CREATING CULTURAL SAFETY

January 2014

Looking at Ottawa

Wabano
CENTRE FOR ABORIGINAL HEALTH

Creating Cultural Safety

LOOKING AT OTTAWA

Table of Contents

INTRODUCTION

According to Statistics Canada, there were 19,200 Aboriginal Peoples living in Ottawa in 2011.[1] This number has likely grown a great deal since. Aboriginal Peoples make up 2% of Ontario's population[2]. Despite the fact that the Canadian health care system is believed to be one of the best in the world, quality health care is not available for many Aboriginal people in Canada. Cultural barriers, fear and mistrust have hindered Aboriginal people from accessing appropriate and quality care which leads to poor health status. According to Anishnawbe Health Toronto, the Aboriginal population in Ontario "has generally noted that they have experienced culturally insensitive healthcare and have noted that at times they [are] also [met] with subtle and overt racism."[3]

Cultural safety can be found in the domain of understanding because it requires the service provider to acknowledge their own lens and self-reflect; it is an outcome of care determined by both the service provider and receiver of care. The concept and conversation on cultural safety can be considered important by statistics alone as "th[e] unequal distribution of adequate health care is a result of the unequal power relations, inadequate access to culturally relevant health care, and lack of appreciation of culture and value differences embedded in western theoretical approaches to health care."[4] For example, in comparison to the general population in Canada: heart disease is 1.5 times higher in Aboriginal people; type 2 diabetes is 3 to 5 times higher and tuberculosis rates are 8 to 10 times higher.[5] Statistics highlight the poor health status of Aboriginal Peoples and cultural safety is indirectly related.

The need for cultural safety is based, in part, on the negative experience of many Aboriginal people with mainstream health care. Cultural differences directly contribute to high rates of noncompliance, unwillingness to visit mainstream health facilities and feelings of fear, disrespect and isolation. Ignoring these differences play a role in poor health status for First Nations, Inuit and Métis people and communities. Many institutions in Canada have made conscious effort impact, acknowledging cultural differences and steps have been made toward the realm of cultural awareness and sensitivity. The reality is that health status for Aboriginal Peoples is not where it should be; but we can get there with culturally safe care.

"I want a place to practice culture openly where there is acceptance and appreciation for who I am."

There is a strong need for culturally safe delivery of care in front-line services in Ottawa given the large Aboriginal population in the city. Literature shows that service providers who understand cultural safety are able to:

- Understand concepts such as discrimination, racism;

[1] Statistics Canada, 2011 National Household Survey Aboriginal Population Profile
[2] Ibid.
[3] http://www.aht.ca/aboriginal-culture-safety
[4] National Native Addictions Partnership Foundation, Working with First Nations People: Culturally Safe Toolkit for Mental Health and Addiction Workers Literature Review (Prince Albert, SK: National Native Addictions Partnership Foundation, 2011) 6.
[5] Health Canada, http://www.hc-sc.gc.ca/fniah-spnia/diseases-maladies/index-eng.php

- Improve health care for Aboriginal people;
- Take time to critically self-reflect;
- Understand that culturally safe care is determined by those receiving care; and,
- Balance power relations.

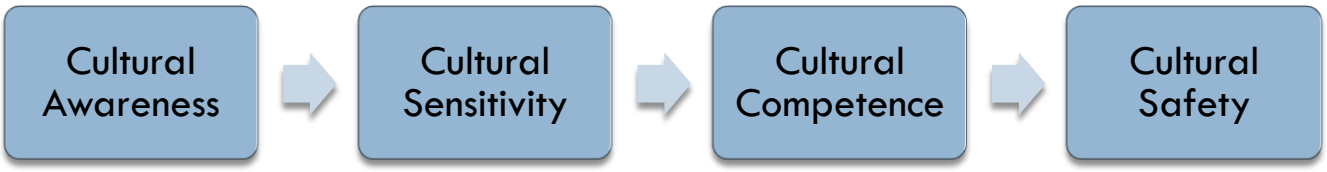
The Wabano Centre for Aboriginal Health in partnership with Tewegan Transition House is developing an adaptable cultural safety curriculum for service providers that specifically meets the needs of the Aboriginal community in Ottawa. This is a two-year iniative funded by the Ontario Trillium Foundation.

Cultural Safety Defined

Culture is commonly defined as beliefs, values, practices, worldview, lifestyle and knowledge belonging to a particular group. Alternatively, "culture can also be understood as a sociopolitical construct with underlying power relationships. It is in this landscape whereby cultural safety resides."[6]Cultural safety was originally introduced in the late 1980s by New Zealand Maori nurse Irihapeti Ramsden as a response to the poor health status of the Maori people.[7] At the time, cultural safety was loosely defined as, "[t]he effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognizes the impact of the nurses' culture on own nursing practice."[8]

Cultural safety is often confused with concepts like cultural awareness, cultural competence and cultural sensitivity. These concepts are not interchangeable but are best viewed as parts of a continuum of care with cultural safety at the ultimate end. The continuum starts with **cultural awareness** which is essentially the acknowledgment of difference. **Cultural sensitivity** is the next phase of the continuum which focuses on respecting that difference. From there, the focus is on the service provider's skills and attitudes and this is **cultural competence**.

FIGURE 1) CONTINUUM OF CARE



Cultural safety includes the skills of the previous phases but is different in that there is a self-reflection component; it "analyzes power imbalances, institutional discrimination, colonization, and colonial relationships as they apply to health care"[9] so that power is muted and service becomes client driven where the receiver of care determines desirable outcomes. The idea is that self-reflection leads to empathy and advocacy that result in better health outcomes. The self-reflection piece comes from the service provider acknowledging their

[6] D. P. Gray & D.J. Thomas as quoted in F. Hart-Wasekeesikaw, Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing (Ottawa, ON: Aboriginal Nurses Association of Canada, 2009)2.
[7] E. Papps & I. Ramsden, Cultural Safety in Nursing: The New Zealand Experience (Great Britain: Elsevier Science Ltd, 1996) 491.
[8] D. Wepa (Ed.), Cultural Safety in Aotearoa New Zealand (New Zealand: Pearson Education, 2005) v.
[9] National Aboriginal Health Organization, Cultural Competency and Safety in First Nations, Inuit and Métis Health Care Fact Sheet (Ottawa, ON: National Aboriginal Health Organization, 2009) 1.

own lens. It forces service providers to focus on themselves and analyze how their lens impacts delivery of care, whether positive or negative. The empathy and advocacy promotes and moves toward understanding.

Rationale

Care that is culturally safe acknowledges the role of the social determinants of health. According to Health Canada, a study was conducted within treatment centres in Saskatchewan where "lost cultural identity" was the most prominent factor for drug and alcohol abuse among First Nations and Inuit people.[10] Aboriginal people often do not access services, even when required, because they are met with cultural barriers and are not given the opportunity to determine the outcome of care.

Current dialogue on cultural safety typically focuses on the colonial history of Canada, best practices in theory, statistics, and skills. Further dialogue in the areas of: self-reflection, best practices translated into step-by-step practical direction and both professional and organizational evaluation/assessment are useful to advance the conversation and to boost implementation of culturally safe care. More specifically, the following questions must be addressed in the developing curriculum:

- Self-reflection
    - What is self-reflection?
    - How do I self-reflect?
    - How long should I do this?
    - What exactly am I reflecting about?
- Translation of best practices
    - What are the step-by-step protocols in a given situation?
- Evaluation/Assessment
    - How do I know if I am in fact providing culturally safe care?
    - What can I do to ensure that culturally safe practices are maintained?

It is crucial to understand both the historical and contemporary contexts of Aboriginal Peoples because of their important role in current Aboriginal health status. Equally, it is important to understand health care contexts as they are managed primarily by non-Aboriginal people.

Purpose

Aboriginal cultural integrity tends not to be highly regarded in Canadian cities; but part of what makes Canada unique is the First Peoples of the land. For Aboriginal Peoples to benefit from all that Canada has to offer, they must feel free to be who they are and to be supported implicitly and explicitly by human service providers (both mainstream and Aboriginal). Support is needed to improve the efficacy of building relationship with Aboriginal Peoples. As establishing trust is the first step in any relationship, particularly a therapeutic one, cultural safety must characterize early exchange.

Wabano and Tewegan Transition House are developing an adaptable curriculum that will enhance cultural safety for Aboriginal Peoples regardless of where they live or with whom they are interacting.

The project will create a foundation to begin creating culturally safe practice in Ottawa in three main areas: law enforcement, child protection and health services. By creating awareness and offering curriculum for

[10] Health Canada, http://www.hc-sc.gc.ca/fniah-spnia/substan/ads/index-eng.php

service providers on how to interact with Aboriginal clients in a way that decreases barriers and promotes understanding, we will begin to create an environment where Aboriginal Peoples can feel a place of belonging in Ottawa. The practical recommendations generated from this work will guide the development of a curriculum that will:

- Share information about Aboriginal people in Canada, in historical and contemporary contexts;
- Offer a simple, realistic and comprehensive way to support human service providers (i.e. police services, health service providers, social workers, etc.) to interact with Aboriginal people in a way that feels safe to them;
- Be consistent with the many other cultural safety curricula developed in urban centres across Canada while having a unique focus upon Ottawa;
- Provide human service managers with key learning objectives and evaluation tools to assess team performance in the domain of creating and maintaining cultural safety; and,
- Demonstrate the links to strategic action and priorities related to inclusion, equity and service.

"There is a need for understanding of history and struggles for inclusion and belonging."

METHODS

While concrete definitions and explanations are not universal, discourse around cultural safety is not new. Information was therefore gathered in two ways: a literature review of existing materials, and dialogue with service providers and Aboriginal community members in Ottawa. The dialogue was achieved through focus groups, one-on-one interviews and a questionnaire.

To efficiently approach curriculum development from the best starting point, a scan of current cultural safety resources was completed. Materials from Wabano, Wabano partner organizations and other relevant organizations were reviewed; mainly existing materials relating to cultural competency, cultural sensitivity, cultural safety and any existing curricula. A full listing of those resources is included in Appendix A.

As there are virtually no cultural safety information resources specific to Ottawa, it was best to converse directly the Aboriginal population who access service and those who provide service. Four focus groups were held and structured to collect information related to:

- how cultural safety is achieved (both through the physical environment and through human interaction); and,
- lived experiences of culturally unsafe practice to allow for concrete examples.

Focus groups were informal in the sense that open conversation beyond the target areas was encouraged.

As Wabano is leading this initiative, it was natural to have a conversation with our staff first to gauge the current situation in health care as it relates to Wabano. If the curriculum is to be offered by Wabano in the future, we must ensure that our staff are champions in this area. The first focus group was conducted with

approximately twelve Wabano staff from various programs who were selected by managers based on their relevant experience.

To assess health care from the perspective of those who access it, we invited clients (not limited to Wabano) to take part in the second focus group. Approximately six clients from the Aboriginal community participated and were selected purposefully by recommendation of Wabano staff and partners with no emphasis on age or sex. Although a smaller group, a creative and rich conversation resulted.

The third focus group was open to external service providers who work with the Aboriginal community in Ottawa. Because statistics show that there is an overrepresentation of Aboriginal Peoples in law enforcement and child protection, representatives from the Children's Aid Society and the Ottawa Police Service were present. There were eleven participants from various levels (front-line workers and managers) selected by their respective organization liaisons. It was perceived as though participants felt hindered from sharing lived experiences, potentially a result of low comfort levels given that the focus group was held at Wabano.

Connections were established at Ottawa Public Health (OPH) throughout the research phase and an opportunity to hold a fourth focus group at the OPH was offered. This was an important opportunity given that the lived experiences of the service providers in the third focus group were seemed to be withheld or potentially thwarted by the hosting environment. The focus group included ten participants, most of which were public health nurses. The participants were self-selected based on interest with no specific criteria.

A questionnaire was distributed to the 300 mainly non-Aboriginal service providers participating in Wabano's annual Mental Health Symposium in September 2013 (n=44). Because participants were attending various workshops and keynote addresses, the questionnaire was kept very short. Essentially, it asked the same questions the focus groups asked but this was viewed as an opportunity to measure the current understanding of cultural safety. The questionnaire can be found in Appendix B. Most service providers could not correctly define the concept, often alluding to cultural awareness or competence. The questionnaire assisted the research phase by informing the components necessary in the curriculum; for example, basic definitions and explanations.

Throughout the research gathering process, several one-on-one interviews were conducted with members of the Aboriginal community in Ottawa, ranging in age. Basically an extension of the focus groups, the interview discussion was much like the focus group discussions. The participants selected for the one-on-one interviews were identified by Wabano staff, members of the community, partner organizations or were potential focus group participants who felt uncomfortable sharing with groups. A total of eight one-on-one interviews were conducted with the input resting heavily on lived experiences and the emotional consequences of these experiences.

All information was reviewed for opportunities related to the development of a cultural safety curriculum that best aligns with the long term vision of a city where Aboriginal people feel included and culturally safe, where there is an institutional guard of Aboriginal cultural identity. Information was also reviewed for opportunities where the development of the curriculum could help organizations grow and be supported.

LITERATURE REVIEW

Canada's historical relationship with Aboriginal people is an important pillar to understanding the health disparities, inequity and the need for culturally safe care.

Existing literature provides a solid foundation and outlines cultural safety frameworks that focus specifically on two areas: retention of Aboriginal students in health programs in Canada; and, cultural competence curricula for Aboriginal and non-Aboriginal service providers who work with Aboriginal populations. Evidently, existing frameworks and reports focus on cultural safety education two-fold; either by encouraging Aboriginal people to pursue health careers to ensure culturally safe care, or by encouraging cultural safety education and awareness for existing human service providers to increase capacity.

What is missing from the conversation is the practical implementation and evaluation of culturally safe policy and protocol. Much of the literature (excluding curricula) available provides explanations of various terms related to cultural safety, often providing specific examples and offering best practices in theory. This is problematic because it is not always easily translated into everyday situations because each situation is unique given that Aboriginal people, cultures and histories vary. Offering best practice examples on paper are not catch-all solutions.

Cultural safety is indirectly related to better health outcomes; but a more comprehensive how-to practice manual is needed so that there is no mistaking what needs to take place in the interaction between service provider and client. Such a practice manual would offer key phrases or actions to take when a situation clearly feels uncomfortable for either party or when desired outcomes are not achieved.

While statistics and history lessons provide the foundation to understanding the current context with respect to Aboriginal health in Canada, an effective cultural safety curriculum or teaching tool must consider the fact that there are many existing resources that explain, in detail, much of the Aboriginal history in Canada. Much of the literature is academic and provides a lot of content that is easily understood on paper but not necessarily easy to interpret and translate into practice.

In the literature reviewed, very few resources discuss what takes place beyond training. There is very little emphasis on self-assessment and evaluations. This is crucial because culturally safe care cannot be ensured if there is no frame of reference or no way to assess. Research shows that assessments focus on evaluating competence rather than safety. The Best Start Resource Centre prepared an information resource called "Open Hearts, Open Minds: Services that are Inclusive of First Nations, Métis and Inuit Families" that includes both self-assessment and organizational assessment tools to assist with building best practices that are inclusive.[11] An assessment tool is useful because it allows service providers to evaluate whether they have absorbed the training and practice; it however, there is virtually no way to evaluate whether a self-reflection took place.

In most cases, Ottawa was left out of the conversation on cultural safety while there are resources specific to other provinces, territories and major cities in Canada.

FOCUS GROUPS

The following is an analysis of the four local focus groups and questionnaire. All quotes are drawn from the focus groups and the questionnaire and have purposefully remained anonymous.

For local frontline service providers, cultural safety had four key components: cultural and self-expression; inclusion; history; and power. Cultural safety allows everyone to feel comfortable and able to express themselves wherever they live and engage with community. Safety is created when the connection between

[11] Best Start Resource Centre, Open Hearts, Open Minds: Services that are Inclusive of First Nations, Métis and Inuit Families (Toronto, ON: Health Nexus, 2013) 24-25.

historical, social and political contexts and contemporary Aboriginal realities are understood. Safety is facilitated by the recognition that there is an inherent power structure in relationships between client and practitioner, doctor and patient, student and teacher or helper and beneficiary that require conscious approaches to ensure that there is *meaningful* decision making and exchange. Ideally power is created *with* others versus over others.

The structure of Ottawa's adaptable cultural safety curriculum is imagined as a continuum of learning that starts with cultural awareness, builds to cultural sensitivity and leads to skills and action reflected in competency and finally, cultural safety. It is a closed loop that regenerates with continuous self-reflection and learning represented in Figure 2.

FIGURE 2) THE CIRCLE OF CULTURAL SAFETY

In the first two phases (awareness and sensitivity), the core cognitive tasks are learning and developing respect. The competency phase is not just about developing and having the skill but about knowing how to use the skills to create positive interactions and environments. The last phase, safety, is a combination of other phases but also where empathy, advocacy and self-reflection create more comfortable exchanges and environments. In this self-reflective phase, assumptions are challenged and may require a return to the cultural safety loop by gaining more knowledge and proceeding through the attitudinal and action phases of development to new levels of safety.

Cultural Awareness

Almost all service providers felt that cultural safety was an important part of performing their daily duties and most felt that the need was greatest with respect to cultural awareness as many Canadians do not understand Aboriginal identity, Canadian history, social determinants of health or the need for greater effort toward reconciliation and inclusion of Aboriginal Peoples in Canada. In most cases, service providers felt the cultural safety curriculum should be mandatory in schools and hospitals or should form a part of core professional development. Therefore, the first phase of the curriculum should include the following modules: identity, history and context.

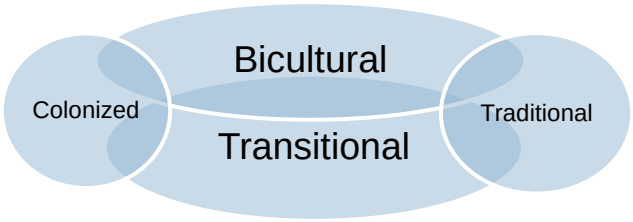
Identity

Human service providers need guidance to understand Aboriginal identity including the distinction between major groups (i.e., First Nations, Inuit and Métis) as well as the stark variation *within* groups based upon lived experiences and connection to traditions and community. It is not safe to assume that cultural values are universally known or understood because whether we are traditional, colonized or bicultural, we all enter into a transitional

"It's important for the service providers to know who we are."

space by learning more about our traditional teachings or by figuring out how to maneuver in Euro-Christian Canadian institutions and environments.[12] The categories (i.e., colonized, bicultural, traditional and transitional) are also not very mutually exclusive as they are illustrated in Figure 3. Rather, there can be much more overlap and flow between any of the categories identified. There is no judgment about where Aboriginal people are in this continuum is necessary: *there is a place for everyone*.

FIGURE 3) VARIATION IN CONNECTION TO TRADITIONAL CULTURE



Many Aboriginal Peoples have suppressed their identity as a reaction to the residential school system by enrolling their own children in Catholic schools and teaching them Euro-Christian values. This second generation wants to learn their Aboriginal culture and language but feel torn and ashamed, caught between wanting to reclaim their Aboriginal roots and distancing themselves from their parents who believed a complete break with history and tradition was best. They constantly face an identity challenge that must be recognized by service providers, particularly in therapeutic contexts.

Some Aboriginal Peoples from remote, isolated and northern regions may respond non-verbally: these non-verbal cues must be shared so that non-verbal exchanges can occur if they are needed. Other times, it is as simple as climate adaptation. For example, when recently arrived Inuit children from the north feel overdressed, they need the freedom to choose and to self-regulate. Service providers can refer back to the 'Circle of Cultural Safety' and be aware of issues such as this.

> *"Can you explain to my teacher why I don't need to wear a jacket in the winter? I tried and she won't understand."*

The spectrum of cultural engagement requires attention to values and behaviors far more than just how people look or sound. Similarly, it is an uncomfortable place for any individual to be expected to represent or to respond to all Aboriginal issues, concerns or cultures. This leads to some Aboriginal Peoples feeling hindered from self-identifying to avoid such awkward expectations or stereotypes, particularly when the subject matter turns to Aboriginal issues.

[12] Lafontaine, Alika: "Reconciling Canada: 2017 and Beyond," presented at the Canada 150/2017 Starts Now (CBC/Radio-Canada) regional conference in Saskatoon, Saskatchewan on May 1st, 2013.

Regardless, all those who self-identify should be allowed to connect to Aboriginal community resources if desired and the purpose of any question about identity is not to judge but to provide a safe space for progression toward a different life. Because identity can be so complex, some simple introductory questions might include:

- *"Is there anything that you would like me to know?*
- *"What do you need?"*
- *"Would you prefer to have someone from (Wabano, Minwaashin Lodge, TI, etc) involved?"*

Framing introductory questions this way allows individuals to ask for traditional practices if they need them. These questions should replace "*where are you from*" because belonging is assumed; there is an important distinction between first peoples and new comers that is necessary for reconciliation to be effective. If a ceremony is being offered for anyone, it is important to ensure that people can opt out without judgment. Beyond variety between and within Aboriginal groups, there are very important stories to share and understand.

History and Context

When Aboriginal Peoples offer a social context, it is often mistakenly viewed as individual character flaws or more simplistically, poor choices. There is a profound difference between knowing **what is** and understanding **why it is so**. Not enough is known about the impact of residential schools and the "Sixties Scoop" on contemporary Aboriginal families, how powerfully social determinants affect human health as well as the pervasive and the tremendous impact of the Indian Act, colonial policy and churches. Historical trauma has left scars that can trigger discomfort in contemporary urban contexts. For example, references to Christianity (i.e, terms like 'sister', 'father') or environments that remind Aboriginal Peoples of residential schools (i.e., bunk beds, large dining halls, dark corridors) may trigger negative reactions. When determining what might feel like a safe form of spiritual expression, service providers could ask:

- *Where do you find spiritual comfort?*
- *Is there something that I can do to help you feel more comfortable here?*

Similarly, little is known about treaties, land claims and current socio-economic conditions of Aboriginal Peoples. Understanding treaties, land claims and socio-economic conditions is important given that they are directly related to the historic relationship between Aboriginal Peoples and Canada which is a relationship built on mistrust of mainstream systems and institutions. Many Canadians still share an ill-advised belief that Aboriginal peoples are just beneficiaries of government handouts. Ideally, there should be opportunities to suppress stereotypes through experiences and connection *with* Aboriginal people which can be achieved through site visits to both high functioning and stressed communities.

> *"Sometimes you are viewed as the 'expert' as a result [of identifying] and others assume you have all the knowledge."*

Recognizing, using and visiting local Aboriginal institutions as a way of becoming familiar with the places where people gather is encouraged. If going into Aboriginal gathering places is impossible, invite ambassadors from these organizations into your organization.

Cultural Sensitivity

Ultimately, Aboriginal people want what everyone else wants; to be respected. Attitude formation and change are key ways to create sensitivity where difference is honored and celebrated. Aboriginal peoples are most respectfully received by an appreciative focus upon their strengths and welcoming, inclusive environments. Some public health discourse requires a decided shift in this regard (i.e., harm reduction efforts), so that the inherent skills and abilities to survive and thrive despite overwhelming odds to the contrary are acknowledged and strengthened.

Inclusion is reflected in public spaces that acknowledge and celebrate differences: a place where everyone feels at home. Institutional guard of Aboriginal culture in Ottawa is rare. There are few roads, schools, neighborhoods, or other public manifestations. If not whole organizations or neighborhoods, at least, rooms, roads or other spaces could given Aboriginal names or include art or architecture that celebrates Canada's first peoples. With the exception of Victoria Island, Wabano, the Odawa Native Friendship Centre and Tungasuvvingat Inuit, there really are few other public spaces where Aboriginal people have visibility. Although there is a high concentration of Aboriginal people in Vanier, this is related primarily to housing affordability and not any sense of place where culture is celebrated, acknowledged and accommodated.

> *"In Ottawa, there's Chinatown and Little Italy. But what space do Aboriginal Peoples have?"*

Familiarity can be amplified with scents (i.e., cedar), paintings, sculptures, artifacts and soothing, warm earth tone colors. Positive energy comes from a smile and the right amount of eye contact[13] to acknowledge presence as well as a structured environment that clearly shows a comfort level with clientele (i.e., discreet monitoring) and open (i.e., barrier and platform free) spaces between reception and the public. Everyone appreciates acknowledgement and warmth that comes with brief eye contact and a smile that says "*you are visible and welcome*".

Enhancing Aboriginal visibility in Canadian institutions also creates a welcoming inclusive space and is facilitated by having Aboriginal nurses, social workers, doctors, administrators, receptionists, police officers, paramedics, lawyers, judges, policy decision makers, therapists, dieticians, wardens, border authorities, professors, scientists, teachers, bus drivers, without ghettoizing them to singularly serve other Aboriginal peoples. With respect to child protection, First Nations, Inuit and Métis team members would be ideal to support First Nation, Inuit and Métis children in care. Other ways of enhancing visibility would include a memorial that acknowledges the history of colonization as well as the contemporary contribution and presence of Aboriginal groups. Representation can be in the form of language (i.e., welcome at entrance in an Aboriginal language), pictures and other visual

> *"We continually search for belonging but don't find it in the city."*

13 The duration of comfortable eye contact is highly variable and cues need to be developed to determine how much is enough or too much.

ways that have meaning. Being made to feel welcome through architecture, art and respectful reception demonstrates sensitivity.

Some institutions have made linguistic and environmental changes (i.e., CAS Inuit and First Nation pods) that have led to other changes in policy and practice. For example, more flexibility and less formality for meetings with clients allows for exchanges to take place in neutral and natural situations (i.e., coffee shops) or culturally positive (i.e., Wabano) environments. In larger institutional settings, a quiet, confidential space could be created where consideration is given to making Aboriginal clients feel welcomed and comfortable. Such accommodation has the potential to reinforce trust and support desired family outcomes.

Greater opportunity for customized culturally-focused intervention and reinforcement of kinship and community ties are warranted. For example, traditional infant care, particularly family beds, takinagans and moss bags as well as the cultural bias of gender distribution and number of children per bedroom must be known, understood and accommodated or adapted as necessary. A crib is not the place for infant slumber and is completely acceptable for a toddler to breastfeed up to four or five years old or longer. Furthermore, because traditional teachings insist that harvesting is based upon need, food storage is a bizarre concept for those who still participate in subsistence economies.

While progress is being made, child apprehension practices in particular must improve. For example, if constable escort is necessary during apprehensions, it must be possible for them to do so in regular clothing. Legislative flexibility is needed to adjust policy and practice accordingly and the curriculum will identify specific areas for legislative change as well as practice guidelines to strengthen the cultural safety of child protection interventions.

Hospitals, because of their highly technical, fast-paced, emotionally charged, high volume atmospheres would do well with client advocate/helper/navigators present who can support any literacy or translation issues. When helpers are absent, technical language should be replaced with clear, simple and easily understood terms and multiple or complex questions broken down into simple ones. When speaking, do so clearly and ask the client if they feel comfortable in their understanding. Of course, situational factors must be taken into consideration. Emergency room staff have very little time for self-reflection and may have to act promptly to save lives. A very quick way to open a conversation about culture would be to ask "*Is there something that you want me to know?*" This makes it easier on the service provider as some questions can feel intrusive and some people don't like to self-identify.

If the hospital chapel, with its altar, is the only place for spiritual expression, it automatically excludes and triggers anyone who has been spiritually or culturally abused at the hands of the church. Ideally, a cedar lodge would *also* be available, particularly in hospitals, but any where that spiritual guidance and ceremony is needed (i.e., family counselling, incarceration, celebrations, long term care and hospice settings). Families should be able to gather, smudge or engage in ceremony when illness, imminent death or birthing is taking place. The transition to and from the spirit world is a very important one for many Aboriginal peoples and often extended families are present.

Cultural Competency

While there is value in knowing and respecting difference, service providers must know how to act and react in the moment. In this phase, it is about the quality of the action. Much of the skill in this phase is about building and *maintaining* trusting relationships. Processes must be adapted to unique circumstances and meet

clients where they are and at their pace. For example, formal systems of identification (i.e., birth certificates, driver's licenses) may not be well known or understood.

In the early stages of a therapeutic relationship, it is imperative to establish trust. If personal histories are characterized by trauma, then exceptional efforts are needed and the widest breadth of choice should be offered. Respect is best communicated in non-judgmental approaches that are inclusive. The focus of training should not be about what "I want" or what "I expect" as the service provider but rather about what will work better and provide support. Service providers need guidance to deal with the fear and mistrust to create an environment where authentic questions are asked and answered, non-judgmentally, without assumption. Service providers also need a curriculum that promotes growth, understanding and support so that it is not regarded as another training program in addition to existing mandated training.

If there is any hint that the interaction is not progressing in the desired direction, authenticity is best. Many service providers are earnest in their efforts to create cultural safety but lack the essential skills or prompting questions that would facilitate positive interactions. It is perfectly legitimate through any process that is obviously uncomfortable to ask the client: "*what would make the process easier*"? Skilled communication is key to guaranteeing cultural safety. Relationships exist in the realm of communication and rebuilding them requires an exchange of ideas verbally and non-verbally, knowing when to speak, when to listen and when long silent pauses and open ended questioning are appropriate for disclosure.

> *"I sense that this is not working, what should we do next?"*

Some contexts require a fine filter to learn if or when a service provider even needs to speak at all. Service providers should take care to ensure that the spirit and intent of all questions are beneficial and be prepared to respond to why the information is needed. If it is not absolutely necessary, do not ask. Ideally, service providers could speak in or greet clients in an Aboriginal language: for example, opportunities exist for people to learn Inuktitut for free in Ottawa. In other scenarios, what is not said is just as important. For example, smoking cessation programs must always acknowledge the sacred place of tobacco rather than singularly viewing it as a commercial public health hazard.

Listening is less confrontational: someone who is present, paying close attention and listening is seeking first to understand and this builds trust. The curriculum will offer guidance on when and how to best lead into sensitive conversations as well as the necessary tools to use positions of authority to create power *with* clients rather than *over* them. Clients want to be engaged in decisions about their health and their lives. The curriculum will have a clear practice component where service providers are guided to check their assumptions, ask appropriate questions in appropriate ways and the role of intonation will be illustrated. When personal or professional limitations are exceeded, referrals will be encouraged.

> *"Let's work WITH communities and build relationships."*

Ultimately, a regularly updated, wide variety of partnerships developed through the use of the Aboriginal Outreach Network will offer clear referral systems that provide two services for one point of contact. For example, when dealing with exploitation of women, it is useful for police to have Minwaashin Lodge's contact

information to ensure that victims get connected to the resources that they need. Even in stressed, hurried and under-resourced environments where some may not have the knowledge, skills or time necessary, limitations must be recognized and quick solutions readily available through referral networks and partnership resources that are useful.

Aboriginal liaisons, working committees and individuals will never singularly have all the answers. The curriculum must clarify who to call under what circumstances and how to facilitate these partnerships. Because questionnaire respondents were almost evenly divided on whether or quantity or quality of service was a priority in their work place (n=44), resolving this essential dilemma means that the curriculum must also include quick referral options for those where quantity of service is a priority.

Cultural Safety

By this stage, human service providers are masters at recognizing and creating conditions where trust can be established and have an almost automatic reflex to check their own assumptions. Their interactions with clients are characterized by empathy and compassion reflected in the tone of their speech as well as the degree that clients are meaningfully engaged in decisions that impact their lives. There are very few tools to support the self-reflective loop that characterizes this phase. Open-ended questions could be helpful such as "*Was that okay?*" "*Was there something that could have made it better?*" but creating conditions where empathy and advocacy can prevail requires a more systematic way of evaluating knowledge, attitudes and skills.

Once basic awareness and competency are established, cultural safety was highlighted as the most impactful phase of the continuum where empathy and advocacy exist. Self-reflection is often what is missing from current cultural safety curricula and guidance in this area is needed. For example, it is incomprehensible for someone who has never been homeless to truly understand the experience; therefore, best to avoid saying '*I understand*' in response to any information shared by a homeless person. Instead, it would be better to express empathy with another assertion that illustrates that you are motivated to advocate on their behalf. Ultimately, if something does not feel right or is not working well, support is needed to clarify what to do (or not do) next. Service providers want to know how to get from competence to safety appropriately. Central to this journey is accepting that empathy is created by listening, learning and creating the space for facilitating and advocating a client driven intervention.

RESOURCES AND REFLECTION

Service providers were clear that there is a need for an articulated vision for the curriculum and its implementation where greater clarity is stated about how it will contribute to amplified voice and visibility of and reconciliation with Aboriginal peoples in Ottawa. The details of how, where and with whom inclusion and reconciliation must be created and maintained would form an integral part of the vision. There was a distinct call for safety curricula to be mandatory at all levels of the organization including management, integrated into strategic priorities and form a part of the core curriculum in schools and core professional development opportunities (particularly in hospitals). With respect to the practical aspect, three strategies were suggested:

- experiential learning opportunities;
- tool kits; and,
- e-learning modules.

Providers were clear that fact-filled, overloaded lecture formats will not enhance relationship building skills. While a PowerPoint presentation may be useful for a select few, *all* learning styles must be accommodated

and the curriculum should be characterized by play, fun, ease, celebration, interaction and experience *in real time* as well as take full advantage of a system of low cost, continuous learning at teachable moments on a daily basis (i.e., daily e-messages with a point of clarity or discussion).

> *"I want to feel like I'm going home."*

In the best case scenario, *experiential* learning would erase stereotypes, focus on similarities and share the voices and experiences of all (i.e., toddlers to Elders). There is always a space of overlap between groups where we share common values as mothers, fathers, men, women and young people. Everyone wants to be valued and appreciated for who they are, hopes to create safety and security for their families or to grow to reach their potential and it is in these shared spaces that rapport and relationship begin. Experiential learning could be facilitated by outreach efforts, expanding and strengthening partnerships, as well as mentorship and volunteer opportunities where allies could work with Aboriginal peoples. Coming together in the spirit of sharing and building relationship would offer a non-threatening way to share lived experiences, ask questions and seek guidance. Reconciliation can be fostered in creative ways by allowing for early positive experiences between Aboriginal children and public service agents (i.e., child participation in police graduation ceremonies). Curriculum models considered valuable for adaption included the Flower of Power exercise where various types of social exclusion are illustrated experientially.[14]

In addition, Aboriginal cultures should be profiled and visible at more celebrations, social events and festivals (i.e., film, seasonal and multicultural) at a wider variety of locations (i.e., schools and police stations) and not just at the Solstice Festival or the increasingly popular Aboriginal Awareness Days in June. Each year city teams have the opportunity to go to Ottawa City Hall during Aboriginal Awareness Days to visit booths and watch demonstrations. Alternatively, service providers could visit a community and interact in informal settings where Aboriginal people feel "*at home*".

The curriculum must include e-learning tools to accommodate staff turnover and variable schedules even though the opportunity for conversation may be lost. For law enforcement agencies, the inclusion of case law and real-life examples are most effective and illustrative. **Cultural safety must also be woven into other curricula with increased representation and visibility of Aboriginal peoples in media and training opportunities.** Care must be taken when using various media to ensure that distortions and negative stereotyping are not reinforced and recognize and use the influence of media on political priorities.

The curriculum should offer guidance regarding the kind of promotional materials or strategies that are best suited for select groups (i.e., posters work for some, but not others). The curriculum should include insights about food sources, consumption and storage, hunting and harvesting practices (i.e., use of guns), family structures (i.e., multigenerational and lone head of households), nonverbal cues, spirituality and ceremonies (i.e., fasting), and the traditional kinship supports often absent in the city. Collective care of children in remote and rural communities is not always applicable in Canadian urban environments. At last, focus group participants would like the curriculum to offer opportunities for an *exchange* of knowledge as well as improved relationship.

[14] http://web2.uvcs.uvic.ca/courses/csafety/mod2/media/flower.htm

Readily Available Tools, Resources and Opportunities

Many programs, tools and opportunities exist to support the first phase of awareness that include a wide range of readily available resources such as:

- The Ottawa Inuit Children's Centre's school based discussions about culture;
- The Children's Hospital of Eastern Ontario's lunch and learn series;
- Neighbourhood committee meetings as a space for sharing;
- Aboriginal liaisons and working committees regionally;
- The Flotilla for Friendship;
- Values checklists for human service providers;
- Regularly scheduled staff meetings as a space for sharing;
- Social media;
- Whole texts on creating healing environments and other cultural sensitivity curricula;
- Human libraries;
- Historical city resources on cultural groups;
- Inuit Awareness training kits (Nunavut Sivuniksavut, Inuit Tapirit Kanatami, Tungasuvvingat Inuit) presented by students with Inuit game demonstrations and inukshuk workshops;
- Scores, potentially hundreds of films, books, articles and other resources are readily available from the National Film Board, Canadian Broadcasting Corporation (CBC), Amazon and the internet including but not limited to:
    - One Dead Indian: The Story of Dudley George and Ipperwash (a made for television movie);
    - Where the Spirit Lives (drama) and We Were Children (documentary) about children's experiences at residential school ;
    - Alanis Obomsawin's documentary Kanehsatake: 200 years of Resistance;
    - Zacharias Kunuk's film Atanarjuat: The Fast Runner;
    - Andrée Cazabon's documentary Third World Canada;
    - Paulette Reagan's book Unsettling the Settler Within;
    - Dr. Martin Brokenleg's collected papers and lectures;
    - Jane Middleton Moz's books and resources;
    - Lyn Gehl's Ally Bill of Responsibilties (http://www.lynngehl.com/my-ally-bill-of-responsibilities.html);
    - CBC's 8th Fire: Aboriginal Peoples, Canada and the Way Forward with host Wab Kinew.[15]

Other programs that amplify inclusive, anti-oppressive practice would also have value and could be adapted (i.e., CAS' Power Circle[16] and social class role plays where the skills of each social class can be illustrated and appreciated). The core parts of the curriculum that should be mandated and those that are not mandated have not been determined at this stage of curriculum development however, it was suggested that non-mandated topics might be better suited to e-learning modules (experiential, books, video).

[15] http://www.youtube.com/watch?v=xmYu-Wppp3c
http://wabkinew.ca/tag/8th-fire/
http://www.cbc.ca/8thfire/2012/03/wab-kinew.html

[16] See Appendix C

Systematic Self and Organizational Assessment

There is wide variation in Canadian knowledge of and experience with Aboriginal communities and an adaptable curriculum that responds to this diversity is needed. Assessment tools are needed to ensure that individuals are streamed into the curriculum at appropriate stages. Some practitioners feel comfortable that they are practicing cultural safety; however, this may not always be the case. Assumptions must always be checked.

Often there are no consequences for racist practice and policy and victims go away quietly, resigned to the Euro-Christian domination of many Canadian institutions. Therefore, non-compliance or no-shows for scheduled appointments may be more about feeling unsafe than about lack of integrity. Similarly, key indicators that could alert service providers to the role and influence of the social determinants of health, especially poverty, are needed so that the context of individual circumstance is addressed more holistically. The Health Equity Impact Assessment (HEIA)[17] administered provincially may be a useful tool as is or adapted to support advancing knowledge about and skills to address determinants of health.

The curriculum and its implementation will also require assessment. Users should be asked to answer the following questions:

- *Did the experience change your views? If so how?*
- *What resources/experiences/information was most useful?*
- *Is there anything that you will share with others? If so what?*

Some suggest practice evaluations to determine if service providers are capable of offering cultural safety. Part of the process of creating cultural safety will also require the deconstruction of current policy and practice to isolate problematic areas as well as weave Aboriginal culture into existing organizational tools and strategic priorities (i.e., fostering at CAS under the broader umbrella of kinship to include community). Organizational assessments would be necessary to determine to what degree operations promote reconciliation with and inclusion of Aboriginal peoples at all levels (i.e., including management). Do policies and protocols understand and respect Aboriginal values and does religion, social class or other culturally influenced interpersonal communication (i.e., body language) impact service delivery? Assessment tools would support teams to recognize and frame interventions with the social determinants of health in mind and use a strengths based focus and appreciative inquiry when working with Aboriginal families and individuals. Assessment would check racism in the workplace and service delivery in Canadian institutions.

> *"We could tell stories and interact with each other."*

[17] http://www.health.gov.on.ca/en/pro/programs/heia/

RECOMMENDATIONS

In no order of priority, the parameters for curriculum development are clear.

1. The curriculum should **suit a variety of contexts, needs and learning styles**.
2. There is a distinct preference for **learning to occur organically and experientially** with a reconciled relationship between Aboriginal Canadians and others as a natural byproduct.
3. Care must be taken to use or adapt **readily available resources and regularly scheduled events** as teaching tools and opportunities.
4. Awareness begins with an understanding of Canadian **history**, variation in Aboriginal **identity** and the powerful influence of **social context** upon individuals. Resources will be made available but the curriculum will focus on the social context.
5. Clear guidance with practical, step-by-step approaches to **creating welcoming interactions and inclusive spaces** must form a part of the curriculum.
6. Skills required for **building and maintaining trusting relationships** must form a large part of the curriculum with opportunity for practice and self-assessment.
7. **Partnerships will be fundamental** to creating and advancing culturally safety and the curriculum should identify what partnerships are needed and appropriate for a variety of scenarios.
8. At last, born of the curriculum, an **organizational and practice self assessment tool** must emerge to hold Canadian institutions to account for their climate of cultural safety.

CONCLUDING REMARKS

Ultimately, Aboriginal Peoples want to be known, visible and have a voice in Canadian society and this forms the foundation for cultural safety to flourish in Ottawa and beyond. Many other Canadian institutions and urban centres are advancing the discourse on cultural safety but in terms of practical application, there is much work to be done. Ottawa's curriculum will move toward the application of knowledge and skills with real life illustrations, demonstrations, stories and experiences that advance understanding and reconciliation. A vision of cultural safety in Ottawa is required to guide curriculum development.

Aboriginal identity *is complex* and cannot be assumed based on appearance. In addition to physical differences, there is wide variation in connection to traditional culture. While no individual can have all the information about each of the three distinct groups as well as the differences within groups, they can and should have access to a resource guide that directs them to partners who can help navigate toward cultural safety in practice and policy. There has rarely been a better time in Canadian history for Aboriginal peoples to take their rightful place 'at the table.'

We thank our partner Tewegan Transition House, and the Ontario Trillium Foundation for funding such an important project.

APPENDICES

Appendix A – References

Baba, L. (2013). Cultural safety in First Nations, Inuit and Métis public health: Environmental scan of cultural competency and safety in education, training and health services. Prince George, BC: National Collaborating Centre for Aboriginal Health. Retrieved from http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/88/CIPHER_report_EN_web.pdf

Best Start Resource Centre. (2013). Open hearts, open minds: Services that are inclusive of First Nations, Métis and Inuit families. Toronto, ON: Health Nexus. Retrieved from http://www.beststart.org/resources/rep_health/OHOM.pdf

Brascoupé, S., & Waters, C. (2009). Cultural safety: Exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. Journal of Aboriginal Health, 05(02), 6-41. Retrieved from http://www.naho.ca/documents/journal/jah05_02/05_02_01_Cultural.pdf

Brokenleg, Dr. M. (2013, September). Culture and Healing. Lecture conducted from the Wabano Centre for Aboriginal Health, Ottawa, ON.

Children's Aid Society. (2012). Exemplifying the sacredness of relationality: An evaluation of the partnership between the First Nation, Inuit, and Métis service providers and the Children's Aid Society of Ottawa. Ottawa, ON: Children's Aid Society.

City of Ottawa. (2010). Diversity snapshot: Aboriginal peoples (First Nations, Inuit, Métis). Ottawa, ON: City of Ottawa. Retrieved from http://ottawa.ca/sites/ottawa.ca/files/attachments/ottpage/aboriginal_en.pdf

Cultural Safety Working Group, & First Nation, Inuit and Métis Advisory Committee of the Mental Health Commission of Canada, (2011). "One focus; many perspectives" A curriculum for cultural safety and cultural competence education. Calgary, AB: Mental Health Commission of Canada. Retrieved from http://www.mentalhealthcommission.ca/English/node/5281

Hart-Wasekeesikaw, F., et al. (2009). Cultural Competence and Cultural Safety in Nursing Education. Ottawa, ON: Aboriginal Nurses Association of Canada.

Health Council of Canada. (2007). Health care renewal in Canada: Measuring up?. Retrieved from Health Council of Canada website: http://www.healthcouncilcanada.ca/rpt_det.php?id=168

Health Council of Canada. (2012). Empathy, dignity, and respect: Creating cultural safety for Aboriginal people in urban health care. Toronto, ON: Health Council of Canada. Retrieved from http://www.healthcouncilcanada.ca/rpt_det.php?id=437

Indigenous Health Advisory Committee, & Office of Health Policy and Communications, (2013). Indigenous health values and principles statement. Ottawa, ON: Royal College of Physicians and Surgeons of Canada. Retrieved from http://www.royalcollege.ca/portal/page/portal/rc/common/documents/policy/indigenous_health_values_principles_report_e.pdf

Indigenous Physicians Association of Canada. , & Royal College of Physicians and Surgeons of Canada, (2009). Cultural safety in practice: A curriculum for family medicine residents and physicians. Ottawa, ON: IPAC-RCPSC. Retrieved from http://www.aht.ca/images/stories/ACSI/IPAC-Cultural-Safety.pdf

IPAC-RCPSC Advisory Committee. (2009). First Nations, Inuit, Métis health core competencies: A curriculum framework for continuing medical education. Ottawa, ON: IPAC-RCPSC. Retrieved from http://www.aht.ca/images/stories/ACSI/IPAC-Core-Competencies.pdf

National Aboriginal Health Organization. (2008). Cultural competency and safety: A guide for health care administrators, providers and educators. Ottawa, ON: National Aboriginal Health Organization. Retrieved from http://www.naho.ca/documents/naho/publications/culturalCompetency.pdf

National Aboriginal Health Organization. (2009, April).Cultural competency and safety in First Nations, Inuit and Métis health care fact sheet. Retrieved from http://www.naho.ca/documents/naho/english/factSheets/culturalCompetency.pdf

National Native Addictions Partnership Foundation. (2011).Working with First Nations people: Culturally safe toolkit for mental health and addiction workers literature review. Prince Albert, SK: National Native Addictions Partnership Foundation. Retrieved from http://nnapf.com/working-with-first-nations-people-culturally-safe-toolkit-for-mental-health-and-addiction-workers-literature-review/

Papps, E., & Ramsden, I. (1996).Cultural safety in nursing: the New Zealand experience. International Journal for Quality in Health Care, 08(05), 491-497.

Shah, Dr. C. (2012). Preparing Ontario's health sciences students for Aboriginal cultural safety: environmental scan. Toronto, ON: Anishnawbe Health Toronto. Retrieved from http://www.aht.ca/images/stories/ACSI/Executive-Summary-Environmental-Scan.pdf

Shah, Dr. C. (2012). Aboriginal cultural safety initiative. Retrieved from http://www.aht.ca/aboriginal-culture-safety

South West Local Health Integration Network. (2010).Aboriginal cross cultural reference for health care providers. London, ON: South West Local Health Integration Network. Retrieved from http://southwestlhin.on.ca/WorkArea/showcontent.aspx?id=5310

Statistics Canada. (2011). NHS Aboriginal population profile, 2011 . Retrieved from http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/aprof/index.cfm?Lang=E&fpv=10000

T. Rowe (Ed.), (2013). Health professionals working with First Nations, Inuit, and Métis consensus guideline. Journal of Obstetrics and Gynaecology Canada (Vol. 35, Num. 6, pp. 1-48). Ottawa, ON: Society of Obstetricians and Gynaecologists of Canada. Retrieved from http://sogc.org/wp-content/uploads/2013/06/gui293CPG1306ErevE.pdf

Tait, Dr. C. (2011). Ethical toolkit: Building honorable and equitable relationships. Retrieved from https://ethicaltoolkit.ca/content/home

Wepa, D (Ed.), (2005). Cultural safety in aotearoa new zealand. New Zealand: Pearson Education.

Wiebe, P. K., van Gaalen, R. P., Langlois, K., & Costen, E. (2013). Toward culturally safe evidence-informed decision-making for First Nations and Inuit community health policies and programs. Pimatisiwin: A Journal of

Aboriginal and Indigenous Community Health, 11(1), 17-26. Retrieved from http://www.pimatisiwin.com/online/wp-content/uploads/2013/07/02Wiebe.pdf

Appendix B – Questionnaire

Wabano
CENTRE FOR ABORIGINAL HEALTH

Cultural Safety Questionnaire

Wabano is currently working to develop a training program on the topic of cultural safety to both increase capacity within our staff and with external service providers. The training program will help to improve front-line services that will benefit the Aboriginal population in Ottawa. Please take a moment to fill out this short questionnaire to help us gauge the current condition in human services – your feedback is appreciated.

1. **I am:**
   ◯ First Nations ◯ Inuit ◯ Métis ◯ Non-Aboriginal

2. **I am (Check all that apply):**
   ◯ Service Provider ◯ Student ◯ Community Member

3. **What does cultural safety mean to you?**
   _____
   _____
   _____
   _____
   _____

4. **On a scale of 1 to 5 (5 being extremely important), how important is cultural safety in addition to your daily duties?**
   ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

5. **Sometimes human service environments are under-resourced; what typically takes priority, quality of service or quantity?**
   ◯ Quality of Service ◯ Quantity of Service

6. **What are the most common barriers to ensuring cultural safety in human services? (Check all that apply)**
   ◯ Lack of knowledge and awareness
   ◯ Under-resourced
   ◯ Time
   ◯ Existing policies/protocols
   ◯ Other: _____

7. **Which of the following would be most helpful for a training program on cultural safety? (Check all that apply)**
   ◯ Hearing people's lived experiences
   ◯ Hands-on activities
   ◯ Hearing about statistics
   ◯ History
   ◯ Discussions
   ◯ Other: _____

8. **Comments**
   _____
   _____
   _____
   _____
   _____

Wabano will be holding a focus group for service providers on October 22nd. If you are interested in participating, please leave your name and contact information:

Name: _____
Email address: _____
Phone: _____

If you are interested in participating, what time of the day do you prefer?
◯ Morning ◯ Afternoon ◯ Evening

Your feedback is important to us – thank you!

Appendix C – Power Circle

Role play activity from CAS' Anti-Oppression Training