality.

Thus, the Medicine Wheel in Aboriginal culture is a physical, mental, emotional, and spiritual device that can allow people to bring relationships to natural forces (McCormick, 1994). People then find harmony with the environment and within themselves (Hart, 2003). Aboriginal views on balance and disharmony share similarities with the equilibrium and disequilibrium principles of ecosystems (Heinonen & Spearman, 2006). Therefore, social workers, health care professionals, and service providers need to look at the whole picture of a person's environment to be served, to get optimum results from the service.

The Medicine Wheel is an Aboriginal therapeutic approach for healing; it promotes wellness, balance, connectedness, harmony, growth, and healing for Aboriginal people (Hart, 2003, Heinenon & Spearman, 2006). The Medicine Wheel focuses on four areas of human kind: physical, emotional, mental, and spiritual health. The Medicine Wheel "reflects the cosmic order and unity of all things in the universe" (Heinenon & Spearman, 2006, p. 241). Significantly, the Medicine Wheel is a symbol of understanding many issues and viewpoints. It exhibits several key and interrelated concepts that are familiar to various Aboriginal approaches to helping. Drug and alcohol addiction problems faced by Aboriginal people are a sign of imbalance, disconnection, and disharmony with their environment (Hart, 2003). Modern psychiatric treatment needs to consider Aboriginal people's values and maintain their traditional systems in mental health treatment for wellness. It is argued that Aboriginal people's healing practices and maintaining their relationship with spirituality will help to encourage patients' interest towards the care they receive (NAHO, 2007).

Various social scientists are advocating that the underlying concept of the Medicine Wheel is connectedness (Hart, 2003; Heinenon & Spearman, 2006, NAHO, 2007). Connectedness is highly emphasized by Moran (1997). According to Moran a lack of connectedness caused many Aboriginal children attending residential schools to lose family and culture, and now they are struggling with chronic diseases, substance abuse, and mental illnesses. It is obvious that loss of cultural values can affect personal and community identity. When a person loses his or her background, he or she may not have reason to live with dignity.

Similarly, McCormick (1994) finds that healing programs would evoke dignity, empowerment, cleansing, balance, discipline, and belonging. He further asserts that

Aboriginal people have a different way of seeing the world, which has to be understood before an effective service or treatment can be provided. Aboriginal people believe in self-transcendence by means of connectedness, which is a common route to healing for them, in order to sustain mental health (McCormick, 1994). The connectedness in this case is about nature and family, where Aboriginal people live and rely on for their well-being (Heinenon & Spearman, 2006; McCormick, 2000; Moran, 1997). Therefore, connectedness can be considered as wholeness for the living requirements of Aboriginal people. The Medicine Wheel represents the balance that exists between all things; balance is, in fact, the basic tenet of healthy living (McCormick, 1994). Healthy living is the indicator of maintaining wellness and functioning life smoothly. The Medicine Wheel, in this regard, helps to connect Aboriginal beliefs together and heals the physical, mental, and addiction problems.

Spiritual belief is important to recover addiction problems of Aboriginal people and their communities (Hart, 2003). If we provide mental health treatment from this perspective drug addicted people become empowered and live peacefully within their cultural boundaries (Coyle, 2001). This is a very important aspect of culturally competent practice, as prescribed in the Aboriginal slogan of "m*ino pimatasiwin*" (Heinenon & Spearman, 2006). It can be said that Aboriginal people need respect in such a way that they can sense and experience their culture and beliefs during any kind of treatment. In this way, alcohol and drug users get benefits from the intervention.

Various authors discussed the impact of residential school systems and how this impact continues to have a harmful effect on the lives of those who have directly or indirectly been impacted (Moran, 2007). It is therefore crucial to understand intergenerational trauma

from the residential schools to know the exact position of clients to provide suitable mental health service.

Summary

It is essential to understand the root cause of the Aboriginal peoples' mental health problems. Recognizing, understanding, and respecting cultures helps to build hope, empowerment, trust, and establish healing alliances. Aboriginal people use healing processes for mental health treatment as a way to recover from personal and social problems. Thus, the implementation of culturally appropriate treatment practices in the public health care system would help to enhance the Aboriginal peoples' mental and physical health.

Chapter 6: Conclusion and Recommendations

Conclusion

The mental well-being of an individual may require a culturally competent intervention, and knowledge about the recipient of the service. Modern psychiatric interventions tend to overlook the recovery and resiliency of Aboriginal cultures. "Culture is treatment, and all healing is spiritual" (York, 1990, as citied in McCormick, 2000). Culture contains a strong sense of family-route identity, family connection, and background of a person. It is the responsibility of service providers and health care professionals to understand these things in order to provide culturally competent intervention for oppressed and vulnerable populations.

As Canada becomes a more racially and ethnically diverse nation, health care systems and providers need to respond to patients' varied perspectives, values, and behaviours around mental health and well-being. Failure to understand these cultural elements and failure to manage cultural and social differences may have significant physical and mental health consequences, especially for minority populations.

As a result of this practicum, I have found that there is a need to connect patients to the community mental health network after discharge from the hospital. This connection helps to enhance patients' living situation and sustained mental well-being. Sustainable mental well-being is only possible when a community client receives consistent care. Therefore, it is our responsibility to build a bridge between the hospital and the community, so clients can navigate in the community safely and comfortably gain optimum benefits after they've been discharged. I found that there are equal roles and responsibilities for health care

practitioners in the hospital and in the community. All partners who are involved for a mentally ill client's care need to know about his or her "ecological situation" and "niche" in the family and in the community. Only then can we provide sustainable health care to these clients. An understanding of the importance of clients' language, family structure and background, mental illness belief systems, traditional health care practices, and religious backgrounds are required resources and elements for professional practitioners to become culturally competent.

Language was a common barrier in preventing access to health care systems and social networks for most of the mental health clients. I found that in many cases there is no family connection for the clients, due to partial or permanent separation from the family.

There is a constant housing issue after discharge for those mentally ill individuals who are admitted to the psychiatric unit from the streets. In addition, many of them do not want to work with case managers or mental health workers. It is due to an environment of mistrust, of not being confident to see a case manager due to mental illness, or the frustration of getting access on time; as a result, patients have to rely on the streets and live wherever they can. A person's victimization due to mental illness can be resolved or minimized through cultural intervention and recognition and provision of traditional cultural practices.

Recommendations

Based on my practicum at the psychiatric unit, a few recommendations have been made to help provide culturally competent intervention for mentally ill people of the North who are in hospital or discharged from hospital.

1. Mental health awareness on local community level needs and education for empowerment.

2. Promote community based holistic health care practice — mental, physical, emotional, spiritual, and social health. Within the framework of holistic health practice, a venture should be established to provide social support, social relationships, employment, intergenerational and intercultural issues and tensions, self-empowerment, and mental health community access. Primary focus should be given to the vulnerable populations in the community who are on the streets or at shelters.
3. Collaborative approach to building capacity: Northern health authorities need to initiate mental health training and workshops with different ethnic and cultural groups to establish a supportive and culturally competent service environment in the community and in the hospital.
4. There is a need to arrange and provide adequate resources, support, and access to mental health populations for housing, daily life skills, medications, and other immediate assistance to post-discharged patients.
5. There should be more group homes or care facilities in northern regions for the discharged patients who come from the streets. Group homes or care facilities provide a home environment, employment, psychosocial rehabilitation, and addiction counselling options and activities for their empowerment.
6. The Northern health authority needs to establish mental health group homes in the community to reduce street-dependent mental health populations. Group homes should facilitate culturally-based activities for mental well-being and healing, constant support, and social activities for empowerment, and regular observation for

medical compliance. This initiative may help reduce hospital visits and health care expenditure overtime.

Summary

Culture refers to one's personal identity and connection with family and descent. Understanding these connections is a process of treatment for Aboriginal people. It is the service provider's responsibility to understand these relationships in order to provide culturally competent services. Failure to understand and manage cultural and social differences may have negative impacts on mental health for minority populations.

A northern health authority should initiate mental health and cultural training programs to establish culturally competent services in the northern health system.

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