

Another Call to Action for Integrating Culture into Forensic Therapeutics

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Forensic mental health services provide care for many people of minority ethnicity whose overrepresentation in these areas is a result of complex structural inequities in society. The need for cross-cultural understanding has long been advocated in forensic practice. Guidance on the integration of culture into forensic assessment has been well described, but little has been written about cultural responsiveness in forensic rehabilitation and recovery-based services. Cultural responsiveness is commonly expressed as a strategic goal for forensic providers, but there is little reported evidence of how to address and measure the effectiveness of cultural responsiveness initiatives. Equity of outcome by ethnicity should be the aim of forensic services, and this requires systematic measurement. Cultural safety, rather than cultural competence, has been promoted as the patient experience services should strive for. A measurement-based care framework can provide tools to evaluate service responses systematically and iteratively to address the challenges in achieving delivery of culturally safe forensic services.

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Societies are becoming increasingly interconnected, leading to increased levels of diversity not previously seen in the clinical practice of psychiatry.^{1,2} In most western settings, there are many people originating from different cultural backgrounds, including indigenous origins, who are markedly over-represented in forensic mental health settings and within the criminal justice system.³ This means it is important to ensure that particular attention is given to address cultural themes in these patients' experiences if equitable health outcomes are to be achieved.⁴ As Hatters Friedman aptly stated, approaching forensic psychiatry without the accurate understanding of the impact of culture allows for erroneous explanations within the forensic practice in the criminal justice system.⁵ Candilis and Griffith argue that culturally sensitive

narrative practice should be a necessary component of all forensic analysis.⁶ Our assertion is that measuring the effectiveness of cultural responsiveness initiatives, including equity of outcome by ethnicity, should be the aim of forensic services, and this requires systematic measurement. We call for a measurement-based care framework to evaluate cross-cultural practices within forensic services.

Kirmayer and Jarvis argued in 2018 that culture affects a patient's experience of mental health, access to care, and engagement with and response to treatment.⁷ Through structural racism and bias, it may strongly affect criminal justice involvement. In 2012, Kirmayer described how the dominant culture exerts its influence by molding health policy and clinical practice such that the needs of other cultural perspectives are overlooked.⁸ He argued that it was crucial to understand the impact of culture on health experience, and advocated for the inclusion of cultural formulation into assessments within psychiatry. This was in part built on the evidence that culture was not central in the development or use of the specific DSM-5 diagnostic criteria but was rather addressed

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more broadly within the Cultural Formulation Interview (CFI).⁹⁻¹¹ The CFI itself presented challenges in practice regarding relevance to the presenting complaint, difficulty engaging patients with severe presentations of mental illness, and even discomfort from the patient perspective in discussing culture and religion.¹¹ Excluding mental health symptomatology variation between different cultures from the DSM-5 diagnostic criteria can lead to Western psychiatrists over-diagnosing severe and persistent mental illness among patients of minority ethnic communities that have disproportionately faced structural and systemic bias compared with those of the dominant culture.¹²

Culture and Forensic Psychiatry

Integrating a cultural understanding into forensic praxis is a pressing need. There are two major domains: the requirement for a culturally responsive forensic assessment and the integration of culture into forensic mental health service (FMHS) delivery. The FMHS provides services to assess and treat individuals with mental illness who intersect with the criminal justice system; treatment varies and can occur within a hospital or community settings.¹³ In 2007, Kirmayer and colleagues wrote a call for action to forensic psychiatry to integrate cultural perspective into forensic assessment to contextualize the individual's actions that led to engagement with the criminal justice system through the lens of their lived experience.¹⁴ The authors emphasized the importance of accounting for culture as a domain of equity and asserted that integrating culture into the judicial system better allows for the aims of the prevention and rehabilitative justice to be achieved.¹⁴ The authors described the implications within forensic assessment, where capacity to form criminal intent, determinations of culpability, and pre-sentencing evaluations could all be informed by culture. Griffith argued similarly that forensic assessment must ensure that the unique experience of the patient from a non-dominant ethnic group be integrated into the forensic formulation.¹⁵

The American Academy of Psychiatry and the Law rose to these challenges by incorporating culture as a key aspect of forensic assessment in the 2015 Practice Guidelines for Forensic Assessment.¹⁶ The AAPL guidelines provide an overview for ethnic disparities in diagnosis, the role of cultural identity in

formulation, and the importance of attuning to language differences.¹⁶ The guidelines focus on the actions and steps that individual practitioners can take toward a more culturally fair and inclusive practice in forensic assessment.¹⁶ The guidelines do not cover the need to integrate culture into forensic care systems, or address rehabilitation, therapeutics, or recovery.

The Royal College of Psychiatrists published the Standards for Forensic Mental Health Services in 2019, which were developed in collaboration with patients and stakeholders.¹⁷ These standards propose the integration of cultural responsiveness into improvement of service quality; specifically training staff in recovery and outcomes approaches and patient perspectives with both being key places to integrate culture into care. These standards outline approaches to admission and assessment, physical health care; treatment and recovery; patient experience; friends, family, and visitors; ward environment; physical security; procedural security; and relational security, among others.¹⁷

Culture and Forensic Therapeutics

As noted, in 2007, Kirmayer and colleagues emphasized assessment and cultural understanding but did not explicitly consider how FMHS should implement cultural perspectives into forensic service provision.¹⁴ Psychiatry in general also continues to struggle to integrate culture consistently and safely into formulation, training, and clinical care. This is likely due to ongoing factors including difficulty enacting institutional change, stakeholder buy-in, and practice change among other factors. More recently, Kirmayer and Jarvis extended their 2007 recommendations to emphasize the need for systematic integration of culture into mental health care.⁷ Among several suggestions offered, they advocated for accreditation standards for cultural competency, which has been defined by others to include the knowledge, skills, and attitudes needed to interact and communicate effectively with individuals across cultures.¹⁸ Furthermore, cultural safety (see below) and anti-racism education in health care education and practice is needed in addition to ongoing policy innovation in this area.

Given that cultural responsiveness has been described in forensic assessment, we were interested in reviewing the evidence from the published literature on the integration of culture into the delivery of FMHS, including interventions, rehabilitation, and

recovery-based services.¹⁶ FMHS can include inpatient and outpatient environments within specialized forensic psychiatric care. We conducted a literature review using the search terms culture, recovery, rehabilitation, and treatment, using the PubMed and Google Scholar databases. Initially, we had included forensic psychiatry in our search terms and found this yielded limited results, so we broadened our scope to include psychiatry in general and mental health. We did not limit our search to specific culturally-relevant services but rather surveyed the literature for types of services offered. Unfortunately, there were no studies that formally evaluated how forensic services addressed culture explicitly. It appears that FMHS must develop and encourage studies that explicitly reference and guide how FMHS can address the equity, diversity, and inclusion challenges faced by FMHS. The remainder of this article will attempt to provide some guidance on how this could be achieved.

The Principle of Cultural Safety

Most forensic services identify cultural appropriateness or responsiveness as a priority of their mission and vision, or models of care. Critics, however, have described that cultural competency is insufficient and stagnant and that cultural safety should be the goal of care.^{19,20} Cultural safety can be conceptualized more broadly as knowledge paired with constant critical reflection about the patient experience within the structures of power that health care is delivered. Cultural competence is an attribute of the service or clinician. Cultural safety is ultimately the lived experience and perception of safety by the patient that results from engagement with the health care system.²⁰ Cultural safety is a different perspective than cultural humility (another widely used term), which centers on reflecting on one's personal and cultural biases and being sensitive to the cultural needs of others.²¹

Curtis and colleagues reiterate the importance of health care delivery and practice moving toward a cultural safety lens with emphasis on achieving health equity.²² There is some evidence that cultural safety is a superior concept in terms of patient outcomes. Tucker and colleagues recruited largely low-income patients to complete questionnaires about their experience in cultural sensitivity.²³ Their results showed that practicing culturally safe medicine not only affects the patient experience but also improves

adherence to treatment recommendations, thereby bolstering the therapeutic relationship.²³ Other studies have also observed that service user satisfaction and a perceived positive therapeutic relationship is related to the social climate where individuals receive care.^{24,25} The studies support that emphasis in FMHS should be placed on cultural safety as it is rooted in patient experience instead of on competency, which is a provider attribute.

Culture in FMHS Governance

The importance of implementing a structured approach to measure and evaluate core domains in forensic service provision has been emphasized in two recent papers. Kennedy and colleagues describe excellence as the ability to consistently improve outcomes by clearly establishing core standards of care and conducting rigorous evaluation and research.²⁶ They use the example of oncology care where, upon diagnosis, patients receive health care that is standardized across sites (referred to as Treatment as Usual, TAU), and patients can provide informed consent to also be enrolled in randomized control trials to advance care. Kennedy *et al.* contended that, unlike the oncology field, the same opportunity for engagement in standardized health care delivery and available treatments was not present, but should be present, in the FMHS provision.²⁶

For excellence to be achieved, the organizational structure, leadership, and care models within FMHS need to deliver TAU in a clear, measured, and personalized manner. At all different levels, rigorous evaluation and qualitative and quantitative research is needed to develop and enhance TAU through care delivery networks. In the second paper, Glancy and colleagues further reinforced the importance of measurement-based care (MBC), which they describe as evaluating patient symptoms and factors in a systematic fashion to inform management plans.²⁷ The authors conceptualized MBC as a logical extension of evidence-based practice and note that there are multiple forensic measurement tools such as the Dynamic Appraisal of Situational Aggression, and the Dangerousness Understanding, Recovery, and Urgency Manual (DUNDRUM) as tools to implement MBC.²⁷ Another example is the Clinical Global Impressions—Corrections tool, which was adapted to assess the efficacy of treatment within the forensic correctional environment.²⁷ The implementation of an MBC framework provides the ability to measure

individual and group differences by ethnicity in a FMHS setting.

Neither of these articles tackles the subject of differential cultural responsiveness, even though it follows that personalized medicine must necessarily be culturally safe to achieve effectiveness or equity of outcome. Equity of outcome is the appropriate measure given that regardless of patients' cultural backgrounds, the outcome regarding their psychiatric health and the care afforded to them within the FMHS should be equal as in other aspects of medical care. If we are interested in achieving equity of outcome across ethnic groups, FMHS need to bring a cultural focus to evidence- and measurement-based practice. Indeed, if appropriate MBC is implemented as these authors suggest, it becomes readily possible to measure differences in experience across cultural groups and measure the impact of developing practices aimed at improving the experience and effectiveness of forensic care. To date, there is no published work addressing these challenges.

There is a shared concern for the lack of standardization of the role of culture across clinical experiences in addition to the need for iterative training to ensure cultural safety.²⁸ Including those with cultural "know-how" (referred to as "brokers" by Kirmayer and colleagues)¹⁴ as key members of a treatment team, serving as not only linguistic translators, but also cultural consultants, is an example of how such sensitivity may be manifest in the care team.²⁹ The design of future services should incorporate culture into service design and streamline the integration of cultural experts or consultants into clinical experiences without the added steps of requesting them through a third-party service. Finally, forensic psychiatry practitioners must critically consider the application of DSM-5 diagnostic criteria given that cultural differences may affect symptomatology and its expression.

Measurement and Cultural Responsiveness

There are two key questions here. The first is whether culturally relevant factors included in the MBC tools are employed. The second is whether the measurements that are taken are analyzed with an eye to equity of outcome or the achievement of cultural safety (e.g., whether systematic biases or poorer outcomes are investigated between ethnic groups in a clinical program).

There are now tools that can guide practice and explicitly measure domains relevant to cultural

competency and cultural safety. The Cultural Formulation Interview (CFI) is the best standardized tool for clinicians to conduct person-centered cultural assessments.¹¹ These culturally-centered assessments can inform diagnosis and treatment planning based on the individual patient's needs and preferences.¹¹ The CFI has been adapted to correctional psychiatric assessments and considers cultural explanations for engagement within the criminal justice system.³⁰

Cultural understanding or formulation must lead to the identification of cultural needs in treatment. Enacting a cultural needs assessment ensures that we review aspects of culture, including religion and spirituality, and determine how they are currently being met within FMHS. A well conducted needs-assessment can be used to cultivate cultural safety.³¹ When it comes to the assessment of risks or strengths, however, there is no structured professional judgment tool for risk assessment, management, or monitoring of progress that attends to culture, identity, or faith.

Even without a tool like the CFI, it is possible to see if equity of outcome is being achieved by performing an analysis of routine process or outcome measures by ethnicity. It is important to assess patient experience, therapeutic engagement, and satisfaction routinely to measure change and to analyze such data by ethnicity to ensure that the goal of equity in experience is being achieved. There are a variety of tools from self-assessment questionnaires to validated tools that measure recovery-based and equity-relevant experience. In 2020, Banks and Priebe conducted a systematic review of scales used to assess the therapeutic milieu of inpatient settings and found five common scales: Ward Atmosphere Scale (WAS), Community-Oriented Programs Scale (COPES), Good Milieu Index (GMI), Characteristics of the Treatment Environment (CTE), and Essen Climate Evaluation Schema (EssenCES).³² The EssenCES has been reported in a variety of FMHS settings. The EssenCES is a 15-item, 5-point Likert scale and poses questions regarding patient and staff experiences.³³ The scale poses statements such as "some patients are afraid of other patients" and "both patients and staff are comfortable on this ward" among others and asks individuals to rate their agreement with such phrases from "not at all" to "very much."³³ The EssenCES tool has been administered within a variety of settings, with inpatient psychiatric and correctional settings being studied in detail.^{34,35}

Its ability to assess ward atmosphere in forensic psychiatric settings with demonstrated structural validity in measuring therapeutic hold, experienced safety, and patient cohesion and mutual support are all very relevant to patient experiences that may be sensitive to cultural understanding.³² Day and colleagues found that the EssenCES could be used to measure and ensure equity of patient experience and outcome while employing a cultural competency lens.³⁴ Practically, the EssenCES could be administered within any ward environment to assess ward atmosphere and individual experience and could be repeated iteratively to assess change.

Cultural Safety as Aim of Staff Training

Moreno and Chhatwal asserted that training and education play a key role in cultivating cultural safety in the next generation of care providers.² The Refugee Assistance Program Workers adapted a checklist from the Greater Vancouver Island Multicultural Society to allow practitioners to recognize areas within the realm of cultural competency.³⁶ Practitioners can assess where they have limitations and could benefit from development to improve client experiences.³⁶ The Canadian Psychiatric Association (CPA) has published guidelines for training in cultural psychiatry to integrate these practices into the care system. The CPA 2021 Guidelines include learning objectives relating to health, psychopathology, clinical practice, and health policy within both the undergraduate and postgraduate medical environments.⁴ They further integrate cultural competency into the Canadian national medical education assessment framework called CANMEDS, such that cultural learning can be easily integrated into residency and medical school curricula.⁴ Aly and colleagues described other avenues of system improvement through adapting models of care such as cognitive-behavioral therapy (CBT) to be attuned with the cultural background of the patient and provider.³⁷ The authors suggested CBT could be culturally adapted using the Awareness, Assessment, and Adjustment model such that philosophical orientation, technical and practical adjustments, and theoretical modifications can be made with specific cultures in mind.³⁷ Regardless of the adaptations considered and implemented, Healey and colleagues emphasize the need for measuring health experiences and doing so iteratively.²⁸

(A Few of the) Major Challenges

Overall, we are approaching cultural challenges in FMHS from a point of paucity of evidence. This may betray the slowness of our specialty to systematically tackle equity, diversity, and inclusion at governance, clinical, and research levels. We have not developed tools to understand the effects of culture in FMHS, most notably the absence of any structured professional judgment tool that includes factors that address culture. Nevertheless, there are ways of measuring dimensions relevant to cultural safety and equity of outcome that can be readily introduced or may already be in use. We anticipate that there will be difficulties in enacting this call to action as seen in the limited uptake of calls made by Kirmayer and colleagues in 2007 and 2019.^{7,14} One main concern in integrating cultural safety in a sustainable manner is to ensure it is not a one-off training on, for example, unconscious bias or anti-racism but rather is a concerted effort across all levels of a service to ensure sustained change. Integrating cultural understanding in a non-tokenistic manner must include perspectives from brokers and service users as key to any programmatic or systemic changes.

Conclusion

The dialogue regarding cultural safety within the practice of psychiatry and, more specifically, forensic psychiatry needs to move from recognition into behavior change. We must integrate measurement-based care that takes consideration of cultural factors. Risk assessment tools need to be analyzed for cross-cultural bias and the dimensions of identity, cultural practices, and faith considered as strengths or protective factors. We call for renewed action toward making education and treatment environments practice cultural safety through the creation of guidelines.^{4,16} Finally, consistent measurement of patient experience is a necessary task. Equity of outcome by ethnicity should be the aim of forensic services. This requires systematic measurement and a measurement-based care framework. Engaging preexisting patient experience measures such as the EssenCES tool would be worthwhile to ensure that both equity of outcome and equity of experience are maintained.

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