

Stumbling, Not Falling: Reviewing Cultural Competency in Fall Prevention Among Older Indigenous People

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Abstract

This case study review analyzes *Healthy Aging through Fall Prevention among Older Aboriginal People: From Many Voices to a Shared Vision* by Reading et al. (2011) through a lens of cultural competency. In addressing the topic of how fall risks affect a specific cultural group, the report highlights the cultural competency pitfalls inherent to the early stages of research. In a report summarizing a symposium held to address fall risks for older Indigenous people, the authors essentialize Indigenous people by referring to them as one cultural mass. They also do not make clear use of the information gathered in this symposium, focusing only on general cultural information rather than individual Indigenous experiences. This report highlights potential improvements in culturally safe and sensitive health care by analysis through Rose's cultural competency continuum and Delvecchio Good & Hannah's process-oriented approach. Integrative research methods such as Knowledge Translation and Participatory Action Research are utilized by the researchers to begin addressing the limitations found in the report. The balance between these positive and negative aspects effectively highlight the obstacles inherent to culturally competency research.

Keywords: cultural competency, Indigenous, health care, process-oriented approach, research obstacles

In the context of health care, cultural competency is a necessary set of behaviours, attitudes, and policies used in appropriate cultural settings to respect and accommodate the complexity of cultural influences in health care (Cross,

Bazron, Dennis & Isaacs, 1989). Using cultural competency to inform cross-cultural definitions of health and to address health issues is crucial (Izquierdo, 2005, p. 767). In taking an in-depth look at the cultural competency used in *Healthy*

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University of Saskatchewan Undergraduate Research Journal
Volume 5, Issue 2, 2019

Aging through Fall Prevention among Older Aboriginal People: From Many Voices to a Shared Vision (Reading et al., 2011), the complexities of successfully applying culturally competent practices begin to emerge. The report was written to document The Symposium on Healthy Aging through Fall Prevention among Older Aboriginal People, an event that explored potential improvements in fall prevention programs and research in order to address how “little is known about what effectively prevents falls and related injuries among older Aboriginal people” (Reading et al., 2011, p. 2). In research addressing a specific cultural group, an approach from a place of cultural competency is vital in order to enact effective and sensitive health care. This paper explores how culture in *Healthy Aging* is employed to understand fall risk, how effective the paper was in employing cultural competency, and how limitations in culturally competent research were addressed. This analysis shows that the report by Reading et al. does not demonstrate complete cultural competency but is rather a starting point on the path towards cultural competency, with the strengths and weaknesses inherent to the beginnings of all research. The research in *Healthy Aging* is an important first step for health care researchers in practicing cultural competency.

Source Paper Summary

The symposium that led to the report *Healthy Aging* was held to address the issue of higher fall risks among older Indigenous people. The authors first outlined the problem using Canadian statistics, including the cost of falls to the health care system. The authors acknowledged that very little is known about fall risks to older Indigenous people and that more must be done to learn about this issue. In order to do so, they held a two-part symposium. The first part was a panel of trained and certified experts in related fields such as health care and Indigenous services. The second part was a dialogue “among key stakeholders in Indigenous health and seniors fall prevention,” including Elders and other relevant community members (Reading et al., 2011, p. 5). Three key themes emerged from this symposium: integrating knowledge practices between Indigenous and Western approaches, hearing from Elders about their suggested approaches to the issue and learning to effectively research the topic at hand.

After the symposium, three lists of recommendations based on symposium-held focus group results were generated; one for research, one for policy, and one for practice. The research recommendations list included training fall-prevention researchers in cultural competency, resulting from the need for respectful and appropriate relationships with the Indigenous research participants (Reading et al., 2011, p. 11). Also included in the list is a focus on tactics to increase the efficacy of current

and future research in fall prevention among Indigenous populations, such as adding fall prevention research into ongoing projects within these communities (2011, p. 12). Five policy suggestions were made, most of which focused on increasing the funding and scope of research in the communities in which this research is being carried out (2011, p. 13). A further eight suggestions were made for practice, four of which acknowledged the specific cultural background on which this fall prevention programming is focused. The practice recommendations were wider in scope than the policy suggestions, but they mostly tackled how to increase community awareness of fall prevention programs, how to incorporate said programs into existing services, and how to support the community in which these programs occur (2011, p. 14).

At the end of the report, Reading et al. outlined a “Focus Group Dialogue Summary,” which focused on relationships between relevant organizations and groups associated with the project. The document closed with a listing of the researchers’ next steps, including a specific list of future research collaborations, a review of all current fall prevention programming, and a commitment to increasing the amount of “fall-related content of healthy policy and practice discussions” (Reading et al., 2011, p. 16). Thus, *Healthy Aging* was an initial foray into the complex world of cultural influences on health care issues, one that acknowledged the need to keep in mind the complex effects that culture can have on health issues. The report seemed like a solid foundation for addressing the issue of fall risks among older Indigenous people, yet close attention needs to be paid to how that summary document handles culture and cultural competency.

Analysis

Healthy Aging explores the phenomenon of increased fall risks for older Indigenous people through a limited lens of culture. Two overlapping cultures are examined – the elderly in Canada and Indigenous people within the land boundaries of Canada. In examining the culture of older people in Canada, the majority of discussion in this report revolves around quantitative data. The authors list statistics regarding fall risks for older Canadians in general, pointing to reduced quality of life and vast health care spending as a result of these falls. They do not delve into any further cultural details that could explain this phenomenon, such as a reduced role of kin in the life of older people, increasing rates of isolation, and the growing stigma surrounding loneliness among the elderly (Stojanovic et al., 2016, p. 10).

The article mainly focuses on the role of Indigenous culture in falling and fall risks. The language used in *Healthy Aging* homogenizes Indigenous people by referencing them as though they have a singular cultural identity. The report regularly refers simply to “Aboriginal people” as a blanket

term, only identifying specific Indigenous identities when referring to individuals at the symposium. An example of this is found in their discussion of key themes, with the authors stating, "By combining the strengths of Aboriginal and non-Aboriginal ways of knowing, we arrive at a perspective referred to as 'two-eyed seeing' by Mi'kmaq Elder Albert Marshall" (Reading et al, 2011, p. 6). The generalization of "Aboriginal" ways of knowing is problematic, as knowledge systems among the Mi'kmaq are not identical to those of, say, the Nehiyaw. Yet this report conflates these Indigenous groups together under the heading of "Aboriginal." The document also does not acknowledge that the Indigenous people who are the target population of the study may not identify as Canadian, though they may collaborate and work closely with Canadian institutions and structures. These instances seem like cultural essentialization, or the reduction of a cultural group to essential characteristics (in this case, their Indigeneity), as they fail to acknowledge the inherent diversity within the researched population of Indigenous peoples. These instances of essentialization may be explained by the need of the researchers begin addressing the problem by taking a broad approach before going into more nuanced detail. As McMillan and Yellowhorn note, "Like all generic phrases, [the term "Indigenous people"] invariably disguise[s] diversity for the sake of convenience" (2004, p. 3). By eliminating diversity, essentialization does not help to understand the cultural reasons for elevated fall risks among Indigenous seniors. Hopefully, the differences in Indigenous cultures will be considered as this issue is further researched. While it is problematic that the umbrella concept of "Indigenous culture" is used in *Healthy Aging*, this is not the only example of misusing culture within the report.

Indigenous culture is first acknowledged in this article by discussing the differences in ways of learning and knowing between Euro-Canadians and Indigenous peoples. The portion of the report that most directly explores Indigenous culture and its relevance to the issue of falling among the elderly begins in the section "Voices of Honoured Elders" (Reading et al., 2011, p. 7). This section details how Indigenous Elders are keepers of ways of knowing and living, emphasizing the value that they bring to the overarching cultural structure in which they live. It also discusses the holistic approach that "Indigenous culture" takes regarding issues such as falls and fall prevention. Yet the contexts in which the researched population live are touched on only briefly in order to outline how they must be integrated with Western approaches. Culture, then, is not intensely explored in *Healthy Aging*. Instead, it provides a backdrop against which future questions may be posed. A useful tool called the cultural competency continuum can be used to address this information deficit. The continuum provides some insight into why the researchers used their cultural approach and

what steps may be taken by the researchers to be more culturally competent.

Patti Rose's cultural competency continuum maps six stages of behaviour and thought that detail the stages of cultural competency. The continuum spans from "cultural destructiveness" to "cultural proficiency" (2011, p. 57). These stages detail how one's understanding of culture can evolve from a harmful, negative approach to one that is capable of fully integrating cultural competency into daily practices. When examined through this continuum, *Healthy Aging* falls within the fourth stage known as "cultural precompetency," where there is a "clear commitment to human and civil rights" and "a desire to support culturally and linguistically diverse populations," yet there is "no clear plan for achieving organizational cultural competence" (2011, p. 60). The report fits into this definition of cultural precompetency. The researchers acknowledge that the risks of falling for older Indigenous people are higher and costlier than they are for non-Indigenous people, and the report was created because there was little understanding as to why this is happening. Yet it only begins to acknowledge that the issue may have cultural roots. Hopefully, the research can move through the remaining stages of Rose's continuum to ultimately reach a place of cultural proficiency, the most aware and effective position of the continuum. While cultural precompetency is not in and of itself negative and is, in fact, a necessary stage of progress towards proficiency, the article has limitations that, when addressed, could move fall-prevention research further along the continuum.

In exploring *Healthy Aging's* position as being culturally precompetent, it is important to acknowledge that the report recognises these limitations and seems to have been written to address them. The executive summary notes that "[t]hese activities fill a critical knowledge gap for fall prevention in Indigenous communities and set the stage for fall prevention programming guided by community needs and scientific knowledge" (2011, p. 4). Yet this knowledge gap could have been reduced during the symposium itself. For instance, this research did not take the information available from the participating Elders as direct and actionable data. Rather, the report took activities and discussions with the Elders as a starting point from which to reflect on how to collect data. The discussion information from the symposium is raw data that could be useful in this particular health care application and the researchers do not make clear what happened with this data. Input from Indigenous community members is itself substantive knowledge that could be used as participant data, yet the report only addresses said input as a framework for future research. Likewise, community-level "experts," whether Indigenous or not, were emphasized over the experiences of Indigenous lay people who have fallen/are at risk of falling. These broad-brush approaches intending to produce Western-style hard data demonstrate

that the authors of *Healthy Aging* did not fully utilize the value of specific cultural information that was available in their symposium. Thankfully, a toolbox of cultural competency has been developed by medical anthropologists and their colleagues to address these limitations. One such anthropological tool is the process-oriented approach.

A process-oriented approach as described by DelVecchio Good & Hannah focuses on understanding people as part of their individual cultural context, rather than trying to apply culturally-specific standards of understanding that are not useful (2015, p. 209). *Healthy Aging* focused on the need to emulate and collaborate with a wide range of experts and how to develop relationships with them. While referencing outside views is an essential part of cultural competency, the focus of the report ought to be on collaborating with the populations under study. Western approaches emphasizing past experiences with other cultural groups may not be relevant to the Indigenous populations that Reading et al. have researched. Instead, the process-oriented approach suggests looking at the specific experiences of the people involved. "Experience of American Colleagues" (Reading et al., 2011, p. 9), a key area of the report, is included to fill the need for the Western standard of "solid" data. Yet the symposium was attended by many Indigenous people, every one of them an expert in their individual cultural contexts that surround fall risks. If Reading et al. were to draw on the valuable resources of the Indigenous people at the symposium by employing the process-oriented approach, they would be able to explore the important intersectional cultural contexts that surround fall risks. Instead, the paper consistently references "Indigenous people" as one group which can have a homogenizing effect, representing Indigenous people as one cultural mass and erasing the diversity of the people who fall under that label. If the authors of the report drew specific data from contextually appropriate sources, such as the Indigenous symposium participants, they could illustrate the complex cultural influences on fall risks in the diverse contexts of elderly Indigenous peoples. Fortunately, a plethora of tools are available to gather said data, which would allow the research underlying *Healthy Aging* to move towards process-oriented approaches in the matter of fall risks for older Indigenous people.

Though there are some limitations to the approach taken by the authors of *Healthy Aging*, there are clear signs that those involved are developing culturally competent practices. The paper's use of knowledge translation is one of these clear signs. The Canadian Institute of Health Research defines Knowledge Translation (KT) as "a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians" (CIHR, 2009). Using knowledge translation to address culturally different forms of knowing in research and health care practices is an

approach that reflects the goals of cultural competency. The report's focus on KT also acknowledges that helping is a complex, ever-changing process that requires true collaboration to be effective, and thus, KT is a powerful tool in cultural research. Related to KT, the paper addressed another concept known as Participatory Action Research (PAR). Bradbury and Reason define PAR as "a participatory process concerned with developing practical knowing in the pursuit of worthwhile human purposes" (2008, p. 16). PAR is a research methodology emphasizing the community, involving and investing community members in research as active participants. PAR also acknowledges that community members can enact effective change on the matter being researched. As a research method, PAR inherently capacity building, allowing participants to grow their skillsets while being valued as individual cultural experts. This capacity-building approach would allow Indigenous people to have direct influence and control over research on their lives. Both KT and PAR are excellent and culturally competent tools for addressing community-level issues such as fall risks among older Indigenous people.

As positive as both KT and PAR are in terms of culturally competent research methodologies, it is vital to consider how they will be used in conjunction with cultural safety. Cultural safety is practiced by creating safe spaces in which peoples' cultural identities are not challenged or attacked, but are understood and welcomed (Papps & Ramsden, 1996, p. 493). The complexities that surround cultural research can be difficult to navigate, and for the population under consideration in this study these complexities cannot be ignored. Complicating cultural factors, both historic and current, make cultural safety a necessary component of this research. Exploring fall risks with older Indigenous people ought to be done in a culturally safe way, or a way that does not deny or offend the cultural identities of participants (Williams, 1993, p. 213). Cultural safety is necessary for the research done by Reading et al. because of the historical legacy with which Indigenous people must live. The Elders participating in the second part of the symposium pointed out that "underlying social phenomena, such as colonialism and public policies, have an [...] impact on peoples' health" (Reading et al., 2011, p. 8). Anderson et al. argue that examining unequal power relationships, such as those found in colonialism and associated historical injustices, is a vital component of cultural safety (2003, p. 197). The intergenerational effects of colonialism and other structural inequalities on the current lives of Indigenous people ought to be carefully considered in the context of this research. Doing so will ensure that any future research carried out on the topic of fall risks is done in a culturally safe way. Observing the tenets of cultural safety would allow this research to move towards cultural competency.

Future Research

It is possible to see the future directions for health care in addressing the fall risks of older Indigenous people in the context of health care systems. If the research underlying *Healthy Aging* was successful in working towards the goal of cultural competency, it could provide greater insight into the issues surrounding the fall risks faced by older Indigenous people. A report issued by the Health Council of Canada stated that Canada's health care system can be "alienating [and] judgmental" for Indigenous patients, with "communication gaps and misunderstandings" resulting from a lack of culturally competent care (2012, p. 10). Research such as that conducted for *Healthy Aging* informs the policies and practices that are enacted through health care practitioners working directly with patients. As a result, research being conducted in a culturally competent manner has the potential to resolve these issues before they arise in the patient-practitioner interaction. Culturally competent research can minimize the suffering of those who fall and lowering the cost to the health care system by preventing future falls. There is also a pressing need for an understanding of cultural competency that moves away from what Narayan refers to as the "packaged picture of culture," an approach which treats cultures as static and unchanging (2000, p. 1083). Instead, operationalizing cultural competency that acknowledges and explores the diversity, both within and across Indigenous communities, would allow for the development of programming and research increasingly effective and appropriate ways. Cultural competency is thus poised to play a significant role in safe, respectful, and effective health care in current and future research.

Conclusion

It is commendable that *Healthy Aging* has taken steps to begin addressing the unique problems posed by fall risks among older Indigenous people. Indeed, *Healthy Aging* demonstrates the challenges of researching a specific cultural group. The lack of background information and the broad scope of the issue can be obstacles on the road to culturally competent work. The limitations of the report include essentializing Indigenous people as a cultural group and lacking transparency as to how the authors would use the contextually-specific cultural information available in the symposium. The study's strengths in committing to the community and Indigenous-oriented research methods of knowledge translation and participant action research show that the report's authors are moving toward cultural competency. In their journey towards practicing culturally competent research, the authors of the report faced

challenging hurdles and wielded helpful tools. Overall, *Healthy Aging* may have stumbled, but the research has not fallen in its journey towards practicing cultural competency.

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