Addressing Social Justice in the Context of Community Health Nursing and Suicide Risk Reduction and Prevention

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Background

- In January of 2007, a multidisciplinary panel with expertise in practice, education and research, from hospital, community and academic settings, was convened under the auspices of the Registered Nurses Association of Ontario (RNAO)

Purpose:

To design a Clinical Best Practice Guideline titled, *Assessment and Care of Adults at Risk of Suicidal Ideation and Behaviour*.

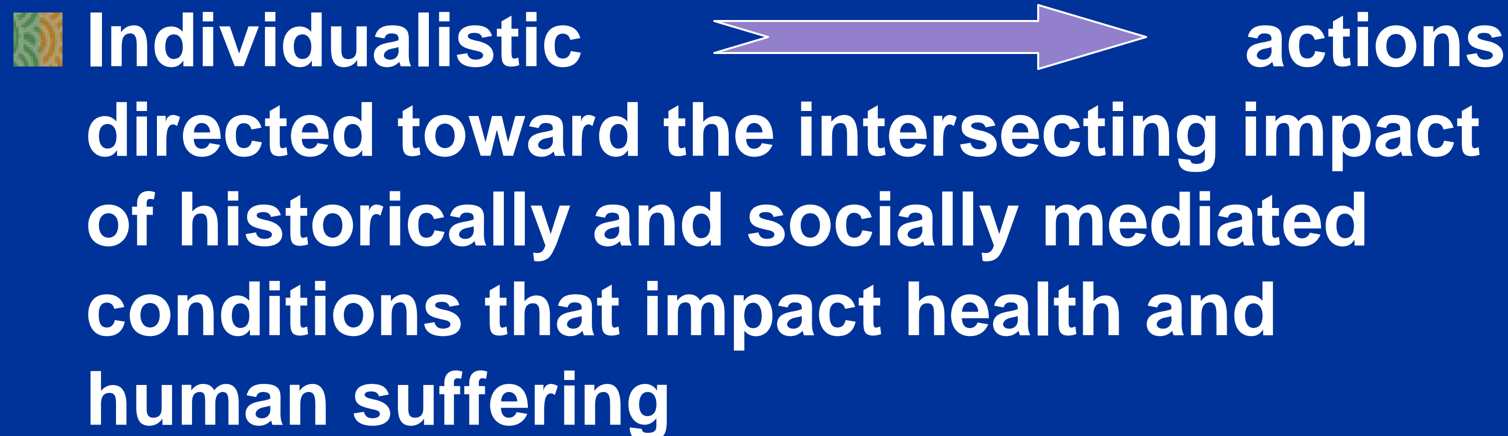
Clinical ‘Best Practice’ Guidelines

- “Systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific clinical (practice) circumstances.”
  (Field and Lohr, 1990, p. 38)

- ‘Best Practice’ Guidelines are developed using the best available evidence.

Social Justice and Nursing

- Health as a human right with a focus on health outcomes as an object of social justice



- Individualistic → actions directed toward the intersecting impact of historically and socially mediated conditions that impact health and human suffering
  (Reimer Kirkham & Browne, 2006)

Cultural Safety

An interpretive lens positioned as a critical cultural perspective

- To examine power relations and its consequences for Aboriginal people (all people)

Cultural Safety

Moves beyond cultural sensitivity to an analysis of:

- the historical basis of discrimination;
- the underlying causes of social and health inequities; and
- the implications of practice in a society characterized by inequities – e.g., the need to recognize and address power imbalances.

Clinical Practice Guidelines and 'Difference': Our Research Process

There is a need to consider:

- 'Difference' as it pertains to attitudes, beliefs assumptions, perspectives and relational processes and practices;
- Power relations between 'cultural' groups that marginalize some kinds of knowledge and privilege others; and
- Structural issues, i.e., institutional racism, discrimination and policies and practices that maintain the 'status quo' – e.g., higher suicide rates of Aboriginal peoples in Canada

Cultural Safety as a Moral and Political Discourse: Nursing Practice

- Reflect on our own ‘cultural’ reality as we engage in clinical practice, research, education and policy (including practice guidelines)– we are all “bearers of culture” – in relationship, we are living a “bicultural” reality;
- Consider the social, economic, political and historical realities of peoples’ lives – i.e., those aspects of a peoples’ lives that shape health and health care; and
- Consider the ‘power’ dynamics in relationship with others.

Questions we might ask?: Cultural Safety as a lens

- Who is writing the clinical practice guidelines, i.e., who is at the table and who is missing?
- What knowledge is guiding this work? What knowledge is missing?
- Who will benefit?
- Will anyone be at risk of not having their needs met, i.e., are the policies and practices inclusive?
- Who is resistant to multiple ways of knowing and why?
- What are the barriers to multiple knowledge sources that are not of the dominant culture paradigm?

Promising Practices

In consideration of other ways of knowing we need to think about:

"…interventions that have not been systematically developed and tested."

(Walker and Bruns, 2007)

Recommendation # 4

- The nurse provides care in keeping with the principles of cultural safety/ cultural competence

Cultural Safety as a Guiding Principle Across Recommendations

- The nurse works with the client to minimize feelings of shame, guilt and stigma that may be associated with suicidality, mental illness and addictions;
- The nurse uses works collaboratively with the client to understand his/her perspective and meet his/her needs; and
- The nurse uses a problem-solving approach to facilitate the client's understanding of how they perceive his/her own problems and generate solutions.

A Critical Cultural Lens: Opportunities

- Raises the conscious awareness and dialogue of clinicians and researchers regarding our understanding of suicide risk reduction and prevention;

- Creates an ‘inclusiveness’ and respect with those who live with the phenomenon of suicide, as we develop guidelines that influence their care/lives;

- Develops a great exchange of ideas and growth among clinicians, researchers, clients and research participants; and

- Has the potential to influence health outcomes.

Clinical Scenario #1

- ‘Fred’ is a 24 year old Chinese VISA student on at an inner city university in Canada. Fred was referred to his university health clinic nurse by his faculty advisor when he indicated his C grades were not adequate, he could not return home with this ‘failure’ and there was no point in continuing [living].

Clinical Scenario #2

- Mary is a 45 year old Oneida woman living with her husband's community in Northern Ontario (remote). She is the mother of two children – 25 year old Brenda who is married and 22 year old William who is attending university in Montreal. Mary is waiting to be transported to a hospital 600 km. from her home because of serious kidney problem (she has Type II Diabetes) – she may require dialysis. She seems unusually sad when you see her in the health clinic today. Her husband tells you that she seems to have lost her appetite, is not sleeping and has lost interest in visiting her friends.

Conclusion

- There are both challenges and opportunities inherent in designing practice guidelines from different philosophical positions, paradigms, disciplinary bodies and ‘cultures.’ The legitimization of other ways of knowing, for example, Indigenous epistemologies, poses challenges for nursing practice in this realm.

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