Cultural Safety

Exploring the Applicability of the Concept of Cultural Safety to Aboriginal Health and Community Wellness

Simon Brascoupé, Department of Sociology and Anthropology, Carleton University

Catherine Waters, BA, MA

ABSTRACT

The goal of the research paper is to explore both the concept of cultural safety and its practical implications for policies and programs designed to improve the health of Aboriginal people and the wellness of Aboriginal communities. The paper demonstrates the concept of cultural safety can shift from a being a tool to deliver health care services to individuals to a new and wider role. The concept of cultural safety can have a significant impact the way policy and services are developed at an institutional level in fields such as health, education, the courts, universities, and governance (both First Nations and other types of government). Four case studies at the end of the research paper show how cultural safety has helped communities at risk and in crisis engage in healing that led to lasting change. The research paper, defines cultural safety and how it differs from cultural competence or trans-cultural training and practices; shows why it's important to move from the concept of cultural safety to the outcome of cultural safety, namely the success of an interaction; explores the idea of a shift from cultural safety for individuals to cultural safety at institutional and policy levels; and provides recommendations in five areas.

KEYWORDS

Colonization, cultural safety, healing and wellness, historical trauma, social determinants of health

INTRODUCTION

1. Introduction and definition

This paper describes and analyzes the concept of cultural safety as it pertains to Aboriginal policy and assesses its usefulness as a means of designing and developing government policy and service delivery. It seeks to draw together a range of literature sources to assess the applicability of cultural safety in a Canadian context.

The aim is to understand First Nations communities at risk and in crisis and the effectiveness of programs designed to address their issues. While focused on cultural safety, the paper broadens to consider other connected issues, as well as the wider determinants of health within a holistic and community-based context. The focus will be on conclusions in the form of lessons learned, best practices and recommendations for government departments, policy-makers, researchers, scholars, and community members.

The concept of cultural safety evolved as Aboriginal people and organizations adopted the term to define new approaches to healthcare and community healing. Much of the literature confirms that a definition of cultural safety should include a strategic and intensely practical plan to change the way healthcare is delivered to Aboriginal people. In particular, the concept is used to express an approach to healthcare that recognizes the contemporary conditions of Aboriginal people which result from their post-contact

National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)
ᑲᓇᑕᒥ ᓄᓇᖃᖅᑲᖅᓯᒪᔪᓄᑦ ᐊᓐᓂᐊᖅᓇᖏᓐᓂᓄᑦ ᑲᑐᔾᔨᖃᑎᒌᑦ

history. In Canada, Aboriginal people have experienced a history of colonization, and cultural and social assimilation through the residential schools program and other policies, leading to historical trauma and the loss of cultural cohesion. The resultant power structure undermined, and continues to undermine, the role of Aboriginal people as partners with healthcare workers in their own care and treatment. In the context of healthcare delivery, culturally unsafe practices have been defined as "any actions that diminish, demean or disempower the cultural identity and well-being of an individual" (Cooney, 1994). As this definition suggests, the term 'cultural safety' has a wide potential of application to other areas of government policy and service. In this sense, the concept of cultural safety represents a potent tool in the development and delivery of policies and services relating to Aboriginal people, not just in the health field, but also other areas of social policy.

However, the generality of this definition also serves as a warning to policy-makers: the precise meaning and implications of the concept of cultural safety remain vague and elusive. To be able to introduce cultural safety into policy and delivery, policy-makers must understand what cultural safety fundamentally means, the difference it makes to policy development and delivery, and where cultural safety lies conceptually and in practice in relation to previous considerations of cultural difference.

This paper seeks to clarify and deepen the definition of cultural safety, and explore practical strategies, approaches and lessons learned that address the key drivers of risk and crisis in First Nation communities. By considering the social and cultural implications of Aboriginal post-contact history, the concept of cultural safety can contribute to a greater understanding of the origins of these crisis situations and how policies can be developed to address them. In the past three decades, there have been some promising indicators of success in community development, such as the healing and wellness movement in Canada and the research results of the Harvard Project (Kalt, 2007). From a policy perspective, whole communities have benefited from policies and practices that might be described as 'culturally safe', bringing cultural considerations into policy development, strategic planning and training. Some communities have achieved remarkable results through innovative social policies, good governance, and sensitive community development. Through these and other initiatives, we are beginning to understand how cultural safety and the resulting trust can play a role in wider social and economic development. The case studies in Appendices A to D provide examples of initiatives undertaken by Aboriginal people within their communities to improve health and well-being following the teachings and symbols of Aboriginal culture.

By reviewing the relevant academic literature, and investigating reports and examples on culturally safe practices, the paper looks at what the concept of cultural safety offers Aboriginal people as they work to regain control over their communities in crisis, both at the community and individual level. It is important to locate the concept of cultural safety within the context of cross-cultural relationships, between Aboriginal service-receivers and non-Aboriginal service deliverers, and to consider how the concept affects relationships, power structures and trust. In the historical context of mistrust and trauma caused by colonization, the building of trust within cross-cultural interaction is critical to policy effectiveness (Wesley-Esquimaux, 2004). This paper considers the changing power structures underlying the growth of trust, and where responsibility lies for deciding if a successful trust relationship has been achieved.

Unfortunately, statistical evidence of the benefits of cultural safety is scarce. The most concentrated investigation of the applicability of culturally safe practice is found in literature from the New Zealand and Australian health care field, largely focused on nursing. Even here, the evidence is largely qualitative and anecdotal. The body of literature examining wider issues of culture in health care delivery, focusing in particular on *cultural competence*, is more extensive and shows that cultural consideration improves health outcomes.

Still less evidence exists on how the concept of cultural safety can be used in relation to communities at risk and in crisis. The studies on nursing and midwifery focus on the interaction between non-Aboriginal health care professionals and Aboriginal patients; they do not extend the discussion of cultural safety to wider issues of social well-being, including the failings of the educational system, drug and alcohol abuse, family dysfunction, and violence. This link to communities in crisis in a general sense may be the subject of more focused examination in academic and professional institutions in the future. A culturally safe delivery system could strengthen the capacity of communities to resist the stressors and build resilience to those forces that push them from risk to crisis.

Cultural safety developed as a concept in nursing practice in New Zealand with respect to health care for Maori people (Wepa, 2005; Williams, 1999). It develops the idea that to provide quality care for people from different ethnicities and cultures, nurses must provide that care within the cultural values and norms of the patient. As we will explore in more detail, the concept of cultural safety challenges the previously accepted standard of transcultural nursing by transferring

National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)
ᑲᓇᑕᒥ ᓄᓇᖃᖅᑳᖅᓯᒪᔪᓄᑦ ᐊᓐᓂᐊᖃᖅᑐᓐᓂᓕᕆᔨᒃᑯᑦ ᑲᑐᔾᔨᖃᑎᒌᑦ

the power to define the quality of healthcare to Aboriginal patients according to their ethnic, cultural and individual norms. Thus, cultural safety as a concept incorporates the idea of a changed power structure that carries with it potentially difficult social and political ramifications (Ramsden, 2002; Cooney, 1994). The introduction of the concept of cultural safety to the debate on cross-cultural healthcare was significant: it questioned and challenged the concept of cultural competence and, by bringing in the notion of safety, it extended the debate by focusing less on the benefits of cross-cultural awareness and sensitivity, and more on the risks associated with their absence.

Canadian practitioners have contributed to the idea of culturally safe practices through community-based institutions, approaches and traditions. There is growing and promising literature demonstrating a link between cultural safety and healing methodologies, which could provide indicators of community health or risk for First Nations communities at risk. The success of healing communities at risk and in crisis, at both the individual and community levels, may lie partially in understanding the distinction between the different concepts of cultural consideration, their relation to each other and their validity in practice.

One of the challenges for Aboriginal communities is deciding their policy priorities, for example, economic development, social deprivation, housing, education, or health. Most research examining issues of practical concern and lessons learned takes its results from communities that are successful. While informative and useful, this research does not pay sufficient attention to communities at risk or in crisis. Therefore, this literature search will take a fresh look at the promising analysis of the prerequisites or starting points for communities on their healing path and how healing begins. As a community strategy, how do you focus on the determinants of health? How do the broader determinants of health play a critical role in community development? What can we learn from communities that have, as a starting point, focused on the broader determinants of health through community healing? If the community is at risk, how do you assess where a community is on its own continuum of healing? And what are the next steps? In addressing these questions, the paper aims to discover the conceptual robustness and practical value of cultural safety as a tool for improving community and individual well-being.

Finally, this paper addresses the relevance of programs and services to the values, traditions, beliefs, and practices of Aboriginal people. The issue of culture and the degree to which it can and should be part of policy design and implementation are complex, but increasingly it is recognized and accepted that policy cannot be effective if it does not acknowledge and take some account of the cultural context in which it is applied. The idea that government policy may fail or its effects be mitigated by cultural misunderstandings or ignorance presents the imperative behind the concept of the cultural safety.

2. Literature Search

The literature search includes academic literature, focused both on health and indigenous cultures, grey literature and the Internet. The timeframe for the search concentrates on the past ten years, from the first serious research on cultural safety, and draws on significant contributions to the canon beyond fifteen years. The potential scope of the subject makes a thorough examination of all sources impossible. However, by tracing the development of the research through the many sources of information, it is possible to see the progress of thinking on this subject and identify trends and gaps in the research. The academic health and indigenous literature, including various electronic databases from selected national, international and indigenous journals, the grey literature research including Aboriginal, government and other reports, studies, etc. An Internet search included national and international literature available on the internet (the Google search identified 6,860,000 citations for "cultural safety;" 455,000 citations for "cultural safety in health care," and 273,000 citations for "cultural safety Canada") presented a comprehensive review of relevant academic and professional research.

3. Cultural Competence and Cultural Safety Evidence Base

The evidence base for cultural competence and cultural safety is being examined from the perspective of quantitative, qualitative and traditional research methods. Cultural competence research provides a foundation for cultural safety; for example, Ramsden (1992) conceptualizes it as a continuum of moving from cultural awareness to cultural competence to cultural safety. Since cultural competence is more broadly practiced around the world and has been in existence longer, there is more research in the literature. Since cultural safety is a relatively new concept and less understood outside indigenous experience, there is less research and mostly of a qualitative nature.

In a major study of the cultural competence evidence-base in health care, the National Center for Cultural Competence found some promising studies supporting health outcomes and patient satisfaction (Goode et al., 2006). They identified primary research articles on health

outcomes and well-being found in Medline from January 1995 to March 2006. The study found that health outcomes and patient satisfaction evidence were very promising but in the early stages of development. They also found that a decrease in the liability of providers or organizations was showing some strong preliminary evidence. Another study by John Hopkins University from 1980 to 2003 found excellent evidence that supported cultural competence training as a strategy for improving the knowledge, attitudes and skills of health professionals (Beach et al., 2005). The study also found good evidence that cultural competence training positively impacts patient satisfaction. A search for current cultural competence literature to December 2008 in PubMed identified 882 papers, including the Beach study, but no other recent evidence-base studies. In summary, while the current evidence shows great promise for cultural competence, there is a need for better-designed studies (Goode, Dunne & Bronheim, 2006; Beach et al., 2005) to advance the evidence base.

The challenge is to extend the understanding of the role of *cultural competence* in health-care delivery to the concept of *cultural safety*, by distinguishing between these concepts and understanding what difference cultural safety brings to policy outcomes. Research on cultural safety is an emerging field; no quantitative and a few qualitative articles were found, a few calling for more evidence based research. Research recognizes that a shift is occurring, that in New Zealand nursing incorporates cultural safety (NZNC, 2005), and nursing is moving towards cultural competence that incorporates some aspects of cultural safety (Salimbene, 1999). Studies in Australia found that cultural safety provides a useful framework to improve the delivery of services to Indigenous peoples (Kruske, 2006). Cultural safety and cultural competence are key concepts that have practical meaning for Indigenous people. They form the basis for effective patient-centred care and the professional advocacy role of the general practitioner (Nguyen, 2008). In response to the lack of evidence-based research on cultural approaches, Anne McMurray (2004) argues for the development of an evidence-based approach in Australia that recognizes that health and illness are socially determined. This requires the involvement of individuals, families and communities; a link between knowledge and caring; and the recognition that culture contributes to the shaping of health behaviours and health outcomes. In Canada, there are a few studies by scholars (Smye & Browne, 2002) that explore how Aboriginal peoples experience culturally safety, to deepen the understanding of the effectiveness of cultural safety tools and interventions in nursing practice. Other researchers, like Jessica Ball (2007a), ask "How safe did the service recipient experience a service encounter in terms of being respected and assisted in having their cultural location, values, and preferences taken into account in the service encounter?" (Ball, 2007a, p.1), explicitly linking service delivery to cultural respect and awareness.

These examples demonstrate part of the difficulty in understanding cultural safety: as a concept, it emerges as a distinct paradigm shift from the concept of cultural competence; but as a practical tool, it appears less as a shift in direction but rather as a further step on a continuum of cultural consideration by practitioners. This duality of meaning and direction between the academic concept and the practical tool will be explored in greater depth.

From the perspective of traditional knowledge, the evidence base for cultural safety is ancient and imbedded in traditional teachings such as the medicine wheel (Brant Castellano, 2008). An evaluation of the Aboriginal Healing Foundation's (AHF) 140 plus projects implicitly identified cultural safety as critical to healing, and that relationships based on acceptance, trust and safety are the first step in the healing process (AHF, 2003a, 2008). In her analysis of the evidence, Marlene Brant Castellano found:

> The evaluation approach adopted was to look for evidence of individual progress along a healing continuum and increased capacity of communities to facilitate that progress. Research results reveal the multiple layers of trauma laid down in the lives of Aboriginal peoples over generations and the path traversed by individuals and communities in recovering capacity for a good life (AHF, 2008, pp. 389-390).

This is consistent with the findings of cultural safety in New Zealand, where establishing and maintaining trust was a prerequisite to negotiating and delivering culturally safe care (Crisp et al., 2008). However, a search through PubMed for current "cultural safety indigenous" research literature identified 156 papers of which none had evidence-based research. In short, though there is significant research on cultural safety in individual healthcare delivery and in Aboriginal community healing projects, there is virtually no broad quantitative evidence to support the considerable qualitative exploration. In addition, the breadth of the definition of the term cultural safety as it is used in much of the literature, explicitly or implicitly, necessarily widens the scope of the literature search.

Finally, no cultural competency and safety research was found that focused explicitly on communities at risk or in crisis. Furthermore, the literature on indigenous

communities' development is focused on best practices, lessons learned and innovation. There is some research on communities in crisis and at risk, such as studies of the dramatic turnaround of *Alkali* Lake and Hollow Water First Nations. The literature clearly demonstrates that there is evidence that healing strategies, with safety as a cornerstone, work to move communities in crisis along the healing path to emerging healthy communities (Lane et al., 2002). In a qualitative evidence-based study, Thomas (2003) argues for a cross-cultural approach that mergers western clinical practices with Aboriginal cultural dimensions as an appropriate strategy to further the healing journey of Aboriginal people.

This paper begins to map out the link between cultural safety and communities at risk or in crisis. Further research and work is needed to demonstrate how cultural safety theory contributes to community development strategies in supporting communities at risk and in crisis. However, it is very promising to apply what is now known and understood about cultural safety to community-based development strategies and, as this paper indicates, is being applied in a number of innovative case studies.

CULTURAL SAFETY AND POWER

Throughout the literature, there is considerable reference to the concept and practice of *cultural competence*. This appears to represent a high-water mark of cultural understanding demonstrated by health-care professionals and, as the literature reveals, is taught and measured as a function of knowledge and understanding of Aboriginal culture by practitioners. Often, references to *cultural safety* in practice are made in relation to cultural competence, as an extension of and improvement to competence. Thus, cultural competence and cultural safety are both represented as points on a continuum of cultural approaches.

Elsewhere, the literature reveals a different understanding of cultural safety as a 'paradigm shift', where the movement from cultural competence to cultural safety is not merely another step on a linear continuum, but rather a more dramatic change of approach. This conceptualization of cultural safety represents a more radical, politicized understanding of cultural consideration, effectively rejecting the more limited culturally competent approach for one based not on knowledge but rather on power.

We will now consider these two conceptualizations of cultural safety.

1. The culture continuum or paradigm shift?

One way to understand the concept of cultural safety and to distinguish it from other cultural reference terms is to situate the concept on a continuum. This demonstrates where cultural safety is situated in terms of negative approaches ranging to the positive. This is a linear depiction of the continuum:

Each of these degrees of cultural awareness and accommodation represents steps in the process of attuning government to the people it governs, and institutions and individuals to the people they serve. On the negative end of the continuum, where cultural destructiveness and cultural incapacity lie, we can see the roots of colonization. The Canadian federation, constructed in 1867 to accommodate the rival 'founding nations' of English and French Canada, must now adapt to its highly diverse multicultural population with immigrants from all over the world, and to its responsibility for the treatment of Aboriginal peoples. It might have been expected that a young country so attuned to diversity would have shown a more enlightened approach to First Nations and greater respect for ancient indigenous cultures. However, the paternalistic legislative and policy stance, and discriminatory attitudes towards Aboriginal people meant that too often western policy deliberately or inadvertently ignored or actively destroyed the languages, cultures and traditions of Aboriginal peoples.

On the positive side of the continuum, beginning with 'cultural pre-competence' and 'cross-cultural sensitivity', there is growing awareness and recognition of the cultures of Aboriginal people. This is an educational phase where government and service providers grow in competence in applying cultural understanding to the services they deliver to Aboriginal people. When cultural safety is reached on the continuum, the result is a transformation of the relationship between the provider and Aboriginal peoples, where their needs and voice take a predominant role. Ramsden envisaged cultural safety as the final outcome of this learning process (NAHO, 2006b). In effect, the continuum shows the concept and practice of cultural safety as based on cultural competence (where the measure of competence lies with knowledge of the health-care professional) with the significant addition of the role and consequent power of the Aboriginal patient in the determination of the relationship.

The following depiction of the cultural safety continuum shows it in circular form, with each spinning out and away from the destructive policy origins.

Cultural Safety Continuum (Brascoupé, 2008)
Arriving at an understanding of the concept of cultural

safety is a journey of self-awareness on this continuum. According to Irihapeti Ramsden, the Maori nurse and educator who developed the concept in her doctoral thesis in 2002, cultural safety is the ultimate goal in a learning process, starting with cultural awareness of a patient's ethnicity and, in culturally safe practice, growing concerns with "social justice ... and nurses' power, prejudice and attitude" (Ramsden, 2002, p. 5). In other words, Ramsden turns the focus of cultural safety away from the cultural understanding and knowledge of the health care worker and onto the power inherent in their professional position. She seeks to redefine cultural safety from a transformative point of view of the Aboriginal person receiving care; the determination of success is by the recipient, who defines the care received as culturally safe, or not.

Ramsden effectively combines the practical and the theoretical conceptions of cultural safety by depicting it both as an extension of cultural competence – where the knowledge and learning of the non-Aboriginal practitioner continues to play a crucial part in the relationship with the Aboriginal patient – and as a radical and explicit departure from it. This dual approach, stressing both knowledge (through cultural competence) and power (through cultural safety), is very attractive, as it depicts the transformation of the relationship through a combination of both conceptual and a practical change.

In the University of Victoria course on cultural safety, the issue of power as central to the concept of cultural safety is reinforced:

> … the recognition that we are all bearers of culture and we need to be aware of and challenge unequal power relations at the individual, family, community, and societal level. There are important differences between cultural safety and the following concepts which are closely aligned with cross-cultural models (University of Victoria, retrieved Nov. 2008, p. 1).

Cultural safety as depicted on the culture continuum is evidently the most advanced concept in terms of practical relevance to the design and delivery of government and institutional policy. The term implies the reversal of cultural danger or peril, where individuals and communities may be at risk or in crisis. The concept entails not just the agreement and understanding that cultural differences matter in social and health policy delivery, but also the need to make a real difference in methods of delivery and the ultimate effectiveness of the policies. In other words, through cultural safety, the power of cultural symbols, practices and beliefs extends political power to the Aboriginal people. Cultural safety is not just a process of improving program delivery; it is also part of the outcome.

Scholar Jessica Ball (2007a) supports this view of cultural safety as an outcome, but views cultural safety as a departure from cultural competence, rather than an extension of it. In essence, she sees a link between cultural sensitivity and cultural competence, but not between these concepts and cultural safety. She stresses that, while the responsibility for cultural competence lies with the service provider, cultural safety turns this on its head, transferring the responsibility (and the power) of determining how successful the experience was to the service recipient. Thus, Ball effectively appears to reject the view of cultural safety on a continuum, regarding it more as a paradigm shift in the relationship.

> Unlike the linked concepts of *cultural sensitivity* or *cultural competence*, which may contribute to a service recipient's experiences, *cultural safety is an outcome*. [Emphasis the author's] Regardless of how culturally sensitive, attuned or informed we think we have been as a service provider, the concept of cultural safety asks: How safe did the service recipient experience a service encounter in terms of being respected and assisted in having their cultural location, values, and preferences taken into account in the service encounter? (Ball, 2007a, p. 1).

Ball goes on to describe five principles necessary for cultural safety:

- **Protocols** – respect for cultural forms of engagement.
- **Personal knowledge** – understanding one's own cultural identity and sharing information about oneself to create a sense of equity and trust.
- **Process** – engaging in mutual learning, checking on cultural safety of the service recipient.
- **Positive purpose** – ensuring the process yields the right outcome for the service recipient according to that recipient's values, preferences and lifestyle.
- **Partnerships** – promoting collaborative practice. (Adapted from Ball, 2007b, p. 1)

Fundamentally, the conceptualization of cultural safety as a step on a continuum or as a paradigm shift rests on the role of power in the relationship. The steps on the linear continuum or the concentric circles effectively depict the responsibilities of the service provider in the relationship. The conceptualization of cultural safety as a paradigm shift

focuses on the role of the recipient, not as a passive receiver of services, but a powerful player in a relationship. In essence, the differences between the two conceptualizations of cultural safety turn on the notion of power in the relationship and the balance of the two roles within it.

In the writings of Ramsden (1999, 2002), Cooney (1994), and Wepa (2004), the authors consider the issue of power in cultural safety, as a transfer of power from the service provider to health care recipients. They explicitly recognize the power imbalance between non-Aboriginal nurses trained in western medicine over Aboriginal patients and locate it within the broader dominant power structures in society (Ramsden, 2002, p. 110). However, the argument does not extend to what specific challenges such a power transfer might bring, and why medical practitioners might actually avoid the term cultural safety because of the political implications (for example, Durie, 2001). Fear of the power implications of cultural safety could result in the concept being reduced or diluted to become "just an educational tool, powerless in terms of cultural change" (Jackson, quoted in Ramsden, 2004, p. 176), in effect, a synonym for cultural competence.

In their article on culturally safe nursing practice and Aboriginal peoples, Stout and Downey (2006) argue that the political challenges are real and encompass a wide set of issues that fall under an umbrella of 'health'. They state that a genuinely culturally safe health process involves questions about the underlying research supporting the health processes, the information gathered and held on the health and social conditions of Aboriginal individuals, and the redefinition of some conditions as diseases, including historical trauma. The context of the interaction between the non-Aboriginal nurse and the Aboriginal patient is built upon structural, institutionalized inequality. To counter this inequality and to 'indigenize' the knowledge base, Stout and Downey cite the introduction of the principles of *ownership, control, access and possession (*OCAP) into the Canadian debate. The OCAP principles are built upon Aboriginal claims for genuine self-determination. They include:

- **Ownership**: a community or group owns information collectively in the same way that an individual owns his or her personal information.
- **Control:** affirms that Aboriginal communities are within their rights in seeking control over all aspects of the research process.
- **Access:** Aboriginal peoples must have access to information/data about themselves and their communities, regardless of where it is currently held. The right for Aboriginal communities to manage and make decisions regarding access to their information and resources.
- **Possession:** Actual physical control of data (ownership identifies the relationship between people and their information). A mechanism by which ownership can be asserted and protected. This is the most legally significant of all the OCAP principles. (Schnarch, 2004, quoted in Stout and Downey, 2006, p. 330)

In other words, the power transfer is real and could threaten existing power structures within organizations and society, including the policies and practices in question. Therefore, it becomes clear that essential factors in the definition of cultural safety are the *visibility* of cultural differences and the *power* that may flow from that visibility, leading to the demand for equality, respect and control by Aboriginal people.

In a tribute to the originator of the concept of cultural safety, Irihapeti Merenia Ramsden, Lis Ellison-Loschmann underlines the fact that cultural safety was a 'big picture' concept, encompassing broad political issues which could seem threatening to wider society:

> [Ramsden] was an expert at seeing the 'big picture'. She linked cultural safety with wider aspirations and contexts common to indigenous people, including notions of citizenship and sovereignty issues. Her later work developed these ideas further in recognizing and drawing on the commonality between the experience of colonization amongst indigenous peoples and the resultant cultural poverty and very real economic poverty which she was witnessing both here [New Zealand] and overseas.
>
> A few of her other contemporaries also recognized the potential legacy of cultural safety early on. Irihapeti's long time friend, lawyer and expert in the area of legal work on Maori rights, Moana Jackson, said in his interview with her: "Its [cultural safety] broadest strength, I think … is that it is a political idea and in the end remedying the ills of our people is a political and a constitutional issue, not in terms of … Parliament, but in terms of changing the mindset of our people about our power and our powerlessness …" (Ellison-Loschmann, 2003, p. 1).

In this way, the concept of cultural safety becomes a challenge to the power establishment in wider society, defined

National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)
ᑲᓇᑕᒥ ᓄᓇᖃᖅᑳᖅᓯᒪᔪᓄᑦ ᐋᓐᓂᐊᖅᓯᐅᕐᓂᓕᕆᓂᕐᒧᑦ ᑲᑐᔾᔨᖃᑎᒌᑦ

not just as a measure of the effectiveness of policy and delivery, but as a very real part of a political power struggle for control over one's own life. Cultural safety becomes a means of changing broad attitudes and deep-seated conceptions, on an individual and community-wide basis.

However, the danger of broadening the definition of cultural safety too widely is that it loses its significance and practical relevance in specific policy areas. Politicizing the relationship between service providers and service recipients is of considerable theoretical interest, particularly in the 'big picture', but may be of limited practical value to either. The problem is two-fold: first, the power relationship is inherently unbalanced, where the qualified healthcare professional retains the power of their professional knowledge and practical capabilities of their position in relation to the relatively less powerful position of the patient; and second, a paradigm shift with a transfer of power may be of less practical value to a patient than a culturally knowledgeable, respectful and sensitive service provider. Literature sources based on practice (including handbooks, field experiments in healthcare delivery and first-hand reports on service delivery) return to the view of cultural safety as a further step on a continuum of cultural understanding, not because of any perception of the political threat of a paradigm shift, but because of tangible practical outcomes. Locating cultural safety on the cultural continuum makes it more achievable, effectively defining it as a better form of cultural competence, building a stronger and more trusting mutual relationship between receiver and provider.

To understand this, we will examine some key policy areas, namely, health, education, and self-determination. First, however, we will briefly touch on the issue of the pre-eminent *visibility* of Aboriginal cultural in any consideration of cultural safety.

2. Multiculturalism and cultural blindness

This section of the paper briefly examines the issue of the *visibility* of Aboriginal cultures. The Assembly of First Nations argues that, to preserve a culture (and in particular a language), it is necessary to make the culture highly visible to Aboriginal and non-Aboriginal people alike (AFN, 2007, p. 10; AFN, 2008, p. 2).

Canada's "diversity model" (Smith, 2003, p. 109) is built on a historical legacy of immigration, largely one based on European cultures, which we recognize today as a defining characteristic of Canadians' self-image and political culture. One of the enduring nation-building myths of Canada's inception as a nation is its founding value of tolerance and accommodation of different cultures, religions and languages. However, the experience of many immigrants to Canada belied this myth of Canadian nationhood and exposed the highly British-oriented bias of government policy and attitudes of the times. In addition, the paternalistic legislative and policy stance of government towards Aboriginal people deprived them of basic human rights as well as what later became known as inherent rights of the First peoples in the land. The assimilationist policies, notably the residential schools policy, not only irreparably damaged the cultural identity of First Nations children in the schools, but also left a legacy of individuals, families and communities in crisis.

In the 1960s, Canada redefined itself explicitly as a multicultural nation, reflecting the civil rights movements in the USA and the image of Canada promoted by the leadership of then Prime Minister Pierre Trudeau. This diversity model, which continues to this day, hinges on two seemingly contradictory principles that form the foundations of public policy regarding ethnicity:

- **Universalism** – implying a blindness to difference, this focuses on individual rights and freedoms.
- **Multiculturalism** – implying a positive recognition of difference, this focuses on a celebration of the many cultures and ethnic origins of many Canadians. (Stasiulis & Abu-Laban, 2004, p. 371)

Canada's relationship with the Aboriginal population demonstrated some of this ambivalence with separate cultural and ethnic identities. In 1969, following consultation between the government of Canada and Aboriginal leaders in which issues of Aboriginals and treaty rights and the right to self-government were prominently discussed, the Trudeau government introduced a 'white paper' which advocated the elimination of separate legal status for First Nations in Canada. The white paper amounted to an all-inclusive assimilation program which, if implemented, would have repealed the Indian Act, transferred responsibility for Indian Affairs to the provinces, and terminated the rights of First Nations people under the treaties made with the Crown.

For Prime Minister Trudeau, the white paper promoted the view of First Nations as Canadians like all others, served by the same departments, programs and services available to other Canadians. In other words, government would be *blind* to cultural differences and Aboriginal traditions, knowledge and languages. In this context, cultural blindness was seen as a virtue, eliminating racism and discriminatory

treatment and attitudes, and effectively treating First Nations as if they were just another ethnic group that made up the multicultural profile of the Canadian population.

This view of Aboriginal society within Canada was vehemently rejected by Aboriginal people. Led by, amongst others, Harold Cardinal (1969), a leading First Nations activist in his powerful book *The Unjust Society*, the response to the White Paper acted as a call-to-arms for First Nations people in Canada. The result was a complete policy reversal by the federal government and the establishment of joint meetings between Aboriginal people and the government to determine policies based on explicit recognition of the distinctive interests of Canada's Aboriginal peoples.

Ultimately, both the concepts of multiculturalism and cultural blindness were entirely inadequate in responding to the demands for recognition by Aboriginal people in Canada. In her book on cultural safety in New Zealand, Wepa draws attention to the distinctions between biculturalism and multiculturalism. Equating indigenous colonized histories with those of other immigrant groups is dangerous and invalid, she states, and risks further marginalizing Indigenous people (Kirkham, 2006, p. 334). Ramsden expresses the same argument that Indigenous people must be seen not as one cultural or ethnic group amongst many, but an equal founding nation and therefore with a rightful claim to a pre-eminent status (Ramsden, 2004, p. 175).

Furthermore, multiculturalism pays scant attention to the historical path that has led to communities facing social, psychological and economic crisis as a result of colonization and discrimination, and to the government's own responsibility. By generalizing Aboriginal culture into the wider cultural mix of the modern Canadian state, it diminishes it and marginalizes the specific self-deterministic claims of Aboriginal people.

The concept of cultural safety can be seen as the direct antithesis of the concepts of both multiculturalism and universalism. Multiculturalism considers all cultures in Canada as having an equal claim on government and societal attention, and universalism downplays differences between individuals and communities into a single citizenry and seeks common interests based on general human rights. In contrast, cultural safety requires the explicit and detailed recognition of the cultural identity of the Indigenous people and the historical legacy of power relations and repression.

The issues of race relations and racism in Canada challenge the dominant myths of national identity of a tolerant, welcoming place where everyone enjoys the same opportunities and treatment at the hands of the state. Scholars in both Canada and the United States have explored such national myths and how they create deeply held assumptions in both White and non-White people which perpetuate patterns of advantage and disadvantage. American scholar Peggy McIntosh turns the race debate on its head by exploring what she calls 'privilege systems,' the "unearned overadvantage [of White people] as a function of unearned disadvantage [of non-White people]" (McIntosh, 1988, p.1). Instead of focusing on non-White people in a White-dominated society, McIntosh focuses on the privileges enjoyed, even unconsciously, by White people, describing White privilege as "an invisible weightless backpack of unearned assets" (ibid, p.1).

Interestingly, this approach turns the notion of racial visibility and invisibility on its head. McIntosh explains that she was "taught to see racism only as individual acts of meanness, not in invisible systems conferring dominance on my group" (ibid, p. 1). Multiculturalism can be seen, not as a 'celebration of diversity', but a means of making culture and race invisible, by blurring and ultimately ignoring important differences between people into a meaningless notion of diversity. Verma St. Denis, a Canadian scholar examining race and education, particularly as it pertains to Aboriginal students, argues that the danger of the 'multi-culturalism myth' is that it creates an ideology of 'racelessness', making race invisible when it should be acknowledged and understood, and reinforcing Whiteness as the standard of what is normal. With colleague, Carol Schick, St. Denis examines racial attitudes in education in the Canadian prairie provinces, observing that the invisibility of White privilege which is accepted sub-consciously as the norm has the effect of marginalizing Aboriginal people and other racial minorities, and causing the 'inferiorization' of Aboriginal people for their apparent failure to meet White measures of success and achievement (Schick & St. Denis, 2005; St. Denis, 2007).

York University scholar Susan Dion takes the same view of race relations in education as St. Denis, underlining the need for carefully designed curricula to trace the history of the 'colonial encounter' between Aboriginal and non-aboriginal people and understand 20th century issues in the light of this history. Dion, like both St. Denis and McIntosh, stresses that the 'transformation' of inter-racial relationships places an obligation on White people to confront and understand their own racial identity and the way their dominant White culture shapes all of society and the norms by which people live (Dion, 2007).

Dion, St. Denis and McIntosh all relate their studies of interracial relations primarily to the field of education and curriculum-design. The relationship between teacher and student carries similar professional power imbalance

as that between a healthcare professional and patient. Although none refer explicitly to the concept of cultural safety, their work explicitly recognizes the power relations and dichotomy of privilege and disadvantage inherent in race relations. Most interestingly, in contrast to the cultural competence model of transcultural relationships, these scholars all point to the need for White people, and White professionals in particular, to understand themselves and their own race and culture, rather than learning about their clients' races and cultures. This element of self-knowledge is integral to cultural safety and any possible redefinition of power relations.

3. Transculturalism and cultural safety

Clear recognition of cultural differences between non-Aboriginal and Aboriginal peoples is not sufficient to address the issue of the levels of recognition, understanding and knowledge, and the political implications that follow. In much of the literature (particularly that focus on nursing), different terms are used, apparently interchangeably, to refer to cultural considerations, ranging from sensitivity, competence, transcultural nursing and more recently to cultural safety. In some writing, the definition of cultural safety risks being flattened into a general concept of cultural understanding. Yet, as we have already seen, the concept of power and the recognition of the complexities of race relations in society are inseparable from cultural safety and distinguish it from other forms of cultural understanding. Ramsden dedicates a full chapter of her doctoral thesis to a discussion of the differences between transcultural nursing and culturally safe nursing (Ramsden, 2002, pp. 109-121).

Transcultural nursing, expounded in the writing of Leininger (1991, 1998) is, according to Ramsden, based on the traditional western approach to health care, represented by the non-Aboriginal nurse. Transcultural nursing focuses on the knowledge and understanding of Aboriginal culture of the Canadian nurse; it therefore uses as its starting point the norms of the nurse and, in this sense, represents an approach based on cultural competence, rather than cultural safety. Transcultural nursing appears to fit the model of race relations criticized by St. Denis and McIntosh, where the White professional establishes the context in which the service encounter will take place. In transcultural nursing, the power to define the norm and the onus for action to understand and know about another culture fall to the nurse (Ramsden, 2002, pp. 112-114). Ramsden views transcultural nursing as part of the multicultural approach to ethnic and cultural diversity; she states that most nurses in New Zealand practice culturally competent nursing naturally, seeing the Maori culture as equivalent to other cultures in a multicultural modern nation state (Ramsden, 2002, p. 116). However, as McIntosh argues, learning about one culture in isolation without examining one's own, cannot advance transcultural relations (McIntosh, 1998). In McIntosh's analysis, transcultural nursing renders White culture invisible, an apparently neutral norm which depicts the nursing encounter as a one-way transaction and not a relationship of equals.

Interestingly, the emphasis in transcultural nursing is on learning, knowledge and understanding in order to allow predictions of the health of individuals, groups and cultures (Leininger, 1991). This practice of training nurses in indigenous cultures became known as ethno nursing and is based on the notion that ethnicity is a central driver of culture. However, the norms, and the power to define the norms, remain those of the nurse, not the patient. The power relationship therefore remains one of dominance by non-Aboriginal service providers over Aboriginal patients. The ultimate success of the relationship is based on and measured by the cultural competence of the non-Aboriginal nurse.

Ramsden redefines the equation between nurse and patient to realign the power structure. She stresses that it is the nurse who is alien to the Aboriginal patient and the norms and the power to define the norms should be in the hands of the person served (Ramsden, 2002, p. 114). In addition, Ramsden rejects the specific emphasis on ethnicity, focusing rather on "human diversity" (Ramsden, 2002, p. 119), which could include wider elements of culture, including gender, income, education, personal and community history, and life chances.

Cultural safety also views the interaction between a non-Aboriginal nurse and an Aboriginal patient as a 'negotiated and equal partnership' (explored in Cooney, 1994; Coup, 1996), in which trust plays a central part in sharing information and in rebuilding the relationship on a different way. The nurse's skill lies in enabling people to say how service can be adapted and to negotiate an agreed approach (Ramsden, 1997).

Crucially, the outcome of the culturally safe practice is a two-way relationship built on respect and a bicultural exchange which aims for equality and shared responsibility. In her research on Inuit indigenous knowledge, Ellen Bielawski underlines that the Inuit people interviewed as part of anthropological studies objected to being questioned and interviewed, not because they wanted to withhold information, but because they wanted an *exchange* of stories and information, where they could learn about the

other people's lives in the same way their own were being examined (Bielawski, 1991, p. 1). In other words, the Inuit people sought equality and mutual respect.

The Assembly of First Nations (AFN) echoes this depiction of cultural safety as a bi-cultural exchange in both directions. The AFN contributes to the distinction of cultural safety by asserting the equality of the provider of the service and the recipient:

> The concept has evolved to define cultural competence to be inclusive of the skills, knowledge and attitudes of practitioners. But this doesn't acknowledge the experience of the patient, so we choose to consider a broader interpretation of cultural safety, in which the interaction between, and experiences of both the patient and the practitioner are respected, and First Nations cultures are visible and have similar power as mainstream culture (AFN, 2008, p. 2).

Furthermore, the AFN underlines the fact that cultural safety can only be defined and determined to be a success by the service recipient of the service, underlining again the issues of power and control:

> The person who receives the services defines whether it was culturally safe. This shifts the power from the provider to the person in need of the service. This is an intentional method to also understand the power imbalance that is inherent in health service delivery (AFN, 2008, p. 2).

From its inception, transcultural nursing was premised on the notion of multiculturalism. The multicultural composition of the United States and Canada make cultural training a central part of nursing:

> Given the multicultural composition of the United States and the projected increase in the number of culturally diverse individuals and groups in the future, it is apparent that there is an increasing need for nurses to focus on the cultural beliefs and practices of clients (Andrews as cited in Cooney, 1994, p. 9).

Transcultural nursing is consistent with the national models of multiculturalism and diversity, the mix of racial, ethnic, cultural, and language groups within the modern North American nation state.

In contrast, writers on cultural safety reject the models of multiculturalism and diversity. As we have seen in the writings of St. Denis and McIntosh, these terms are part of the Canadian sense of national identity, but in fact can be seen as reinforcing White cultural dominance and diluting all other cultures into a raceless 'otherness'. Cultural safety operates explicitly on a bicultural model, in which there are two parts to the dynamic relationship (Kearns, quoted in Ramsden, 2002, p. 110). All the literature on cultural safety reviewed looked specifically at Indigenous people, which underlines that biculturalism in this context applies not to any two cultures that may be at play in a social or professional interaction, but to the biculturalism of the dominant culture and the indigenous culture.

The significance of this debate between transcultural approaches to nursing and culturally safe nursing practice lies in the danger of redefining cultural safety away from structural and multifaceted social and political inequality to a more culturally descriptive approach. The writings of many politically-conscious commentators (Ramsden, 2002; Stout & Downey, 2006; Cooney, 1994) return to the political underpinnings of cultural safety to ensure that the term does not drift into the analytical framework of transcultural and ethno-nursing. In their definition, cultural safety is not built on knowledge and understanding of the indigenous culture, nor even on sensitivity to it. They insist on the political implications of self-determination and equality that form the foundations of cultural safety.

> Cultural sensitivity and Transcultural Nursing are both concerned with having knowledge about ethnic diversity. This seems to be the basis of misinterpretation of the concept of Cultural Safety. The term 'culture' is read as 'ethnicity'. But the skill for nurses does not lie in knowing the customs or even the health related beliefs of ethno-specific groups. The step before that lies in the professional acquisition of trust (Ramsden, 2002, p. 118).

Cultural safety has been described as superior to transcultural nursing because it does not require or expect nurses to become knowledgeable about other cultures but rather to understand and respect that other cultures have different ways of seeing things and doing things. The power is not on the nurse to decide what the individual should or must do (Coup, 1996, quoted in Ramsden, 2002, p. 118).

The emphasis on training in cultural safety is focused specifically on the history of Indigenous people who have suffered from colonization, with lasting effects on their well-being. Therefore, cultural safety pedagogy would focus on history, and the political, social and economic conditions, and environment of Indigenous people. Scholar Susan Dion describes this learning process as 'remembrance' and stresses that both Aboriginal and non-Aboriginal people in Canada

have been shaped by the colonial experience (Dion, 2007).

Ultimately, the deficiency of cultural competence is that it is, as both a concept and as a practice, too one-sided and focuses on the knowledge and training of the service provider. This focus reinforces inherent power positions and reduces the role of Aboriginal patients to one of passive receivers of culturally competent behaviours. This is not to say that cultural competence does not play a crucial part in a successful interaction, but it cannot on its own create an equal relationship.

The transformation of the relationship cannot be effected through more culture training and greater knowledge by the service provider. The literature reinforces that a shift in the power positions needs to take place to build a strong relationship based on genuine respect, inclusive decision-making and joint effort. Such a culturally safe approach depends on the capacity, confidence and knowledge of both parties. Rather than viewing cultural safety as a mere shift of power, it can be viewed as mutual empowerment, where Aboriginal communities and individuals at risk or in crisis take an equal part in the solutions. The most constructive outcome of culturally safe Aboriginal and non-Aboriginal engagements are healthy and productive communities and individuals. Both parties require the capacity to play their part in successful engagements; this capacity depends on the knowledge, understanding and confidence of both, as well as their self-knowledge and cultural self-awareness.

This could be threatening to both Aboriginal and non-Aboriginal parties and carries risk for both. Power brings both opportunity and cost, and the added power accorded by a culturally safe approach to policy-delivery imposes responsibilities on Aboriginal institutions, governance structures and individuals. As stated at the outset of this paper, cultural safety can be taught and learned. Both parties in the cross-cultural engagements require the building blocks to manage and deploy the power of their position. These building blocks enable the parties to 'navigate' the engagement, allowing both parties to build the capacity not only to engage in an equal relationship, but to meet their goals. Where Ramsden and Ball saw cultural safety as an outcome in itself, the navigator models (see Goodman, 2006) use the process of culturally safe cross-cultural engagement as a means of achieving the real goals – the health and well-being of individuals and communities.

Ultimately, the goal of both the Aboriginal and non-Aboriginal members of the relationship is to work together to effect change for individuals and communities at risk or in crisis. At the individual, institutional and government levels, the parties need to view cultural safety as neither an extension to cultural competence on the cultural continuum, nor as a paradigm shift, but as a navigation model to transform cross-cultural relationships.

4. Social determinants of health

The context into which cultural safety must be applied is complex and varied, and the profound issues that accompany health concerns place additional pressure on government and social services to improve health outcomes for Aboriginal people. The environment in which people live has a profound effect on their health difficulties. These are known as the social determinants of health (SDOH), including poverty, unemployment, poor education, bad nutrition, poor housing, and unclean water. There is a huge and rich body of literature in this field, some of which has been collected and coordinated by the Commission on Social Determinants of Health, set up by the World Health Organization (WHO) in 2005 to promote health equity through a global movement. In its Final Report "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," the Commission stated that:

> Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. Within countries there are dramatic differences in health that are closely linked with degrees of social disadvantage. Differences of this magnitude, within and between countries, simply should never happen (WHO, 2008).

In the context of SDOH, we can determine that there are three vantage points that must be considered as part of cultural safety: the past, the present and the future. For cultural safety to be achieved, all three viewpoints must form part of the understanding in bicultural exchanges. The past refers to the *history* of colonization and past injustices (again reflecting Dion's reference to the need for 'remembrance'). The present refers to the current *lifestyle* and living conditions that determine health. And the future refers to the *aspirations and life chances* of the people, as the people look to their future and for improvements in health, education and opportunity. In the study of Aboriginal women's experiences with health care provision in British Columbia, Browne, Fiske and Thomas (2000) interviewed many First Nations women. One of the interviewees talked about the non-Aboriginal doctor's attitude to her return to school:

> He was proud, he was happy, I was going to school, I

> was doing well. I talked about my goals and things like this to him and he, he encouraged me. He encouraged me and he said that there's nothing holding me back and I can be better than he is. And that's what I liked (quoted in Browne, Fiske & Thomas, 2000, p. 24).

Even a brief consideration of SDOH points to the potentially wide application of the concept of cultural safety to many areas of Aboriginal policy which influence health outcomes. The focus of the literature that explicitly explores cultural safety is limited to a narrow area of healthcare delivery, specifically nursing. But to limit the discussion to nursing and health care delivery ignores the many issues, such as education, economic opportunity, and lifestyle issues (such as nutrition, smoking, and alcohol and drug consumption) that are integral to the area of health care delivery.

Although the academic and professional literature concentrates almost exclusively on a narrow range of health care delivery, it is clear that cultural safety must extend beyond health if its full implications are to be realized. If, as we have explored, cultural safety is concerned with relationships, trust, and respect in order to improve social outcomes, its relevance to a multitude of policy areas and social services is self-evident.

The issues raised under the banner of SDOH are of critical concern to communities at risk or in crisis. Projects to deal with health or other social problems in isolation of the context and environment in which many Aboriginal people live are unlikely to achieve lasting change. Aboriginal healing is concerned with holistic well-being, which supports programs that address specific problems, such as drug and alcohol addiction. Healing is an approach to SDOH that looks at the wider context, including the legacy of historical trauma, to find lasting solutions. Since many healing projects involve cross-cultural service encounters, cultural safety must be part of the healing process. Ultimately, it can be seen from practical experience that, to achieve optimal outcomes, cultural safety and cultural competence are both simultaneously necessary to the relationship: awareness and knowledge of Aboriginal culture and history, cultural self-knowledge by service provider, and a mutual and respectful relationship that focuses not only on specific service delivery but also on the aspirations and broader well-being of the client. Cultural competence and cultural safety are not mutually exclusive and may be the optimal combination to affect social improvement.

Through community healing, Aboriginal communities are able to effect preventative and remedial programming, drawing on the strengths of Aboriginal knowledge, culture and traditions (such as inter-generational support and learning) within the community. From outside the community, Aboriginal people are empowered to demand culturally safe *and* culturally competent engagements with professional service providers to support and enhance community healing initiatives.

In order to explore the full meaning of cultural safety and its possible application to different areas of social policy, we now analyze a number of specific policy areas which make up the context and environment for Aboriginal health and wellness.

APPLICATION TO POLICY AREAS

Although the literature on cultural safety does represent an academic analysis, the ultimate aim of the concept is intensely practical. Many of the studies on health care delivery for Indigenous people in Canada, United States, New Zealand, Australia, and other countries are interested in cultural issues only as a means of improving program effectiveness and health outcomes. In this section, we examine some areas of public policy where the literature on cultural safety examines the relevance of the concept to produce these practical outcomes: health and the social determinants of health; education; and self-determination. In addition, in a subsequent section, the relevance of cultural safety is considered in the context of the criminal justice system.

Until now, much of the discussion on cultural safety has focused on individual health care professionals; in other words, we consider the power relations between two individuals – the nurse and the patient – when we consider cultural implications. However, key to this section is the recognition that it is *institutions* – government departments, hospitals, clinics, schools, etc. – that must demonstrate cultural safety and cultural competence in order to effect cultural change in the design and delivery of policy. This implies that the culturally safe behaviour and knowledge and the power transfer must be institutionalized. The impact of a single good doctor or nurse who builds respect, equality and trust into the relationship is not enough if the underlying policies and structures are culturally unsafe. The National Center for Cultural Competence (NCCC) defines culturally competent organizations as demonstrating:

- Set of values, principles & structures to work cross-culturally.
- Work in the cultural contexts of communities they serve.
- Work part of policy-making, administration, practice and service delivery.

- Systematically involve clients, families and communities.
- Cultural competence is a long-term developmental process.
- Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (NCCC, retrieved Nov. 2008)

In the following areas of public policy, the issues of institutional cultural competence and structural power play pivotal roles in determining social policy outcomes.

1. Health

To understand health as a policy area, it is necessary to consider the wider definition employed by the World Health Organization (WHO) and further supported by the WHO's Commission on Social Determinants of Health (SDOH). WHO reports that the most common definition of health for the last fifty years is "a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity" (Ustun & Jakob, 2005, quoted in Stout, 2008, p. 3). In this definition, the term 'social well-being' potentially includes a vast number of issues as social determinants of health, including a healthy cultural identity based on family and community life. As we have stated, a history of colonization, paternalistic policy-making, and residential schools actively destroyed or undermined the cultural identity of Aboriginal people in Canada.

Throughout the literature on cultural safety, the concern focuses on the failure of health policies and institutions to produce positive outcomes for Aboriginal people. As individuals and as communities, many Aboriginal people in Canada suffer from health and safety risks that appear as catastrophic failures within a wealthy, modern society.

Health issues are inherently part of the wider social and cultural context of Aboriginal life. The National Aboriginal Health Organization (NAHO) lists the broader determinants of health as:

- **Access** – hospitals, clinics, technology, healthcare practitioners being available within the community.
- **Colonization** – the legacy of poor health choices, and social dependency.
- **Cultural continuity** – the cultural foundation of traditional knowledge and cultural practices in the community to sustain healthy lifestyles.
- **Globalization.**
- **Migration** – relocation of communities to make way for logging, mining or hydro-electric damming.
- **Poverty** – unemployment and poor quality of life.
- **Self-determination** – Aboriginal people taking control over their own decisions as individuals and communities.
- **Territory** – the loss of traditional territory and occupations on the land, including the capacity to sustain a community through agriculture, fishing and hunting. (NAHO, 2007, p.11)

The National Conference on Social Determinants of Health brought together public health scholars and practitioners, and lists the following as the SDOH:

- Aboriginal status.
- Early life.
- Education.
- Employment and working conditions.
- Food security.
- Gender.
- Health care services.
- Housing.
- Income and its distribution.
- Social safety net.
- Social exclusion.
- Unemployment and employment security. (National Conference SDOH, 2002)

These again reflect the wider context of social, cultural and economic factors that influence health care provision and outcomes for Aboriginal people.

Constitutionally, health policies fall under provincial jurisdiction and the federal government has not, for the most part, accepted legal or fiduciary responsibility for the health care of Aboriginal people. However, in practice, Health Canada delivers major programs in Aboriginal health, focusing on community health, environmental health, non-insured health benefits, alcohol and drug rehabilitation, hospital services and capital construction.

Figures reported by Statistics Canada in 2002 show that some aspects of First Nations health are improving, such as longer life expectancies and reduced mortality rates (quoted in Government of Canada, 2004, pp. 228-220). At the same time, there are many other areas of concern, such as:

- Life expectancy remains lower than that of the Canadian population.
- Combined, circulatory diseases and injury account for nearly half of all mortality among First Nations people.

- Suicide and self-injury were the leading causes of death for youth and young adults, higher than the comparable Canadian population.

- Motor vehicle collisions were a leading cause of death for all Aboriginal age groups.
- First Nations have a rate of tuberculosis six times higher than the Canadian population.
- Rates of diabetes are increasing.
- The smoking rate has increased, well over the Canadian population. (Health Canada, 2000, 2008)

These health problems are symptomatic of underlying social, economic and political conditions that determine the health and life expectancy of Aboriginal people. Many Canadian studies have focused on income as a determinant of health, and a more recent trend in Canada, the United Kingdom and other European countries has been to view health outcomes as a result of people experiencing systematic material, social, cultural, and political exclusion from mainstream society. The inequalities of health have their roots in other societal inequalities reinforcing the political implications of health as a public policy issue.

A Health Canada report detailing plans for 2007-2008 (Health Canada, 2007) demonstrates the wide variety of initiatives and continuing programs designed to address the government's major issues of concern and the resources dedicated to addressing them. However, despite significant improvements in health in general (including First Nations, Inuit, Métis, and urban Aboriginal groups), significant health inequalities in Canada persist, most notably among Aboriginal peoples (Raphael, 2004a, p. 8). Medicare means that lack of access to medical care cannot account for the inequalities. Similarly, the evidence over many decades shows that differences in health behaviours (such as tobacco and alcohol consumption, physical activity and diet) do not explain the disparities. Raphael and others determine that the inequalities in health can be explained in the different environments and conditions of life experienced by different groups in Canada. Income is a SDOH in itself, but it also gives an indication of other factors, including early life experiences, education, food security, employment, and working conditions.

The cost to be paid for culturally unsafe practices in terms of good health outcomes and social inclusiveness demonstrate that the status quo is not a satisfactory option. As Raphael notes, medical services that evoke these responses below are clearly of no use to individuals or the community. They include:

- Low utilization of available services.
- Denial of suggestions that there is a problem.
- Non-compliance with referrals or prescribed interventions.
- Reticence in interactions with practitioners.
- Anger.
- Low self-worth.
- Complaints about lack of 'cultural appropriateness' of tools and interventions. (Raphael, 2004a)

Part of the difficulty of making lasting significant changes to the environment in which Aboriginal people live and the consequences they suffer lies in the approach taken by government to the governance of Aboriginal people. The paternalistic neo-colonial approach to Aboriginal affairs, both in legislation and public administration, is summed up in the continuing attitudes promoted in the Indian Act. The Act appears to violate the tenets of cultural safety, in that it perpetuates the institutionalization of outdated power structures, paternalistic policy-making and imposed western norms for Aboriginal self-determination.

Health policy regarding Aboriginal people which reflects the prescription of cultural safety could provide the policies to improve health outcomes, the institutional structures for on-going partnership and shared responsibility, and the symbolism of enlightened governance. In 2002, the Royal Commission on the future of health care in Canada published its report and dedicated a chapter to address specifically the health issues of Aboriginal people. The Report gathered considerable evidence of the gap between Aboriginal health indicators and Canadian society in general, including such issues as diabetes, HIV infection, cardiac problems, and high rates of disability, especially mental disability (Government of Canada, 2004, p. 219). The submissions of many Aboriginal people and organizations made clear that the route to improved health outcomes lay in greater involvement and control of health care policy and services of Aboriginal people and in broader inclusion of and respect for traditional approaches to healing. The Commission reflected this in its call for more partnership programs and ventures between government, institutions and Aboriginal communities (Government of Canada, 2004, pp. 219-220).

As noted by Stout and Downey (2006), changes in the institutions of governance and policy-making carry significant political implications. Political and institutional recognition that colonization, historical trauma, dislocation and loss of territory carry lasting health effects, carry

political weight and financial cost. Prime Minister Stephen Harper's apology to Aboriginal people for the residential schools program was the public culmination of many years of political and social struggle by Aboriginal people for recognition of past injustices. The most positive outcome of such recognition is the acceptance of partnership as a means of sharing power, responsibility and outcomes.

The partnership model is very complex within the context of the number of First Nations, with different governance models (for example, self-government agreements, Government of Nunavut and Land Claim Agreements), and within a federal national structure (jurisdictions of the federal government for Aboriginal affairs, and of the provincial government for health and social policy). In addition, a partnership approach can exist not just at the government or institutional level, but importantly also at the individual level. As Browne, Fiske and Thomas (2001) uncover in their study of health care for First Nations women in BC, individual doctors and nurses can achieve excellent relations with Aboriginal patients through practising an individual form of partnership, through sharing, trust and respect.

However, for communities at risk and in crisis, individual initiatives are not enough. Institutional partnership necessarily implies greater power in the hands of Aboriginal institutions, with complex negotiated power-sharing arrangements with different levels of government and institutions. Different First Nations have different health care priorities and partnership capacity, requiring potentially different power-sharing arrangements. Furthermore, government has an obligation to ensure accountability and transparency. As the negotiations between First Nations and the federal government on self-government demonstrated, a single model of power-sharing imposed on all the parties is unrealistic and does not account for the many different aspirations of First Nations.

As the Romanow Report underlined, partnership cannot function in an environment of competing jurisdictional claims (NAHO, 2001; First Nations Chiefs Health Committee, 2000, quoted in Government of Canada, 2004, p. 221). Different models for shared responsibility have been proposed, including (1) the status quo, where Health Canada enters into agreements with individual First Nations for delivery of health and social services; (2) health service delivery linked to an expanded First Nations self-government model; and (3) transfer of First Nations health issues to provincial jurisdiction. In its submission to the Romanow inquiry, NAHO called for a multi-jurisdictional approach to health service reform (NAHO, 2001, quoted in Author, 2002, p. 224).

Any bi-jurisdictional or multi-jurisdictional partnership on primary health care must have as its foundation equal involvement of First Nations. The cultural safety model requires that the power-sharing be genuine, be based not just on western institutions and concepts, including jurisdiction, constitutionality, and the court system. In addition, it must be based on genuine respect for traditional approaches to decision-making, holistic healing and community-building.

Historians of the evolution of public health talk about two revolutions in public health improvements: the first was the control of infectious diseases, and the second the battle against non-communicable diseases. Romanow calls these two revolutions 'illness models' and calls upon government and civil society to bring about a third revolution which he refers to as a 'wellness' model. The wellness model moves from a consideration of illness towards illness prevention and a holistic sense of well-being. To bring this about, Raphael talks in terms which invoke the thinking behind cultural safety. The wellness model requires:

- Inspired leaders genuinely committed to share power with those less fortunate.
- A commitment to social inclusion and Civil Society that provides opportunities for all Canadians to participate in the things that count in our neighbourhoods across this great country.
- An understanding that hopelessness kills and hopefulness with opportunity is a prescription for good health. (Romanow, in Raphael, 2004, p. ix)

Most tellingly, Romanow talks about sharing power as a determinant of health and well-being. This recalls the work of Ramsden, Cooney and others on the pivotal role of power in cultural safety. Similarly, the sense of hopefulness and opportunity underpin the notions of aspiration and looking to the future that emerge from the literature on cultural safety. Romanow's vision fits well within the cultural safety model.

2. Education

Health care dominates the literature on cultural safety virtually to the exclusion of all other social issues. However, as we saw in the discussion of the social determinants of health, it is impossible to separate health care from the wider social context. Possibly the single most important social issue for inclusion within the cultural safety model is education, particularly at the secondary and post-secondary levels. There is a vast body of literature on education policy

and Aboriginal people, but very little that explicitly links it with the concept of cultural safety.

Issues surrounding the residential schools program put primary and secondary education squarely in the discussion on cultural safety, as the source of cultural destructiveness and anomie. Like other Aboriginal policies, education has been governed by federal and provincial government policies that were paternalistic, imposed and assimilationist. Within the context of education policy, the term 'anomie' has particular resonance, particularly in light of the history of residential schools. The term, developed by French sociologist, Emile Durkheim in 1893, describes a state in which there is a breakdown of the norms that guide individual and group social behaviour. A norm is a socially enforced rule or custom of behaviour which shapes individuals' expectations of how they should behave and how others will behave towards them. Norms are created and passed on through family and community life, cultural ceremony, rituals, stories, and religions.

Furthermore, Durkheim extended the use of the term anomie as part of functionalist theory. Functionalism focuses on the structure and workings of society, and views society as a series of interdependent parts – family, education, religion, law and order, media – which act as an organic whole. Later he expanded the concept to include psychological anomie, where individuals lose their personal moral regulation, leading potentially to depression and suicide. There is both personal anxiety and a disruption in the rhythm of social life, as economic status and family anomie increase in the face of normlessness and powerlessness (Greene, 2003, p. A-22).

Educational institutions, curricula and styles of learning are part of the structural functionalist model that produces economic prosperity, social stability and individual and community well-being. If individuals are removed from their family and cultural home, the cultural anomie they experience cuts them off from the norms of their society, leaving a legacy of personal and community damage.

As part of the healing process, education at secondary and post-secondary levels in particular plays a crucial part of building strong Aboriginal communities. Stable, resilient communities need capable, confident human resources to become community leaders, skilled workers and good parents. However, despite the great emphasis in Canadian culture on the value of education, modern western education fails many Aboriginal youth. Under the Indian Act, the federal government provides educational services to First Nations students from ages 6 to 18 that are living on reserve. In fact, while most on-reserve elementary schools are federally funded, provincial governments maintain jurisdiction over secondary education.

Despite progress reported in education achievement of Aboriginal students over the past forty years, disparities in educational achievement between Aboriginal and non-Aboriginal youth persist. Scholars Paul Maxim and Jerry White studied students across Canada and found that, compared with non-Aboriginal youths, young Aboriginal people aged 18-20 are much more likely to be without a high school diploma (42.5 per cent versus 23.5 per cent) and much less likely to be in post-secondary education (35.5 per cent versus 53.9 per cent). The lower rate of high school completion also widens the gap between Aboriginal and non-Aboriginal economic and social prospects (Maxim & White, 2006, p. 34) International comparisons show these disparities even more starkly: Canada currently ranks among the top five on the United Nations' Human Development Index, which measures economic growth with the capabilities of the country's population. Canada's Aboriginal population ranks 78th (Kloster, 2008).

Cultural safety addresses these issues of cultural anomie and powerlessness. The central tenets of cultural safety as applied to education would require: (1) Aboriginal people exercising control over the education of their children and youth, possibly through partnerships with educationalists and institutions; and (2) recognition of and respect for traditional education and indigenous knowledge.

Aboriginal people have asserted their own aspirations for community-based education. In the report of the Royal Commission on Aboriginal peoples (RCAP) (1996), the Commission recommended that Aboriginal people should have a greater voice in determining the shape and content of the education of Aboriginal children and youth. The report based its recommendations on a vision of the relationship between non-Aboriginal Canadians and Aboriginal peoples, founded on the recognition of Aboriginal peoples as self-governing nations (Government of Canada, 1996). However, in reality, partnerships or shared power arrangements over education are, like the issue of health care, complicated by federal and provincial jurisdiction over the education of Aboriginal children and youth, and by the role of the institutions themselves. Cooperative ventures, such as Aboriginal-specific programs and services, special funding and Aboriginal involvement in curriculum design, have been successful at the post-secondary level in colleges and universities. These bicultural efforts at cultural safety in education have succeeded in helping Aboriginal students gain entry to and stay in mainstream post-secondary institutions. Examples include: the First Nations University, started in 1976 in partnership with the University of Regina is overseen by the Federation of Saskatchewan Indian Nations; the Gabriel Dumont Institute of Native

Studies, also a partnership venture with the University of Regina. Also, the Province of British Columbia signed a memorandum of understanding (MOU) with the First Nations of B.C. regarding a new relationship to promote the education and advancement of First Nations people in B.C. The MOU is written in terms that are consistent with the principles of cultural safety, in terms of equal partnership, respect for First Nations languages and cultures, and Aboriginal control over program curricula and programs.

Traditional approaches to education are based on the hunter-gatherer life on the land, allowing people to gain sound knowledge and understanding about the environment and underlying ecological processes. This knowledge was passed down from generation to generation through various methods of traditional education. Through family and community, the Elders pass onto youth the norms, knowledge and moral values of the whole society. Traditional learning processes included ceremonies, rituals, imitation, demonstration, oral story-telling, and songs (Ulluwishewa, Kaloko & Morican, 1997, pp. 1-3).

The power relations addressed within the definition of cultural safety are applicable to the education relationship. As in the health field, within the concept of cultural safety, power is transferred to the person who receives the service, to judge whether the service was culturally safe. In the educational setting, cultural safety refers to the student's feelings during the learning exchange, while the teacher must demonstrate cultural competence (in the sense of knowledge of the culture of the student) and cultural safety (in the sense of respect, trust and equality of the interaction) (NAHO, 2006a).

Culturally safe teaching practices have also been the subject of considerable study, though the actual term 'cultural safety' has not been transferred from the health literature. Scholar Pamela Toulouse draws on growing research when she argues that Aboriginal students' self-esteem is a key factor in success in school. She lists a number of factors that contribute to the academic success of Aboriginal students:

- Educators who have high expectations and truly care for Aboriginal students.
- Classroom environments that honour who they are and where they come from.
- Teaching practices that reflect Aboriginal learning styles (differentiated instruction and evaluation).
- Schools with strong partnerships with Aboriginal communities. (Toulouse, 2008, pp. 1-2)

As in the health arena, the success of the bicultural educational encounter between teacher and student must be a two-way exchange, based on an equal partnership. The teacher's skills and knowledge must allow for the student to feel respected and understood. The student must feel safe in order to enter into their part of the encounter.

3. Self-determination

As discussed in Part I of this paper, a key factor in the definition of cultural safety in much of the literature is the transfer of power from the service provider to the service recipient. Specifically, the literature talks about the power held by a Canadian doctor or nurse in relation to the Aboriginal patient, derived from their position of authority, education and professional knowledge, their questioning of the patient, and ultimately in their decision regarding treatment. However, as stated, there is little in the literature to explain this power transfer: what power does the Aboriginal patient have, particularly as all the sources of the health care professional's power are still in place? What does the power transfer enable the Aboriginal patient to do?

To find some answers to these questions, it is necessary to look elsewhere in the literature on self-determination of Aboriginal peoples. The two phrases, 'self-determination' and 'self-government', are sometimes used interchangeably. We use the term 'self-determination' in this context, as it implies a broader range of arrangements where an individual or a community exercises control over their lives. While self-government conveys a generally similar meaning, it has been used to mean the negotiated transfer of certain powers of government to First Nations. While this is certainly relevant, self-government could be just one of several ways in which Aboriginal people exercise power.

In the body of literature on Aboriginal self-government, the concept of cultural safety does not appear. However, power plays an important part in the definition of cultural safety as defined by Ramsden, Cooney, Stout and Downey and others, and self-determination is about power. Used in the context of health care, the term 'self-determination' has both conceptual connotations for Aboriginal people of regaining a cultural identity damaged by colonization, and practical connotations of improving health outcomes through personal empowerment.

Simply put, self-determination is seen by Aboriginal people as a means of regaining control over the management of matters that directly affect them and preserve their cultural identities. Self-determination as a concept encompasses a variety of forms which allow Aboriginal people to regain control at some level. At the same time, it may be a matter of practicality for Aboriginal people to take

advantage of those forms of self-determination which can be negotiated and agreed quickly. For this reason, in the field of health and education, partnerships with non-Aboriginal institutions, such as clinics, health and wellness programs, universities, and colleges, have achieved promising results in promoting health and learning.

Other forms of self-determination demonstrate the flexibility of the term, allowing actions which reclaim control or assert cultural identity to fall within its definition. These could include: a strong political voice through Aboriginal organizations; inspirational community leadership and role models; the reinterpretation of historical events; use of Aboriginal languages; the formation of inter-tribal and international networks; recognition and respect for traditional knowledge; the establishment of Aboriginal schools, colleges, community centres, clinics, treatment centres, and cultural and spiritual institutions; the use of cultural symbols and ceremony in the community and in wider Canadian society; a greater role for Elders; the use of consensual decision-making; the use of traditional healing and justice; and negotiated treaties and agreements granting greater governance powers to First Nations. Finally, the literature on cultural safety in health care implies that self-determination exists also in the form of individual confidence and self-esteem, personal choices about treatment, an equal exchange of information with health care professionals, and a feeling of trust.

The forms of self-determination adopted by each First Nation depend on the wishes and needs of the community and the issues they face. Indeed, as University of Victoria Indigenous advisor Roger John said as part of the University of Victoria course on cultural safety, indigenous communities struggle to decide the best way to take control:

> Power to define, because that's one of the first powers that's taken away from us as Indigenous people, is that we're no longer able to decide who is Indigenous and who is not … The power to define who we are, to decide who's who, who's a member of our community and who's not. The power to protect our land, to protect ourselves, to protect our family … And then the power to decide is probably one of the areas we're hurting the most in now, … we need to reclaim ourselves and there's lots of struggle in our communities now about that power – who's going to decide what we do and how we do it? (University of Victoria, accessed Nov. 2008).

As John suggests, communities must build collective, inclusive decision-making processes based on Aboriginal principles to decide what is best for them.

In terms of self-government, the options available to First Nations are limited by constitutional and legal considerations and the willingness of the Canadian government and the courts to cede governance powers to First Nations. From 1995, self-government was the cornerstone of federal government Aboriginal policy in accordance with section 35 of the Constitution Act, 1982 (Inherent Right of Self-Government). At a Special Chiefs Assembly held in Vancouver in March 2005, First Nations Chiefs issued a news release stating that they were united in charting a path to self-government:

> The plan calls for a formal political accord between First Nations and Canada, a joint framework for the recognition and implementation of First Nations government, and immediate initiatives to support First Nations consensus and necessary capacity development. The plan also calls for the elimination of the Department of Indian Affairs to be replaced by a new Ministry of First Nations-Crown Relations and an Aboriginal and Treaty Rights Tribunal (AFN, 2005).

With the hindsight of some years since these words were written, it is evident that self-government in the formal sense of negotiated agreements on the transferring of governance powers and funds to First Nations has been piecemeal and limited, with serious reservations on both sides of the negotiation.

Taiaiake Alfred, a Kanien'kehaka scholar and commentator on the effects of colonialism on Indigenous peoples, interprets the present situation in Canada as 'two competing agendas' at work. Alfred sees self-government as the way of assimilation, wrongly focusing on "money and jurisdiction. It is about the psychological effects of cultural destruction through colonialism." Alfred observes that "big institutional solutions will not work … People are not prepared to handle self-government at this point. Self-government is not a form of government that is a reflection of their culture and their values. It is not authentic" (TVO, 2005). Alfred views self-government as an alien form of self-determination, defined and expressed in foreign terms and subject to foreign processes.

This points to the need for a more spiritual and traditional form of self-determination. The emphasis is not on power so much as on empowerment and Aboriginal people making their own decisions that directly affect them, using the language, values and processes of their culture. In fact, far from the formal negotiating tables of

the self-government policy, many thousands of projects and programs have been spearheaded by Aboriginal communities to deal with specific issues of health, education or social programming.

The aspects of this form of self-determination, focusing on spirituality, tradition, respect, and community are in keeping with the concept of cultural safety. The cultural safety model of Aboriginal power does not advocate separateness of the Aboriginal community. Alfred expressed a vision in keeping with cultural safety, of a 'respectful relationship between two nations' (TVO, 2005). This is consistent with Ramsden's conception of cultural safety as, by definition, bicultural (Ramsden, 2004; Coup, 1996), based on equality and respect. Ramsden did not conceive cultural safety with any separatist or independent political connotations; it was a way of defining a two-way relationship.

PERSONAL AND COMMUNITY HEALING

One of the basic premises of the power of self-determination for Aboriginal people is the capacity and skills of community leaders and members to exercise that power. As we saw when looking at education, First Nations are developing institutions and curricula to build the capacity in their youth. However, one of the legacies of colonialism is social and economic conditions that often preclude full participation in their community and wider society.

These conditions, which we touched on when considering the social determinants of health, put communities at risk and potentially in crisis unless healing can take place. In this section we look at the subject of healing from three perspectives: the concept of healing in general, community healing, and indigenous knowledge and law.

1. Healing

The Aboriginal healing movement is based on a traditional community-based shared counselling process which includes physical, emotional, mental, and spiritual healing. It traditionally involves Elders bringing together the people involved in a dispute or harmful incident to talk, listen and learn from each other and to agree on a solution.

Healing can be visualized as part of the circle of life, of balance and harmony, as taught through the medicine wheel. The medicine wheel encapsulates the four components of the human experience which are referred to as states of being: spiritual, emotional, physical and mental. Through these states of being, people can achieve healing through a balanced, holistic approach. While there are variations in the way First Nations depict the medicine wheel, generally the healing path of the medicine wheel includes a:

- Talking Lodge.
- Listening and Teaching Lodge.
- Healing Path Lodge.
- Healing Lodge.

In practice, the healing movement has included various activities which can support Aboriginal peoples in coming to terms with wrongs and injustices. These have included participation in traditional healing and cultural activities, such as: culturally based wilderness camps, treatment and healing programs, counselling in groups, and community development projects. Healing can be at the level of the individual, the family or the community.

As part of the process of addressing past injustices, Aboriginal communities have implemented traditional healing methods. For example, the Aboriginal Healing Foundation was founded in 1998 to design, manage and implement a healing strategy for Métis, Inuit and First Nations people affected by the legacy of physical and sexual abuse suffered in residential schools. As part of the reconciliation process in June 2008, the Prime Minister apologized to residential school victims in the House of Commons. In addition some provincial governments have devised joint strategies to address issues of healing, such as the Ontario Aboriginal Healing and Wellness Strategy.

Healing can come in the form of the acknowledged truth of Aboriginal peoples' suffering, including the Prime Minister's official apology on behalf of all Canadians, and the establishment through partnership of the Truth and Reconciliation Commission (TRC) in 2008. The TRC was established through agreement by legal counsel for residential schools students, legal counsel for the churches, the Government of Canada, the Assembly of First Nations and other Aboriginal organizations. Its stated purpose is to inform:

> …all Canadians about what happened in these schools so that the Commission can guide and inspire Aboriginal peoples – and all of Canada – in a process of truth and healing on a path leading towards reconciliation and renewed relationships based on mutual understanding and respect (TRC, 2008).

Healing is promoted by the TRC as a society-wide exercise, whereby Aboriginal and non-Aboriginal peoples come to terms with the past and redefine the future. In this

way, the healing relationship is depicted in the same way as the cultural safety model and is consistent with the writings of St. Denis and McIntosh regarding the need for mutual understanding and also self-knowledge and understanding.

Healing also comes in the form of practical work and funding. In 1994, the Ontario Government and fifteen First Nations and Aboriginal organizations introduced the collaborative Aboriginal Healing and Wellness Strategy and renewed it in 2004. The strategy comprised two parts: the first focused on Aboriginal health, including giving Aboriginal people more control over planning and delivery of health care services to their communities; and the second focusing on family healing, dealing with issues of families at risk, including domestic violence and dysfunction (Ministry of Community and Social Services, 1994). Emerging from this strategy is a healing method that is consistent with the essential features of cultural safety: equality of First Nations people in a partnership, recognition and respect for Aboriginal culture, knowledge of Aboriginal culture, the implementation of traditional knowledge, and the self-determination of Aboriginal people. Aboriginal communities were able to channel funds in a variety of traditional and mainstream programs to help families, including support in situations of family violence, suicide prevention, community wellness programs, medical hostels, drug and alcohol treatment centres, and traditional healing lodges.

For example, the Odawa Native Friendship Centre (ONFC) in Ottawa runs a healing and wellness program focusing on the social impacts of colonization. Wellness focuses on the present, producing functional individuals, families, communities, and nations, and also on the future by encouraging aspirations in young Aboriginal people (ONFC, retrieved November 2008).

2. Community healing

The literature on cultural safety is curiously silent on the issue of communities in crisis. The cultural safety of nurses' interaction with Aboriginal patients is defined in individual terms, with the feelings of the individual patient determining the success of the interaction. But the application of cultural safety to the wellness of a community is not considered.

In "E-nakaskakowaaahk=A Step Back," Canadian scholar Peter Kulchyski (2004) describes the three informal questions he asks when getting a sense of the overall well-being of an Aboriginal community:

1. Culture – are the children playing and laughing in their own Aboriginal languages?
2. Respect for Elders – are there Elders in the community who are being treated with respect?
3. Health and safety of the people – can I drink the water? (Kulchyski, 2004, p. 1)

Kulchyski underlines that the use of Aboriginal languages and the central role of Elders goes beyond the ceremonial, and is the link to the cultural wealth of the community in terms of traditional knowledge and history. Through the Elders, the community has access to the traditional symbols and practices of healing that foster cultural identity. Kulchyski's criteria underline both culture and the material living conditions under which people live.

However, Aboriginal communities face different challenges depending on their history and resources. It is possible to imagine other questions that could be asked in different circumstances, such as questions about the state of housing, the existence of employment opportunities, and the condition of the family. In the literature on Aboriginal communities and economic development are descriptions of communities who have healed from crisis to create a vibrant healthy life for their residents. In reviewing some communities that are on the healing path, the example of the Oujé Bougoumou Crees shows how cultural safety could be applied to community healing. The community was relocated seven times in 50 years to make way for mining operations. Finally, in 1990, in a settlement with the governments of Quebec and of Canada, the community was recognized as a band and received money and land to build their community. Oujé-Bougoumou constructed their community to showcase their spiritual renewal, building traditional symbols of healing into their physical structures. An aerial view of the community shows the healing circle, with open, modern architecture in its public buildings. From "the very beginning, our objective has been to build a place and an environment that produces healthy, secure, confident and optimistic people" (Bosum, retrieved November 2008).

Cultural symbols are an important part of the healing process, reflecting cultural identity in the design of their living space. Cultural symbols also play a part in the body of wisdom and knowledge built over generations.

3. Indigenous knowledge and law

Indigenous knowledge is "a complete knowledge system with its own epistemology, philosophy and scientific and logical validity…which can only be understood by means of pedagogy traditionally employed by the people themselves" (Battiste & Henderson, 2000, p. 41).

Knowledge is the condition of knowing something with familiarity gained through experience or association. The traditional knowledge of Aboriginal peoples has roots based firmly in the Canadian landscape and a land-based

life experience gained over thousands of years. Traditional knowledge offers a view of the world, aspirations, and a way to define certain life truths, different from those held by non-Aboriginal people whose knowledge is based largely on European philosophies (Bilawski, 1991, p. 11). In Nunavut, the Inuit traditional knowledge, expressed in the Inuit Qaujimajatuqangit (IQ), forms a guiding set of values for the whole territorial government (Pauktuutit, 2006, p.6).

Indigenous knowledge is passed from generation to generation, by word of mouth, ceremonies and teachings, and has been the basis for agriculture, food preparation, health care, education, conservation, and the wide range of other activities that sustain a society and its environment in many parts of the world for many centuries.

Much of indigenous knowledge stems from the broad understanding of the ecosystems in which Indigenous people live and ways of using natural resources in a sustainable manner. However, colonial education systems replaced the practical everyday life aspects of indigenous knowledge and ways of knowing with western notions of abstract knowledge and academic ways of learning. Part of cultural safety includes the efforts by Aboriginal people in Canada to preserve their traditional knowledge and to teach it to their children. Similarly, the responsibility on Canadian service deliverers is to give due respect and place to indigenous knowledge in many areas of life, including health, education, family relations, healing, justice, community life, and governance.

Indigenous knowledge is subject to considerable misunderstanding and stereotyping by Canadian society.

> … today as in the past they are prey to stereotyping by the outside world. By some they are idealized as the embodiment of spiritual values; by others they are denigrated as an obstacle to economic progress. However, they are neither: they are people who cherish their own distinct cultures, are the victims of past and present-day colonialism, and are determined to survive (Strong, 1990, p. 6).

Indigenous knowledge allows Aboriginal people to express themselves in languages and terms which reinforce their social, spiritual, political, and cultural identity. While indigenous knowledge can be of practical use to individuals and families, in the context of cultural safety, its significance is in the recognition of and respect shown by service providers for traditional ways of doing things.

Indigenous knowledge also encompasses traditional laws. For many years, the legal systems of Canada's Aboriginal people were ignored or dismissed because they were inconsistent with western laws and legal jurisprudence. Aboriginal customary laws, like Aboriginal stories, history and songs, were not written down, and Aboriginal societies generally did not accord a single person or group with the authority to define and enforce the laws. Therefore, following colonization, in a western tradition of written laws, legal jurisprudence and formal court structures, Aboriginal customary laws had no place (Pauktuutit, 2006, p. 9). However, strains and problems on the criminal justice system have encouraged policy-makers and judges to look more closely at Aboriginal law in relation to Aboriginal offenders.

Canada has long relied heavily on incarceration; while this is a problem for the population in general, it is of particular concern to the Aboriginal people, both urban and rural, living on- and off-reserve. Aboriginal people are disproportionately over-represented in Canadian prisons (Haslip, 2000, p. 3). To address this issue and to consider Aboriginal culture and indigenous knowledge as part of a possible solution, in 1996, the federal government announced the Aboriginal Justice Strategy and amended the sentencing provisions of the Criminal Code to meet the needs of Aboriginal offenders. Over many years, the social, economic and political dislocation of Aboriginal people through colonization led to conditions of life that result in a higher incidence of crime among Aboriginal peoples and alienation from the criminal justice system. The Supreme Court, while acknowledging that not all Aboriginal communities have the same conception of sentencing and justice, gave the view that: "most traditional Aboriginal conceptions of sentencing place a primary emphasis upon the ideals of restorative justice" (LaPrairie, 1990, p. 726, quoted in Haslip, 2000, p. 4) and that "the different conceptions of sentencing held by many Aboriginal People share a common underlying principle … the importance of community sanctions" (LaPrairie, 1990, p. 727, quoted in Haslip, 2000, p. 4). In the context of inter-dependent members of a community living in a sometimes harsh environment, restoration of stability and the preservation of the community were of paramount importance in the traditional justice system.

Indigenous knowledge and laws strengthen Aboriginal people in claiming the respect and equality in relation to figures of authority in Canadian society, including nurses, teachers, social workers, judges, and others. The strength of the community and its stability are fundamental to Aboriginal people; social cohesion has been the key to survival for many Indigenous people, both physically and culturally (Strong, 1990).

It is evident that Aboriginal people can draw on the strength of their indigenous knowledge and cultures.

However, as Ramsden insists, the cultural safety model is about the combination of two cultures, interacting in the course of everyday life in a multitude of ways. In this sense, there is the opportunity for enrichment for non-Aboriginal society as well in terms of mutual respect and understanding. In the Truth and Reconciliation Report, Anne Salmond comments: "...the process of opening Western knowledge to traditional rationalities has hardly yet begun" (Bielawski, 2004, p. 1).

CONCLUSION

The concept of cultural safety has extended beyond its origins in the literature concerning nursing in New Zealand. It resonates with Indigenous peoples around the world, and has been explored in academic literature, government reports and professional studies in relation to the health of Indigenous people, particularly in New Zealand, Australia and Canada. Similarly, it relates usefully to other subjects where Indigenous people are disproportionately disadvantaged in social policy areas, such as education, economic opportunity and criminal justice. However, it remains confined largely to academic studies and government reports, and little hard evidence appears to have been applied to professional practice. It seems that the practicalities of cultural safety as an *outcome* rather than a *concept* have yet to be realized.

This is in part due to the lack of evidence based on extensive field research. The vast majority of the literature remains qualitative and anecdotal. The qualitative data needs to be substantiated in quantitative studies that can provide comparative data over time and cross-sectional data. This data would allow government and practitioners to assess the usefulness of cultural safety as a part of professional practice by non-Aboriginal service providers (whether health care professionals, teachers, social workers, judges or lawyers) in relation to their Aboriginal clients. Such quantitative studies require lengthy timespans to produce meaningful data. These may be underway, but as yet such evidence is not available. From an Aboriginal perspective the evidence for cultural safety is imbedded in traditional knowledge, teachings and values of Elders and healers.

Furthermore, as several writers have discussed, the concept of cultural safety carries an explicit political component. This derives from the express transfer of power in a culturally safe exchange from the professional to the Aboriginal client, where the success of the exchange is judged by the Aboriginal person, and not the professional. Expressing cultural safety in terms of power explicitly challenges the existing power structures within institutions and wider society and can appear threatening. The professional literature (that is, literature from medical and nursing documents that are written by and for practicing professionals) suggests that, even when forcefully promoting Aboriginal interests, the term cultural safety is often avoided in favour of cultural competence or transcultural practice. As explored in the paper, while these alternative terms express a genuine desire to improve service delivery and service effectiveness to Aboriginal people, they stress a different angle on the non-Aboriginal professional - Aboriginal client relationship. In some cases, the term cultural safety appears to be used interchangeably with cultural competence, diluting the significance of the concept of cultural safety as it originated in New Zealand nursing literature.

The long-term value of the concept of cultural safety as a tool for cultural regeneration is hard to assess and depends on the integrity of the processes that underlie the concept of cultural safety. In New Zealand, when the term was first being debated in civil society and government, there was a suggestion that the term 'cultural safety' could be changed to be less politically challenging without diluting its significance and reach. This was rejected by many Maori observers who felt that cultural safety *is* and *must be seen as* a challenge, to effect real change in the delivery of medical and government services.

The differences between the concept of cultural safety versus cultural competence and transcultural practice are profound, but they could be used to imply different angles of the same exchange. Cultural competence and transcultural practice, like cultural safety, are both based on an assumption of respect for Aboriginal people, their culture and knowledge, and the building of trust between the professional and the client. Cultural competence and transcultural practice are both defined in terms of the non-Aboriginal professional's knowledge and understanding of the culture of their Aboriginal client.

Cultural competence (and the linked concepts of cultural sensitivity and transcultural practice) is based on the *process* of building an effective service delivery interaction with Aboriginal clients, rather than the *outcome* of the success of the interaction. However knowledgeable or sensitive the professional is, this does not in itself ensure the effectiveness of the interaction.

The concepts of cultural competence and transcultural practice measure success in terms of the knowledge of professionals; therefore, recommendations for achieving cultural competence contained in the literature commonly feature extensive culture training for professionals (nurses). Proponents of the concept of cultural safety (see Ramsden, Coup, Cooney, and Ball,) regard this as useful

but inadequate. While it is desirable that professionals be knowledgeable of Aboriginal cultures, this criterion is inadequate to ensure that the *outcome* of the interaction with Aboriginal clients is culturally safe. For Ramsden, Cooney and Coup, the approach taken in cultural competence falls far short because it leaves the *power* of the interaction in the hands of the professional. For these writers, knowledge of Aboriginal cultures may be helpful, but it is not necessary for culturally safe interaction to take place. It can be extrapolated from their writing that a professional without in-depth knowledge of Aboriginal culture can still perform their work in a culturally safe manner.

Cultural safety relies rather on the expectation on the parts of the non-Aboriginal professional and the Aboriginal client that it is the client who has the power to make decisions regarding their health (or other matters) and also the power to judge if the interaction has been culturally safe. Unlike training to acquire knowledge of Aboriginal culture, training under cultural safety focuses on the nature of cultural safety itself (respect, trust, sharing) and on the history of Aboriginal people that contributes to the contemporary conditions of many Aboriginal People (colonization, residential schools, etc.).

Some of the difficulties of implementing culturally safe practice can be discerned in the brief analysis of specific areas of policy in the paper. Health is an area of social policy that lends itself particularly well to the practice of cultural safety. Non-Aboriginal doctors and nurses, with the education and professional qualifications in western science and medicine, with the confidence and certainties of their culture, have considerable power. Studies (see Browne, Fiske and Thomas) show how individual health professionals have considerable impact when they show the respect and attitudes that could be described as culturally safe. Respect for the Aboriginal patient extends beyond the individual to their culture, to the teachings of their traditional knowledge, practices and spirituality and to their aspirations for the future.

However, for cultural safety to become entrenched in professional practice in health and other policy areas, including education at all levels, justice, and social work, cultural safety has to be practiced not just by individuals but also by institutions. Pamela Toulouse's writing about promoting education for Aboriginal children, spoke not just of teachers and their direct relationship with Aboriginal students, but also of the curricula, the teaching and learning styles, Aboriginal content in lessons, language and even the physical design of schools. For example, she asserts that even a welcome sign over the door in the Aboriginal language of the Aboriginal students can create a respectful and encouraging sense of belonging (Toulouse, 2008). Similar examples of cultural safety can be found in the case studies in the appendices of this paper.

Professionals may display culturally safe behaviour and language in the execution of their job individually, but for significant changes to take place in Canadian society, institutions and government must display culturally safe attitudes and put in place training that ensures consistency in service delivery. In literature on the nature of discrimination and alienation (see Haslip, 2000), it is evident that the most difficult type of discrimination to address is systemic discrimination. Systemic discrimination is discrimination embedded in policies and practices that appear neutral on the surface and implemented impartially by practitioners.

However they have a disproportionately adverse affect on specific groups of people. This is evident in the literature on the experiences of Aboriginal people in the criminal justice system, the secondary and post-secondary education system, the health system, and in other areas of social determinants of health (such as housing, employment, nutrition, poverty, etc., see Raphael, 2004). This suggests that systemic discrimination or lack of effective outcomes stem from institutional and governmental failure in relation to cultural safety. Finally, cultural safety begs the question of what power means and how it can be exercised. The literature on cultural safety does not explore how power can support Aboriginal people in their interactions with non-Aboriginal service deliverers. However, looking at the literature on self-determination, we find many ways in which Aboriginal people gain greater control over matters that affect them, many of which are much less complex and easier to implement than self-government. Academic thinking on issues of Aboriginal power considers how individuals, families and communities gain power by simply engaging in struggles or actions; winning or losing can be less important than the *action* of standing up for one's beliefs and interests (Kulchyski, 2005).

This power applies not just to Aboriginal individuals in a private interaction with a professional person, but also to families and communities. Kulchyski (2005) explores this in the concept of community wellness. He sees empowerment as a source of community and family pride through engaging in struggles and taking steps to improve lives and promote healing. He relates empowerment explicitly to the strengths of Aboriginal communities: Aboriginal language, culture, ceremonies, traditional knowledge, and spirituality. Although this is not explicitly related to the concept of cultural safety, it is useful as it leads to the issue of communities at risk and communities in crisis. Since the literature on cultural safety focuses strongly on the individual level of Aboriginal people interacting with

health care professionals, it is largely silent on the issues of community wellness and communities at risk and in crisis. First Nations Elders and practitioners see cultural safety as a means to strengthen individual, family and community resilience to respond to crisis and community stress. In this sense communities see cultural safety as that first step along the healing path. However, moving from the issue of power to culture, it is possible to see links that could be explored in literature in the future.

RECOMMENDATIONS

Recommendations include the following:

Training:

1. Training for professionals who deliver services directly to Aboriginal people in Aboriginal cultural (to achieve cultural competence).
2. Training for professionals in the history of the Aboriginal community they are interacting with (to start the process of achieving cultural safety).
3. Training for professionals and institutional administrators in the concept and practice of cultural safety.
4. Support for cultural safety educators to have a dialogue on a regular basis and create a body of teaching materials.
5. Professional competencies to include cultural safety for all service deliverers, not just those who have regular contact with an Aboriginal client-base.
6. Role models and case studies in terms of culturally safe practice to be put in place within institutions to promote cultural safety best practices in an applied context.
7. A training manual or guide to be developed that incorporates the concepts of cultural safety, cultural competency and healing to provide Aboriginal communities with a step-by-step how to manual on cultural safety.
8. A training manual to be developed to support organizations in developing their own training and policies on cultural safety.
9. Community leaders to be trained in cultural safety, to build in the symbols of empowerment that could establish community pride and renewal. In conjunction with other initiatives, cultural safety could be promoted as renewed power and social standing of Aboriginal culture.

Qualifications and reward:

1. Professional qualifications to require an understanding of culturally safe practice.
2. Reward strategies to be developed to reflect a ‘cultural safety’ competency.

Research:

1. Support and participation in studies on cultural safety by Aboriginal institutions and First Nations communities, possibly in partnership with academic institutions or professional institutions.
2. Lobby through Aboriginal institutions and leaders for government support for research into cultural safety and the possible applications in public policy and organizational policy.
3. Build a body of data on the experiences of Aboriginal service recipients on cultural safety to reinforce good practice and training (through interviews, questionnaires and studies).

Strategies:

1. Cultural safety and healing strategies should be included in First Nations community initiatives, programs and policies dealing with the stressors that push them from risk to crisis.
2. First Nations students should be recruited to post-secondary programs to assume healthcare jobs and other positions of authority.
3. Aboriginal leaders and communities should be involved in establishing standards and policies on cultural safety, through partnership in health, education and other fields.

Education:

1. First Nations to work with post-secondary institutions to ensure that support programs are culturally appropriate and to support training of teachers and administrators in cultural safety.
2. Post-secondary institutions to build strong relationships with local First Nations to foster links and gain new Aboriginal entrants. (Brascoupé, 2008)

APPENDIX A - Tsow Tun Le Lum Society Case Study

Substance Abuse Treatment Centre

Tsow-Tun Le Lum means "helping house," providing addiction and substance abuse programs in an accredited treatment centre in Lantzville, on Vancouver Island, British Columbia. It also supports the survivors of trauma and residential schools. Its mission is to strengthen the ability of First Nations people to live healthy, happy lives and to have pride in their native identity.

In the first phase of the Tsow-Tun Le Lum program, participants learn about:

- Trust building and safety of the individual.
- Physical, emotional and sexual abuse.
- Effects of unresolved trauma and cultural oppression.
- Consequences of shame.

The Tsow-Tun Le Lum Centre like other Aboriginal Healing Foundation projects have learned that building safety and trust is a critical first step because clients have lost the sense of safety because of trauma and effects of residential school. The following information was collected at the Aboriginal Healing Foundation's Projects Gathering "Safety" workshop on April 22, 2008 in Saskatoon, Saskatchewan.

What is safety?
Safety for the Aboriginal Healing Foundation's (AHF) projects can be defined as both personal safety and cultural safety, alluding to the identity of every person as an individual and as a member of a cultural community. The first step in the healing process is to establish safety and trust with clients. Safety can restore power and control to survivors and foster responsibility for self and a feeling of belonging.

Safety for Aboriginal Healing Foundation Projects (Simon Brascoupé, 2008)

Personal Safety: ***What do we mean by personal safety for survivors, workers and in centres?***

Building trust:
Build foundation with clients to start intensive treatment.
Dependability, consistency.

Ensure confidentiality:
Confidentiality and privacy policies clear at all levels of contact (personal and professional).

Client rights:
Rights clearly stated; code of ethics, guiding principles, etc.
Communicate centre's principles, e.g., posters in healing centres.
Advocate for client's rights.
Group/team rules or self-directed guidelines created by clients.

Safe therapeutic process:
Intake, triage area or buffer zone for evaluation of needs.
Explain and introduce the process clearly to clients.
Orientation process and package for clients.
Explain and define worker/client boundaries.
Explain plan or road map for healing journey.
Clients develop and maintain self-care plan and/or a wellness plan.
Let clients know they have freedom of choice with options.
Empower clients.

Appropriate:
Sincere, non-judgemental, trustworthy.
Walk the talk; be visible and involved in the community.
Love oneself and have humility.
Have good intentions about what you do as a service provider.
Respect choices, cultural diversity in community and other people's ways.
Don't impose beliefs onto others.
Have a mentor to turn to for support.
Practice self-care techniques.
Ensure workers are healthy mentors.
Safe hiring; reference, security checks, etc.

Create safe atmosphere:
Warm, respectful, welcoming environments.
Be available, consistent, open and unbiased.
Create an environment where clients don't feel

shame, e.g., especially if they don't have knowledge or experience.
Respect is key (signage that encourages respect).
Listen and learn.
Be accepting, empathic and don't criticize.
Be non-judgemental, patient and respectful.
Use humour.

Create comfortable place:
Building should be warm and welcoming.
Orientation of building and grounds.
Create space for healing.
Naming, i.e., name of facility should be meaningful culturally.

Reinforce safety:
Through proper closure, follow-up and aftercare.
Survivors need to know that assistance is available throughout their healing journey.

Cultural Safety: ***What does cultural safety mean for survivors, workers and centres?***

Elders:
Elders' participation is key. Know who providers are, i.e., Elders who have walked the talk.

Cultural activities:
Explain and introduce process, i.e., reconnect to culture.
Follow cultural protocols.
Utilize local cultural resources.
Traditional ceremonial practices.
Augment with western, alternative and other practices.
Encourage participation in the cultural program and activities.
Feasts, i.e., appropriate behaviour/protocols for Elders' feasts.
Freedom to choose to participate.
Respect all cultures – be appropriate for audience and not exclusionary, e.g., smudge, sweet grass, eagle feather.
Understand family unit and structure and respect relationships, i.e., what does it mean to be father/mother/grandfather/son/aunt etc.
Encourage parents to educate their children.
Understand who we are as First Nations people, e.g., do not let diversity become a barrier, such as religious denominations.

Cultural competency training:
Ensure staff understands the diversity of the community.
Become familiar with cultural and other ways, e.g., not only one way.
Being a First Nations person is a way of life.
Provide cross-cultural workshops.
Provide education and awareness about cultural teachings and traditional ceremonies.
Provide appropriate teaching and encouragement.
Understand ceremonies and protocols, e.g., similarities/difference between churches and First Nations.
Retain, speak and learn traditional languages.

Physical environment reinforces cultural identity:
Gardens, healing ponds, sweat lodges, etc.
Healing room for ceremonies and resource.
Utilize cultural symbols, e.g., buffalo hides, elk horns, eagle feathers, dream catchers.

Lessons Learned

Creating safety and trust is a critical first step for First Nations individuals and communities. The Aboriginal Healing Foundation projects have demonstrated this approach to safety which includes both personal and cultural safety, such as in the case of the Tsow-Tun Le Lum Treatment Centre.

Policy Implications

Strategies for communities in crisis and at risk should include *safety* in the development, design and implementation.

Rationale

If in fact safety is a critical first step, and without it the development of safety and trust, the effectiveness of a project, relationship or strategy is endangered – policy, programs and plans for communities at risk and in crisis should have a carefully crafted approach to safety at all levels of development, design and implementation. This could be incorporated in capacity development (community development), participatory approaches, again at all levels and include use of traditional knowledge.

Project implementation

The AHF and this case study clearly demonstrates how successful projects incorporate safety at all levels of delivery and show policies makers how to design projects that meet the needs of communities at risk and in crisis.

Safe Trusting Relations

When working with First Nations communities building trust can be critical to program or project success, particularly with communities at risk and communities in crisis. These communities' dysfunctions stem from colonization caused by historical trauma and residential school. The first step in the healing process is to establish safety and trust. Safety can restore power and control to survivors and foster responsibility for self and a feeling of belonging. So it is critical that the government team and individuals working with communities at risk and in crisis develop safe and trusting relations with First Nations communities. Developing safe and trusting relationships can be accomplished through cultural competency training and an institutional cultural competency policy. (AHF, 2008)

APPENDIX B - Hollow Water First Nation Case Study

Community Holistic Circle Healing (CHCH), Manitoba

Hollow Water First Nation is one hundred fifty miles northeast of Winnipeg. In 1984 a healing and development team was formed to work in Hollow Water and the Métis settlements of Manigotogan, Aghaming and Seymourville. The team was comprised of political leaders, service providers from all health and service agencies. The team's objective was to create a safe and healthy community for their children and grandchildren by achieving two objectives: 1. to facilitate individual and community healing journeys; and 2. to coordinate integrated program services, such as education, politics, health, religion, and economy.

Safe and Healthy Community

Hollow Water was a community in crisis; it had a history of violence, suicide, addiction problems and sexual abuse. Community Holistic Circle Healing made a remarkable transformation through community healing and restorative justice. Hollow Water clearly demonstrates that a community-based approach founded on traditional knowledge can successfully deal with historical trauma and residential schools painful past. In 1988 they established a program called S.A.F.E.:

> What followed was a very active period of learning and healing. The Resource Group consulted with many groups across North America who was dealing with similar issues and by 1988 had set up their own training program called S.A.F.E. (Self-Awareness For Everyone), modeled after the New Directions Training being offered at that time by the community of Alkali Lake. This step allowed them to bring this type of training to as many of their community members who were willing to begin a journey of personal healing and development (Bushie, n.d.).

The team found that building of trust and communication contributed to a dramatic increase in disclosures. The team would gently record the victim's story; they ensured the victim's safety; and with the presence of trusted people offered support to the victim through the crisis. Healing at Hollow Water occurred at the community, family and individual level.

The Healing Journey is shown in the medicine wheel, as a four step process that in the experience of Hollow Water took three to five years. In the end, it resulted in restitution and reconciliation between the abuser and the victim, the victim's family and the whole community. Every journey begins with the talking circle where all sides are heard – individuals speak from the heart. It is here at the talking stage that personal and cultural safety is critical to getting the process started. Many believe that colonization has resulted in mistrust of authority by First Nations communities which is a barrier to be overcome in every process and relationship. Whether it's hearing their anger, stories and pain or silence – building trust through safe practice is a huge challenge. The second step is learning, the circle shares what it has learned from each other in the talking circle. The third step is the healing journey where there is consensus on the path to follow. Finally, the results are transformation, restoration and reconciliation.

Medicine Wheel: The Healing Journey (Brascoupé, 2008)

Hollow Water has achieved remarkable results through its CHCH approach. The team identified further work needed to link their work to other issues and priorities.

1. Healing Lodge: build a healing lodge that can serve as a centre for both residential and outreach programs with the capacity to take in whole families.
2. Cultural Foundations of Treatment: to blend it with Hollow Waters traditional healing approach the healing practiced by dominant culture professional psychologists.
3. Linking Treatment to Training: link treatment to training, which transforms healing to social and economic well-being of the community.

4. The Key Role of Women: women have led the healing movement in Anishnaabe communities. The long-term key to transforming our community is to educate our women to their responsibilities, not only as mothers, but also as community members.
5. Re-orienting Policing Programs: develop cultural competency of police in the community to understand healing models.
6. Economic Development as Treatment: beyond training people there is a need for incubating local enterprises where community members can put their energies.
7. Youth: a comprehensive youth healing and development initiative to shift the underlying pattern of life from dysfunction and abuse to wellness and prosperity. (Bushie, n.d.; Dickie, 2000)

APPENDIX C - Mapping the Healing Journey Case Study

Case studies of the Healing Movement in Eskasoni, Esketemc, Hollow Water, Mnjikaning, Squamish, and Waywayseecappo First Nations.

These case studies clearly link colonization to trauma that generated a wide range of dysfunctional and hurtful behaviours (such as physical and sexual abuse) in First Nations communities. Through the healing process, communities build capabilities to perform as strong partners in relationships with non-Aboriginal service professionals. Without the confidence and capacity for engaging in culturally safe relationships with non-Aboriginal institutions and professionals, equality in the relationship is impossible.

Dysfunction occurs at the community, family and individual level; this study concretely identifies steps and processes to achieve healing and wellness in communities at risk and crisis. Two remarkable examples are Hollow Water and Alkali Lake who transformed from communities in crisis to communities on their healing path. These First Nations have found a way to interrupt old dysfunctional patterns and to introduce new patterns of living that are sustainable and healthy.

There have been a wide range of experiences, programs and activities in the Aboriginal healing movement in the past three decades. Here is a breakdown of the broad categories:

- Participation in traditional healing and cultural activities.
- Culturally based wilderness camps and programs.
- Treatment and healing programs.
- Counselling and group work.
- Community development initiatives.

In both the Hollow Water and Alkali Lake case studies the healing process began at the individual and family level.

Individual Healing Journey

Stage 1: The Journey Begins. The healing journey of individuals often begins when they come face to face with some inescapable consequence of a destructive pattern or behaviour in their life or when they finally feel safe enough to tell their story.

Stage 2: Partial Recovery. At this stage individuals have mostly stopped their addictive behaviour, but the driving forces that sustained it are still present.
Stage 3: The Long Trail. Once someone has reached a hard-won sense of stability, it takes a great deal of courage, discipline and motivation to continue on the healing journey.

Stage 4: Transformation and Renewal. Ultimately the healing journey is about the transformation of consciousness, acceptance and spiritual growth. (Lane et al., 2002)

The Four Seasons of Community Healing

Stage 1: Winter - The Journey Begins. This stage describes the experience of crisis or paralysis that grips a community. The majority of the community's energy is locked up in the maintenance of destructive patterns. The dysfunctional behaviours that arise from internalized oppression and trauma are endemic in the community and there may be an unspoken acceptance by the community that this state is somehow normal.

Stage 2: Spring - Gathering Momentum. This stage is like a thaw, where significant amounts of energy are released, visible and positive shifts occur. A critical mass seems to have been reached and the trickle becomes a rush as groups of people begin to go through the healing journey together which was pioneered by the key individuals in stage one. These are frequently exciting times. Momentum grows and there is often significant networking, learning and training. The spirit is strong.

Stage 3: Summer - Hitting the Wall. At this stage, there is the feeling that the healing movement has 'hit the wall'.

Front-line workers are often deeply tired, despondent or burned out. The healing process seems to be stalled. While there are many people who have done healing work, there are many more that seem left behind. There is the growing realization that it is not only individuals, but also whole systems that need healing. There may already be some new initiatives in these systems (education, governance, economics, justice, etc.). In some cases these initiatives appear to become institutionalized and lose the sense of spark and hope that characterized them in stage two. In other cases, while awareness has begun to shift, old patterns of working persist for lack of new (and culturally relevant) models and strategies. The honeymoon stage is over as the community begins the difficult work of transforming deeply entrenched patterns and reconstructing a community identity that was forged in oppression and dysfunction.

Stage 4: Fall - From Healing To Transformation. In Stage Four, a significant change in consciousness takes place. There is a shift from healing as "fixing" to healing as "building," as well as from healing individuals and groups to transforming systems. The sense of ownership for your own systems grows and the skill and capacity to negotiate effective externally, and reciprocal relationships develop. Healing becomes a strand in the nation-building process. Civil society emerges within communities and the Aboriginal community at large and a shift of responsibility begins to take place. The impetus for healing moves from programs and government to civil society.

Where to start with Communities at Risk and Communities in Crisis?

When a community is at risk or in crisis, it is difficult to know where to start. The healing journey provides some concrete direction because both the community and individual healing journeys are mapped out and modeled. Often the journey begins when key individuals in the community begin to question and challenge the status quo, often making significant transformations in their own lives, by starting their own healing journey. They reach out to other individuals to provide mutual support and initiate healing and crisis intervention activities. Another part of the starting point is programs, where community members and program staff combine their forces work closely to develop a wider strategy. These interagency groups plan and implement collaborative interventions and initiatives.

Communities in Crisis: Starting Points

Both these starting points lead to healing at the individual and community levels. Core groups form around health, healing, sobriety, and wellness to begin the long-term process of healing with the support from Elders and outsiders. The following maps out the steps communities go through in beginning and developing their healing journeys:

Drivers

- Dedicated key individuals (often women) respond to their awareness that things are bad and there is an alternative.
- Leaders and staff within programs are tasked with addressing the consequences of some part of the "crisis."
- Visionary and courageous political leaders within the community create a climate for healing.

Awareness

- Those driving the process often view the key tasks as creating awareness of the need for healing and may be largely focused on the outward face of the problem (e.g. "alcohol is what is holding us back").

Action Steps

- Personal healing and revitalization experiences; formation of informal core groups and networks for mutual support.

Indicators

- People begin their own healing journeys. A growing number of people seek help for a particular presenting issue or problem. Success/failure is measured in stark terms (drinking vs. not drinking).

Risks

- Restraining forces, often from within the community itself, ranging from denial of the issues to overt and intimidating opposition directed at key individuals.

Lessons Learned

The process of community and individual healing are more clearly articulated with a recognizable pathway, steps and indicators that are reproducible for communities at risk and communities in crisis.

In the healing path individuals and communities rely on traditional knowledge and ceremony to create safe and healthy starting points.

Policy Implications
Programs and strategies that support community healing and wellness based on concrete steps and plans laid out in *Mapping the Healing Journey* can be beneficial to communities at risk and in crisis and is an important starting point when there is no apparent way forward.

Rationale
Mapping the Healing Journey offers some evidence that this approach is effective in reducing rates of offenders reoffending and significant cost savings of restorative justice over incarceration of offenders. It also provides a clear step-by-step process enabling communities at risk and communities in crisis to start the healing journey at the micro-level; how community members begin the process that works for First Nations communities.

Project implementation
The process of the healing journey focuses on individual and community healing combined with program coordination to achieve collaborative interventions and initiatives. The case studies make it clear that community members and program managers can be trained to design, plan and implement community healing.(Lane et al., 2002)

APPENDIX D - From Truth to Reconciliation Case Study

Aboriginal Healing Foundation

A recent article by Marlene Brant Castellano confirms and further elucidates the importance of safety to the individual and community healing. She further explains the process of reconciliation between Aboriginal and non-Aboriginal People.

> Individuals who have suffered trauma in childhood vary in their ability to integrate their experiences into the narrative of their lives. Reports from project participants confirmed that healing from painful or suppressed memories begins with awareness of barriers to a satisfying life and beginning recognition of the sources. Awareness can develop gradually or be precipitated by a crisis such as a health problem, breakdown of a marriage, or being charged with an offence. Projects typically found that Legacy education about the history and impacts of residential schools and group events that centred on cultural activities supported readiness to engage in therapeutic activities and relationships. In the beginning stage of healing, survivors need to feel safe. Establishing cultural safety, affirming identities that had been forcibly suppressed, was an important feature of most projects.(Marlene Castellano Brant, 2008)

Castellano like others looks for a common thread, and she points to developing cultural safety in healing, that people often referred to as "spiritual." She believes that individuals talk about "different ways of making a connection to something greater than themselves and their individual griefs" (Brant Castellano, 2008, p. 398). They desire to connect with the "natural world, the stream of history, family and community, or in some cases, with a spiritual being who is friendly" (ibid). Trust lost by colonization and residential schools is regained through a long process that begins with personal and cultural safety.

The model for Stages of Community Healing is similar to the model in Mapping the Healing Journey, it includes the following steps:

1. Core group forms.
2. Gathering momentum.
3. "Hitting the wall."
4. Healthy individuals / vibrant community.

Healing begins in an environment of safety and trust. The transformation to a healthy state is made possible by a climate of safety and an attitude of mutual trust.

Lesson learned

The healing process while understood and mapped-out is found to be a long-term process: "Healing the legacy of residential schooling, whether at the individual or community level, is not a linear process" (Brant Castellano, 2008, p.394). The stages are approximate models of complex real-life events and survivor's progress and then circle back on earlier stages when confronted with recurrent challenges. For communities, change was described as "like ripples unfolding in a pool, where each new circle contains the previous ones" (ibid). The healing process begins with individuals, often instigated by youth, then rallies at the family level and finally finds a home at the community level.

National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)

REFERENCES

Aboriginal Healing Foundation (2003a). *From Truth to Reconciliation: Transforming the Legacy of Residential Schools*, (pp. 8, 108, 391, 392, 395, and 403). Ottawa: AHF.

Aboriginal Healing Foundation (2003b). *Third Interim Evaluation Report of Aboriginal Healing Foundation,* Program Activity, Kishk Anaquot Health Research, (pp. xvi, 49, 64, 74, 81). Ottawa: AHF.

Aboriginal Healing Foundation (2006a). Summary, A Healing Journey: Final Report, Ottawa: AHF. http://www.ahf.ca/publications/research-series.

Aboriginal Healing Foundation (2006b). Volume I – A Healing Journey: Reclaiming Wellness, Final Report, Ottawa: AHF, http://www.ahf.ca/publications/research-series.

Aboriginal Healing Foundation (2006c). Volume II – Measuring Progress: Program Evaluation, Final Report, Ottawa: AHF. http://www.ahf.ca/publications/research-series

Aboriginal Healing Foundation (2006d). Volume III – Promising Healing Practices in Aboriginal Communities, Final Report, Ottawa: AHF. http://www.ahf.ca/publications/research-series

Aboriginal Healing Foundation (2008). Safety, *Poster Series*. Ottawa: AHF

Aboriginal Institutes' Consortium (2009). Aboriginal Institutions of Higher Education, published by Canadian Race Relations Foundation. www.crr.ca.

Aboriginal Nurses Association of Canada (2002). Nursing Educational Needs Analysis. Ottawa, http://www.anac.on.ca/tobacco/AHN_Final-en.pdf

Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Basu Khan, K., Reimer Kirkham, … Smye, V. (2003). "Rewriting" Cultural Safety Within the Postcolonial and Postnational Feminist Project: Toward New Epistemologies of Healing. *Advances in Nursing Science, 26* (3), 196-214.

Assembly of First Nations (2005). First Nations Chiefs Unite to Clear Path, http://www.afn.ca/article.asp?id=621

Assembly of First Nations (2007). National First Nations Language Strategy, Annual General Assembly, July 5, 2007, http://www.afn.ca/misc/nfnls.pdf

Assembly of First Nations (2008). First Nations Cultural Safety in Post-Secondary Education, http://www.afn.ca/article.asp?id=3962

Ball, J. (2007a). *Creating Cultural Safety in Speech-language and Audiology Services*. PowerPoint Presentation: Presented at the Annual Conference of the BC Association of Speech-Language Pathologists and Audiologists, Whistler, BC, October 25, 2007.

Ball, J. (2007b). Supporting Aboriginal Children's Development. In *Early Childhood Development Intercultural Partnerships,* University of Victoria, retrieved Nov. 2008, www.ecdip.org/capacity/.

Ball, J. (2008). Cultural Safety in Practice for Children, Families and Communities. In *Early Childhood Development Intercultural Partnerships,* University of Victoria, retrieved Nov. 2008, www.ecdip.org/culturalsafety/.

Beach, M.C., Price, E.G., Gary, T.L., Robinson, K.A., Gozu, A., Palacio, A., Smarth, C., Jenckes, … Cooper, L.A. (2005). Cultural Competence: a Systematic Review of Health Care Provider Educational Interventions. In *Welch Center for Prevention, Epidemiology, and Clinical Research*, Johns Hopkins University, Baltimore, Maryland, Med Care. Apr. *43*(4), 356-73.

Bilawski, E. (1991). Inuit Indigenous Knowledge and Science in the Arctic. Part of Symposium, *The Anthropology of Science and Scientists,* Washington D.C.: American Association for the Advancement of Science, Washington, D.C., www.carc.org/pubs/v20no1/inuit.htm.

Blue, A.W., Keyserlingk, E.W., Rodney, P., & Starzomski, R. (1999). A critical view of North American health policy. In H. Coward & P. Ratanakul (Eds.), *A cross-cultural dialogue on health care ethics* Waterloo, (pp. 215-225). ON: Wilfrid Laurier University Press.

Bosum, A., Ouje-Bougoumou Cree Nation, retrieved Nov. 2008. www.ouje.ca

Brant Castellano, M. (2008). A Holistic Approach to Reconciliation: Insights from Research of the Aboriginal Healing Foundation, *From truth to reconciliation: Transforming the legacy of residential schools*, Aboriginal Healing Foundation Research Series. http://www.ahf.ca/publications/research-series

Browne, A.J., Fiske, J. & Thomas, G. (2001). First Nations Women's Encounters with Mainstream Health Care Services & Systems, British Columbia Centre of Excellence for Women's Health. Available On-line: http://www.bccewh.bc.ca/publications-resources/documents/firstnationsreport.pdf

Buckley, H. (1992). From Wooden Ploughs to Welfare: Why Indian Policy Failed in the Prairie Provinces. Montreal and Kingston: McGill-Queen's University Press.

Bushie, B. (n.d). *Community Holistic Circle Healing: A Community Approach, Community Holistic Circle Healing.* Hollow Water, Manitoba, International Institute for Restorative Practice. Retrieved November 2009. http://www.iirp.org/library/vt/vt_bushie.html.

Cardinal, H. (1969). *The Unjust Society*. Douglas and McIntyre, Vancouver.

Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) (2001). Strategic Framework for the Inclusion of Indigenous Health in Nursing Curricula and the Development of Recruitment and Retention Strategies for Indigenous Australians in Nursing Education.

Cooney, C. (1994). A Comparative Analysis of Transcultural Nursing and Cultural Safety. *Nursing Praxis in New Zealand. 9*(1), 6-11.

Cornell, S., Curtis, C. & Jorgensten, M. (2003). *The Concept of Governance and Its Implications for First Nations*. Native Nations Institute for Leadership, Management, and Policy, Udall Center for Studies in Public Policy, The University of Arizona.

Coup, A. (1996). Cultural Safety and Culturally Congruent Care. *Nursing Praxis in New Zealand. 11*(1), 4-11.

Couzos, S. & Murray, R. (1973). *Aboriginal Primary Health Care: An Evidenced-based Approach*. South Melbourne: Oxford University Press.

Crisp, J., Potter, P.A., Griffin Perry, A., & Taylor, C. (2009). *Potter and Perry's Fundamentals of Nursing*, (3rd [Australian] ed.), Chatswood, N.S.W.: Mosby Elsevier Australia.

Crowe, K.J. (1991), *A History of the Original Peoples of Northern Canada* (Revised edition), Montreal and Kingston: McGill-Queen's University Press.

Davidhizar, R. (2001). Teaching Culture within the Nursing Curriculum Using the Giger-Davidhizar Model of Transcultural Nursing Assessment. *Journal of Nursing Education, 40*(6), 282-284.

Dickason, O.P. (1997). *Canada's First Nations* (2nd ed.), Toronto: Oxford University Press.

Dickie, B. (2000). *Hollow Water,* National Film Board of Canada, 48 minutes. http://www3.nfb.ca/collection/films/fiche/?id=50027.

Dion, S. (2007). Disrupting Molded Images: Identities, Responsibilities and Relationships – Teachers and Indigenous Subject Material, *Teaching Education, 18*(4), 329-342.

Dowd, T. & Eckermann, A. (1992). Cultural Danger or Cultural Safety: Remote Area Health Services. *The Australian Nurses Journal, 21*(6), 11-12.

Dowling, J. *Transversing the Cultural Gap- Cultural Awareness on Deployments*. Retrieved Nov. 2008, http://www.defence.gov.au/dpe/dhs/infocentre/adfnursingofficers/forum/2002/Cultural%20Diversity%20in%20the%20ADF.doc.

Durie, M. (2001). *Cultural Competence and Medical Practice in New Zealand*. Australian and New Zealand Boards and Council Conference. http://aictp.com/Resources/Cultural%20CCompetence.html.

Ellison-Lochsmann, L. (2003).Cultural Safety Kawa Mhakaruruhau, Auckland, NZ: Massey University, Retrieved December 2008 http://culturalsafety.massey.ac.nz

Flores, G., Gee, D. & Kastner, B. (2000). The Teaching of Cultural Issues in U.S. and Canadian Medical Schools. *Academic Medicine, 75*, 451-455.

Frideres, J. S. (1983). Native Peoples of Canada: Contemporary Conflicts (4th ed.), Scarborough: Prentice Hall Canada.

Goodman, A (2006). The Story of David Olds and the Nurse Home Visiting Program. *Grants Results Special Report*, Robert Wood Johnson Foundation. http://www.rwjf.org/files/publications/other/DavidOldsSpecialReport0606.pdf

Goode, T. D., Dunne, M.C. & Bronheim S. M. (2006). The Evidence Base for Cultural and Linguistic Competency in Health Care. *The Commonwealth Fund, 37.* http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=413821

Government of Canada Correctional Service Canada (2008). retrieved January 2009 http://www.csc-scc.gc.ca/text/pblct/so/aboriginal.

Government of Canada Health Canada (2000). *A Statistical Profile on the Health of First Nations in Canada for the Year 2000* report. www.hc-sc.gc.ca/

Government of Canada Health Canada (2004). *Building on Values: The Future of Health Care in Canada (The Romanow Commission)*. www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/romanow-eng.php.

Government of Canada Health Canada (2008). Health of Aboriginal People, retrieved Nov. 2008, http://www.hc-sc.gc.ca/fniah-spnia/index-eng.php.

Government of Canada Indian and Northern Affairs Canada (1996). *Royal Commission on Aboriginal Peoples,* www.ainc-inac.gc.ca/ap/pubs/sg/sg-eng.asp.

Government of Ontario Ministry of Community and Social Services (1994). Aboriginal Healing and Wellness Strategy. http://www.mcss.gov.on.ca/mcss/english/pillars/community/programs/aboriginal_healing.htm.

Greene, R. W. (2003). *Sociology and You.* Ohio: Glencoe McGraw-Hill. http://www.glencoe.com/catalog/index.php/program?c=1675&s=21309&p=4213&parent=4526.

Haslip, S. (2000). Aboriginal Sentencing Reform in Canada – Prospects for Success: Standing Tall with Both Feet Planted Firmly in the Air. *Murdoch University Electronic Journal of Law*, *7*(1).

Hurley, M.C. & Wherrett, J. (2000). Commentary on the Report of Royal Commission on Aboriginal Peoples, Parliamentary Library.

Kalt, J. (2007). The State of the Native Nations: Conditions under U.S. Policies of Self-Determination, *The Harvard Project on American Indian Economic Development*, Oxford University Press.

Kirkham, S. R. (2006). Review of the book *Cultural safety in Aotearoa New Zealand. Contemporary Nurse 22*(2), 333-4.

Kloster, D. (2008). Aboriginal Resource Council, quoted in Victoria Times Colonist, June 11, 2008.

Kruske, S., Kildea, S. & Barclay, L. (2006). Cultural safety and maternity care for Aboriginal and Torres Strait Islander Australians, *Women and Birth, 19*(3), 73-77.

Kulchyski, P. (2004). E-nakaskakowaaahk=A Step Back: Nisichawayasihk Cree Nation and the Wuskwatin Project. Winnipeg: Canadian Centre for Policy Alternatives, Manitoba Branch.

Kulchyski, P. (2005). *Green Green Water* Documentary Film, Panniqtuuq Summer School, Baffin Island, http://www.umanitoba.ca/faculties/arts/departments/native_studies people/kulchyski.html.

Kulchyski, P., McCaskill, D. & Newhouse, D. (Eds.) (1999). *In the Words of Elders: Aboriginal Cultures in Transition*, Toronto: University of Toronto Press.

Lane Jr., P., Bopp, M., Bopp, J., & Norris, J. (2002). Mapping the Healing Journey: The Final Report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Solicitor General Canada and the Aboriginal Healing Foundation. APC 21 CA, 2002. http://ww2.ps-sp.gc.ca/publications/abor_corrections/pdf/apc2002_e.pdf.

Leininger, M. (1991). Transcultural Nursing: The Study and Practice Field. *Imprint*.

Leininger, M. (1998). Leininger's Theory of Nursing: Cultural Care Diversity and Universality. *Nursing and Health Care*, *1*, 152-160.

Lenburg, C. (1995). *Introduction and Content to Promoting Cultural Competence.* Washington, DC: American Academy of Nursing.

Maxim, P. & White, J. (2006). School Completion and Workforce Transitions among Urban Aboriginal Youth. In J. P. White, S. Wingert, D. Beavon, & P. Maxim (Eds.), *Aboriginal Policy Research Moving Forward, Making a Difference*, Vol. III. (pp. 33-52). Toronto: Thompson Educational Publishing.

McClennon-Leong, J. & Kerr, J. R. (1999). Alternative Health Care Options in Canada, *Canadian Nurse*, *95*(10), 26-30.

McIntosh, P. (1988). *White Privilege: Unpacking the Invisible Knapsack*, Wellesley College Center for Research on Women.

McIntosh P. (1998). White Privilege, Color and Crime: A Personal Account. In C. R. Mann & M. S. Zatz, (Eds.). *Images of Color, Images of Crime: Readings*, Los Angeles: Roxbury Publishing Company.

Narayan, M. (2002). Six Steps Towards Cultural Competence: A Clinician's Guide. *Home Health Care Management & Practice*, *14*(5), 378-386(9).

National Aboriginal Health Organization (2006a). Cultural Safety/ Competence in Aboriginal Health: An Annotated Bibliography. Ottawa: NAHO.

National Aboriginal Health Organization (2006b). Fact Sheet: Cultural Safety, January 31, 2006. Ottawa: NAHO.

National Aboriginal Health Organization (2007). Slides, *Broader Determinants of Health in an Aboriginal Context*. Ottawa: NAHO.

National Center for Cultural Competence, Retrieved November 2008 http://www11.georgetown.edu/research/gucchd/nccc/.

Nguyen H.T. (2008). Patient Centred Care - Cultural Safety in Indigenous Health. *Australian Family Physician*. *37*(12), 990-4.

Nursing Council of New Zealand (2002). *Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing and Midwifery Education and Practice*. ISBN 0-908662-12-2. http://www.nursingcouncil.org.nz/culturalsafety.pdf.

Nursing Council of New Zealand (2005). Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice. Nursing Council of New Zealand, http://www.nursingcouncil.org.nz/Cultural%20Safety.pdf Odawa Native Friendship Centre, retrieved Nov. 2008, http://www.odawa.on.ca

Parboosingh, J. (2003). Medical Schools' Social Contract: More than just Education and Research. *Canadian Medical Association Journal*, *168* (7), 852-853.

Paterson, B., Osborne, M. & Gregory, D. (2004). How Different Can You Be and Still Survive? Homogeneity and Difference in Clinical Nursing Education. *International Journal of Nursing Education Scholarship, 1*(1): 1–13.

Pauktuutit Inuit Women of Canada (2006). *The Inuit Way: a guide to Inuit culture.* Ottawa: Pauktuutit Inuit Women of Canada.

Paul, D. (1998). 'It's not as Easy as just Walking in the Door': Interpretations of Indigenous People's Access to Health Care. *Australian Journal of Primary Health- Interchange*, *4*(1).

Pence, A. & Ball, J. (2000). Two Sides of An Eagle's Feather: University of Victoria Partnerships with Canadian First Nations Communities. In H. Penn (Ed.), *Theory, Policy and Practice in Early Childhood Services*. (pp. 36-48). Buckingham, United Kingdom: Open University Press.

Polaschek, N.R. (1998). Cultural Safety: A New Concept in Nursing People of Different Ethnicities. *Journal of Advanced Nursing*, *27*, 452-457.

Ramsden, I. (1992). Kawa Whakaruruhau: Guidelines for Nursing and Midwifery Education. Wellington, NZ: Nursing Council of New Zealand.

Ramsden, I. (1996). The Treaty of Waitangi and Cultural Safety: The Role of the Treaty in Nursing and Midwifery Education in Aotearoa. In Nursing Council of New Zealand, *Guidelines for cultural safety in nursing and midwifery education.* Wellington, NZ: NCNZ.

Ramsden, I. (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*, Wellington: Victoria University. http://culturalsafety.massey.ac.nz/RAMSDEN%20THESIS.pdf.

Raphael, D. (2004a). *Social Determinants of Health: Canadian Perspectives*. Toronto: University of Toronto Press.

Raphael, D. (Ed.) (2004b). The Social Determinants of Health: Canadian Perspectives. Canadian Scholars' Press.

Raphael, D. (2008). Introduction to the Social Determinants of Health. In D. Raphael, D. (Ed.), *Social Determinants of Health: Canadian Perspectives* (2nd ed.). (pp. 5-18) Toronto: Canadian Scholars' Press.

Redwood-Campbell, L., MacDonald, W.A. & Moore, K. (1999). Resident's Exposure to Aboriginal Health Issues, Survey of Family Medicine Programs in Canada. *Canadian Family Physician*, *45*, 325-330.

St. Denis, V. (2007). Aboriginal Education and Anti-Racist Education: Building Alliance Across Cultural and Racial Identity, *Canadian Journal of Education*, *30*(4), 1068-1092.

St. Denis, V. & Schick C. (2005) Troubling National Discourses in Anti-Racist Curricular Planning. *Canadian Journal of Education*, *28*(3), 295-317.

Salimbene S. (1999). Cultural Competence: A Priority for Performance Improvement Action. *Journal of Nursing Care Quarterly, 13*(3), 23-35.

Shah, C.P. & Svoboda, T. (1996). The Visiting Lectureship on Aboriginal Health: An Educational Initiative at the University of Toronto. *Canadian Journal of Public Health, 87*(4), 272- 274.

Smith, M.S. (2003). Race Matters and Race Manners. In Brodie, J. and Trimble, L. (Eds.), *Reinventing Canada: Politics in the 21st Century,* Toronto: Prentice Hall.

Smye, V. & Brown, A.J. (2002). Cultural Safety and the Analysis of Health Policy Affecting Aboriginal People. *Nurse Researcher, 9*(3), 42-56.

Smylie, J. (2001). A Guide for Health Professionals Working with Aboriginal Peoples: Health Issues Affecting Aboriginal Peoples. *SOGC Journal*, *100*(1), 1-15.

Stasiulis, D. & Abu-Laban, Y. (2004). Unequal Relation and the Struggle for Equality: Race and Ethnicity in Canadian Politics. In M. S. Whittington & G. Williams (Eds.), *Canadian Politics in the 21st Century* (6th ed.), Toronto: Thomson Nelson.

Stout, M. D. & Downey, B. (2006). Nursing, Indigenous Peoples and Cultural Safety: So what? Now what? In *Contemporary Nursing*, International Council of Nurses, http://www.contemporarynurse.com/archives/vol/22/issue/2/article/749/nursing-indigenous-peoples-and-cultural-safety.

Strong, M. (1990). Foreword, in J. Burger, *The Gaia Atlas of First Peoples: A Future for the Indigenous World*, (p. 6). Penguin Books, Ringwood. http://www.ens.gu.edu.au/ciree/LSE/MOD5.HTM#res1

Toulouse, P. R. (2008). *Integrating Aboriginal Teaching and Values into the Classroom,* in Government of Ontario, Literacy and Numeracy Secretariat. www.edu.gov.on.ca/eng/literacynumeracy/inspire/research/Toulouse.pdf.

Townsend, T. & M. Wernick (Eds.) (2008). *Hope or Heartbreak: Aboriginal Youth and Canada's Future*, Horizon Policy Research Initiative and Government of Canada Policy Research, *Horizons, 10*(1), 4-6. http://www.policyresearch.gc.ca/doclib/Horizons_Vol10Num1_final_e.pdf

TVO interview (2005). *Allan Gregg in Conversation With …* March 27, 2005; www.taiaiake.com.

Ulluwishewa R., Adbul Aziz Kaloko & Dyhairuni Hj Mohammed Morican (1997). *Indigenous Knowledge and Environmental Education*. Paper presented at Environmental Education Workshop, University of Brunei Darussalam. www.unesco.org/education/tlsf/TLSF/theme_c/mod11/uncom11/htm.

University of Victoria, Cultural Safety: Peoples Experiences of Colonization in Relation to Health Care (module 1) Retrieved January 2009. http://web2.uvcs.uvic.ca/courses/csafety/mod1/notes2.htm

University of Victoria, Cultural Safety: Peoples Experiences of Colonization in Relation to Health Care (module 3), Retrieved January 2009. http://web2.uvcs.uvic.ca/courses/csafety/mod3/index.htm

Wachtler, C. & Troein, M. (2003). A Hidden Curriculum: Mapping Cultural Competency in a Medical Programme. *Medical Education*, *37*(10), 861-868(8).

Wepa, D. (2003). An Exploration of the Experiences of Cultural Safety Educators in New Zealand: An Action Research Approach. *Journal of Transcultural Nursing*, *14*(4), 339-348.

Wepa, D. (Ed.) (2004). *Cultural Safety in Aotearoa, New Zealand*. Auckland: Pearson Education.

Wesley-Esquimaux, C. & Smolewski, M. (2004). Historic Trauma and Aboriginal Healing. Ottawa: Aboriginal Healing Foundation.

Williams, R. (1999). Cultural Safety — What Does It Mean for Our Work Practice? *Australia and New Zealand Journal of Public Health, 23*(2).

William, T. & Bellefeuille, G. (2006). An Evidence-based Formative Evaluation of a Cross Cultural Aboriginal Mental Health Program in Canada, *Australian e-Journal for the Advancement of Mental Health* (AeJAMH), *5*(3).

World Health Organization (2008). Final Report - Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health, Commission on Social Determinants of Health.