Frameworks that inform cultural responsiveness principles & practices

HUMAN RIGHTS

Human rights legislation and conventions, in particular The Convention on the Rights of Persons with Disabilities, apply when providing mental health care.

Non-discrimination is central to the right to health. The cultural rights of service users and community members need to be respected. The right to freedom of expression obliges services to provide information in accessible and understandable ways.

The right to protection of the family obliges health services to recognize diverse family and kinship relations when providing health care.

Racism, sexism, homophobia and all other forms of discrimination have negative effects on individuals, families and communities. Experiences of discrimination can and do cause psychological harm. They affect the resilience of individuals and communities and their capacity to cope with external stressors (Victorian Equality Opportunities and Human Rights Commission, 2020).

SOCIAL & CULTURAL MODELS OF HEALTH

Social and cultural models of health focus on three main dimensions: how groups think about health, how health and illness are created in social contexts, and how health care services are used and organised. This not the same as adopting a 'biopsychosocial approach' when working with individuals and in order to explain their situation or develop care and treatment plans.

The meaning attributed to health, illness and distress reflect the culture, politics, and moral structures of individuals and groups. Terms, concepts and meanings vary within groups, across societies and change over time. We need to experience connections to culture, language, family and community for the sake of our physical, social and emotional wellbeing.

Health and illness are socially produced and distributed — some social groups have more health or illness than others. Variations in health status generally follow a gradient, with overall health tending to improve with improvements in socioeconomic position. More unequal societies are associated with poorer health outcomes across the society. Those who are most disadvantaged suffer the most (Wilkinson & Pickett, 2011). All social determinants of health are mediated by culture.

Health care is also socially organised.

> In culturally diverse societies, the dominant culture, which is expressed through social institutions, including the health care system, regulates what sorts of problems are recognized and what kinds of social or cultural differences are viewed as worthy of attention (Kirmayer, 2012, p. 149).

Racialised communities – indigenous peoples, immigrants and refugees, as well as some long-established ethnic, linguistic, cultural and religious communities – experience substantial inequities in mental health. These groups are more likely to experience mental health problems, experience problems more

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often and have more difficulty accessing appropriate mental health care These disparities arise in the context of social disadvantage, including poverty, exposure to violence, racism and discrimination (Gee et al., 2014; Kirmayer & Jarvis, 2019).

INTERSECTIONALITY

People's lives are multi-dimensional and complex. Race, ethnicity, age, gender, sex, sexual orientation and gender expression, ability, religion, faith and spirituality and so much more, can intersect in a single person or interaction.

People can experience multiple and unique forms of discrimination and oppression that cannot be conceptualised separately. People can also experience privilege and oppression simultaneously.

An intersectional approach invites participation for those who have been excluded and silenced. It involves thinking beyond individual identities and social factors, and focuses on people's experiences of discrimination at the points of intersection (Crenshaw 1989; Hankivsky, 2014).

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