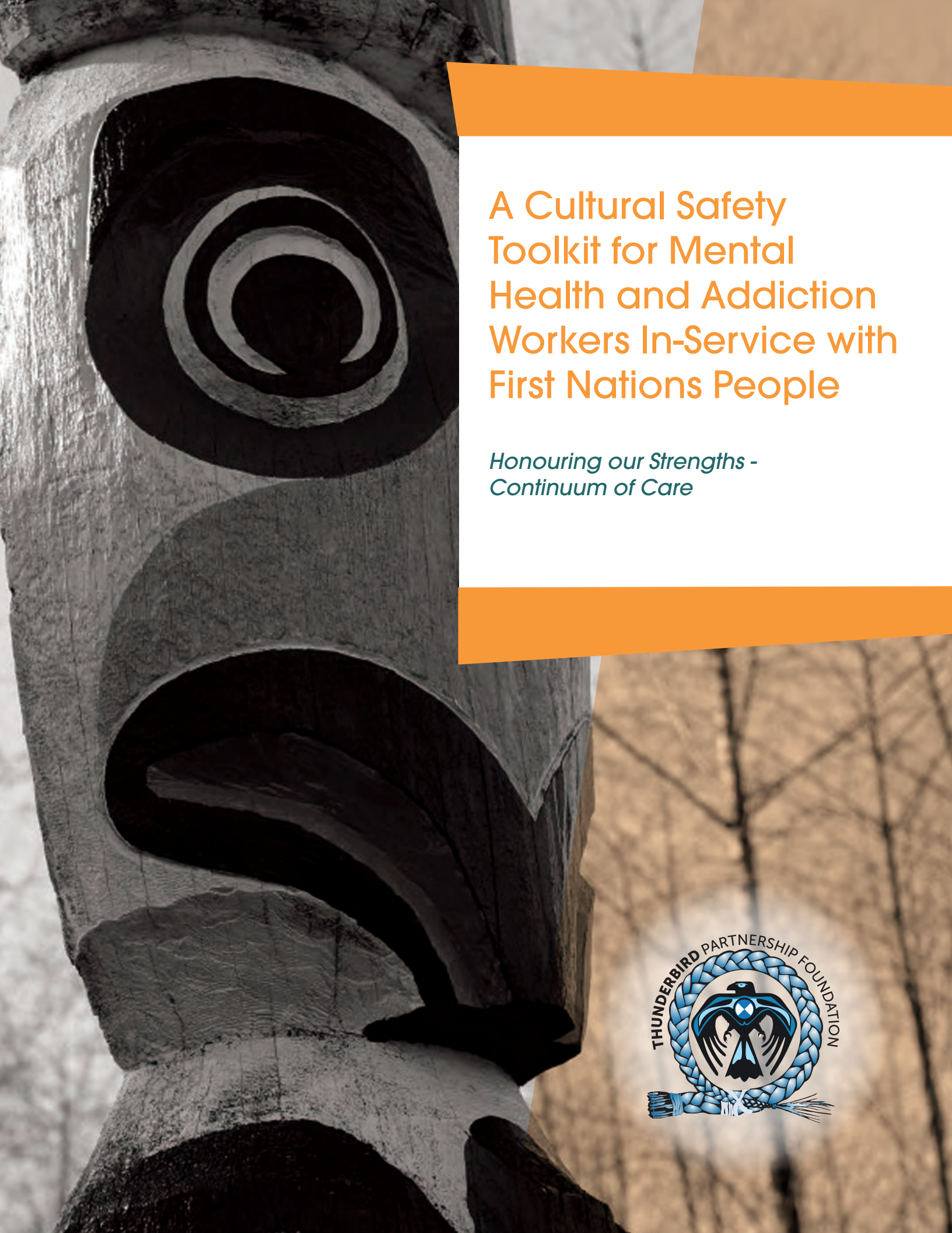


A Cultural Safety Toolkit for Mental Health and Addiction Workers In-Service with First Nations People

Honouring our Strengths - Continuum of Care

THUNDERBIRD PARTNERSHIP FOUNDATION

Table of Contents

Suggested Tools for Renewal Framework's Stepping Stones:

Cultural Humility

"The starting point for such an approach is not an examination of the client's belief system, but rather having health care/service providers give careful consideration to their assumptions and beliefs that are embedded in their own understandings and goals of their encounter with the client." (California Health Advocates, 2012)

Putting cultural humility into practice, as a foundational principle in the Renewal Framework Stepping Stones, corresponds with First Nations teachings around humility. For example, Turner states, "First Nations people viewed our relationship with nature as an equal one; humility is to know ourselves as a sacred part of Creation, no better and no worse than other parts (2010:19). Furthermore, cultural humility "does not assume a hierarchy of skills and competencies, but does call for the capacity to change in response to humility" (Eisenbruch and Eisenbruch, 2005: Cultural humility). In 1998, Melanie Tervalon and Jann Murray-Garcia came up with the concept of cultural humility, which is defined as follows:

"a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (Tervalon and Murray-Garcia, 1998:117).

Tervalon and Murray-Garcia identify that understanding the client's health beliefs and practices are vital to cultural safety. For example, not understanding First Nations beliefs and practices creates a proxy of "non-Native for Native knowledge, values and identity" (Hampton, 1995:35 in Maina, 1997:301), which contributes to the loss of identity the client may feel. Thus, cultural humility is the support to cultural safety in the Renewal Framework Stepping Stones.

The following activities and videos in this toolkit are used to promote Cultural Humility:

1.Watch video on Cultural Humility definition:
http://youtu.be/SaSHLbS1V4w

2.For a visual of what cultural humility is, hand out NNAPF's *Cultural Humility Venn Diagram in Appendix A.

3.Reflective Journals will help you focus your thoughts and feelings in order to have a clearer picture of your beliefs, values, assumptions, and bias. In addition, it will also guide you in your transformational learning.

4. Answer the following question in your Reflection Journal:

"What is reflection? (e.g., in an everyday sense, reflection is a 'looking back' on experiences; in a university and professional context, it is a looking back on experiences so as to learn from them. Therefore, reflection is a means of constructing knowledge about one's self and about the world.)

5. Handout out Appendix B, NNAPF's Steps to Self-Reflection. Complete the handout. Then in your Reflection Journal, write down your beliefs, values, cultural practices, and social structures.

6. Handout Appendix C, NNAPF's 5 W's to Cultural Safety.

7. Write in your reflective journal, your impressions of this quote: *"Being humble means recognizing that we are not on earth to see how important we can become, but to see how much difference we can make in the lives of others." - Gordon B.Hinckley*

8.Watch the following video to understand the reflection process: "The Express":
http://www.wingclips.com/movie-clips/the-express/your-rules-too

9. After watching the video, answer some question on reflecting to write in your Reflection Journal:

• What were the coach's assumptions?

• What were the impact(s) of these assumptions?

• How did Ernie challenging the beliefs, values, and social structure impact the situation?

• What were your thoughts and feelings?

• What did you learn about yourself and your assumptions?

• How do your assumptions affect your work life?

10. Complete the Care Quality Questionnaire in Appendix D, to identify your role in providing quality care for your clients.

11.Watch video on traditional healing:
http://youtu.be/aEGMzXq6W4A

• What are thoughts on this video?

• What did you learn from this video?

Critical Reflection

"Who are you when no one else is around?"
Step two of the Renewal Stepping Stones is Critical Reflection which is defined as, "a social theory that emphasizes self-reflection and is pertinent to cultural safety because understanding what one brings to the environment will develop a critical mindset (Pockett and Giles, 2008). For example, a critical mindset is influenced by ones profession, professional ethics, one's own values and one's life experience and it's important to understand how all of these influencing factors impact on one's relationship within a helping profession and specifically when the relationship is outside the mainstream population. Essentially, it's important to develop a critical mindset to be able to open space to a differing world view and set of values. This critical mindset is necessary to translate effectively between two different world views.

* As of June 2015, the National Native Addictions Partnership Foundation (NNAPF) changed its name to the Thunderbird Partnership Foundation, a division of NNAPF Inc. For more information, visit www.thunderbirdpf.org.

The following activities in this toolkit are used to promote critical reflection.

1. Write in your Reflection Journal the following questions about how much do you know right now? Answer the questions below to the best of your ability, then again at the end of this lesson plan.

a)Think of some of the 'complaints' that non-Indigenous people have regarding First Nations, Inuit and Métis people. (i.e., they are lazy and can't hold down a job, they drink too much alcohol.) Are these complaints valid?

b)What is the difference between practical and symbolic reconciliation? Should there be a separation? Why is this significant to First Nations, Inuit and Métis peoples in Canada?

2. Complete the Assumption Analysis Table in Appendix E. Assumption Analysis involves thinking in such a manner that it challenges beliefs, values, cultural practices, and social structures in order to assess their impact on our daily proceedings. Assumptions are our way of seeing reality and aid us in describing the order of relationships.

Prior to watching the video clip, think about the opening setting you observe.

3. Watch the following video clips then answer the questions in your reflective journal:

"Charlotte's Web" - Write a list of assumptions you made prior to watching the video, during the video and after the video about your beliefs, values, cultural practices, and social structures.
http://www.wingclips.com/movie-clips/charlottes-web/scarecrows

4. Here are some questions for you to answer in your reflective journals:

• What were the crow's assumptions?

• What were the impact(s) of these assumptions? How would challenging the beliefs, values, cultural practices, and social structure impact the crows?

• In what ways could the crows challenge the beliefs, values, cultural practices, and social structures in order to assess their impact on our daily proceedings?

• What did you learn about yourself and your assumptions?

• How do your assumptions affect your work life?

"Gandhi" - Despite a potentially violent confrontation ahead, Gandhi refuses to adjust his path chooses to walk into danger with the willingness to absorb punishment to retain his dignity.
http://www.wingclips.com/movie-clips/gandhi/other-cheek

5. Here are some questions to answer in your reflective journal:
• What were the priest's assumptions?
• What were the impact(s) of these assumptions?
• How did Gandhi challenge the beliefs, values, and social structure impact the situation?
• What were your thoughts and feelings?
• What did you learn about yourself and your assumptions?
• How do your assumptions affect your work life?

Critical Reflection

Critical reflection is the process of analysing, reconsidering and questioning experiences within a broad context of issues (e.g., issues related to social justice, curriculum development, learning theories, politics, culture, or use of technology).

"Reflection activities provide the bridge between community service activities and the educational content of the course. Reflection activities direct the student's attention to new interpretations of events and provide a means through which the community service can be studied and interpreted, much as a text is read and studied for deeper understanding." (Bringle & Hatcher, 1999).

6. Study the handout Critical Reflection Standards in Appendix F.

7.In your Reflection Journals, write what the quote means to you?
"The process of healing must be based on our traditional spiritual values of respect, pride, dignity, sharing, hospitality and mutual aid... Self-reliance begins with the individual, then is built fy the family, then by the community, and finally, by our relations with other nations." - Chief Jean-Charles Pietacho and Sylvie basile, Mingan First Nation community.

Cultural Sensitivity

"We may have different religions, different languages, different colored skin, but we all belong to one human race." - Kofi Annan (Ghanaian Diplomat, 7th UN Secretary-General, 2001 Nobel Peace Prize Winner; b. 1938)

Cultural Sensitivity is defined as, "recognition of the differences between cultures and world view (Chandler, 2002). There is more to appreciating that differences exist, sensitivity requires the health care provider to be vigilant in promoting practice with specific and targeted attention to world view and cultural meaning. Sensitivity goes beyond recognizing differences to include appreciation for and comfort with differences.

The following activities in this toolkit will be used to promote cultural sensitivity.

1. Write in your Reflection Journal, the following questions about what you know right now:

a. What do you know about First Nations, Inuit, and Métis people of Canada?

b. How are they unique from each other?

c. What is culture?

d. Name ten Indigenous languages in Canada.
How many are there?

e. How do First Nations believe about dreams?

2. Watch video on Cultural Sensitivity:
"The Do's and Don't's of Cultural Sensitivity" - learn how to be culturally sensitive:
http://www.youtube.com/watch?v=tRl6ALEjeV0&feature=colike

3. Complete the Diverse Knowledge Table in Appendix H.

4. Study the handout in Appendix I, Iceberg Model to visually understand culture.

5. Watch the videos in "Sharing the Role of Aboriginal Traditional Culture in Healing from Addictions"
http://www.addictionresearchchair.ca/creating-knowledge/provincial/sharing-the-role-of-aboriginal-traditional-culture-in-healing-from-addictions/what-is-being-shared/view/

6. Write in your reflection journal, the following questions:

a) How do these stories contribute to your understanding of cultural sensitivity?

b) What are the forces that create, define, and mold your culture's core values?

Cultural Awareness

"Culture is You, Culture is Me, Culture is Humanity."
~ Dr. Angela Jackson

Cultural awareness "addresses the diversity between clients and between health care provider and each client. At this stage of the stepping stones, the health care provider is bring forth the learning from step one to three and is actively pursuing a greater awareness of the culture and world view of the clients / client population so that the health care provider can meaningfully assists with integrating Aboriginal and Western therapeutic practices (Papps, 2005).

The following activities will be used to promote cultural awareness:

1. How much do you know right now and answer these questions in your Reflection Journal:

a. Why is 1876 significant to First Nations people in Canada and what impact did it create on First Nations people in Canada?

b. How do First Nations, Inuit and Métis peoples of Canada maintain their culture?

c. In what way is the land important to First Nations, Inuit and Métis peoples of Canada?

d. What are the benefits and obligations of kinship relationships?

2. Watch videos on Indian Residential School:

"*Into the West - Carlisle Indian School*" - A video clip from TNT's mini-series "Into the West" showing what young Native American children went through in the name of assimilation.
http://www.youtube.com/watch?v=yfRHqWCz3Zw&feature=colike
"Kill the Indian, Save the Man" - Interview with IR survivor
http://youtu.be/eJKrGu2cwT0

3. Write in your Reflection Journal some reflection questions that could help you better understand the client you are working with:

• What do you know about the client's community's cultural teachings?

• Are you aware of the client's family supports?

• What do you know about colonialism?

• Has your client or any of his/her family been to Indian Residential School?

• How do you think Indian Residential School impact your client?

• What is the significance of a cultural ceremony (i.e., smudging ceremony)? Source:
http://www.aboriginalhr.ca/en/resources/getstarted/cultures

Cultural Competency

"Colonialism is not satisfied merely with holding a people in its grip and emptying the native's brain of all form and content. By a kind of perverted logic, it turns to the past of the oppressed people, and distorts, disfigures, and destroys it." ~Frantz Fanon, The Wretched of the Earth (1963)

Cultural Competence is a process that involves the health care provider actively developing their knowledge and skills specific to clients/client populations culture and world view while demonstrating a clear definition of the limits and boundaries in knowledge, skills, cultural specific practice. Cultural competency develops a strong foundation to promoting a culturally safe environment for the client (IPAC-RCPSC Family Medicine Curriculum Development Working Group, 2009).

Furthermore, according to the Honouring our Strengths Report, Cultural competence requires that service providers, both on- and off- reserve, are aware of their own worldviews and attitudes towards cultural differences; and include both knowledge of, and openness to, the cultural realities and environments of the clients they serve. To achieve this, it is also necessary for indigenous knowledge to be translated into current realities to meaningfully inform and guide direction and delivery of health services and supports on an ongoing basis (8).

The following activities will be used to promote cultural competence.

1.How much do you know right now and answer these questions in your Reflection Journal:

a. How is access to resources (human, spiritual, environmental) among the communities?

b. What happens when Aboriginal peoples start adopting some of the ideas, values, and socio-cultural practices of colonial agents? (e.g., hierarchal power structures, patriarchal family structures, material accumulation, individualism, alcohol)

c. As a result of this colonial economy shift, what became obstacles to progress and settlement? (Aboriginal peoples); and what were labeled as? (The Indian Problem)

d. What is internalized colonialism?

e. What are the characteristics Aboriginal peoples are experiencing because of internalized colonialism? (Economic marginalization - high unemployment; environmental exploitation and destruction; Dramatic socio-cultural disequilibrium - chaos)

f. What is decolonization and why is it important to the health and wellbeing of First Nations and Inuit peoples in Canada?
Watch a satire of Australian colonialism titled, "Babakiueria"
http://www.youtube.com/watch?v=SHK308_MTiU&feature=colike

2. Write in your Reflection Journal your impression of the video, "Babakiueria."

3. Study the Five Stages of Colonialism Theory Diagram in Appendix K.

Phase 1:

The Steady State is pre-contact when First Nations and Inuit had their own social, political, economical, cultural societies and structures.

1. Watch video *"500 Nations Intro - Creation Through the Eyes of American Indians"*: http://youtu.be/RygOSKqeYU8

2. Answer the following question in your Reflection Journal:
• What are the traditional world views, philosophies, and spiritual intact?

3. Watch video *"500 Nations The Story of Native Americans - 1"*: http://youtu.be/EedWZ_jaTiE starting at 0:16:50 until 45:95

4. Answer the following questions in your Reflection Journal:

• What are the Aboriginal laws and customs function to maintain social cohesion in families and communities?

• How are the Aboriginal family structures?

• Are the Aboriginal communities are autonomous and self-sufficient?

• How are the land and resources utilized?

• How did the Aboriginal leaders negotiate territories and international relations?

Phase 2:

First Encounter is the arrival of European colonial agents seeking economic profits and Aboriginal people enter the global market system, created by the Europeans, as producers of resources.

1.Watch video "*500 Nations The Story of Native Americans - 2*": http://youtu.be/XLM-HKPi7r4

2. Answer the following questions in your Reflection Journal:

• What begins to happen in this global market system to Aboriginal peoples?

• What happens to the production for trade (hunting, trapping, supplying)? How does this impact the local resources?

• Why do the Aboriginal peoples adjust their philosophical and spiritual relationships with the animal peoples in order to exploit them for profit?

• How has the pre-contact international relations begin to look after there are competition for resources and access to European commodities.

• Why are there social relations with colonial agents through trade, intermarriage and prolonged contact?

• What happened with the introduction of foreign diseases? (e.g., epidemics, dramatic decline in population decline - between 30% and 90%, target groups: children who were the future and old people who were knowledge keepers)

• What do you think Aboriginal peoples begin to feel after this phase? (e.g., demoralization: lose faith in traditional medicine and healers, guilt, self-hate)

Phase 3:

The Imposition of Colonial Relations is when power imbalances occurred. (e.g., Dominant vs Subordinate)

1. Watch the following video on Indian Residential Schools. Where are the children? Healing the legacy of residential schools from: http://www.wherearethechildren.ca/

2. Answer the following questions in your Reflection Journal:

• Why was there an increase in colonial presence? (settlement)

• How was the increase demand for Aboriginal land impact Aboriginal peoples? (displacement)

•What happened when colonial economy shift from trade to agriculture? (Aboriginal labour and skills were not needed anymore; relationship shifts from interdependence to dominate/ subordinate)

• What was being used to justify colonial theft? (Racialization theories popularized)

• What was the solution to the Indian Problem? (extinction or assimilation)

• How was this accomplished? (Missionaries impose Euro-Canadian ideals, values, and practices; family structures - patriarchal, hierarchy - deference to authority, material accumulation, private property and individualism)

• How did Christianity contribute to the Indian Problem? (religious justification for political, social and economic domination)

• How were European ideals, values, and practices imposed onto Aboriginal peoples? (Colonial administration, later federal government - The Indian Act)

• What are examples of these impositions? (e.g., confinement and external political and social control; disempowered local authority; residential schools: psychological and physical violence; economic sanctions; prohibition of traditional spiritual practices; low-quality services and educational opportunities; exclusion)

• What impact did racialization have on Aboriginal peoples? (denying Aboriginal peoples equal access and opportunity; kept in a state of dependence; subordination and demoralization; creation of a huge and dehumanizing social service-delivery)

Phase 4:

Manifestations of Internalized Colonialism is when Aboriginal peoples experience marginalization and internalized colonialism:

1. Watch the following video on impact of colonialism: http://www.youtube.com/watch?v=7KXGaah8AoE&feature=colike

2. Answer the following questions in your Reflection Journal:

• What are the impacts of internalized colonialism on Aboriginal communities? (e.g., violent crimes, high suicide rates, penal incarceration, social assistance dependency, chemical dependence, low education levels; generational cycles of the above)

• How are Aboriginal families impacted? (family dysfunction and estrangement; family violence, wife battery, child abuse, child abandonment, children in social service care, sexual assault and incest; generational cycles of the above)

• What does dehumanization and alienation mean and why would it be relevant to Aboriginal peoples in this phase? (e.g., cultural, schizophrenia, low self-esteem and confidence, self-hate, feelings of inferiority, apathy and lethargy, feelings of hopelessness, increase in health problems, increase in psychological and mental disorders; generational cycles of the above)

Phase 5:

Decolonization is the rejecting of the colonizer and his victimization and reclaiming languages, culture, spirituality, ceremonies and communities.

1. Watch the following video on decolonization: http://www.youtube.com/watch?v=yfdCaFEls_c&playnext=1&list=PL72B89C3DCBAB248B&feature=results_main

2. Answer the following questions in your Reflection Journal:

• How do Aboriginal people decolonize? (Appropriate tools, such as schooling, life skills, etc. of the oppressor to challenge oppression)

• How do Aboriginal people resist in direct and indirect ways to reject the colonizer?

• What do Aboriginal peoples need to recover? And why? (The individual needs to recover the sense of: safety, identity, power, integrity, possibility, abundance, connection, strength, compassion, self-protection, autonomy, faith)

3. To encourage critical thinking on decolonization, answer the following questions in your Reflection Journal:

• How would you know when this stage is reached?

• Who will benefit from decolonization? Why?

• What do you think should be the next steps for First Nations, Inuit, Métis, and Canada's relationship?

Reciprocity

"[The concept of reciprocity was] used by Cree and others when getting stories or knowledge from others – it was seen as taking something away from someone, so you had to give something back for it to be an equal and respectful exchange." ~ Herman Michell

The process of reciprocity which is a moral theory that First Nations people value and is "the outline of our non voluntary social obligations – the obligations we acquire in the course of social life... examples include some of our obligations to our families, to future generations, and to obey the law" (Becker, 1990:3). As such, reciprocity is closely linked with world view and values of First Nations people. This principle is foundational to the provision of services and supports. For example, much of the health care system is individually focused, necessarily so, while family, community and an obligation to the future are foundational to wellness for First Nations people.

The following activities will be used to promote the concept of reciprocity:

1. How much do you know right now, answer the following questions in your Reflection Journal:

• What is the First Nations belief on reciprocity?

• Acknowledging a shared history, what does this mean?

• What is the history of Indigenous peoples in the place you now live?

• When did First Nations people have the right to vote?

• What is the significance of Stolen Sisters?

• What is the Royal Commission on Aboriginal Peoples?

• What does culture mean to you?

2. Exchanging stories (e.g., Share a life experience you believe is similar to your clients life and how you overcame the obstacle.)

3. Share Community Conversation Sheets - Reciprocity: http://www.addictionresearchchair.ca/wp-content/uploads/2012/02/Community-Conversation-at-a-Health-Centre.pdf

4.View video: Oren Lyons - "We Are Part of the Earth" http://www.youtube.com/watch?v=bSwmqZ272As&feature=colike

Cultural Safety

[An environment] *"which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what, they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening."* (Williams, 2003, p3).

Cultural Safety builds upon all previous stepping stones to speak to the service provider within the context of the service organizations or environment. Cultural safety extends beyond cultural awareness and sensitivity within services and includes a reflection of cultural, historical, and structural differences and power relationships within the care that is provided. It involves a process of ongoing self-reflection and organizational growth for service providers and the system as a whole to respond effectively to First Nations people (AFN, NNAPF, and FNIHB, 2011:8) through culturally relevant service policies, protocols, and relationships with First Nations communities and service provider environment. For example, most health and wellness service providers promote a non-culturally specific environment, a clean pallet so to speak while an environment that promotes First Nations culture would actually promote inclusion and engagement.

Furthermore, cultural safety is defined as extending *"beyond cultural awareness and sensitivity within services and includes reflecting upon cultural, historical, and structural differences and power relations within the care that is provided. It involves a process of ongoing self-reflection and organizational growth for service providers and the system as a whole to respond effectively to First Nations people"* (Honouring our Strengths Report, 2011,8).

1. Write in your Reflection Journal what you know about the following questions:

a) What day in 2008 did Prime Minister Stephan Harper apologize to the Indian Residential School survivors?

b) Why was this apology significant to First Nations people in Canada?

c) Do you know anyone who was moved emotionally by this apology?

2. Watch video on Indian Residential School Statement of Apology by Prime Minister Stephen Harper: http://www.aadnc-aandc.gc.ca/eng/1100100015677/1100100015680

3.Write in your Reflection Journal your feelings and thoughts about the apology.

4. Watch videos on cultural safety: http://web2.uvcs.uvic.ca/courses/csafety/mod2/glossary.htm http://www.ubc.ca/okanagan/culturalsafety/__shared/printpages/page10860.html

5. Group exercise

a) In small groups consider how cultural safety can be created in your workplace.

b) Discuss and write down a range of activities that you can feed back to the larger group.

c) The facilitator will invite a whole group discussion to share everyone's ideas.

d) From the group discussion, choose at least three strategies that you will be able to personally put into practice.

e) Record these individually on your assessment sheet and hand in to the facilitator.

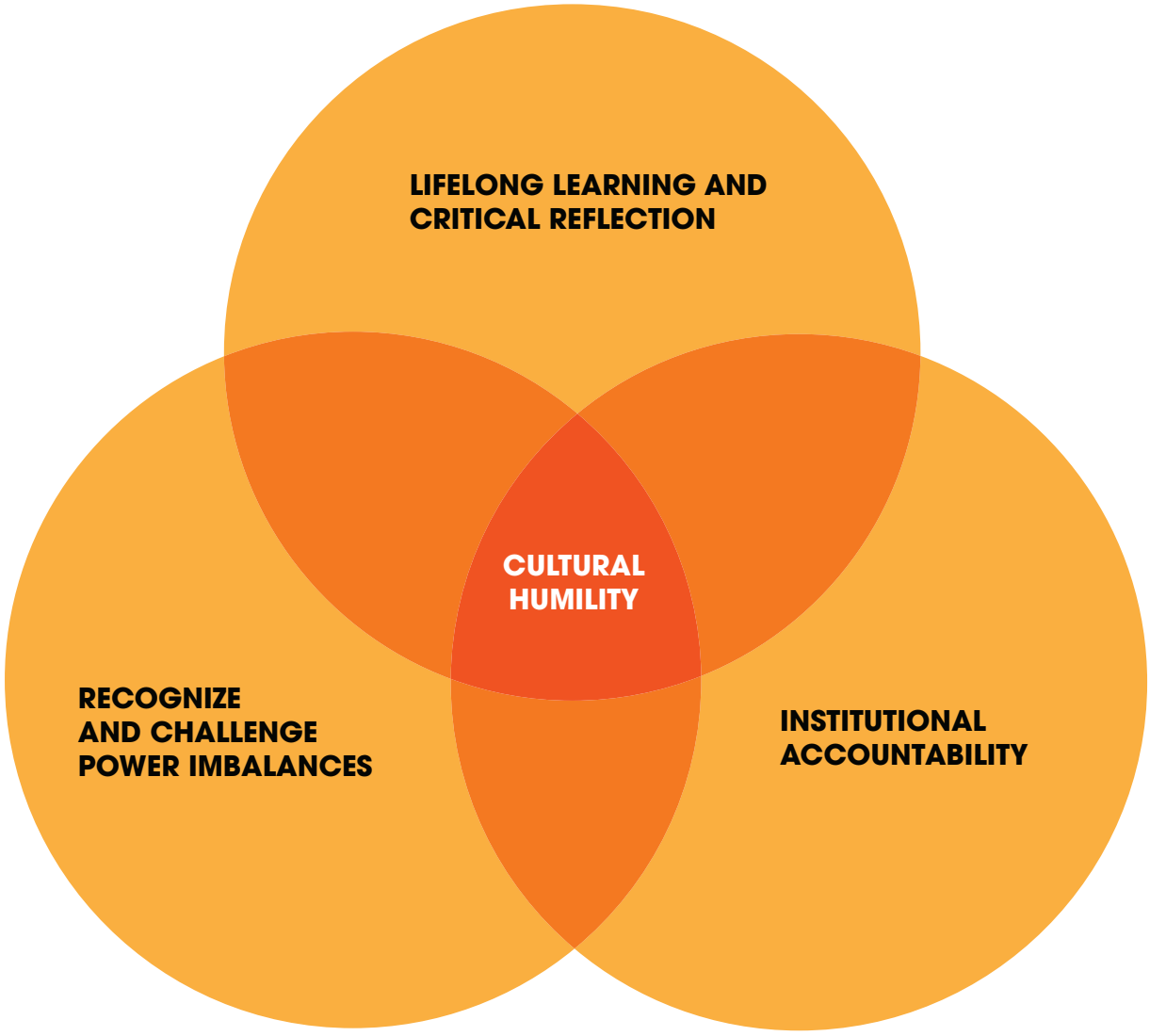
6. Review the NNAPF's Renewal Stepping Stones to Cultural Safety Sheet in Appendix G

APPENDICES

A: NNAPF's* Cultural Humility Venn Diagram

*As of June 2015, the National Native Addictions Partnership Foundation (NNAPF) changed its name to the Thunderbird Partnership Foundation, a division of NNAPF Inc. For more information, visit www.thunderbirdpf.org.

Cultural humility is, **"a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations."** (Tervalon and Murray-Garcia, 1998:117)



B: NNAPF's Self-Reflection Steps
Here are some strategies which will help you achieve the deep thinking within your Reflection Journal:

B. NNAPF'S SELF REFLECTION STEPS

Here are some strategies which will help you achieve the deep thinking within your Reflection Journal

a)
b)

C: The 5 W's of Cultural Safety

Who is Cultural Safety for?

Anyone who is not the dominant culture needs to have a culturally safe environment to feel respected and valued. The dominant culture in Canada is the Western, non-Indigenous culture. Therefore, to respect and improve the wellness of all people, cultural safety is necessary.

What is Cultural Safety?

Cultural safety is an effect of a strengthening, encouraging, and empowering the cultural identity of Indigenous peoples. According to the 2011 Honouring Our Strengths Report,

"Services, both in Indigenous or non-Indigenous environments, recognize the cultural diversity within First Nations and aim to competently relate to individuals, families and communities in consideration of, and in relation to, their social, political, linguistic, economic and spiritual realities. This extends beyond cultural awareness and sensitivity within services and includes reflecting upon cultural, historical, and structural differences and power relationships within the care that is provided. It involves a process of ongoing self-reflection and organizational growth for service providers and the system as a whole to respond effectively to First Nations people." (9)

When should Cultural Safety be relevant?

Colonization has been the main factor of the broken down family and social structures of Indigenous peoples. In addition, understanding the historical trauma of the oppressive policies enforced upon Indigenous peoples needs to be acknowledged, and understood to witness the detrimental impact these oppressive policies have had on Indigenous peoples.

Where is Cultural Safety needed?

It is important to break the cycle of colonization within the very institutions that have disrupted Indigenous family and social systems. Cultural safety is needed in every institution, community, organization that serves and employs Indigenous people.

Why is Cultural Safety needed?

We all have culture, whether we are First Nations, Métis, Inuit, or of European descendent. Cultural safety is needed to be able to provide excellent care by acknowledging, respecting and honouring the cultural values and norms of the people requiring care.

How is NNAPF's Renewal Leadership Team addressing Cultural Safety?

The development of a cultural safety toolkit is one of the renewal projects from the Honouring Our Strengths recommendations by the cultural practitioners and Elders at the NNADAP Renewal Indigenous Knowledge Forum. The purpose of this cultural safety toolkit is to assist mental health and addiction workers to effectively and safely communicate, verbally and non-verbally, with First Nations clients. This toolkit builds upon a common value within many cultures, which is humility.

D: Care Quality Questionnaire

The following questions were taken from the Care Quality Commission's website (http://archive.cqc.org.uk/applicationhelp/equality,diversityandhumanrights.cfm) and adapted to this lesson plan.

Promotion of equality, diversity and human rights

How do you ensure that the promotion of equality, diversity and human rights influence your service priorities and plans?

Increasing the influence of equality, diversity and human rights

What are you doing to increas the influence of the equality, diversity and human rights issues on the planning and delivery of the services.

Addressing client's diverse needs:

What do you do to understand the diverse needs of people who use your services?

How do you act on these needs?

How do you let people know what you do about this?

What capacity do you have in terms of skills base, knowledge and experience as well as resources, to deal with diverse needs?

Ensuring human rights and diversity issues are embedded in your practice:

When completing this section, your answers should demonstrate how you meet the demands of equality, diversity and human rights. If there are any where the answers are not applicable, you should identify these.

Make sure race, age, gender (including gender identity), sexua orientation, disability, religion and beliefs are included in process.

Provide information and services accessible to people who use them.

Ensure staff understand and respect people's faith.

Encourage an open and inclusive environment where people feel comfortable expressing themselves.

E: NNAPF's Assumption Table

List some assumptions that you have regarding First Nations issues and/or mental health or addictions:

Assumption	Where did this assumption come from?	How certain are you this assumption is true?	What is a challenge to this assumption?	What have you learned about your assumption?

F: Critical Reflection Standards Table

Below is a chart of the important points to your critical reflection. Critical Reflection Goal = Thinking Critically.

Critical Thinking Standard	Description	Associated questions to ask to check your thinking
Integration	Service experience clearly related to the learning	Have I clearly shown the connection between my experience and my learning?
Clarity	Expands on ideas, express ideas in another way, provides examples or illustrations where appropriate.	Did I give an example? Is it clear what I mean by this? Could I elaborate further?
Accuracy	All statements are factually correct and/or supported with evidence.	How do I know this? Is this true? How could I check on this or verify it?
Precision	Statements contain specific information	Can I be more specific? Have I provided sufficient detail?
Relevance	All statements are relevant to the question at hand; all statements connect to the central point.	How does this relate to the issue being discussed? How does this help us/me deal with the issue being discussed?
Depth	Explains the reasons behind conclusions and anticipates and answers the questions that the reasoning raises and/or acknowledges the complexity of the issue.	Why is this so? What are some of the complexities here? What would it take for this to happen? Would this be easy to do?
Breadth	Considers alternative points of view or how someone else might have interpreted the situation.	Would this look the same from the perspective of….? Is there another way to interpret what this means?
Logic	The line of reasoning makes sense and follows from the facts and/or what has been said.	Does what I said at the beginning fit with what I concluded at the end? Do my conclusions match the evidence that I have presented?
Significance	The conclusions or goals represent a (the) major issue raised by the reflection on experience.	Is this the most important issue to focus on? Is this most significant problem to consider?
Fairness	Other points of view are represented with integrity (without bias or distortion)	Have I represented this viewpoint in such a way that the person who holds it would agree with my characterization?

Modified source: Paul, R & Elder, L. 2001. The Miniature Guide to Critical Thinking. The Foundation for Critical Thinking

G: NNAPF's Renewal Stepping Stones' for Cultural Safety

NNAPF's Stepping Stones for Cultural Safety uses the Four Elements (Earth, Water, Fire, and Air) to explain the progression to Cultural Safety. The four elements are required in the physical realm of all human beings and there are a variety of interpretations of these four elements. Below is an example of an Ojibway perspective:

1. Earth represents the land we live on. The teaching of the earth "is to show respect for all BEINGS and to know the importance of all beings." Thus, beginning to understand Cultural Safety from the element Earth would ensure Cultural Humility by respecting all beings not just human beings.

2.Water represents healing and medicines. The teaching of water is "the place of deep introspection and reflection." The second step to cultural safety would be Critical Reflection because of need for self-reflection.

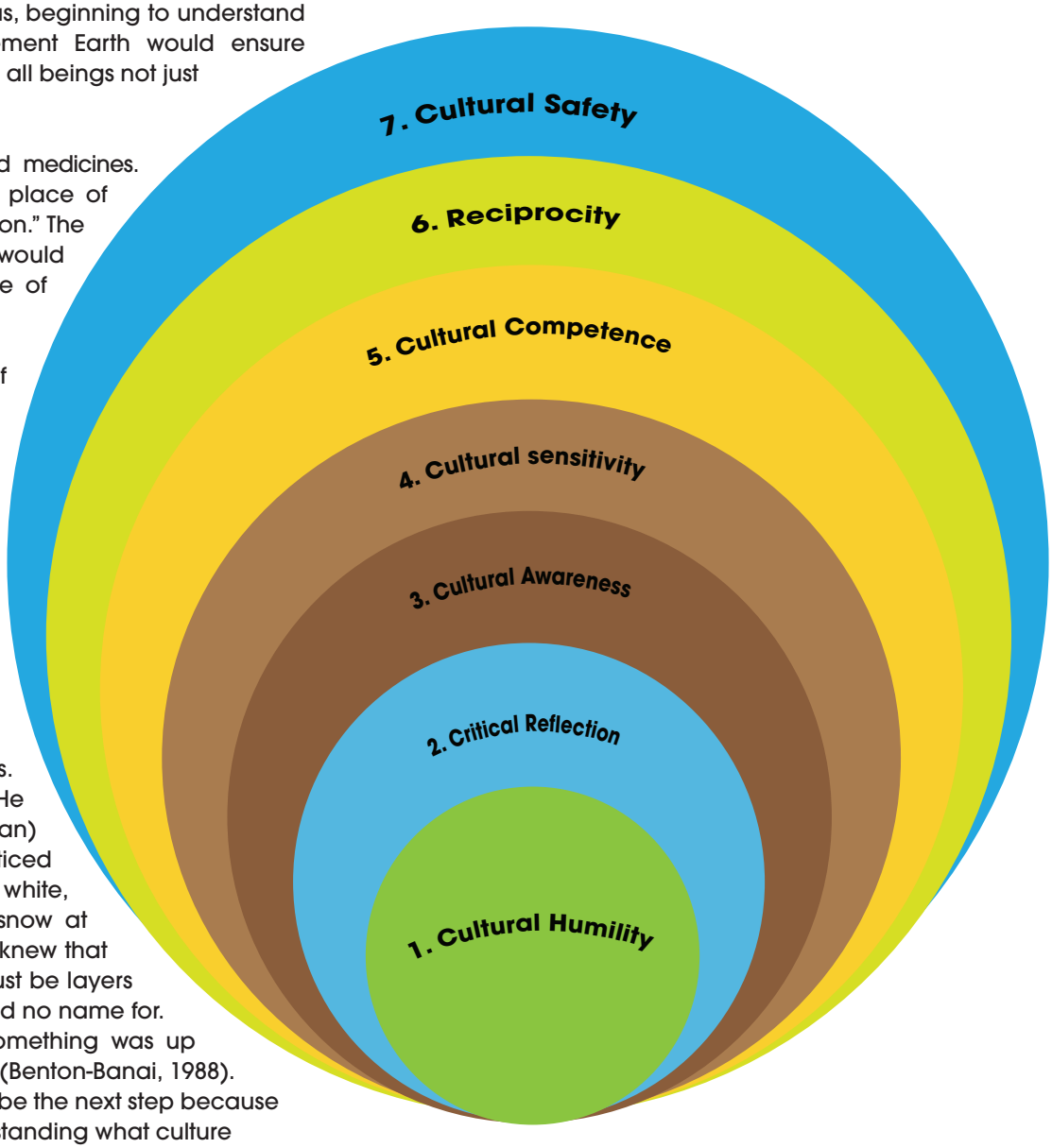
3. Fire represents the heart of Mother Earth. The teaching of fire is "the place of knowledge and wisdom." The third step to Cultural Safety is Cultural Awareness because it is the knowledge and wisdom of self and others "distinctive spiritual, material, intellectual and emotional features and to value systems, traditions and beliefs."

4. Air represents new beginnings. The teaching of air is "He (Waynaboozhoo or Original Man) looked up into the sky and noticed that the clouds were fleecy white, pure, and cold just like the snow at the tops of the mountains. He knew that high above the Earth there must be layers of air and elements that he had no name for. Nonetheless, he knew that something was up there that held it all together." (Benton-Banai, 1988). Thus, Cultural Sensitivity would be the next step because developing insight and understanding what culture is and the diverse relationship is the intention of Cultural Sensitivity.

5. Cultural Competence is when the health care provider works within the clients cultural needs by respecting and understanding the client's culture and historical trauma.

6. Reciprocity is about keeping the balance with in the relationship, as well as building trusting relationships.

7. In conclusion, Culturally Safety is an effect of a strengthening, encouraging, and empowering the cultural identity of Indigenous peoples with NNAPF's Renewal Stepping Stones.



H: NNAPF's Diversity Table

Diversity between traditional Aboriginal cultures and mainstream Western culture

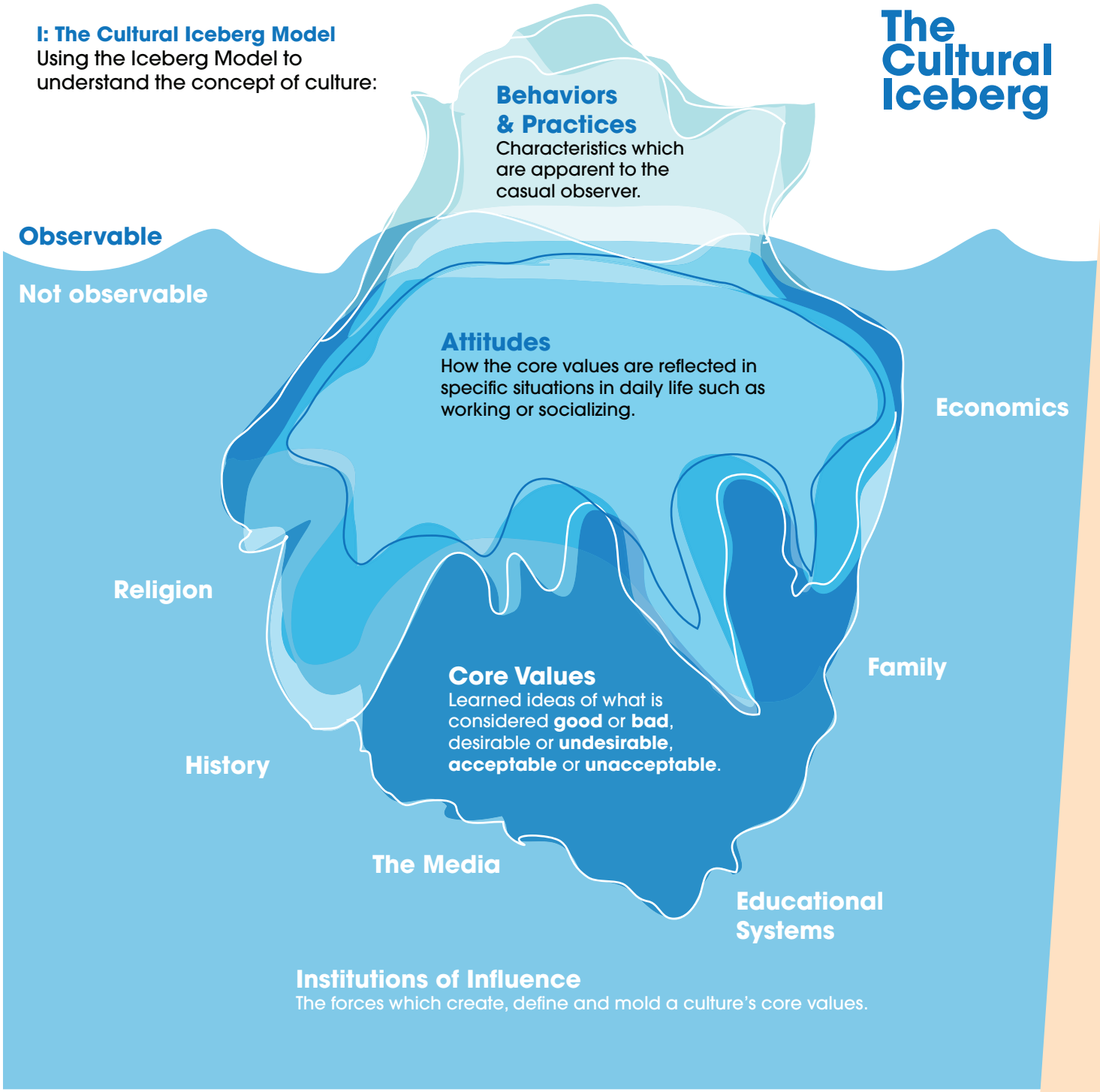
TRADITIONAL CULTURE	MAINSTREAM WESTERN CULTURE
Community is the foremost of all values	Individualism is the foremost value
The future tense is dominant	Tradition of printing and literacy
The world is understood mythically	The present is the dominant tense
Goals are met with patience	The world is understood scientifically
Ownership is often communal	Goals are met with aggressive effort
Gifts are regarded as social glue	Ownership is reward for hard work
Work is often motivated by group need	Gifts are regarded as holiday issues
Aging is a source of wisdom	Work is motivated by ambition
Eye contact is thought over-assertive	Aging is decay and loss
Silences are acceptable anywhere	Eye contact is part of conversation
Assertiveness is non-communal	Silences are a waste of time
Listening skills are prized	Assertiveness is a basic social skill
Soft spoken words carry farthest	Communication skills are prized
Nodding signifies understanding	Emphasis carries the day
Handshake is soft, signaling no threat	Nodding signifies agreement
Collective decisions are consensual	Handshake is firm, assertive
A faith in harmony with nature	Collective decisions are put to a vote
Family is extended family	A faith in scientific control of nature
Responds to praise of the group	Family is nuclear family
	Responds to praise of the individual

H: NNAPF's Diversity Table

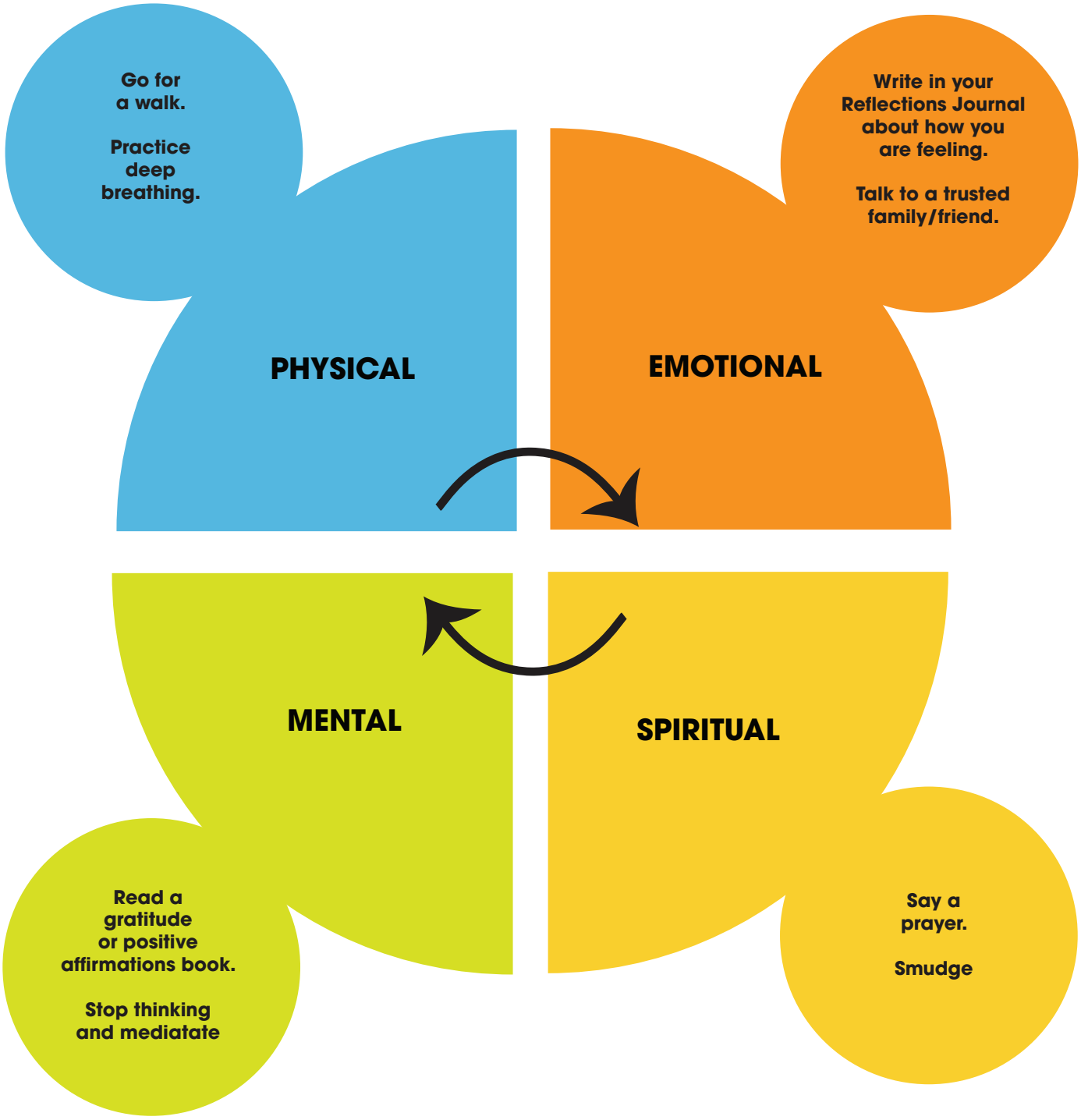
Now you write out areas of practice that you could see Western and Aboriginal knowledge being used in your community and/organization?

WESTERN KNOWLEDGE	ABORIGINAL KNOWLEDGE

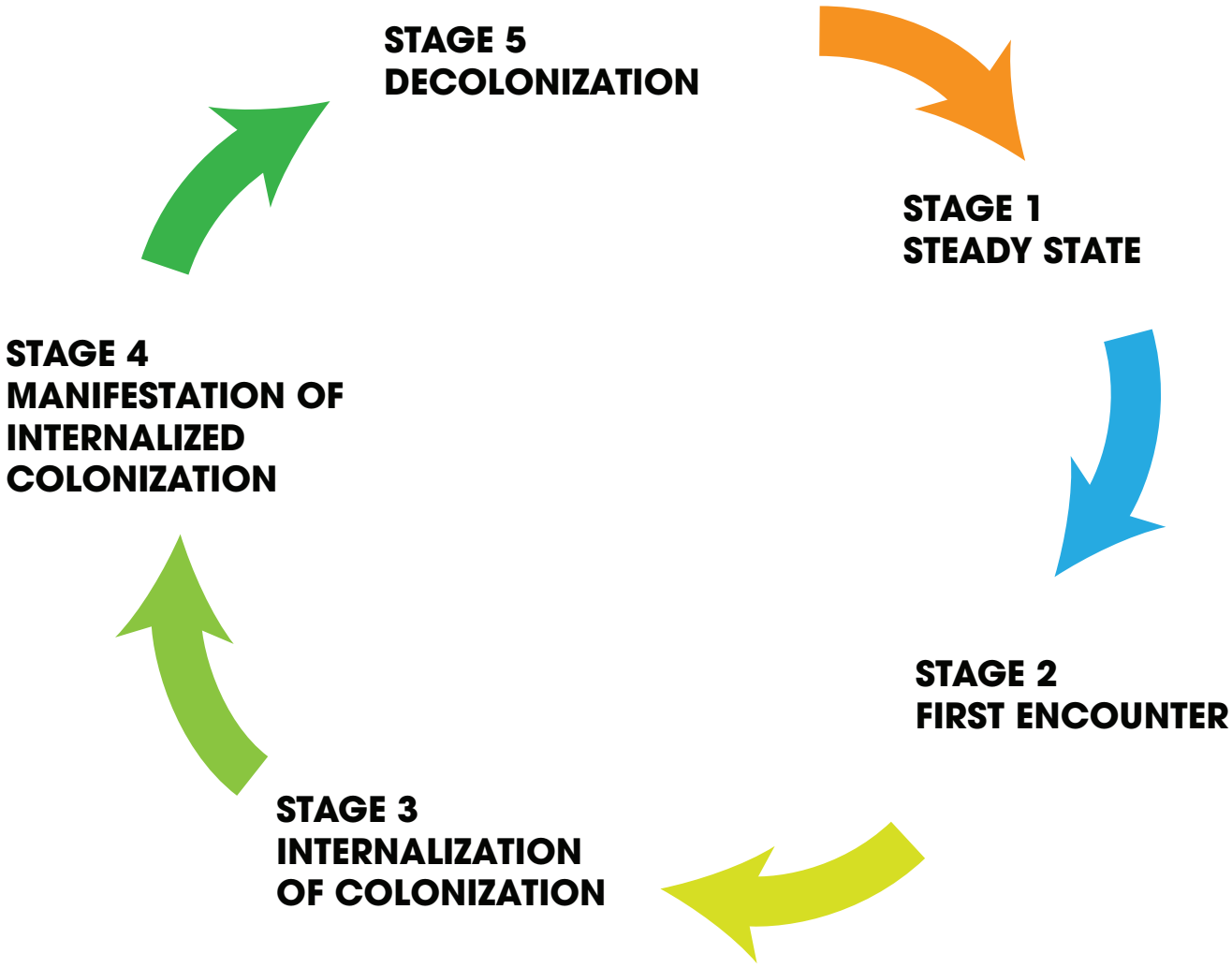
I: The Cultural Iceberg Model
Using the Iceberg Model to understand the concept of culture:



J: NNAPF'S SELF - CARE SUGGESTIONS



K: FIVE STAGES OF COLONIALISM THEORY BY DR. WINONA WHEELER AND RODOLPHO PINO



"Knowing others is wisdom, knowing yourself is Enlightenment." – Tao Tzu

Renewal Project Workplan Overview

The NNADAP Renewal Process is a comprehensive, culturally relevant and evidence-informed review of the National Native Alcohol and Drug Abuse Program (NNADAP). Through a variety of interrelated activities, the Renewal Process is seeking to systematically enhance, renew, and validate on-reserve addiction prevention and treatment services. In doing so, the process has been engaging First Nations communities, service providers, representative organizations, and others to develop a strategic vision for NNADAP that will guide program planning and service delivery over the next five to 10 years.

There are a number of steps the Renewal Project Coordinator will take to ensure an evidence- based product is created. A case study is one way to ensure effective community-based programs and services are being acknowledged and documented. The lessons learned will be compiled in a draft report and shared with the NNAPF team and the White Raven Healing Centre for feedback via web-based meeting space (Adobe). Once the feedback is incorporated, a second draft report will be created for the Renewal Leadership Team to review and give feedback at the quarterly Renewal Leadership meeting. Once this feedback is incorporated, the Renewal Leadership Coordinator will engage the field (NNADAP, YSAC, and Community Health) for a discussion of key concepts and findings. The Renewal Project Coordinator will then draft a practical support product and continue the dialogue with the Community of Practice team via Adobe. A working product will be created from these discussions and distributed for broader feedback via website within a 30-day window. This process will produce a finalized product that will be translated and distributed electronically.

Each project will consist of extensive research and scanning of existing literature, services, and/ or templates to identify key components. The development of the projects will use the change management tools, such as surveys, email sharing, and the consultation process. Knowledge exchange and transfer will be instrumental in the whole process.

Project Overview and Purpose

The development of a cultural safety tool kit is a renewal opportunity from all the elements found in the Honouring Our Strengths (2011) report. Accordingly, the report introduces cultural safety as, "extends beyond cultural awareness and sensitivity within services and includes reflecting upon cultural, historical, and structural differences and power relationships within the care that is provided. It involves a process of ongoing self-reflection and organizational growth for service providers and the system as a whole to respond effectively to First Nations people (AFN, NNAPF, and FNIHB, 2011:8). Therefore, the purpose of this cultural safety tool kit is to assist mental health and addiction workers to effectively and safely communicate, verbally and non-verbally, to First Nations clients.

Cultural Safety Literature Review

Many First Nations and Inuit people do not feel safe in accessing health care because they have been marginalized and have experienced oppression and racism within the health care field (Kurtz et al., 2008). For example Kurtz and colleagues (2008) interviewed Aboriginal women regarding their encounters with the health care system in which they "talked about feeling judged and discriminated against simply because they are Aboriginal" (2008:57). This lack of culturally safe access to health care contributes to health disparities such as the "alarming rates of suicidal thoughts and attempts" (Assembly of First Nations [AFN] and First Nations Information Governance Committee [FNIGC], 2007:32) among First Nations and Inuit people. The Public Health Agency of Canada acknowledges that health disparities impact on First Nations and Inuit people in Canada, and these "are not randomly distributed; they are differentially distributed among specific populations (e.g. Aboriginal peoples)" (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004:iv). Furthermore, this unequal distribution of adequate health care is a result of unequal power relations, inadequate access to culturally relevant health care, and lack of appreciation of culture and value differences embedded in Western theoretical approaches to health care. Thus, a focus on illness disconnected from other parts of self and environment, a disregard for culture and identity being integral to one's health, and a secular approach to spirituality are often entrenched in the health care field (Sen and Ostlin, 2007).

Cultural safety is a concept that was first introduced in New Zealand to address this lack of adequate health care (Papps and Ramsden, 1996), and it has since been integrated by many health care providers, (e.g., Sioux Lookout Meno Ya Win Health Centre in Northern Ontario has services that address the health and cultural needs of their Aboriginal population (Walker et al., 2010). Cultural safety supports First Nations and Inuit people to influence and advocate for culturally relevant, health care services, which increases access of health services by First Nations and Inuit people (AFN, NNAPF, and FNIHB, 2011). In addition, cultural safety is derived from an Indigenous perspective and aims to create awareness of the social, cultural, economical, and political determinants of health often experienced by First Nations and Inuit people (Brascoupé and Waters, 2009). The role of non- Indigenous health care workers would be as collaborators and they will be able to identify indicators to measure the success of cultural safe within the health care field (Stout and Downey, 2006).

Cultural safety is viewed as an outcome that is determined by the client, and cultural competence is one way to achieve cultural safety (Brascoupé and Waters, 2009). Cultural safety is about the client experience, and cultural competency is not the only avenue to create cultural safety. For example, cultural safety is can be created through environmental factors such as health care environments that promote health with specific attention to culture. The health environments that make space for cultural forms of prayer, including the use of smudging, the role of elders, round rooms for cultural practices, or native-specific artwork that promote health. Another contributing factor in creating cultural safety is to have health care policies that facilitate the delivery of health care services; for example, policies that include the role of elders and cultural spiritual practices as part

of a multi- disciplinary approach (IPAC-RCPSC Family Medicine Curriculum Development Working Group, 2009). Thus, cultural safety addresses the gap (i.e., lack of open and trusting relationships) that exists among health care providers. It creates an awareness of ethnocentric attitudes and beliefs that have been caused by colonialism (National Center for Cultural Competence, 2004).

The scope of the literature review uses journal articles, research papers, thesis papers, dissertations, as well as grey literature. The search engines used were PubMed, Medline, ScienceDirect, and ProjectMUSE. In addition, grey literature search included websites (e.g., National Aboriginal Health Organization and World Health Organization) and newsletters.

The search criterion was based on cultural relevance of evidence-based and peer-reviewed articles. The search terms used were cultural safety, cultural competence, cultural awareness, culture, cultural sensitivity, cultural humility, critical reflection, reciprocity, Aboriginal, First Nations, Indigenous, colonialism, mental health, indigenous knowledge, and spirituality.

The literature identified and analyzed cultural safety as it applied to mental health and addiction health providers in Canada. The specific objectives were to:

- establish definitions for cultural competence, cultural safety, cultural humility, etc.
- define how cultural safety is different from cultural awareness and cultural competence
- find evidence-based examples of cultural safety in Canada
- identify skills necessary for best practice of cultural safety
- create a tool kit based on the evidence-base and best practices that are culturally relevant

Cultural competence/safety is a result of a series of learned skills and practices that inform the health care environment, policy, and practice that could also be applied in the field of substance use and mental health. Guerin (2010) distinguishes a culturally safe environment that includes a progression of decolonization interventions (early period: cross-cultural training; middle period: decolonization workshops; and later period: needs popular support) Papadopoulos, Tilki, and Taylor (1998) examine cultural competence as a model in four stages: cultural awareness, cultural knowledge, cultural sensitivity, and cultural competence. As well, Dadlani and Scherer (2009) examine cultural competency using three stages as it relates to psychotherapists: awareness, knowledge, and skills. All the cultural competency processes examined in this review show that cultural safety is an outcome determined by the Indigenous client. However, to address cultural safety from a First Nations perspective, reciprocity is a step that needs to be considered, as noted by Dr. Herman Michel:

It is important to be aware of recognized cultural protocols in Aboriginal communities. One of the common protocols used today is the offering of Tobacco. Some use gifts. In the Cree culture the "act of offering" Tobacco is adhering to the ethic of reciprocity. When you take something from nature we disrupt the balance of life. To restore the balance we offer tobacco in exchange. That's why we place tobacco down on the ground before we pick plants or take the life of an animal. We honor their spirit so we humans can live. We say a prayer of thanks. We humans are part of nature. Spirit filters through all life. Thus everything is "alive" in a spiritual way. And so our stories are sacred as spirit flows through them. That's why we offer tobacco in exchange for stories (2011, personal communication).

First Nations clients share their lived experience with mental health/addictions (MH/A) workers, and in order for their culture to be acknowledged, reciprocity needs to be respected.

Renewal Framework Stepping Stones

The Renewal Framework Stepping Stones were designed out of this respect, which include six steps, with the foundational step being cultural humility. The framework was created to assist in developing awareness and identifying a process towards cultural safety. The Stepping Stones are a process towards cultural safety and build upon one another with the foundation of Cultural Humility being the first step. The second step is Critical Reflection, which is a social theory that emphasizes self-reflection and is pertinent to cultural safety because understanding what one brings to the environment will develop a critical mindset (Pockett and Giles, 2008). The third step is Cultural Awareness, which addresses the diversity within each client and assists with integrating Aboriginal and Western therapeutic practices (Papps, 2005). The fourth step is Cultural Sensitivity, which is recognition of the differences between cultures (Chandler, 2002). The fifth step is Cultural Competence, which is a process the health care worker goes through to achieve a culturally safe environment for the client (IPAC-RCPSC Family Medicine Curriculum Development Working Group, 2009). The sixth step is Reciprocity, which is a moral theory that First Nations people value and is "the outline of our nonvoluntary social obligations – the obligations we acquire in the course of social life...examples include some of our obligations to our families, to future generations, and to obey the law" (Becker, 1990:3). The seventh and final step is Cultural Safety (see page 4 for definition).

Earth, Water, Fire, and Air are the four elements of First Nations teachings and will be used to teach about the four steps in the Renewal Framework Stepping Stones. The four elements are required in the physical realm of all human beings. "The cycle of life from conception to death follows the same path as the teachings of the elements and harmony. The ideal is a system of balance where each interconnected element is respected and treated with the honour that First Nations were taught at the beginning of time" (Union of Ontario Indians, 2009:10). The teaching of Earth will be used to teach about cultural humility.

Stepping Stone One: Cultural Humility

Earth represents the land we live on. The teaching of the earth is "to show respect for all BEINGS [emphasis added] and to know the importance of all beings" (Union of Ontario Indians, 2009:37). Thus, beginning to understand Cultural Safety from the element Earth would ensure Cultural Humility by respecting all beings, not just human beings. Putting cultural humility into practice, as a foundational principle in the Renewal Framework Stepping Stones, corresponds with First Nations teachings around humility. For example, Turner states, "First Nations people viewed our relationship with nature as an equal one; humility is to know ourselves as a sacred part of Creation, no better and no worse than other parts (2010:19). Furthermore, cultural humility "does not assume a hierarchy of skills and competencies, but does call for the capacity to change in response to humility" (Eisenbruch and Eisenbruch, 2005: Cultural humility). In 1998, Melanie Tervalon and Jann Murray-Garcia came up with the concept of cultural humility, which is defined as follows:

a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations (Tervalon and Murray-Garcia, 1998:117).

Tervalon and Murray-Garcia identify that understanding the client's health beliefs and practices are vital to cultural safety. For example, not understanding First Nations beliefs and practices creates a proxy of "non-Native for Native knowledge, values and identity" (Hampton, 1995:35 in Maina, 1997:301), which contributes to the loss of identity the client may feel. Thus, cultural humility is the support to cultural safety in the Renewal Framework Stepping Stones.

Cultural humility has a number of important components, such as self-reflection, willingness to learn from the client, relationship building, and the concept of lifelong learning (Chang, Simon, and Dong, 2010). In addition, cultural humility ensures a less controlling, less authoritative style when communicating with clients (Tervalon and Murray-Garcia, 1998). The Renewal Framework Stepping Stones recognize that cultural safety is an ongoing, reflective process.

Humility helps us to understand this obvious truth: No one knows it all; no one is ignorant of everything. We all know something; we are all ignorant of something. Without humility, one can hardly listen with respect to those one judges to be too far below one's own level of competence. But the humility that enables one to listen even to those considered less competent should not be an act of condescension or resemble the behavior of those fulfilling a vow (Freire, 1998:39 cited in Lyons, 2011).

Health care providers who begin with cultural humility in their relationship with clients will be more attentive to the cultural needs of First Nations clients. Juarez and colleagues (2006) discuss how incorporating cultural humility into the medical curriculum assisted physicians learning about differences in cultures and exploring their own belief system. Hunt (2005) suggests that health care workers begin with cultural humility in order to encourage a respectful relationship between the client and health care worker, which will help to identify similarities, differences, as well as the client's priorities, goals, and capacities. Furthermore, engaging in an ongoing process of developing self-awareness skills and recognizing the client's distinctive perspectives is encouraged under cultural humility. The California Health Advocates (2007) also mention that culture is not a blueprint and that cultural humility should be a foundation for cultural competency. Thus, the health care providers who have integrated cultural humility will be more willing to learn from their client's cultural experiences and needs.

McCormick (2000) acknowledges the connection to meaning, family, spirituality, and identity especially with culture. In addition, Indigenous values such as courage, humility, generosity, and family honour can serve as a preventative and curing agent in a mental health program.

Cultural humility as a value-based learning concept to cultural safety is just one of the many value- based learning concepts in the cultural competence process. One such learning concept is cultural empathy, which is defined as "the learned ability of counselors to accurately gain an understanding of the self-experience of clients from other cultures – an understanding informed by counselors' interpretation of cultural data" (Ridley and Lingle, 1996:32 cited in Trimble, 2010:249). Trimble (2010) explains that "If a counsellor challenges the legitimacy and value of what is real and authentic for traditionally oriented ethnocultural clients the query will likely call into question a counsellor's perceived multicultural competence by the client" (2010:242).

Another learning concept that examines the cultural competence process is cultural desire that Campinha-Bacote (2002) describes as the want rather than the need of the health care worker to become culturally competent. Furthermore, cultural desire is a learning concept as well as a passion to be receptive and flexible with client differences and similarities. Cervantes and Parham (2005) explain that spirituality is not the same as religiosity, and they recognize the client's spiritual essence is important to create a safe counselling environment. However, health care providers who recognize their own knowledge base value the importance of the client's world view. Therefore, cultural humility, as the foundational and first step in the Renewal Framework Stepping Stones, will generate an understanding of First Nations teachings regarding humility.

Stepping Stone Two: Critical Reflection

Water represents healing and medicines. The teaching of water is "the place of deep introspection and reflection" (Laframbroise and Sherbina, 2008). The second step to cultural safety would be Critical Reflection because of process of self-reflection. However, citical reflection is a step further than self reflection.

Critical thinking is the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, or communication, as a guide to belief and action. In its exemplary form, it is based on universal intellectual values that transcend subject matter divisions: clarity, accuracy, precision, consistency, relevance, sound evidence, good reasons, depth, breadth, and fairness. (Scriven & Paul, 1987)

In the literature review, many authors discuss the importance of self-reflection as a necessary step to cultural competence. Andrews and Boyle (2002) identify what cultural assessment skills, along with critical thinking skills, are needed to acquire the necessary care for all cultural groups. Additionally, Bearskin (2011) examines cultural competence and cultural safety through an understanding of Indigenous relationships with self, others, the environment, and the universe. The author also identifies that all people are bearers of culture, so self-discovery is important to cultural safety.

In addition, the College of Nurses of Ontario (2009) created a guide to assist nurses in providing culturally sensitive care. The guide describes the elements of providing culturally sensitive care as self-reflection, acquiring cultural knowledge, facilitating client health care needs, and being cognizant of non-verbal communication.

The Indigenous Physicians Association of Canada and the Association of Faculties of Medicine of Canada (2009) created a curriculum for undergraduate medical students to discuss how cultural safety should emphasize self-reflection that would address the power imbalances the health care worker brings to the client-health care worker relationship. The New Zealand Psychologists Board (2009) also created guidelines emphasizing the importance of recognizing and respecting the Maori as a diverse population. This guide also includes a number of learning outcomes, such as allowing clients to be involved in their health outcomes and cultural safety is more about self-reflection and the experiences of clients.

Walker and Sonn (2010) state that cultural competence requires more than becoming culturally aware or practising tolerance, it is the ability to identify and challenge one's own cultural assumptions, values, and beliefs. In addition, developing empathy and connected knowledge and the ability to see the world through another's eyes were important to cultural competency (Walker and Sonn, 2010).

All the literature examined enforce the need for self-reflection, however, this project will take this self-examination a step further with critical reflection. The outcome of this step would be the ability to answer the question: Who are you when no one else is around? This self-reflective question leads into cultural awareness because it acknowledges that we are all bearers of culture.

Stepping Stone Three: Cultural Awareness

Fire represents the heart of Mother Earth. The teaching of fire is "the place of knowledge and wisdom" (Laframboise and Sherbina, 2008). The third step to Cultural Safety is Cultural Awareness because it is the knowledge and wisdom of self and others of their "distinctive spiritual, material, intellectual and emotional features…[and] value systems, traditions and beliefs (UNESO, 2001: para. 5).

Goforth (2007) acknowledges the diversity and similarities across Aboriginal communities so the therapeutic practices must be determined within these communities. Marr and colleagues (2009) describe an Indigenous mental health care model called "the Knaw Chi Ge Win model" and how sharing of information, protocols, as well as continuous educational support are part of this model. They explain that health care has improved with the integration of Aboriginal and Western therapeutic practices.

Some recommend integration of both Western and traditional healing methods. They recommend that Western practitioners need to work together with traditional healers in order to create opportunities for training and education for both Western and traditional healers (Korhonen, 2004; Goforth, 2007; Bojuwoye and Sodi, 2010).

The Royal Australian College of General Practitioners (2010) examine best practices of cultural safety training and the need for evaluation of the program to ensure that cultural safety is being taught adequately and that health care workers grasp the concepts. They recommend using adult-style learning principles, engaging participants, relating the topic to participants, allowing participants to see the relevance, and ensuring participants feel in control of their learning environment.

The outcome of this step would be the ability to identify both Western and Aboriginal knowledge and find ways to integrate them into practice. This step influences cultural sensitivity because it identifies what culture means from each perspective.

Stepping Stone Four: Cultural Sensitivity

Air represents new beginnings. The teaching of air is "He (Waynaboozhoo or Original Man) looked up into the sky and noticed that the clouds were fleecy white, pure, and cold just like the snow at the tops of the mountains. He knew that high above the Earth there must be layers of air and elements that he had no name for. Nonetheless, he knew that something was up there that held it all together" (Benton-Banai, 1988:42). Cultural Sensitivity is the next step because developing insight and understanding of what culture is and its diverse relationships is the intent of Cultural Sensitivity.

Hulme (2010) explains that to have an effective health outcome, health care workers should be able to modify the services and interventions to suit the needs of their clients. In addition, acknowledging the importance of culture in therapeutic practices will lead to a more effective health care service (Hulme, 2010). Trimble (2010) recognizes that health care workers should acknowledge cultural world views and modify conventional approaches and practices to suit the cultural world views of their clients. Woods (2010) also recognizes that mental health workers should be inclusive and culturally responsive to the differences among their clients rather than respond with assumptions.

The outcome of this step would be the ability to comprehend culture and how it impacts one's views of the world. This step applies to cultural competence by being responsive to the historical, economical, social, and cultural differences.

Stepping Stone Five: Cultural Competence

Elders remind us that listening to Mother Earth will ensure everything will fall into place. Once these four elements are understood and respected, Cultural Competence has begun. According to the Honouring our Strengths Report, *Cultural competence requires that service providers, both on- and off- reserve, are aware of their own worldviews and attitudes towards cultural differences; and include both knowledge of, and openness to, the cultural realities and environments of the clients they serve. To achieve this, it is also necessary for indigenous knowledge to be translated into current realities to meaningfully inform and guide direction and delivery of health services and supports on an ongoing basis (8).*

Ashton (2010) created a cultural safety training guide for health care workers that provides an understanding of the historical contexts of Aboriginal people (e.g., the impact of the Indian Act, the assumed European superiority of Aboriginal people, and the legacy of residential schools) and are important to cultural competence. Clark and colleagues (2010) discuss the power relations within the health care worker and client relationships as being important to cultural safety. They state that health care workers should be holistic, have respect for cultural taboos, and encourage a multidisciplinary team. Adelson (2000) examines culture through the evolution of the old, new, and adopted practices. Garrett and Pichette (2000) recommend that mental health workers should avoid making assumptions, be understanding to Aboriginal culture and identity, and explore the world views of clients. Stout and Downey (2006) examine the concept of self-determination and the utilization of traditional knowledge and medicines among Indigenous people is not just "nice to know" but a critical area of awareness and understanding that needs to be captured in educational curricula. De Crespigny and colleagues (2006) note that it is vital to acknowledge how historical trauma has contributed to the ill health of Aboriginal people in Australia.

Clingerman (2011) acknowledges the importance of acquiring knowledge of the inequities, disadvantages, and injustices of vulnerable groups. As well, Gone (2001) examines dominant cultural practices that try and influence communities that have been historically oppressed. Aho and colleagues (2011) recommend that cultural competent education tools should be designed for flexibility and involve the students in the planning.

Consequently, by recognizing and respecting the world views and histories of First Nations, as told by First Nations in their language, and time given to teach the Creation story and ways of doing, cultural revitalization of First Nations values allows for decolonization. It is not as simple as being able to name the cultural values of a given, or any, First Nation, it is to know the origin and meaning of the original story, including its words, spirit names, ceremony, and related activities. In addition, decolonization is a process that will take more than one generation to deconstruct. Maori scholar Linda Smith noted:

In a decolonizing framework, deconstruction is part of a much larger intent. Taking apart the story, revealing underlying texts, and giving voice to things that are often known intuitively does not help people to improve their current conditions. It provides words, perhaps, an insight that explains certain experiences…To acquiesce is to lose ourselves entirely and implicitly agree with all that has been said about us [Aboriginal people]. To resist is to retrench in the margins, retrieve what we were and remake ourselves. (Smith, 1999:3–4).

The outcome of this step would be the ability to comprehend how historic trauma and colonialism has impacted on Aboriginal people. This step influences the next one by exchanging knowledge and respecting First Nation teachings of reciprocity.

Stepping Stone Six: Reciprocity

In order to ensure a relationship is strong and respected, there needs to be reciprocity. Reciprocity is defined as, "The act of entering empathically into the point of view or line of reasoning of others; learning to think as others do and by that means sympathetically assessing that thinking. (Reciprocity requires creative imagination as well as intellectual skill and a commitment to fairmindedness.)" (Foundation for Critical Thinking, 2011). Reciprocity is an ongoing act that is honoured by both parties involved. In this literature review, reciprocity is about building the relationships between the client, health care practitioner, family, and community. As noted by Ferguson and Campinha-Bacote (1997), a theoretical model that uses face-to-face encounters to allow one to make their own judgment on a specific cultural group is examined. De Crespigny and colleagues (2006) discuss the importance of listening to cultural community leaders, linking Aboriginal and non-Aboriginal programs to create information sharing, and being an advocate as ways to develop inclusive and culturally relevant partnerships. Durie (2001) acknowledges the doctor-patient relationship could be improved by appreciating the values, perspectives, beliefs of the community and where the treatment plan includes community input. Petrucka, Bassendowski, and Bourassa (2007) examine how relationship building is important to cultural safety and discuss the involvement of community elders as an example of relationship building. Zolner (2009) examines how collaboration with front-line workers could assist in developing culturally competent assessment practices. Rigby and colleagues (2011) created a teaching tool for cultural competence and recommend that teaching tools should not be lengthy, learning and teaching should have a flexible approach, and the role for community elders should be increased.

Arnold, Appleby, and Heaton (2008) discuss how reciprocal partnerships and collaborations equal success in cultural safety. In addition, the sharing of knowledge will increase cultural safety. Marsden (2006) discusses how acknowledging traditional methods could be used to restore and continue Indigenous health education practices. In addition, knowledge exchange moves beyond differences and disconnections and is inclusive of traditional-based Indigenous health knowledge. The Aboriginal Nurses Association of Canada (2011) explains how being inclusive and sharing knowledge are ways to build relationships and understanding cultural values like respect is a reciprocal process that is a cultural value.

Browne and colleagues (2009) examine cultural safety and the importance of acknowledging the historical context of marginalized and oppressed groups; however, it is equally important to acknowledge the individual client's experiences.

Therefore, the outcome of this step would be the ability to move beyond the normal Western, therapeutic approach and to acknowledge and respect Aboriginal therapeutic approaches, as well as utilizing these Aboriginal approaches to therapeutic healing.

Stepping Stone Seven: Cultural Safety

Once Reciprocity has been established, *Cultural Safety* is acknowledged and thereby the state of being safe begins. Cultural safety is only determined by the client. It goes beyond the relationship between the health care provider and the client to ensure the health care environment is also cultural responsive by *actively and continuously assessing and working to facilitate change through building cultural competency in health care structures and process, such as service design, policy, human resources, service delivery, and in achieving health outcomes that are culturally relevant and meaningful.*

The National Aboriginal Health Organization (NAHO) (2008) states that cultural safety is "within an Indigenous context means that the educator/practitioner/professional, whether Indigenous or not, can communicate competently with a patient [client] in that patient's [client's] social, political, linguistic, economic, and spiritual realm" (2008:4).

NAHO (2008) created a cultural competency and safety guide for health care administrators. It identifies that health care workers need to be willing to incorporate the necessary accommodations to bridge the power relationship between the health care worker and the client. The Aboriginal Nursing Association of Canada (ANAC) (2009) discusses how cultural safety is more than cultural awareness and competence. ANAC recommends that health care workers acknowledge the racism, discrimination, and prejudice that First Nation's people often experience. ANAC (2011) also recognizes the importance of understanding Aboriginal history and contemporary life to cultural competency and safety.

The First Nations of Quebec and Labrador Health and Social Services Commission (2003) explains the belief from an Aboriginal traditional world view that all things are connected and how it is important to acknowledge this world view when addressing Aboriginal healing and health. Johnstone and Kanitsaki (2007) argue that cultural safety needs to be communicated and understood in order to be effective. In addition, Walker and colleagues (2009) identify how cultural safety must include the client's perspectives in all service delivery and interventions.

Cameron and colleagues (2010) explain that a culturally safe space is one where Indigenous and non-Indigenous protocols are not compromised. Furthermore, cultural safety should be an outcome rather than a theory. Tait (2008) identifies that guidelines involving Aboriginal communities should be grounded in Aboriginal epistemologies and world views. Thus, mental health and addiction programming should focus on the strengths of both Western and Aboriginal knowledge to create a culturally safe environment.

Conclusion

Cultural safety is when a client feels comfortable within the mental health or addictions worker's environment; thus, it is the clients who determine when they are culturally safe. Mental health or addictions workers could assist in creating a culturally safe environment by having the ability to be flexible as well as being able to modify the interventions or programming that are used to work with clients. Furthermore, the foundation of the Renewal Framework Stepping Stones is built on "Cultural Humility," so the mental health or addictions worker will address their own perceptions and biases upon meeting the client.

Each step of the Renewal Stepping Stones build upon each other and strengthens the learning process of the health care or addictions worker. All the steps to achieving the outcomes of each stage are critically important to developing cultural safety. This discussion is the first step in creating a tool kit complete with exercises and resources designed to build and enhance skills relevant to each stage of the process described in this paper.

Ensuring that culture is recognized within the continuum of care is part of the decolonization process that First Nations people are striving to achieve. Based on the literature and wise practices in NNADAP, to be skilled in practices of cultural respect and to work effectively with First Nations communities we must:

- acknowledge our own cultural practices and individual behaviours and the impact that they may have on First Nations people
- understand and acknowledge the impact of colonialism on First Nations people
- learn about First Nations diverse cultures, values, and beliefs
- act differently to our usual culturally preferred ways in order to respond to the issues we have learned about
- take initiative to create cultural safety
- review on a continuous basis and be open to direct and indirect feedback

All the steps are critically important in achieving cultural safety. However, there is one gap that needs to be addressed in this process, which is the evaluation of cultural safety training. Just because one has taken cultural competence or cultural safety training does not mean one actually grasps the concepts or understand why they are applicable to health care. Therefore, a Cultural Safety Evaluation Guide will be Stage II of this renewal project to support health care practitioners to evaluate the impact of their cultural safety training.

References

Aboriginal Nurses Association of Canada (ANAC) (2009). Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing. Ottawa, ON: Author. Retrieved from: http://www.anac.on.ca/ Documents/Making%20It%20Happen%20Curriculum%20Project/FINALFRAMEWORK.pdf

———(2011). Cultural Competency and Cultural Safety: Curriculum for Aboriginal Peoples. Ottawa, ON: Author. Retrieved from: http://www.anac.on.ca/Documents/Cultural%20Competency%20and%20Cultural%20Safety.pdf

Adelson, N. (2000). Re-imagining Aboriginality: an Indigenous peoples' response to social suffering. Transcultural Psychiatry, 37(1): 11–34. doi: 10.1177/136346150003700101

Aho, L., Ackerman, J., Bointy, S., Cuch, M., Hindelang, M., Pinnow, S., and Turnbull, S. (2010). Health is life in balance: students and communities explore healthy lifestyles in a culturally based curriculum. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 8(3): 151–168. Retrieved from: http://www.pimatisiwin.com/uploads/ jan_2011/06AhoAckerman.pdf

Andrews, M. and Boyle, J. (2002). Transcultural concepts in nursing care. Journal of Transcultural Nursing, 13(3): 178–180. doi: 10.1177/10459602013003002

Arnold, O., Appleby, L., and Heaton, L. (2008). Incorporating cultural safety in nursing education. Nursing BC, 40(2): 14–17.

Assembly of First Nations (AFN) and First Nations Information Governance Committee (FNIGC) (2007). First Nations Regional Longitudinal Health Survey (RHS) 2002/03: The Peoples' Report. Revised second edition. Retrieved from: http:// www.rhs-ers.ca/sites/default/files/ENpdf/RHS_2002/rhs2002-03-the_peoples_report_afn.pdf

Assembly of First Nations (AFN), National Native Addictions Partnership Foundation (NNAPF), and First Nations and Inuit Health Branch (FNIB) (2011). Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada. Ottawa, ON: Health Canada.

Bearskin, R.L. Bourque (2011). A critical lens on culture in nursing practice. Nursing Ethics, 18(4): 548–559. doi: 10.1177/0969733011408048

Becker, L.C. (1990). Reciprocity. Chicago, IL: University of Chicago Press. [Originally published 1986 by London, UK: Routledge and Kegan Paul.]

Benton-Banai, Edward. (1988). The Mishomis Book: The Voice of the Ojibway. Hayward, WI: Indian Country Communication Inc.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., and Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. BMC Health Services Research, 7: 15. doi: 10.1186/1472-6963-7-15

Bojuwoye, O. and Sodi, T. (2010). Challenges and opportunities to integrating traditional healing into counselling and psychotherapy. Counselling Psychology Quarterly, 23(3): 283–296. doi: 10.1080/09515070.2010.505750

Brascoupé, S. and Waters, C. (2009). Cultural safety: exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. Journal of Aboriginal Health, 5(2): 6–41. Retrieved from: http://www.naho. ca/jah/english/jah05_02/V5_I2_Cultural_01.pdf

Browne, A.J., Varcoe, C., Smye, V., Reimer-Kirkham, S., Lynam, M.J., and Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. Nursing Philosophy, 10(3): 167-179. doi: 10.1111/j.1466-769X.2009.00406.x

California Health Advocates (2007). Are you practicing cultural humility? The key to success in cultural competence. Retrieved from: http:// www.cahealthadvocates.org/news/disparities/2007/are-you.html

Cameron, M., Andersson, N., McDowell, I., and Ledogar, R.J. (2010). culturally safe epidemiology: oxymoron or scientific imperative. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 8(2): 89–116. Retrieved from: http:// www.pimatisiwin.com/online/wp-content/uploads/2010/09/07CameronAndersson.pdf

References

Campinha-Bacote J. (2002). The process of cultural competence in the delivery of healthcare services: a model of care. Journal of Transcultural Nursing, 13(3): 181–184. doi: 10.1177/10459602013003003

Cervantes, J.M., and Parham, T.A. (2005). Toward a meaningful spirituality for people of color: lessons for the counseling practitioner. Cultural Diversity and Ethnic Minority Psychology, 11(1): 69–81.

Chandler, B. (2002). Cultural sensitivity. In K. Krapp (ed.). Encyclopedia of Nursing and Allied Health. Vol. 1 Gale Cengage. eNotes. Retrieved from: http://www.enotes.com/cultural-sensitivity-reference/cultural-sensitivity

Chang, E., Simon, M., Dong, X. (2012). Integrating cultural humility into health care professional education and training. Advances in Health Sciences Education, 17(2): 269–278. doi: 10.1007/s10459-010-9264-1

Clark, L., Colbert, A., Flaskerud, J.H., Glittenberg, J., Ludwig-Beymer, P., Omeri, A., Strehlow, A.J., Sucher, K., Tyson, S., and Zoucha, R. (2010). Chapter 6: Culturally based healing and care modalities. Journal of Transcultural Nursing, 21(Suppl. 4), 236s-306s. doi: 10.1177/1043659610382628

Clingerman, E. (2011). Social justice: a framework for culturally competent care. Journal of Transcultural Nursing, 22(4): 334–341. doi: 10.1177/1043659611414185

College of Nurses of Ontario (2009). Practice Guideline: Culturally Sensitive Care. Toronto, ON: Author. Retrieved from: http://www.cno.org/Global/docs/prac/41040_CulturallySens.pdf

Dadlani, M. and Scherer, D. (2009). Culture in psychotherapy practice and research: awareness, knowledge, and skills. Retrieved from: http://www.divisionofpsychotherapy.org/dadlani-and-scherer-2009/

de Crespigny, C., Kowanko, I., Murray, H., Wilson, S., Kit, J.H., and Mills, D. (2006). A nursing partnership for better outcomes in Aboriginal mental health, including substance use. Contemporary Nurse, 22(2): 275–287. doi: 10.5172/ conu.2006.22.2.275

Durie, M. (2001). Cultural Competence and Medical Practice in New Zealand. Wellington, NZ: Australian and New Zealand Boards and Council Conference. Retrieved from: http://ebookbrowse.com/gdoc.php?id=57591779&url=f075500bf366abde28dec2820cef1316

Eisenbruch,M.andEisenbruch,R.Volich(2005).Culturalcompetence-background.Retrievedfrom: http://www.eisenbruch.com/Further_resources/Cultural_diversity/Cultural_competence_-_background.htm

Ferguson, S.L. and Campinha-Bacote, J. (1997). Cultural competence: a critical factor in child health policy. Journal of Pediatric Nursing, 12(4): 260–262.

First Nations of Quebec and Labrador Health and Social Services Commission. (2003). Adapting Our Interventions to Native Reality. Wendake, QC: Author. Retrieved from: http://library.catie.ca/PDF/P29/22675.pdf

Foundation for Critical Thinking. (2011). "Glossary of Critical Thinking Terms." Retrieved from: http://www.criticalthinking.org/pages/glossary-of-critical-thinking-terms/496#glossary-r

Freire, P. (1998). Teachers as Cultural Workers: Letters to Those Who Dare Teach. The Edge: Critical Studies in Educational Theory. [Translated by D. Macedo, D. Koike, and A. Oliveira.] Boulder, CO: Westview Press.

Garrett, M.T., and Pichette, E.F. (2000). Red as an apple: Native American acculturation and counseling with or without reservation. Journal of Counseling and Development, 78(1): 3–13. doi: 10.1002/j.1556-6676.2000.tb02554.x

Goforth, S. (2007). Aboriginal healing methods for residential school abuse and intergenerational effects: a review of the literature. Native Social Work Journal, 6: 11–32. Retrieved from: https://zone.biblio.laurentian.ca/dspace/ handle/10219/392

References

Gone, J.P. (2001). Affect and its Disorders in a Northern Plains Indian Community: Issues in Cross-cultural Discourse and Diagnosis. [Unpublished doctoral dissertation, University of Illinois.] Retrieved from:

http://sitemaker.umich.edu/ joseph.p.gone/files/gone_diss.pdf

Guerin, B. (2010). A framework for decolonization interventions: broadening the focus for improving the health and wellbeing of Indigenous communities. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 8(3): 61–83. Retrieved from: http://www.pimatisiwin.com/uploads/jan_2011/03Guerin.pdf

Hampton, E. (1995). Towards a redefinition of Indian education. In M. Battiste and J. Barman (eds.). First Nations Education in Canada: The Circle Unfolds. Vancouver, BC: UBC Press, pp. 5–46.

Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security (2005). Reducing Health Disparities – Roles of the Health Sector: Discussion Paper, December 2004. Retrieved from: http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf

Hulme, P.A. (2010). Cultural considerations in evidence-based practice. Journal of Transcultural Nursing, 21(3): 271–280. doi:10.1177/1043659609358782

Hunt, L.M. (2005). Beyond cultural competence: applying humility to clinical settings. Park Ridge Center Bulletin, 24(3–4): 134–136.

Indigenous Physicians Association of Canada (IPAC) and Association of Faculties of Medicine of Canada (AFMC) (2009). First Nations, Inuit, Métis Health Core Competencies: A Curriculum Framework for Undergraduate Medical Education. Retrieved from: http://www.afmc.ca/pdf/CoreCompetenciesEng.pdf

IPAC-RCPSC Family Medicine Curriculum Development Working Group (2009). Cultural Safety in Practice: A Curriculum for Family Medicine Residents and Physicians. Ottawa, ON: Author.

Johnstone, M.-J. and Kanitsaki, O. (2007). An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context. Journal of Transcultural Nursing, 18(3): 247–256. doi: 10.1177/1043659607301304

Juarez, J. Anderson, Marvel, K., Brezinski, K.L., Glazner, C., Towbin, M.M., and Lawton, S. (2006). Bridging the gap: a curriculum to teach residents cultural humility. Family Medicine, 38(2): 97–102.

Korhonen, M. (2004). Helping Inuit Clients: Cultural Relevance and Effective Counselling. Ottawa, ON: National Aboriginal Health Organization. [Also published in International Inuit Circumpolar Journal, 6(s2): 135–138.]

Kurtz, D.L.M., Nyber, J.C., Van Den Tillaart, S., Mills, B., Okanagan Urban Aboriginal Health Research Collective (OUAHRC) (2008). Silencing of voice: urban Aboriginal women speak out about their experiences with health care. Journal of Aboriginal Health, 4(1): 53–63. Retrieved from: http://www.naho.ca/jah/english/jah04_01/08SilencingVoice_53-63. pdf

Laframboise, S. and Sherbina, K. (no date). The medicine wheel. Retrieved from: http://dancingtoeaglespiritsociety.org/medwheel.php

Lyons, J. (2011). Paulo Freire's educational theory. Retrieved from: http://www.newfoundations.com/GALLERY/Freire.html

Maar, M.A., Erskine, B., McGregor, L., Larose, T.L., Sutherland, M.E., Graham, D. Shawande, M., and Gordon, T. (2009). Innovations on a shoestring: a study of a collaborative community-based Aboriginal mental health service model in rural Canada. International Journal of Mental Health Systems, 3:27. doi:10.1186/1752-4458-3-27

Maina, F. (1997). Culturally relevant pedagogy: First Nations education in Canada. Canadian Journal of Native Studies 17(2): 293–314. Retrieved from: http://www2.brandonu.ca/library/cjns/17.2/cjnsv17no2_pg293-314.pdf

Marsden, D. (2006). Creating and sustaining positive paths to health by restoring traditional-based Indigenous health- education practices. Canadian Journal of Native Education, 29(1): 135–145.

References

McCormick, R. M. (2000). Aboriginal traditions in the treatment of substance abuse. Canadian Journal of Counselling, 34(1): 25–32. Retrieved from: http://cjc-rcc.ucalgary.ca/cjc/index.php/rcc/article/view/152/367

Mezirow, J. (1990). How critical reflection triggers transformative learning. In Fostering Critical Reflections in Adulthood: A Guide to Transformative and Emancipatory Learning. San Francisco, CA: Jossy-Boss, pp. 1–20. Retrieved from: http://www.graham-russell-pead.co.uk/articles-pdf/critical-reflection.pdf

National Aboriginal Health Organization (NAHO) (2008). Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators. Ottawa, ON: Author. Retrieved from: http://www.naho.ca/documents/naho/ publications/culturalCompetency.pdf

National Center for Cultural Competence (2004). Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs. Washington, DC: Georgetown University Center for Child and Human Development. Retrieved from: http://nccc.georgetown.edu/documents/Cultural_Broker_Guide_English.pdf

New Zealand Psychologists Board (2009). Guidelines for Cultural Safety: The Treaty of Waitangi and Māori Health and Wellbeing in education and Psychological Practice. Wellington, NZ: Author. Retrieved from: http://www. psychologistsboard.org.nz/cms_show_download.php?id=83

Papadopoulos, I. Tilki, M., and Taylor, G. (1998). Transcultural Care: A Guide for Health Care Professionals. London, UK: Quay Books.

Papps, E. (2005). Chapter 2 — Cultural safety: daring to be different. In D. Wepa (ed.). Cultural safety in Aotearoa New Zealand. Auckland, NZ: Pearson Education New Zealand, pp. 20–28.

Papps, E. and Ramsden I. (1996). Cultural safety in nursing: the New Zealand experience. International Journal for Quality in Health Care, 8(5): 491—497.

Petrucka, P., Bassendowski, S., Bourassa, C. (2007). Seeking paths to culturally competent health care: lessons from two Saskatchewan Aboriginal communities. Canadian Journal of Nursing Research, 39(2): 166–182.

Pockett, R. and Giles, R. (eds.) (2008). Critical Reflection: Generating Theory from Practice: The Graduating Social Work Student Experience. Sydney, AU: Darlington Press.

Purnell, L. (2005). The Purnell Model for Cultural Competence. Journal of Multicultural Nursing and Health, 11(2): 7–15. [Previously published in Transcultural Nursing, 2002, 13(3): 193–196. doi: 10.1177/10459602013003006]

Ridley, C. and Lingle, D.W. (1996). Cultural empathy in multicultural counseling: a multidimensional process model. In P. Pedersen, J. Draguns, W. Lonner, and J. Trimble (eds.). Counseling Across Cultures (4th ed.). Thousand Oaks, CA: Sage, pp. 21–46.

Rigby, W., Duffy, E., Manners, J., Latham, H., Lyons, L., Crawford, L., and Eldridge, R. (2011). Closing the gap: cultural safety in Indigenous health education. Contemporary Nurse, 37(1): 21–30. doi: 10.5172/conu.2010.37.1.021

Sen, G. and Ostlin, P. (2007). Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why It Exists and How We Can Change It. Final Report to the WHO Commission of Social Determinants of Health. Retrieved from: http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf

Smith, L. Tuhiwai (1999). Decolonizing Methodologies: Research and Indigenous Peoples. London, UK: Zed Books.

Stout, M. Dion and Downey, B. (2006). Nursing, Indigenous peoples and cultural safety: so what? now what? Contemporary Nurse, 22(2): 327–332. doi: 10.5172/conu.2006.22.2.327

References

Tait, C. L. (2008). Ethical programming: towards a community-centred approach to mental health and addiction programming in Aboriginal communities. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 6(1): 29–60. Retrieved from: http://www.pimatisiwin.com/uploads/445206868.pdf

Tervalon, M. and Murray-Garcia, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9(2): 117–125. doi: 10.1353/hpu.2010.0233

The Royal Australian College of General Practitioners. (2010). Cultural Safety Training: Identification of Cultural Safety Training Needs. South Melbourne, AU: Author. Retrieved from: http://www.racgp.org.au/Content/NavigationMenu/ About/Faculties/AboriginalandTorresStraitIslanderHealth/CulturalSafetyTraining/Cultural_Safety_Training_ Identification_of_cultural_safety_training_needs.pdf

Trimble, J.E. (2010). Bear spends time in our dreams now: Magical thinking and cultural empathy in multicultural counselling theory and practice. Counselling Psychology Quarterly, 23(3): 241–253. doi: 10.1080/09515070.2010.505735

Turner, F.J. (ed.) (2010). Social Work Treatment: Interlocking Theoretical Approaches. Fourth edition. Oxford, UK: Oxford University Press. [First published in 1996 by New York, NY: The Free Press.]

Union of Ontario Indians. (2009). Through the Eyes of a Child: First Nation Children's Environmental Health. Retrieved from: http://www.anishinabek.ca/download/Through%20the%20Eyes%20of%20a%20Child%20-%20FN%20Enviro%20Health.pdf

UNESCO (United Nations Educational, Scientific and Cultural Organization) (2001). UNESCO Universal Declaration on Cultural Diversity. Retrieved from: http://portal.unesco.org/en/ev.php-URL_ID=13179&URL_DO=DO_TOPIC&URL_SECTION=201.html

Walker, R. and Sonn, C. (2010). Working as a Culturally Competent Mental Health Practitioner. In N. Purdie, P. Dudgeon, and R. Walker (eds.). Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Canberra: AU: Commonwealth of Australia, pp. 157–180. Retrieved from: http://www.ichr.uwa.edu.au/files/ user5/Working_Together_book_web_0.pdf

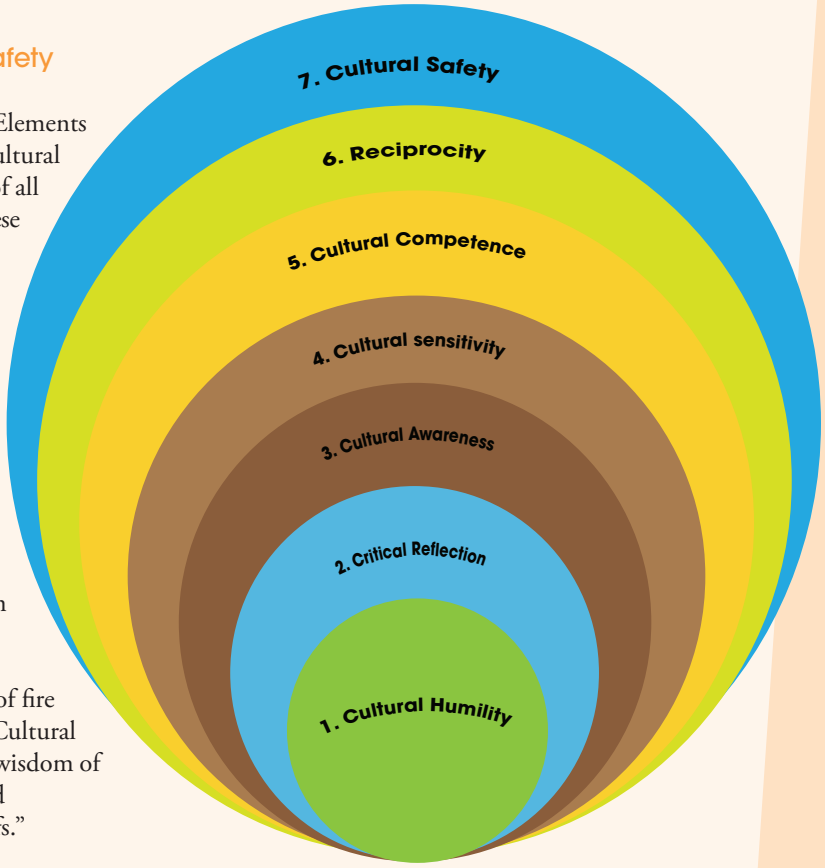
Walker, R., Cromarty, H., Kelly, L., and St. Pierre-Hansen, N. (2009). Achieving culturally safety in Aboriginal health services: implementation of a cross-cultural safety model in a hospital setting. Diversity in Health and Care, 6(1): 11–22.

Walker, R., Cromarty, H., Linkewich, B., Semple, D., St. Pierre-Hansen, N., and Kelly, L. (2010). Achieving Cultural Integration in Health Services: Design of Comprehensive Hospital Model for Traditional Healing, Medicines, Foods and Supports. Journal of Aboriginal Health, 6(1): 58–69. Retrieved from: http://www.naho.ca/documents/journal/jah06_01/06_01_06_Cultural_Integration_in_Health_Services.pdf

Woods, M. (2010). Cultural safety and the socioethical nurse. Nursing Ethics, 17(6): 715–725. doi: 10.1177/0969733010379296
Zolner, T. (2003). Considerations in Working with Persons of First Nations Heritage. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 1(2): 41–58. Retrieved from: http://www.pimatisiwin.com/uploads/1437201498.pdf

References

NNAPF's Renewal Stepping Stones' for Cultural Safety



NNAPF's Stepping Stones for Cultural Safety uses the Four Elements (Earth, Water, Fire, and Air) to explain the progression to Cultural Safety. The four elements are required in the physical realm of all human beings and there are a variety of interpretations of these four elements. Below is an example of an Ojibway perspective:

8. Earth represents the land we live on. The teaching of the earth "is to show respect for all BEINGS and to know the importance of all beings." Thus, beginning to understand Cultural Safety from the element Earth would ensure Cultural Humility by respecting all beings not just human beings.

9. Water represents healing and medicines. The teaching of water is "the place of deep introspection and reflection." The second step to cultural safety would be Critical Reflection because of need for self-reflection.

10. Fire represents the heart of Mother Earth. The teaching of fire is "the place of knowledge and wisdom." The third step to Cultural Safety is Cultural Awareness because it is the knowledge and wisdom of self and others "distinctive spiritual, material, intellectual and emotional features and to value systems, traditions and beliefs."

11. Air represents new beginnings. The teaching of air is "He (Waynaboozhoo or Original Man) looked up into the sky and noticed that the clouds were fleecy white, pure, and cold just like the snow at the tops of the mountains. He knew that high above the Earth there must be layers of air and elements that he had no name for. Nonetheless, he knew that something was up there that held it all together." (Benton-Banai, 1988). Thus, Cultural Sensitivity would be the next step because developing insight and understanding what culture is and the diverse relationship is the intention of Cultural Sensitivity.

12. Cultural Competence is when the health care provider works within the clients cultural needs by respecting and understanding the client's culture and historical trauma.

13. Reciprocity is about keeping the balance with in the relationship, as well as building trusting relationships.

14. In conclusion, Culturally Safety is an effect of a strengthening, encouraging, and empowering the cultural identity of Indigenous peoples with NNAPF's Renewal Stepping Stones

Annotated Bibliography

Adelson, N. (2000). Re-imagining Aboriginality: an Indigenous peoples' response to social suffering. Transcultural Psychiatry, 37(1): 11–34. doi: 10.1177/136346150003700101

Adelson explains that culture evolves with the old, new, and adopted practices. In addition, culture is a way for someone to identify self. She notes that culture is not a cure, and what needs to be examined is how clients take ownership of their identity. This is a form of decolonization as well as reaffirming one's identity which are important to cultural competence.

Aho, L., Ackerman, J., Bointy, S., Cuch, M., Hindelang, M., Pinnow, S., and Turnbull, S. (2010). Health is life in balance: students and communities explore healthy lifestyles in a culturally based curriculum. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 8(3): 151–168. Retrieved from: http://www.pimatisiwin.com/uploads/jan_2011/06AhoAckerman.pdf
Aho and colleagues recommend culturally competent education tools designed for flexibility, integrating western and Indigenous traditions, and use of constructivism theory.

Aboriginal Nurses Association of Canada (ANAC) (2009). Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing. Ottawa, ON: Author. Retrieved from:
http://www.anac.on.ca/Documents/Making%20It%20Happen%20Curriculum%20Project/FINALFRAMEWORK.pdf
The Aboriginal Nurses Association of Canada created this guide to educate nurses about how cultural safety is more than cultural awareness and competence. It involves understanding the power relationships inherent in health care services, rectifying the health inequities, and exposing the historical context of health care. ANAC recommends that health care workers should acknowledge the racism, discrimination, and prejudice that First Nation's people often experience. Also noted is that cultural safety is determined by the client.

ANAC (2011). Cultural Competency and Cultural Safety: Curriculum for Aboriginal Peoples. Ottawa, ON: Author. Retrieved from:
http://www.anac.on.ca/Documents/Cultural%20Competency%20and%20Cultural%20Safety.pdf
The Aboriginal Nurses Association of Canada created a cultural competency and cultural safety training curriculum for nursing students, both Aboriginal and non-Aboriginal, to improve Aboriginal learning and to create cultural awareness. This curriculum identifies the importance of understanding Aboriginal history and contemporary life in relation to cultural competency and safety. It also identifies that there are diverse ways of communicating with Aboriginal people, such as dreams. ANAC explains how being inclusive and sharing knowledge are ways to build relationships. As well, understanding cultural values like respect is a reciprocal process, which is a cultural value. ANAC further explains that Indigenous knowledge cannot be found in a book because it is passed down generationally through language, and there is more than one form of indigenous knowledge.

Juarez, J. Anderson, Marvel, K., Brezinski, K.L., Glazner, C., Towbin, M.M., and Lawton, S. (2006). Bridging the gap: a curriculum to teach residents cultural humility. Family Medicine, 38(2): 97–102.
Juarez and colleagues discuss how incorporating cultural humility into the medical curriculum assists residents in being more attentive to their clients' perspective and social context. The authors discuss how this integration could assist with learning about differences in cultures as well as cultivating self-awareness. The article describes the methods of integrating cultural humility in the curriculum by exposure to diverse beliefs or exploring one's own belief.

Andrews, M. and Boyle, J. (2002). Transcultural concepts in nursing care. Journal of Transcultural Nursing, 13(3): 178–180. doi: 10.1177/10459602013003002
Andrews and Boyle discuss the training text that synthesizes transcultural knowledge for nursing. They identify that cultural assessment skills, along with critical thinking skills, are needed for nurses to provide the necessary care to all cultural groups.
Arnold, O., Appleby, L., and Heaton, L. (2008). Incorporating cultural safety in nursing education. Nursing BC, 40(2): 14–17.
Arnold, Appleby, and Heaton discuss how reciprocal partnerships and collaborations equal success in cultural safety. In addition, the sharing of knowledge will increase cultural safety.

Ashton, C. (2010). Cultural safety training manual. Ontario Métis Family Records Center, Special Edition 1. Retrieved from:
http://www.omfrc.org/newsletter/omfrcspecialedition1.pdf
This manual is used as a cultural safety training guide for health care workers. The steps to achieving cultural safety in this guide are to understand the historical contexts of Aboriginal people (e.g., the impact of the Indian Act, the assumed European superiority of Aboriginal people, and the legacy of residential schools). The author notes how institutional racism is prominent in many settings and often goes unnoticed under European lens.

Annotated Bibliography

Assembly of First Nations (AFN) and First Nations Information Governance Committee (FNIGC) (2007). First Nations Regional Longitudinal Health Survey (RHS) 2002/03: The Peoples' Report. Revised second edition. Retrieved from: http://www.rhs-ers.ca/sites/default/files/ENpdf/RHS_2002/rhs2002-03-the_peoples_report_afn.pdf

The Assembly of First Nations and First Nations Information Governance Committee partner to create a survey that is culturally relevant and appropriate to Aboriginal people.

Bearskin, R.L. Bourque (2011). A critical lens on culture in nursing practice. Nursing Ethics, 18(4): 548–559. doi: 10.1177/0969733011408048
Bearskin examines cultural competence and cultural safety by understanding Indigenous relationships with their selves, others, the environment, and the universe. She identifies that all people are bearers of culture so self-discovery is important to cultural safety. In addition, she explains that cultural safety is not about cultural practices of the community but about being aware of the social, political, and economic positions of the communities. Furthermore, cultural safety is about paying attention to the health care disparities and advocating for improvement. Finally, Bearskin recommends exposing unequal power relations and examining the historical, social, and political perspectives of health care.

Becker, L.C. (1990). Reciprocity. Chicago, IL: University of Chicago Press. [Originally published 1986 by London, UK: Routledge and Kegan Paul.]
In Becker's book, reciprocity is explored as a moral theory and virtue. It is a social obligation to society, families, law, and the future generations. In addition, reciprocity is about returning "all of the good we receive" as a way of showing gratitude and building character. This book is useful by providing the theory for the Stepping Stone - Reciprocity.

Benton-Banai, Edward. (1988). The Mishomis Book: The Voice of the Ojibway. Hayward, WI: Indian Country Communication Inc.

Benton-Banai writes about the history of Ojibway history and culture. Benton-Banai offers insightful Ojibway teachings which is useful in identifying the values of an Indigenous community.

Brascoupé, S. and Waters, C. (2009). Cultural safety: exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. Journal of Aboriginal Health, 5(2): 6–41. Retrieved from: http://www.naho.ca/jah/english/jah05_02/V5_I2_Cultural_01.pdf
Brascoupe and Waters explore how cultural safety applies in Aboriginal health and community wellness. Cultural safety addresses the role that power has in the relationship of the client and health care worker. Thus, to achieve cultural safety, the client's needs and voices take the predominant role in the relationship, which in turn transforms the relationship. Furthermore, Brascoupe and Waters discuss the steps to cultural safety is a self-awareness journey.

Browne, A.J., Varcoe, C., Smye, V., Reimer-Kirkham, S., Lynam, M.J., and Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. Nursing Philosophy, 10(3): 167-179. doi: 10.1111/j.1466-769X.2009.00406.x
Browne and colleagues examine cultural safety within a Canadian context as it pertains to knowledge translation. The authors distinguish how the post-colonial histories of Canada and New Zealand differ, and this has affected how cultural safety is interpreted within Canada. The authors note that it is important to acknowledge the historical context of marginalized and oppressed groups; however, it is equally important to acknowledge the client's individual experiences. Furthermore, the authors position cultural safety as a critical element to social justice curriculum.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., and Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. BMC Health Services Research, 7: 15. doi: 10.1186/1472-6963-7-15
Bhui and colleagues evaluate models of cultural competence programs and their effectiveness in education and service delivery using a systemic review. From the 109 papers reviewed, nine were evaluated for their effectiveness. The review showed that cultural competence emphasized the authentic willingness and desire of the health professional to understand and learn. The teaching and learning methods that showed to be effective in teaching cultural competence were limited because there needs to be more work in establishing appropriate outcome measures.

Annotated Bibliography

Bojuwoye, O. and Sodi, T. (2010). Challenges and opportunities to integrating traditional healing into counselling and psychotherapy. Counselling Psychology Quarterly, 23(3): 283–296. doi: 10.1080/09515070.2010.505750

Bojuwoye and Sodi recommend the integration of both Western and traditional healing methods and say that Western practitioners need to work together with traditional healers. They explain that this collaboration will create opportunities in training and education for both Western and traditional healers.

California Health Advocates (2007). Are you practicing cultural humility? The key to success in cultural competence. Retrieved from: http://www.cahealthadvocates.org/news/disparities/2007/are-you.html

This article examines how culture is not noticeable unless the person is not in a familiar cultural environment. It recommends acknowledging that culture is not a blueprint for a client's behaviour nor is it static and that the practice of cultural humility should be foundational for cultural competence. The article gives a sample exercise to create awareness of one's own culture and identity.

Cameron, M., Andersson, N., McDowell, I., and Ledogar, R.J. (2010). culturally safe epidemiology: oxymoron or scientific imperative. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 8(2): 89–116. Retrieved from: http://www.pimatisiwin.com/online/wp-content/uploads/2010/09/07CameronAndersson.pdf

Cameron and colleagues explain that culturally safe space is one where Indigenous and non-Indigenous protocols are not compromised. Furthermore, cultural safety should be an outcome rather than a theory.

Ferguson, S.L. and Campinha-Bacote, J. (1997). Cultural competence: a critical factor in child health policy. Journal of Pediatric Nursing, 12(4): 260–262.

Ferguson and Campinha-Bacote use a theoretical model to show a cultural competence process to effectively communicate with diverse beliefs and populations. In this model, they identify five concepts: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural awareness is explained as one being cognizant of one's own beliefs and views in order to be aware of other beliefs and views. Cultural knowledge is being defined as a process where one would seek the client's cultural beliefs to identify any cultural practices that would impact health outcomes. Cultural skill is defined as a way of accessing the client's cultural teachings. Cultural encounters are about creating the relationship needed for culturally relevant health outcomes.

Campinha-Bacote J. (2002). The process of cultural competence in the delivery of healthcare services: a model of care. Journal of Transcultural Nursing, 13(3): 181–184. doi: 10.1177/10459602013003003

Campinha-Bacote examines the process of cultural competence with cultural desire as another component. Cultural desire is defined as a want rather than a need for the health care worker to become culturally competent. Furthermore, cultural desire is a learning concept as well as a passion to be receptive and flexible with client differences and similarities. In addition, she explains that cultural incompetence or lack of culturally responsive services in health care that clients receive negatively impacts the health care service industry.

Cervantes. J.M., and Parham, T.A. (2005). Toward a meaningful spirituality for people of color: lessons for the counseling practitioner. Cultural Diversity and Ethnic Minority Psychology, 11(1): 69–81.

Cervantes and Parham explain that spirituality is not the same as religiosity and that recognizing the client's spiritual essence is important to counselling. They identify that self-examination is important in understanding what the health care worker brings to the relationship with the client. The health care worker should know their own knowledge base.

Chandler, B. (2002). Cultural sensitivity. In K. Krapp (ed.). Encyclopedia of Nursing and Allied Health. Vol. 1 Gale Cengage. eNotes. Retrieved from: http://www.enotes.com/cultural-sensitivity-reference/cultural-sensitivity

In this website, cultural sensitivity is defined and identified as a recognition of the diverse ways in which people from diverse cultures communicate and relate. In addition, Chandler explains how culture is not only diverse among cultures, but within as well. For example, assuming "a common culture is shared by all members of a racial, linguistic, or religious group is erroneous." Therefore, cultural sensitivity is about having a genuine concern and openness to learn diverse ways of being.

Chang, E., Simon, M., Dong, X. (2012). Integrating cultural humility into health care professional education and training. Advances in Health Sciences Education, 17(2): 269–278. doi: 10.1007/s10459-010-9264-1

Chang and co-authors discuss how to integrate cultural humility into health care training. The authors explore Chinese philosophy and values as well as the importance of self reflection and active listening. Family, health care system, and community support are intrinsic to the Chinese philosophy, which could enhance the comprehension of diverse cultures. Furthermore, this philosophy is adaptable to other cultural societies.

Annotated Bibliography

Clark, L., Colbert, A., Flaskerud, J.H., Glittenberg, J., Ludwig-Beymer, P., Omeri, A., Strehlow, A.J., Sucher, K., Tyson, S., and Zoucha, R. (2010). Chapter 6: Culturally based healing and care modalities. Journal of Transcultural Nursing, 21(Suppl. 4), 236s-306s. doi: 10.1177/1043659610382628
Clark and colleagues discuss the diversity of how cultures view mental health and illness. They explain by acknowledging the power relations within the health care worker and client relationships are important to cultural safety. In addition, the authors recommend that health care workers be holistic, have respect for cultural taboos, and encourage a multidisciplinary team. They also explain how strategies that encourage equity, independence, and cultural appropriateness will be effective.

Clingerman, E. (2011). Social justice: a framework for culturally competent care. Journal of Transcultural Nursing, 22(4): 334–341. doi: 10.1177/1043659611414185
Clingerman examines how culturally competent education, practice, and research are needed to develop culturally competent interventions. In addition, the author acknowledges that it is important to acquire knowledge of the inequities, disadvantages, and injustices of vulnerable groups.

College of Nurses of Ontario (2009). Practice Guideline: Culturally Sensitive Care. Toronto, ON: Author. Retrieved from: http://www.cno.org/Global/docs/prac/41040_CulturallySens.pdf
This guide was created to assist nurses in providing culturally sensitive care. The main focus is to ensure that the needs of clients are met. The elements of providing culturally sensitive care are self-reflection, acquiring cultural knowledge, facilitating client health care needs, and being cognizant of non-verbal communication. The guide provides a series of scenarios for nurses to discuss in addition to the number of recommended directives.

Dadlani, M. and Scherer, D. (2009). Culture in psychotherapy practice and research: awareness, knowledge, and skills. Retrieved from: http://www.divisionofpsychotherapy.org/dadlani-and-scherer-2009/
Dadlani and Scherer examine cultural competency using three stages as it relates to psychotherapists: awareness, knowledge, and skills. Awareness is identified by using the "ADDRESSING" framework to understand the socio-cultural aspects of a psychotherapist's own biases and assumptions. Knowledge is offered to help understand the diverse populations of a psychotherapist's client base. The authors discuss having the adequate interpersonal skills in order to acquire a positive outcome for clients.

de Crespigny, C., Kowanko, I., Murray, H., Wilson, S., Kit, J.H., and Mills, D. (2006). A nursing partnership for better outcomes in Aboriginal mental health, including substance use. Contemporary Nurse, 22(2): 275–287. doi: 10.5172/conu.2006.22.2.275
de Crespigny and colleagues discuss how the participatory action research and methodology contribute to building partnerships and collaborations with Aboriginals from Australia. Furthermore, the authors note that it is vital to acknowledge how historical trauma has contributed to the ill health of Aboriginal peoples in Australia. The importance of listening to cultural community leaders, linking Aboriginal and non-Aboriginal programs to create information sharing, and being an advocate are ways to develop partnerships that are inclusive and culturally relevant.

Durie, M. (2001). Cultural Competence and Medical Practice in New Zealand. Wellington, NZ: Australian and New Zealand Boards and Council Conference. Retrieved from:
http://ebookbrowse.com/gdoc.php?id=57591779&url=f075500bf366abde28dec2820cef1316
Durie discusses a cultural competence framework that entails domains of cultural impact, aim of cultural competence, applications to medical practice, and implications for the medical profession. He explains how cultural safety is about client experience and cultural competence is about health care workers advocating on behalf of their clients' cultural needs. In addition, Durie acknowledges that the doctor-patient relationship could be improved by appreciating the values, perspectives, and beliefs of the community based on its culture. Thus, the treatment plan is not just the doctor and patient but includes community input.

Eisenbruch, M. and Eisenbruch, R. Volich (2005). "Cultural competence - background." Retrieved from:
http://www.eisenbruch.com/Further_resources/Cultural_diversity/Cultural_competence_-_background.htm
Eisenbruch and partners have a website which shares information and research about mental health - for patients, communities and health systems. The evolution of cultural competence is a concept discussed in this website. In this website, cultural humility (a lifelong process of self-reflection and self-critque) is discussed as a skill for cultural competence. Cultural humility does not mean mastering traditional knowledge, but developing self awareness and respect of different ideologies.

Annotated Bibliography

First Nations of Quebec and Labrador Health and Social Services Commission. (2003). Adapting Our Interventions to Native Reality. Wendake, QC: Author. Retrieved from: http://library.catie.ca/PDF/P29/22675.pdf
The First Nations of Quebec and Labrador Health and Social Services Commission explains the belief from an Aboriginal traditional world view that all things are connected. Therefore, it is important to acknowledge this world view when addressing Aboriginal healing and health.

Lyons, J. (2011). "Paulo Freire's educational theory." Retrieved from: http://www.newfoundations.com/GALLERY/Freire.html
This is a website dedicated to Paulo Freire's Educational Theory. Freire states to learn, one should "construct knowledge from knowledge they already possess" and knowledge needs to be discussed and reflected upon to be understood.

Garrett, M.T., and Pichette, E.F. (2000). Red as an apple: Native American acculturation and counseling with or without reservation. Journal of Counseling and Development, 78(1): 3–13. doi: 10.1002/j.1556-6676.2000.tb02554.x
Garrett and Pichette examine how institutional racism and other negative oppressions continue to create difficulty for Aboriginal people. The authors recommend that mental health workers should avoid making assumptions, be understanding to Aboriginal culture and identity, and explore client world views. They suggest these recommendations will assist in working with client's needs and goals to well-being.

Glen, S. (1995). Developing critical thinking in higher education. Nurse Education Today, 15: 170-176.
Glen identifies how critical thinking is more than problem solving and that it is about challenging one's truths and openness to new truths. She illustrates a framework of higher education that include taking a personal stand, relativizing one's experience, being sensitive to knowledge forms of others, exercising critical judgment, recognizing its provisionality and contested character, and deepening understanding and assimilation-encountered knowledge. She states there are different kinds of knowledge, practices, ideologies, and values that are vital to achieving critical thinking.

Goforth, S. (2007). Aboriginal healing methods for residential school abuse and intergenerational effects: a review of the literature. Native Social Work Journal, 6: 11–32. Retrieved from: https://zone.biblio.laurentian.ca/dspace/handle/10219/392
Goforth discusses how many Aboriginal communities are developing culturally relevant interventions that could be adapted for use in other Aboriginal communities. However, in order for Aboriginal communities to continue with these interventions, they must have the necessary resources. The author acknowledges the diversity and similarities across Aboriginal communities, so the therapeutic practices must be determined within them. Goforth recommends the integration of both Western and Aboriginal therapeutic practices.

Gone, J.P. (2001). Affect and its Disorders in a Northern Plains Indian Community: Issues in Cross-cultural Discourse and Diagnosis. [Unpublished doctoral dissertation, University of Illinois.] Retrieved from: http://sitemaker.umich.edu/joseph.p.gone/files/gone_diss.pdf
Gone examines how dominant cultural practices try and influence communities that have been historically oppressed.

Guerin, B. (2010). A framework for decolonization interventions: broadening the focus for improving the health and wellbeing of Indigenous communities. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 8(3): 61–83. Retrieved from: http://www.pimatisiwin.com/uploads/jan_2011/03Guerin.pdf
Guerin examines a progression of interventions needed (early period: cross-cultural training; middle period: decolonization workshops; and later period: needs popular support). In addition, the author discusses how there is a need to evaluate the effectiveness of these interventions.

Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security (2005). Reducing Health Disparities – Roles of the Health Sector: Discussion Paper, December 2004. Retrieved from: http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf

Hulme, P.A. (2010). Cultural considerations in evidence-based practice. Journal of Transcultural Nursing, 21(3): 271–280. doi:10.1177/1043659609358782
Hulme explains how clients should have a voice in all decisions and that developing a knowledge system of diverse cultures is important to cultural safety. In addition, to have an effective health outcome, the health care worker should be able to modify services and interventions to suit the needs of the client. The author states by acknowledging the importance of culture in therapeutic practices, this will lead to more effective health care services.

Annotated Bibliography

Hunt, L.M. (2005). Beyond cultural competence: applying humility to clinical settings. Park Ridge Center Bulletin, 24(3–4): 134–136.
Hunt describes how cultural competency has no explicit criteria and could assist with enforcing stereotypes of diverse cultures. The author suggests instead to begin with cultural humility to encourage a respectful relationship between the client and health care worker to identify the similarities, differences, as well as the client's priorities, goals, and capacities. Furthermore, the author encourages the health care worker to engage in an ongoing process of developing self-awareness skills and to recognize the client's distinctive perspectives.

Indigenous Physicians Association of Canada (IPAC) and Association of Faculties of Medicine of Canada (AFMC) (2009). First Nations, Inuit, Métis Health Core Competencies: A Curriculum Framework for Undergraduate Medical Education. Retrieved from: http://www.afmc.ca/pdf/CoreCompetenciesEng.pdf
This curriculum was created for undergraduate medical students. The IPAC and AFMC discuss how cultural safety should emphasize self-reflection in order to address the power imbalances that health care workers bring to the client-health care worker relationship.

IPAC-RCPSC Family Medicine Curriculum Development Working Group (2009). Cultural Safety in Practice: A Curriculum for Family Medicine Residents and Physicians. Ottawa, ON: Author.
The IPAC-RCPSC Family Medicine Curriculum Development Working Group employs self-reflection as a key skill. As well, participants can begin to reflect on their world view, to observe how it might be different from that of their patients, and to engage in a therapeutic encounter that is Indigenous centred.

Johnstone, M.-J. and Kanitsaki, O. (2007). An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context. Journal of Transcultural Nursing, 18(3): 247–256. doi: 10.1177/1043659607301304
Johnstone and Kanitsaki examine how cultural safety needs to be better understood in order to be effective. In addition, supporting the request for more evidence of cultural safety benefits is needed.

Korhonen, M. (2004). Helping Inuit Clients: Cultural Relevance and Effective Counselling. Ottawa, ON: National Aboriginal Health Organization. [Also published in International Inuit Circumpolar Journal, 6(s2): 135–138.]
Korhonen compares how the values and relationship factors of effective counselling are similar in traditional Inuit and Western therapeutic methods. Western and traditional Inuit helping correspond, and cognitive/cognitive behavioural approaches especially complement Inuit cultural practice.

Kurtz, D.L.M., Nyber, J.C., Van Den Tillaart, S., Mills, B., Okanagan Urban Aboriginal Health Research Collective (OUAHRC) (2008). Silencing of voice: urban Aboriginal women speak out about their experiences with health care. Journal of Aboriginal Health, 4(1): 53–63. Retrieved from: http://www.naho.ca/jah/english/jah04_01/08SilencingVoice_53-63.pdf
Kurtz and co-authors examine how colonial structures and systems (also viewed as structural violence) have contributed to silencing Aboriginal women's voices, which in turn impact the health services they seek. This article is important in affirming the need for a culturally safe environment, such as the accessing health services through a community-based centre. The women using this service acknowledged they felt heard and had more control over their own health care.

Laframboise, S. and Sherbina, K. (no date). The medicine wheel. Retrieved from: http://dancingtoeaglespiritsociety.org/medwheel.php
Laframboise and Sherbina discuss the medicine wheel concept in this website. In addition, traditional knowledge is shared on Indigenous philosophies and teachings. The medicine wheel is examined and is understood as one of the oldest teachings of First Nations people. The four "biopsychosocial and spiritual foundation[s]" are described as the "healthy minds (East), strong inner spirits (South), inner peace (West) and strong healthy bodies (North)." Furthermore, the medicine wheel teachings are identified as a mirror of self-reflection.

Maar, M.A., Erskine, B., McGregor, L., Larose, T.L., Sutherland, M.E., Graham, D. Shawande, M., and Gordon, T. (2009). Innovations on a shoestring: a study of a collaborative community-based Aboriginal mental health service model in rural Canada. International Journal of Mental Health Systems, 3:27. doi:10.1186/1752-4458-3-27
Marr and colleagues describe the Knaw Chi Ge Win model, an Indigenous mental health care model, as innovative and community-based. They explain how this model has increased access to mental health care in the rural, high-needs area. The authors also explain how sharing of information, protocols, as well as continuous educational support are part of this model. The health care has improved with the integration of Aboriginal and Western therapeutic practices; however, there are challenges to this innovative model including the lack of resources, health information regarding the impact of Aboriginal healing, and outcomes.

Annotated Bibliography

Maina, F. (1997). Culturally relevant pedagogy: First Nations education in Canada. Canadian Journal of Native Studies 17(2): 293–314. Retrieved from: http://www2.brandonu.ca/library/cjns/17.2/cjnsv17no2_pg293-314.pdf
Maina discuss the need for educating a disrupted heritage, as well as the skills needed for success. Maina emphasizes the need for educators to learn the colonial history and its impact of First Nations communities.

Marsden, D. (2006). Creating and sustaining positive paths to health by restoring traditional-based Indigenous health-education practices. Canadian Journal of Native Education, 29(1): 135–145.
Marsden discusses how acknowledging traditional methods could be used to restore and continue Indigenous health education practices. In addition, knowledge exchange moves beyond differences and disconnections.

McCormick, R.M. (2000). Aboriginal traditions in the treatment of substance abuse. Canadian Journal of Counselling, 34(1): 25–32. Retrieved from: http://cjc-rcc.ucalgary.ca/cjc/index.php/rcc/article/view/152/367
McCormick acknowledges the connection to meaning, family, spirituality, and identity with culture. In addition, Indigenous values such as courage, humility, generosity, and family honour can serve as a preventative and curing agent in a mental health program.

McEldowney, R. and Connor, M.J. (2011). Cultural safety as an ethic of care: a praxiological process. Journal of Transcultural Nursing, 22(4): 342–349. doi:10.1177/1043659611414139
McEldowney and Connor examine from a postmodern perspective the concept of cultural safety and integrate a new theoretical model as an ethic of care. The authors note the importance of health care workers to take responsibility for their own culture and its effect on populations from other cultures. In addition, they emphasize ethical decision making as an important skill that will enable the health care worker to seek out a fair outcome for the client.

Mezirow, J. (1990). How critical reflection triggers transformative learning. In Fostering Critical Reflections in Adulthood: A Guide to Transformative and Emancipatory Learning. San Francisco, CA: Jossy-Boss, pp. 1–20. Retrieved from:
http://www.graham-russell-pead.co.uk/articles-pdf/critical-reflection.pdf
Mezirow is a professor of adult learning and has written many books on the subject, which have won numerous awards. This current book examines critical reflection and how it is important to learning. Critical reflection challenges our beliefs in our previous perceptions and allows one to give adequate meaning to encounters with the world and self. Emancipatory education challenges beliefs and offers new ways of seeing and understanding.

National Aboriginal Health Organization (NAHO) (2008). Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators. Ottawa, ON: Author. Retrieved from:
http://www.naho.ca/documents/naho/publications/culturalCompetency.pdf
The National Aboriginal Health Organization created a cultural competency and safety guide for Health Care Administrators. It states that the health care worker needs to have the ability to be compassionate, sensitive, and empathic to be culturally competent. In addition, the health care worker must also be willing to incorporate the necessary accommodations to bridge the power relationship between the health care worker and the client. Furthermore, learning the client's cultural environment as well as appreciate its diversity is the onus of the health care worker. The health care worker must understand the diverse social determinants of health that impact the health of their client in order to be culturally competent.

National Center for Cultural Competence (2004). Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs. Washington, DC: Georgetown University Center for Child and Human Development. Retrieved from:
http://nccc.georgetown.edu/documents/Cultural_Broker_Guide_English.pdf
The National Center for Cultural Competence discuss the need to increase the cultural and linguistic competence of health care and mental health programs. This guide was created to assist with cultural competency programming and training. The concept discussed is cultural brokering which is defined as a "negotiator" position that could bridge or link the gap of health care worker and clients of diverse cultural heritage. One key concept in this manual is the idea of self-determination, where the client determines their own needs and decision-making.

Annotated Bibliography

Assembly of First Nations (AFN), National Native Addictions Partnership Foundation (NNAPF), and First Nations and Inuit Health Branch (FNIB) (2011). Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada. Ottawa, ON: Health Canada.
The National Native Addictions Partnership Foundation, the Assembly of First Nations, and the First Nations and Inuit Health Branch of Health Canada partner together to renew the National Native Alcohol and Drug Abuse Program with a culturally relevant drug strategy.

New Zealand Psychologists Board (2009). Guidelines for Cultural Safety: The Treaty of Waitangi and Māori Health and Wellbeing in education and Psychological Practice. Wellington, NZ: Author. Retrieved from: http://www.psychologistsboard.org.nz/cms_show_download.php?id=83
The New Zealand Psychologists Board created guidelines for New Zealand students studying psychology. The authors emphasize the importance of recognizing and respecting the Maori as a diverse population. In addition, there are a number of learning outcomes, such as allowing clients to be involved in their health outcomes and noting that cultural safety is more about self-reflection and the experiences of clients.

Papadopoulos, I. Tilki, M., and Taylor, G. (1998). Transcultural Care: A Guide for Health Care Professionals. London, UK: Quay Books.
Papadopoulos and colleagues examine cultural competence as a model of four stages: the first stage is cultural awareness, the second stage is cultural knowledge, the third stage is cultural sensitivity, and the fourth stage is cultural competence. This model acknowledges critical reflection, power imbalances, respect for diverse cultures, and communication skills that are needed in order to be culturally competent.

Papps, E. (2005). Chapter 2 — Cultural safety: daring to be different. In D. Wepa (ed.). Cultural safety in Aotearoa New Zealand. Auckland, NZ: Pearson Education New Zealand, pp. 20–28.
Papps discuss cultural safety and how it is important to the health care system. Self-reflective practices are important to cultural safety.

Petrucka, P., Bassendowski, S., Bourassa, C. (2007). Seeking paths to culturally competent health care: lessons from two Saskatchewan Aboriginal communities. Canadian Journal of Nursing Research, 39(2): 166–182.
Petrucka and colleagues examine cultural competency and discuss how it is about relationship building because the values, trust, respect, communication, and understanding are vital components needed to achieve cultural competency. In addition, they note that involving community elders is an example of relationship building.

Pockett, R. and Giles, R. (eds.) (2008). Critical Reflection: Generating Theory from Practice: The Graduating Social Work Student Experience. Sydney, AU: Darlington Press.
Pockett and Giles examine the importance of critical reflection to create "new professional knowledge." In addition, critical reflection could improve the health care by creating knowledge based on their own experiences. Consequently, critical reflection will assist health care workers to "find ways to act more responsibly in uncertain environments." (viii).

Purnell, L. (2005). The Purnell Model for Cultural Competence. Journal of Multicultural Nursing and Health, 11(2): 7–15. [Previously published in Transcultural Nursing, 2002, 13(3): 193–196. doi: 10.1177/10459602013003006]
Purnell presents an overview of the Purnell Model for Cultural Competence framework. This model is a holistic framework that assists health care professionals in understanding the culture of their clients (e.g., how a client views high-risk behaviours). This framework is useful for assessing, planning, implementing, and evaluating interventions.

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. Welington, NZ: NCNZ.
Ramsden educates on the issues of health care workers who work with Indigenous clients. In addition, Ramsden discusses the importance of the Treaty of Waitangi and its role in ensuring cultural safety. In this report, cultural safety is identified as being more than ethnicity, it is inclusive of age, gender, sexual orientation, etc. and focuses on "everyone has a culture" theory. Furthermore, by understanding the Treaty of Waitangi, the health care provider will understand the historical context of the Maori. Finally, linking cultural safety and The Treaty of Waitangi as being one component of Maori wellbeing.

Annotated Bibliography

Rigby, W., Duffy, E., Manners, J., Latham, H., Lyons, L., Crawford, L., and Eldridge, R. (2011). Closing the gap: cultural safety in Indigenous health education. Contemporary Nurse, 37(1): 21–30. doi: 10.5172/conu.2010.37.1.021

Rigby and colleagues examine cultural safety in Indigenous health education. They recommend that teaching tools should not be lengthy, have a flexible approach to learning and teaching, and increase the role of community elders. In addition, group identity and cohesion were key issues when addressing cultural safety. The authors note that there are differences within the same cultural group depending on their geographic locations.

Roberts, A. (2008). Challenging borders and barriers: cultural competence must embrace anti-oppression frameworks. Crosscurrents: The Journal of Addiction and Mental Health, 11(3): 16.

Roberts examines how racism has impacted on health care access. She states that systemic discrimination is often reflected in the system of mental health care. There are a number of challenges related to systemic racism, such as limited access to language interpretation services, cultural misinterpretation, clinician neutrality, inadequate training, over-reliance on Eurocentric therapies and models of care, emphasis on evidence-based practice, and scarcity of funding for ethno-racial services. In this article, Dr. Kwame McKenzie, CAMH, states the importance of taking a systemic approach, being advocates, and being innovative with the needs of the communities.

Sen, G. and Ostlin, P. (2007). Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why It Exists and How We Can Change It. Final Report to the WHO Commission of Social Determinants of Health. Retrieved from: http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf

Sen and Ostlin explore the inequity of the health care systems and structures among women. This report identifies why this inequity exists and how it could be rectified by addressing women's rights to health.

Smye, V. and Browne, A.J. (2002). 'Cultural safety' and the analysis of health policy affecting aboriginal people. Nurse Researcher, 9(3): 42–56.

Smye and Browne examine how colonization has had a devastating impact on Indigenous people, so understanding the health and social relations and practices are shaped by dominant organizational, institutional, and structural conditions. The authors recommend examining the unequal power relations and the social and historical processes that organize these relationships. In addition, the authors suggest the issues of institutional racism and discrimination that continue to shape the provision of health care for Aboriginal people in Canada should be critically assessed.

Stout, M. Dion and Downey, B. (2006). Nursing, Indigenous peoples and cultural safety: so what? now what? Contemporary Nurse, 22(2): 327–332. doi: 10.5172/conu.2006.22.2.327

Stout and Downey examine the concept of "self-determination" and the utilization of traditional knowledge and medicines among Indigenous people as not just "nice to know" but a critical area of awareness and understanding that needs to be captured in educational curricula. They encourage the need for champions in learning institutions who can break down the barriers that hinder development and integration of such curricula. This will ensure that the curricula are grounded in an accurate historical perspective consistent with the experience of Indigenous populations.

Tait, C.L. (2008). Ethical programming: towards a community-centred approach to mental health and addiction programming in Aboriginal communities. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 6(1): 29–60. Retrieved from: http://www.pimatisiwin.com/uploads/445206868.pdf

Tait argues that guidelines involving Aboriginal communities should be grounded in Aboriginal epistemologies and world views. In addition, the mental health and addiction programming should focus on strengths of both Western and Aboriginal knowledge.

Tervalon, M. and Murray-Garcia, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9(2): 117–125. doi: 10.1353/hpu.2010.0233

Tervalon and Murray-Garcia argue that understanding the health beliefs and practices of clients are vital to cultural safety. In addition, an evaluation of the cultural competency training taken by health care workers should be done, as some make the assumption they are culturally competent just because they had the training. The authors note that health care workers need to be flexible and humble in order to let go of their own biases and assumptions. They also note that cultural humility ensures there is a less controlling, less authoritative style when communicating with clients.

Annotated Bibliography

The Royal Australian College of General Practitioners. (2010). Cultural Safety Training: Identification of Cultural Safety Training Needs. South Melbourne, AU: Author. Retrieved from: http://www.racgp.org.au/Content/NavigationMenu/About/Faculties/AboriginalandTorresStraitIslanderHealth/CulturalSafetyTraining/Cultural_Safety_Training_Identification_of_cultural_safety_training_needs.pdf
This project provides best practices for cultural safety training for health care workers. One of the main aspects of this article is the need for an evaluation of cultural safety training programs to ensure that cultural safety is taught adequately and health care workers grasp the concepts. The recommendations from this article are to use adult-style learning principles, engage participants, relate the topic to participants, allow participants to see the relevance, and ensure participants feel they are in control of their learning environment.

Towland, C. (2010). Cultural competence in social care and health. Retrieved from: http://ezinearticles.com/?Cultural-Competence-in-Social-Care-and-Health&id=4747156
This article is grey literature on cultural competence and culture. The author states that in order for a health care worker to be cultural competent, a range of knowledge, understanding, values, attitudes, and skills are required. Some examples include the knowledge and understanding about self, concepts of culture, and cultural knowledge; the values and attitudes about celebrating diversity and respecting individuality; and the skills of cultural communication and assessment. There is an emphasis on having health care workers visualize how these skills relate to their practice and self-reflection.

Trimble, J.E. (2010). Bear spends time in our dreams now: Magical thinking and cultural empathy in multicultural counselling theory and practice. Counselling Psychology Quarterly, 23(3): 241–253. doi: 10.1080/09515070.2010.505735
Trimble explains how promoting cultural empathy is important to cultural safety. Cultural empathy is defined as a continued learning skill that acknowledges the world views of other cultures. The author also states that having respect for clients, establishing a good rapport with them, as well as being less judgmental will assist in cultural safety. Furthermore, health care workers should acknowledge that cultural world views are profound in many Aboriginal clients and, therefore, should modify conventional approaches and practices to suit the cultural world views of their clients. Health care workers should also gather knowledge from the communities in order to gain a better understanding of their clients' environments.

Mawhiney, A. and Nabigon, H. (2010). "Aboriginal Theory: A Cree Medicine Wheel Guide for Healing First Nations in Social Work Treatment: Interlocking Theoretical Approaches. Turner, F.J. (ed.) Fourth edition. Oxford, UK: Oxford University Press. [First published in 1996 by New York, NY: The Free Press.]
Mawhiney and Nabigon discuss the Aboriginal approach to healing using the medicine wheel. The authors explain the significance to relationship to self, others, and the land. Humility is a value that is part of the Cree way of being.
United Nations Educational, Scientific and Cultural Organization (2001). UNESCO Universal Declaration on Cultural Diversity. Retrieved from: http://portal.unesco.org/en/ev.php-URL_ID=13179&URL_DO=DO_TOPIC&URL_SECTION=201.html

Union of Ontario Indians. (2009). Through the Eyes of a Child: First Nation Children's Environmental Health. Retrieved from: http://www.anishinabek.ca/download/Through%20the%20Eyes%20of%20a%20Child%20-%20FN%20Enviro%20Health.pdf
In the Union of Ontario Indians website,

Walker, R. and Sonn, C. (2010). Working as a Culturally Competent Mental Health Practitioner. In N. Purdie, P. Dudgeon, and R. Walker (eds.). Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Canberra: AU: Commonwealth of Australia, pp. 157–180. Retrieved from: http://www.ichr.uwa.edu.au/files/user5/Working_Together_book_web_0.pdf
This chapter discusses that culturally competency requires more than becoming culturally aware or practising tolerance; rather, it is the ability to identify and challenge one's own cultural assumptions, values, and beliefs. In addition, developing empathy and connected knowledge, including the ability to see the world through another's eyes, are important to cultural competent.

Walker, R., Cromarty, H., Kelly, L., and St. Pierre-Hansen, N. (2009). Achieving culturally safety in Aboriginal health services: implementation of a cross-cultural safety model in a hospital setting. Diversity in Health and Care, 6(1): 11–22.
Walker and colleagues examine how cultural competency is defined by the health worker where cultural safety is defined by the client. They note that cultural safety must include the perspectives of the clients in all service delivery and interventions.

Annotated Bibliography

Walker, R., Cromarty, H., Linkewich, B., Semple, D., St. Pierre-Hansen, N., and Kelly, L. (2010). Achieving Cultural Integration in Health Services: Design of Comprehensive Hospital Model for Traditional Healing, Medicines, Foods and Supports. Journal of Aboriginal Health, 6(1): 58–69. Retrieved from: http://www.naho.ca/documents/journal/jah06_01/06_01_06_Cultural_Integration_in_Health_Services.pdf

Walker and co-authors discuss cultural competence and how it is integrated in many health care systems to address the health inequities.

Williams, R. (1999). Cultural safety - what does it mean for our work practice? Australian and New Zealand Journal of Public Health, 23(2): 213–214.

Williams examines how cultural safety needs to begin with critical reflection. Cultural safety programs are needed to enhance health care services and promote effective service delivery. One effective way to encourage cultural safety is to use an action research framework based on critically reflective questions.

Woods, M. (2010). Cultural safety and the socioethical nurse. Nursing Ethics, 17(6): 715–725. doi: 10.1177/0969733010379296

Woods identifies a model that illustrates the connection between the social and ethical components of cultural safety. Cultural safety is based on individual and collective self-sufficiency, social justice, and the values of empowerment, trust, and respect. The author notes how a client's identity and autonomy are important to cultural safety, as well as being flexible to cultural norms. The mental health worker should be inclusiveness and culturally responsive to a client's differences rather than respond with one's own assumptions. Cultural safety addresses the power and control within a society and acknowledges that all individuals have the right to health care even if it is not mainstream health care.

Zolner, T. (2003). Considerations in Working with Persons of First Nations Heritage. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 1(2): 41–58. Retrieved from: http://www.pimatisiwin.com/uploads/1437201498.pdf

Zolner examines how collaboration with front-line workers could assist in the development of culturally competent assessment practices.

NOTES

NOTES

NOTES


THUNDERBIRD PARTNERSHIP FOUNDATION