



“One Focus; Many Perspectives”

**A Curriculum for Cultural Safety and
Cultural Competence Education**

**Prepared for the Mental Health Commission of
Canada**

**By the
Cultural Safety Working Group, First Nation, Inuit
and Métis Advisory Committee of the Mental Health
Commission of Canada**

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Introduction

This curriculum is designed as a catalyst for dialogue and change within the mental health and addictions system. It is intended for use by as broad a range of people as possible; mental health consumers, their families, practitioners, managers, policy makers, politicians and members of the public. The curriculum is offered as a vehicle for conveying, and for engaging people in applying, the central messages contained in the Report “Holding Hope in our Hearts” prepared for the Mental Health Commission of Canada (MHCC) by members of the First Nations Inuit and Métis Advisory Committee (FNIM AC) to the MHCC.

The Report documents what was learned through consultation with 147 people (2/3 aboriginal and 1/3 non-aboriginal) in 27 focus groups conducted in 5 Western Canadian cities in November/December 2009. Participants were asked to reflect on “What is working? What is not working?” in the current system. Their central message was that transformation of the mental health system will require more than micro-level practices or individual change efforts. What is needed is change at all practice levels including individual practitioner/client interfaces, groups within organizations or agencies, the full organizational level, and the systems-wide level which includes practice, program design and policy. Further, the multiple forms of engagement required at all these levels must be guided by the principles and practices of relational practice, ethical engagement, cultural safety and cultural competence.

The curriculum is intended as a tool for change. Change begins with shifts in beliefs and perceptions that translate into changed behaviors of individuals, groups and systems. Only with internal shifts in peoples’ attitudes and understandings can transformation be achieved and sustained in the outer world of shared meanings and actions. Consequently, this curriculum invites active engagement of participants in experiential learning. Small group experiential learning, supported by principles of using the circle as an optional form for learning is the format used throughout this curriculum to facilitate the relationship building, development of mutual understanding and reflective practice that converge with the findings arising from the focus groups. Ideally, to model the principles embedded within the curriculum, it is best implemented by a co-facilitation team, one FNIM and the other a non-aboriginal person with complementary skills, with a maximum of 20 participants. The facilitators need to be prepared to model

relational practice and ethical engagement in the methods used and approach taken.

In each session, the intent is for facilitator(s) to present the content orally in their own words as a catalyst for participants to actively engage in group discussion and circle sharing. The dialogue generated within the group is where learning occurs. The content is provided, not as material to be read during the group time, but as a resource to facilitators and other participants. Facilitators should have integrated the content, be prepared to give their own verbal explanation of each of the concepts, and then invite group discussion so the focus is kept on oral communication, rather than having people bury their faces in the printed material.

Overview of Modules

The curriculum consists of four modules. The modules can be thought of as the four corners of a stand holding a container. Each corner of the stand represents one of the four topics that is the focus of learning and discussion; the container represents the group or circle space that participants will fill with their contributions in a learning process of emergent meaning-making, guided by the co-facilitators. The container symbolizes indigenous wisdom and ways of thinking, doing and being in relationship, while the four-sided frame represents how indigenous ways can be respectfully nested in larger society. The container also represents an ethical space which individuals engaged in the group process may intentionally and mutually design and occupy. The one focus is that of respectful and responsive group relationship as a vehicle for learning. The multiple perspectives are those four corners of the curriculum from which understanding about FNIM experience with mental health can be deepened.

Each module can be delivered in three hours, more or less, depending on the circumstances. A delivery time of three hours each allows all four modules to be dealt with in a two-day workshop, if desired. Alternatively, each module can stand alone. Although 15 to 20 participants are optimal, larger numbers of participants can be accommodated by the incorporation of small group activities.

Modules:

- 1. Holding Space for Experiential Learning: Groups/Circles;**
- 2) Learning from Experience: “Glimpses of Light”;**
- 3) Cultural Competency, Cultural Safety: Attitudes and Actions That Matter;**
- 4) Multiple Stigmas: First Nation, Inuit, Métis Experience.**

1. Holding Space for Experiential Learning: Groups and Circles

The purpose of this module is to teach people how to manage a group or circle and allow the curriculum to emerge in the group/circle learning

process. It describes the role of the facilitators in “holding” the group/circle, bringing in “seed” content that will fertilize the discussion within the group, and inviting the participants to inform the dialogue with their life experiences. The module will teach about creating an experiential learning process in which circle members build on what they know and become collaborative learners/teachers in co-constructing mutual understanding, in contrast with pedagogy that offers a set curriculum and focuses on content, on “givens” rather than emergent understanding. The primary content is to learn about process although the module will also address reflective practice, relational practice, relational cultural competence, cultural safety, ethical space and ethical engagement.

2. Learning From Experience: “Glimpses of Light”

The purpose of this module is to present through a DVD, stories of individuals from diverse cultural backgrounds about their experiences of mental illness. Their messages are offered as a catalyst for ongoing discussion to deepen understanding of the needs and resilience of people who experience mental illness, and in particular, aboriginal people and their families. The DVD invites reflection on all aspects of the mental health system.

3. Cultural Competency and Cultural Safety: Attitudes and Actions That Matter

The purpose of this module is to engage participants in reflecting upon the findings from the focus group consultations, on the meaning of cultural safety and cultural competence, and on their own roles in creating and contributing to culturally safe relationships and environments, and culturally competent systems. The module features principles and practices, metaphors and liberating concepts that emerged from the consultations, and offer a foundation for reflection on and redesign of systems of care.

4. Multiple Stigmas: First Nation, Inuit, Métis Experience

The purpose of this module is to increase awareness of multiple stigmas and their effects upon mental health consumers and their families, particularly First Nation, Inuit and Métis. It will invite participants to look at types of stigma and their impact, how they are perpetuated, what efforts are being made to reduce stigma, and to consider what they can do to eliminate stigma.

Module One

Holding Space for Experiential Learning; Groups and Circles

The purpose of this module is to immerse participants in a process based on values and the five principles of circle learning, one that moves beyond cognitive learning to engage hearts and spirits. Participants will take from the experience a “felt” awareness and understanding of how the values, principles and practices are essential prerequisites for reflective practice, relational practice, relational cultural competence and the creation of an ethical space in which cultural safety is an outcome.

Objectives:

- **To identify the values that guide participation in the circle; hospitality, honesty, equality, respect and honour.**
- **To discuss the five principles and practices of circle learning:**
 1. **mutual respect and responsibilities**
 2. **self-determination**
 3. **build on what we know**
 4. **response to complexity**
 5. **hopeful positive change**
- **To become familiar with the concepts of reflective practice, relational practice, relational cultural competence and cultural safety.**
- **To experience the circle as an ethical space of engagement characterized by reflective practice, relational practice and relational cultural competence of which the outcome is cultural safety**
- **To discover that when participants are guided in their interaction by values, principles, practices and relational concepts, the circle exemplifies a culturally safe place - the medium becomes the message.**

Introductory Exercise:

In a group formed into a circle, participants introduce themselves by sharing their name, roles within their work and family lives, and stating what they hope to take away from this experience. A talking stone or stick may be used and each person holds the floor until the talking piece is passed along or another signal is given such as saying “that is all I have to say”.

And/or...

Participants introduce themselves by stating their name and any other identifying information then choose an item in their possession and share what it says about their cultural identity and personal story. Once again this is shared in a roundtable or talking circle format.

Content Presentation: values

Five values guide relationships within the circle; hospitality, honesty, respect, equality and honour. The practice of these values creates a safe meeting ground within any group, particularly one with aboriginal and non-aboriginal members.

Hospitality refers to the creation of a welcoming space where everyone is safe, comfortable, willing and able to work together.

Honesty means there are no hidden agendas, game-playing or manipulation. The intent for coming together is to learn from one another and build mutual understanding based in our most authentic experience of ourselves and others.

Equality is the essence of the circle; everyone in the circle is equally important and equally valued. The circle knows no hierarchy. The group facilitators or circle keepers have unique roles and responsibilities for taking care of the process and the people.

Respect is shown in deeply listening to others as well as to one's own inner process and viewing whatever emerges as a potential learning opportunity, rather than standing in judgment of self or others.

To **honour** self and others is an essentially loving, accepting response that opens the door to deeper levels of engagement and understanding.

Each group participant has the responsibility to uphold these values. The facilitators or circle keepers have the added responsibilities of paying attention to each group member as well as the group as a whole, of keeping the group safe by being first responders to any problems arising, and once the group has decided its direction, upholding the collective will of the group.

These values represent ideals that can be actualized by enacting the principles described below.

Content Presentation: principles and practices of Indigenous based group process

Guiding principles and practices

There are five principles and practices that apply to one-on-one relationships, group-to-group, system to system and nation to nation. When these principles and practices are embodied and upheld in relationships at all levels of society, they become examples of relational

cultural competence, the outcome of which is cultural safety. In this sense, they are prerequisites to cultural safety.

Mutual Respect and Responsibilities

We must respect that each person has his/her own life path, responsibilities and challenges. We take responsibility for ours, personally and professionally and do what we can to support others in carrying out their responsibilities without “taking over”. As with each of the principles, this applies at all levels, both inside a person (heart, mind, spirit, and body) and outside (person to person, group to group, etcetera.)

Self-determination

On an individual level, this means honoring one’s own right and the right of others to be what they are by meeting people where they are in their process and accepting them. On a nation-to-nation level, it means honoring the right to sovereignty. No one has the right to rob someone else’s right to self-determine, to exercise their autonomy. We must take care to distinguish when “empowerment” is in fact control, and learn how to support and respect the agency of others.

Building on what we know

Building on what we know means people are experts in their own lives; it is through true dialogue that they find out what they know and don’t know. People need to cultivate such dialogue within them selves to develop consciousness of their inner lives, their belief systems and biases, to make what is invisible visible. Intentional consciousness is required; choosing a path of honesty and authenticity and bringing this into one’s relationships. Being awake to what is within oneself as one interacts with another is an integral part of reflective practice.

Response to Complexity

Nothing is black or white, either/or; rather everything is on a continuum that can be matrixed in multiple dimensions, everything is in flux, in change and movement. Our response to complexity needs to be intentional in order to honor the emerging complexity of an individual’s unique path, which is not linear, not quantifiable or comparable (you are not more ahead than me). As complexity emerges and takes on new forms and shapes, so must our response; we watch for patterns and respond.

It is important not to make any assumptions about who people are or can be. Our ability to resonate with one another is compromised by judgments and stereotypes. Judgments impede our natural generous way of connecting. To return to freshness in our relationships means finding something to love about the person, being curious to learn more about him and being aware that he is not safe with me as long as I have judgment. It is my responsibility to work through my own judgment.

Instead of imposing, instead of envisioning only as far as you can see, remain open to what is beyond, don't pretend to know where you are going. Trust the organic process of exploration, one step at a time, rather than being led by a fixed outcome. We need to see the wholeness (an indigenous perspective), rather than lapse into reductionism.

Hopeful Positive Change

Hopeful positive change links to self-determination. I can hold hope for you that is not linked to an outcome and is defined by you, not by me, without knowing what positive change is for you. Only the person's soul can know what is good or bad for that person. We must wait to be invited. The challenge is to look at something and know there is nothing wrong here. Rather than putting energy into judgment, we need to "hold space" for the positive potential of the person and the situation to emerge, and believe in that potential even when the person does not.

Large Group Discussion – open discussion or circle talk

How do these principles and practices apply to you, personally and professionally? How do they relate to your work and life experiences?

Content Presentation: reflective practice, relational practice, cultural safety, relational cultural competence, systemic cultural competence, ethical space, ethical engagement and cultural safety

These concepts can serve as tools for assessing, critiquing and improving our own practice and the organizational, institutional and policy structures that make up our mental health and addictions system.

Reflective practice requires a cultivated ability to look within. The quality of our relationships always begins and ends with what is going on in our inner world. To be able to watch our thoughts, feel our feelings and understand the meaning of our thoughts and feelings is essential to being conscious and aware of our behaviors in relationships. In some cases we need to go steps deeper to find the motivations and wounds that may be influencing our perceptions, attitudes and behaviors.

Reflective practice is a conscious, mindful alertness to what one says, does, feels and thinks while in relationship in order to take responsibility for understanding and clearing aspects of one's inner life that interfere with building a relationship of trust and safety that honors the autonomy of each person. By recognizing and treating each relationship challenge as an opportunity for learning, it is a powerful way to move on in one's personal growth.

Relational practice builds on reflective practice and focuses on the quality of the relationship established with an individual or group as a primary

concern. If the relationship is respectful, mutual understanding can be built, joined perspectives developed and problems or conflicts overcome.

“Relational approaches” is another key idea of which Smye et al., (2010) provide an overview. This concept “recognizes that peoples’ experiences, including health and illness experiences are shaped by the contextual features of their lives – social, historical, political, cultural and geographic as well as other factors such as age, gender, class, ability, biology and so on.” (Hartrick Doane & Varcoe, 2005, 2007, 2008). Relational approaches refer to more than respectful, supportive, caring and compassionate relationships. Although interpersonal connections are a central feature of excellent relational practice, this view takes into account “how capacities and socio-environmental limitations” influence health and wellbeing, the illness experience, decision-making and the ways people manage their experiences” (Browne, Hartrick Doane, Reimer, Macleod & McLellan, 2010).

Cultural safety is the experience of recipients of care when they feel safe and protected in their cultural identity and their practices and perspectives are respected, despite real or perceived differentials in power related to systemic barriers. The systemic barriers to responsive and reflexive care that honors human experience may be due to a history of colonization or other influences.

Relational cultural competence is the human relational capacity to seek and find compassionate understanding within, between and among people of differing cultural backgrounds and perspectives. (Hanson, 2010)

Systemic cultural competence refers to the structural characteristics that operate at group, organizational or health system levels that either support or take away from the ability of front line care providers to employ culturally competent attitudes and approaches to mutual understanding and positive relationships that provide an opportunity for cultural safety.

Large Group Discussion- open discussion or circle talk:

Participants personalize these concepts by relating them to their own experiences, personal and professional, and sharing their thoughts with others in the group through a roundtable or talking circle.

Content presentation: ethical space – ethical engagement

Ethical space has been written about originally by Roger Poole (1972) and later picked up by indigenous writers such as Willie Ermine. The notion of ethical space speaks to the space between two individuals or groups coming from differing perspectives with a view to establishing a process leading to mutual understanding, including an understanding of differences.

Ermine's work has been described in the following way: "Ethical space, a concept proposed by Roger Poole, is formed when people from different contexts, with disparate worldviews, encounter one another. Ethical boundaries are determined by individuals, families, history, culture, religion and collective principles. These ethical boundaries, in part, contribute to defining the ethical space between people... [Ermine] argued for the adoption of a collaborative, partnership-based approach to interactions in order to facilitate this dialogue and to create the potential for new ways of thinking and understanding."

Ethical engagement is a commitment to joining in ethical space to negotiate the terms by which the relationship may be developed and the interests of each group protected in an ethical and moral way. The concept of a negotiated or ethical space between two cultural paradigms, established for the purpose of developing new insights and perspectives drawing on both scientific and traditional knowledge, is gaining traction. The development of such a space needs to rely on a process of thinking about, negotiating and balancing values and priorities across differences to provide for the differences becoming a source of strength.

For example, a government agency offering a well-timed, well-planned, responsive, multiple year, financially adequate funding arrangement to support an important program or service is an outcome that can only be arrived at through a joint planning process between government and program representatives characterized by ethical engagement. This example is in contrast to the all too frequent practice of government imposing program and funding guidelines without consulting with service providers to determine the best fit to actual needs.

Closing Round Table/Circle Reflections on process and content of learning:

Participants share thoughts and feelings on the process of working in roundtable or circle ways and other aspects of the workshop. A question to consider – how did this workshop process support the development of a negotiated ethical space?

Module Two

Learning from Experience: “Glimpses of Light”

Objectives:

To provide, through the viewing of the film and subsequent discussion, an opportunity for participants:

- **to consider multiple perspectives on mental health**
- **to reflect on their own roles and responsibilities**
- **to learn from one another through individual reflection and group discussion.**

Introductory Exercise:

Participants introduce themselves, sharing briefly about their interest in mental health and addictions.

Introduction to “Glimpses of Light”:

This film is an initiative of the Cultural Safety working group of the First Nations, Inuit and Métis Advisory Committee of the Mental Health Commission of Canada in collaboration with the Mood Disorders Association and the Native Mental Health Association of Canada.

Mental Health is a challenging area for all cultural groups. The FNIM AC produced the film to contribute the voices of those with lived experience of mental illness to inform understanding of principles and practices of care that are culturally safe and culturally competent for Aboriginal people and all Canadians. First Nations, Inuit or Métis peoples face unique challenges due in part to their historical experiences and family and community contexts. For the populations of First Nations, Inuit and Métis in rural and remote areas, services are limited and specialist resources minimal. Whether rural or urban dwellers, FNIM may encounter stigma related to their race as well as their mental illness.

Building on oral tradition, the DVD provides a vehicle for direct expression without the moderating influence of print based material. The film is an invitation for viewers to consider multiple perspectives and to reflect on their roles and responsibilities. It will be helpful to people with lived experience, supportive family members, and practitioners of various disciplines; therapists, program designers, educators, researchers, and policy developers.

None of the individuals on the screen are actors; they are volunteers with lived experience.

“Glimpses of Light” is introduced on screen at the beginning of the film in the following way: “This film brings together voices from diverse cultural

backgrounds sharing life stories about the paths traveled while navigating their life experience of mental illness. These messages are meant to act as a catalyst for ongoing discussion to deepen our understanding of the needs and resilience of people who experience mental illness and in particular Aboriginal people and their families.”

A. Reflection Questions During Viewing:

- 1) What stories are being told by the film?
- 2) What thoughts and feelings come to your awareness while viewing the film?
- 3) What are the implications for your relationships?

B. Individual Journal Reflection Questions:

Individual journaling can be done at home later or as a private exercise for 10 or 15 minutes before going into group discussion.

After viewing the 15 minute film, reflect on the following questions. Record your reflections in your journal. Share the film and your reflections with a colleague and discuss your thoughts related to your practice in the future.

- 1) What were your thoughts and feelings while viewing the film?
- 2) How are the concepts of “disconnection” and “reconnection” helpful in care provision, given the historical context of residential school, child welfare interventions, intergenerational effects and loss of cultural identity?
- 3) What suggestions were made for alternatives to the biomedical model?
- 4) How can family care givers, peers or service providers provide care for the whole person, including honoring spiritual beliefs and practices?
- 5) How can a need for a safe place, sanctuary or refuge be met in community or institutional settings?
- 6) What is particularly “culturally competent” about the way in which the service providers thought about or provided care?
- 7) What mistakes were made by service providers?

- 8) What is most memorable about the stories?

View the film followed by round table/circle reflections on one or more of the following questions or small group breakouts (with larger group).

C. Group Discussion Guide - Post Viewing Questions:

- 1) How were the four elements (earth, air, fire, water) depicted in the film and how is nature useful in healing?
- 2) What is the role of the family in healing and supporting mental health and recovery?
- 3) What awareness and personal capacity do I need to cultivate in order to connect with the thoughts and feelings of people with diverse lived experience? What do I already know that would be helpful?
- 4) What have I learned about the intersection of my culture with the culture of others, the bio-medical model, and FNIM cultures?
- 5) What are the right questions to be asking myself and others in order to further my understanding and practice?
- 6) What are my next steps in ongoing learning and application? What resources do I know about that I want to share with the group that could be helpful to the group?

Closing round table/circle:

What are the main insights you will take away from the film and discussions and how will you use them?

We invite feedback to the nmha@telus.net.

Module Three

Cultural Competency and Cultural Safety: Attitudes and Actions That Matter

The purpose of this module is to present highlights from the Report on the Western consultations that hold promise as pillars for building change. Participants will explore how these concepts can serve as the infrastructure to stabilize new thinking, change attitudes and inspire actions that result in greater cultural competence and cultural safety in mental health and addictions.

Objectives:

- **To review the concepts of cultural competence and cultural safety**
- **To consider how selected findings from the Report “Holding Hope in our Hearts” can suggest ways forward in our own practice and in the organizational, institutional and policy structures that make up our mental health and addictions system.**
- **To experience collaborative learning and co-constructing mutual understanding.**

Introductory Exercise:

In pairs, share stories of personal experience with cultural safety or the lack of it. Each person tells a story – half time for each person to speak. Each person listens to the story of their partner and brings the other person’s story back to the group. No paper or pens are used – the listener embodies the story and when they return they tell their partner’s story from memory.

Content Presentation: cultural competence and cultural safety

A literature review carried out for the Report found the following definitions of culture, cultural competence and cultural safety.

In a recent position statement (2010) the Canadian Nurses Association (CNA) defined **culture** as “the processes that happen between individuals and groups within organizations and society that confer meaning and significance” (CNA citing Varcoe & Rodney, 2009).

Cultural competence “is the application of knowledge, skills, attitudes or personal attributes required by nurses [or other providers] to maximize respectful relationships with diverse populations of clients and co-workers.” Further, the underlying values for cultural competence are inclusivity, respect, valuing differences, equity and commitment.” (CNA referencing Aboriginal Nurses of Canada (ANAC), Canadian Association of Schools of

Nursing (CASN) & Canadian Nurses Association (CNA), 2009; CNA, 2010a, Registered Nurses Association of Ontario (RNAO), 2007 and World Health Organization (WHO).

CNA states further that cultural issues are intertwined with socio-economic and political issues and as an organization, it expresses commitment to social justice as central to the social mandate of nursing.

Related to the concept of social equity, CNA defines **cultural safety** as both a process and an outcome whose goal is to promote greater equity. It focuses on root causes of “power imbalances and inequitable social relationships in health care”. (ANAC, CASN & CAN, 2009; Kirkham & Browne, 2006, as cited in Browne et al., 2009)

While cultural competence is an important concept, it can sometimes overlook systemic barriers, which makes it inadequate to fully address health-care inequities. Cultural safety, however, “promotes greater equity in health and health care ... [as it addresses the] root causes of health inequities.” (CNA, 2010b) As quoted by CNA: “Cultural safety is a relatively new concept that has emerged in the New Zealand nursing context. It is based on understanding power differentials inherent in health service delivery and redressing these inequities through educational processes.” (CNA, 2010)

CNA believes that the responsibility of supporting cultural competence is shared among individual nurses [providers], employers, educators, professional associations, regulatory bodies, unions, accrediting organizations, government and the public. The view of the authors of the final Report is that cultural safety is most likely to be achieved as an outcome by recipients of care if investments in cultural competence occur throughout the care system from the service interface to system wide policy levels.

A literature review of selected publications entitled “Supporting Mental Wellness of First Nations, Inuit and Métis Peoples in Canada: Cultural Safety” (Smye, Browne and Josewski, 2010) speaks about hope. The authors note that the hope related to the work on cultural safety is that it will enhance the ability of healthcare providers and others to deal more effectively with major structural and relational issues and barriers facing indigenous and non-indigenous communities. The authors see the research and analysis related to cultural safety and cultural competence as tools to deal with identified inequities in health, education and social services.

“**Relational approaches**” is another key idea about which Smye et al., (2010) provide an overview. This concept “recognizes that peoples’ experiences, including health and illness experiences are shaped by the

contextual features of their lives – social, historical, political, cultural and geographic as well as other factors such as age, gender, class, ability, biology and so on.” (Hartrick Doane & Varcoe, 2005, 2007, 2008). Relational approaches refer to more than respectful, supportive, caring and compassionate relationships. Although interpersonal connections are a central feature of excellent relational practice, this view takes into account “how capacities and socio-environmental limitations” influence health and wellbeing, the illness experience, decision-making and the ways people manage their experiences” (Browne, Hartrick Doane, Reimer, Macleod & McLellan, 2010).

Content Presentation: Highlights of Report “Holding Hope in our Hearts”

The Western focus group findings are fully presented in the Report “Holding Hope in our Hearts”. Here, we highlight selected “Principles and Practices”, “Metaphors” and “Liberating Concepts” as exemplars of ideas and actions that hold promise for effecting positive change at all levels of the mental health and addictions system by contributing to cultural competence and cultural safety.

Principles and Practices

These principles and practices apply to programs, services and the systems supporting policy and program development and service delivery.

Valuing and learning from diversity

Rebuilding and nurturing mutual respect between all cultural groups and peoples is fundamental for a just and healthy society and for creating an effective mental health system that honors and integrates the best of the knowledge systems of each culture so they contribute to the whole.

” I realize that what happens in a culturally safe place is that you are open to new ways of thinking. With each person, I am making new meaning, Myself, I feel cultural safety when I am being treated with dignity, and I know its absence: when I am being treated as an object.” (Symposium [S], Ottawa)

Respect

Respecting the lived experience of care recipients, their family, friends and care providers is essential to honouring them and their process of becoming and healing in the world. A person can never know the full extent of another’s inner world but relational practice and ethical engagement can provide a safe bridge into a deeper and more authentic understanding of the other.

“Most of the family support work we do is trying to get from them how they see their world, how do they perceive it. It is all about hearing from them.” (Service Provider [SP], Yellowknife)

“People come because they feel safe...others have told them it is okay to come... they are not going to be judged or pathologized or labeled with the problem...they just need somebody to talk to and to know that they are actually present. To me if you can't be present, go drive a truck. It is about balancing out the pain with the hopes, and to be able to hold both.” (SP, Whitehorse)

Strengths-based approaches

Working from a focus on the strengths and capacities of a person or group is to affirm the positive and build from what is known to be strong. In Appreciative Inquiry this is known as seeking out the life giving forces, seeing them clearly and investing in them as a source of positive growth.

“What we do is development with them, capacity building. We get them to realize that they do have the solutions and that they are the ones who are the experts.” (SP, Iqaluit)

Centrality of connectedness and relationships

The centrality to healing of connectedness and relationships comes from traditional Aboriginal ways of knowing that view illness as a result of disconnection. Disconnection from self, family, community, the natural world and Creator at a spiritual level is the most fundamental problem. What is needed is a “*soul to soul handshake*” (S, Ottawa) as a foundation for relationships intended to help a person rebuild connections that serve as a bridge back into a connected way of living.

“Disconnection is from culture, from selfhood, from your own sense of agency; disconnect on a community level. It is pervasive. These are communities characterized by disconnection [within the community] and disconnection between the services and the population they are supposed to serve.” (SP, Whitehorse)

Culture as healer and therapy

Culture and cultural continuity is fundamental to positive identity.

“The bottom line is to regain our culture. When we started this project, our own Board who are all Inuit gave it the title “rising up through your own culture”. (SP, Iqaluit)

Part of using culture to support healing involves exploration of music, art and creative expression as therapy. One's Mother Tongue is a powerful vehicle for connecting with culture.

"On the land is where I regained my language...and learned all the knowledge about the traditional roles of men and women and children..." (SP, Yellowknife)

Well-proven cultural therapeutic practices have been showcased in the community-based projects funded by the Aboriginal Healing Foundation (AHF) www.ahf.ca, which was an outcome of the Royal Commission on Aboriginal People (RCAP) www.ainc-inac.gc.ca/ap/rrc-eng.asp.

"In terms of the RCAP, all the answers were already there...on how to do more culturally appropriate treatment, how to work cross culturally. The answers are all there; the blue print is there. It really boggles my mind, you know, what more needs to be done?" (SP, Yellowknife)

"I have always said that aboriginal people have to take ownership of their own people. And through the AHF we have had tremendous support from them recognizing alternatives to mainstream technologies so to speak, and to able to more key into the cultural part of our people." (SP, Saskatoon)

Recovery model

The recovery model has many helpful principles and practices including the use of peers and community agencies. It recognizes that recovery in addictions and mental health includes relapse, and often, movement onto further stages of recovery. Individual recovery needs to be supported by family and community level recovery. Policies and practices that govern the provision of programs and services should support recovery as a process at all levels. The recovery model used must be reflective of indigenous ways of knowing, culture, values and healing methods.

"I have been working in recovery for years with people on mental health on an individual level, but there is recovery at a bigger level as well. There needs to be a sharing of power and resources, and the respect for where people come from. For the aboriginal communities, they need to be the drivers." (SP, Yellowknife)

Well-funded, flexible Programming

Providing options that are community driven, flexible, responsive, and delivered within the context of multi-year stable funding provide

for the most effective programs; otherwise, enormous energy is consumed by continual fund raising.

“I would say that 90% of the work I do for this center is keeping funds moving.” (SP, Iqaluit).

Fundamentals first and “Do no further harm”

Food, clothing, shelter (housing), safety are important and foundational for healing as they meet the basic needs of human life. To “do no further harm” is to honor that each person involved in relational engagement has vulnerabilities and past woundedness and as a fundamental principle, the intention is to not add to the burden of pain or trauma through negative relational experiences.

Metaphors

Metaphors are powerful ways of supporting human beings in understanding their experiences and the world around them. Shared metaphors help to create bridges of shared meaning and shared understanding.

Two Way Street

Relationship building and sharing time between people and within groups is a two way street with each person making an important contribution.

“This (building cultural safety) is a process, a learning opportunity, to build cultural competence that is a two way street. The people who hold onto the information are the FN, Inuit and Métis, and we have to be willing to share. The opposite is also true; the level of secrecy in government prohibits sharing. How do we build the intentional space in which people are safe to ask the questions?” (S, Ottawa)

“We have to negotiate a shared understanding of the problems that confront us.” (SP, Winnipeg)

“Aboriginal people can do a lot for all people if we are listening to their wisdom. We need to respect each other, have partnerships.” (SP, Saskatoon)

Walking Together

When people walk together, the best way to relate and see each other is to walk side by side with neither leading nor following.

“A phrase shared by a presenter at the Native Mental Health conference in 2009 was that our people would call this ‘walking

together.’ It is the closest, simplest way to approach talking about cultural safety. What are the barriers to doing this? They have a lot to do with power, and being self-reflective about power relationships. In my case, I am a white psychiatrist, working with the Feds, and I need to be self-reflective about that.” (S, Ottawa)

“How can we grow it to a point where we can have a common ground, to be able to develop something that can be a complement to the rest of the Nation, from the aboriginal perspective? This is the struggling part of aboriginal healing...to be legitimately involved within the process. Where is that common ground? Where is the respect for one another?” (SP, Saskatoon)

Liberating concepts

Liberating concepts are ideas that provide a foundation for redesigning our systems of care.

Humanized and humanizing relationships

Healing is about creating opportunities for each human being to become all they can be that requires approaches that are humanized and whole, not fragmented and mechanical.

“It takes confidence to speak from your heart, comfort with who and what you are, to show your face. It is important to build on Aboriginal perspectives of a ‘good way’ and Friere’s thoughts about being “fully human” in order to participate in humanized societies that counteract dehumanizing forces.” (S, Ottawa)

“The more we work, the more we understand; it is about building a relationship with another human being.” (SP, Saskatoon)

Healing and recovery as learning and growth

Healing and recovery is a human process that requires acquiring new insights, new knowledge and skills that support us in moving on to the next stage of becoming. An experience of safety is fundamental to being open to new learning.

“When you enter a circle and it is safe, it permits whatever in you that is related to what others are saying to surface, and new understandings to emerge. Safe circles are where we continue our journey of learning.” (S, Ottawa)

Knowing self – knowing other in context

To learn to know another, we must know ourselves and much of what we know and understand grows out of the context of our lives.

The Elders tell us that we need to know who we are and where we come from in order to move on in life.

“‘You don’t know me and how can you work with me if you don’t know me?’ and ‘You don’t know me but you get to define me and by defining me you get to decide what happens in our relationship’ are quotes from an Aboriginal man that point the way for a human relationship of shared ‘knowing’ that is fundamental to ‘working with’ someone to assist in recovery. Power inequities are fundamental to any human relationship and the systemic and relational power dynamics must be consciously managed.” (S, Ottawa)

Speak the truth in love to people

Human history has shown us many times over that more positive change comes from love than from fear and anger. Love generates openness/expansion and fear/anger generates resistance/contraction. Fundamental to any positive change is finding the many truths that we all bring and speaking them to each other with loving presence and within a mutually created ethical space.

“We need to speak the truth in love to people. And there is no solo advocacy; it’s about collective advocacy” (S, Ottawa.)

Intentional disruption is good

Complexity theory tells us that a complex system will not change unless there is an intentional disruption in the patterns that hold the system in current ways of operating. Cultural safety and relational practice may provide the foundation for a set of intentional interventions to modify the complex mental health and addictions system.

“It (cultural safety) is a practice that at some level disrupts. Culturally safe practice would disrupt the status quo; there would be a broader effect, some action-ability. One thing that is different about it is that it is meant to disrupt the system.” (S, Ottawa)

“When do I get to say, it’s wrong? Where do you ethically, spiritually and morally draw the line and say I can’t go past that line?” (SP, Yellowknife)

Intuition, wholeness and change

Intuition is a source of connection to inner guidance of many forms. Our spiritual selves know what our wholeness looks like and guidance from that centre helps us to return to the wholeness that is unique to each person. Healing often requires change and reintegration, reconnection with all four aspects of being – mind,

body spirit and heart. That inner wholeness provides the base from which relationships with family, community, culture and land can be strengthened. Each individual in sharing stories of healing and change inspires and guides others.

“I think of my relationships and I realize that another part is speaking from the heart. The spiritual, the intuitive part is such an important part of us. Spirit is important in the healing journey. We talk about human relationships that are culturally safe, trusting, equal, respectful; all possible when we engage each other on all those levels of heart, mind spirit and the physical. In my exchanges with people, I can identify moments of change for me as well as them because I am engaged on all those levels because we have had that full engagement. Often I will share my stories when the person triggers that for me, regardless of so called professional boundaries. We need to start with our own sphere of influence.” (S, Ottawa)

Closing Round Table/Circle Reflections on changing attitudes and actions:

Participants share thoughts and feelings on:

- Actions they will take to become more culturally competent in their personal and professional lives
- Actions they will take to support cultural competence and cultural safety within their own spheres of influence
- Reflections on the co-construction of mutual understanding through group or circle learning – observations of behaviors observed in the group that are seen to be culturally competent.

Module Four

Multiple Stigmas: FN, I, M Experience

Module Objectives:

- To increase awareness of types of stigma and their effects upon mental health consumers, family members and practitioners
- To deepen understanding of the sources of stigmatization of FN, I, M that compound the stigma associated with mental illness
- To further understand self-stigma
- To discuss how stigma is perpetuated; for example, use of professional jargon, labeling, marginalization of culturally different populations, media stereotypes
- To learn about anti-stigma interventions and how they work.

Introductory Exercise:

Participants introduce themselves and share an experience of stigma in their lives, whether as the object of stigma or observer in stigma influencing human relationship or interaction.

Content Presentation: stigma, discrimination, self-stigma, anti-stigma
Terms are defined and references provided for further learning.

The Mental Health Commission of Canada has written “Stigma and Mental Illness: A Framework for Action by the Canadian Mental Health Association” undated accessed from www.cmha/data/1/rec_docs/1959_stigma.pdf accessed May 1, 2011.

In that paper **stigma** refers to negative attitudes or beliefs that are held about people who are perceived as different. Because stigma relates to internal thoughts, it is difficult to take legal action against it. Discrimination is the behavior resulting from stigma. **Discrimination** refers to actions to exclude others because of their perceived differences, but it can also manifest in more overt actions of hostility and aggression. There are legal protections against discrimination, which focuses on the behavior itself, rather than on its victims.

Individuals with mental illness and their family members may also experience “**self-stigma**”, viewing themselves with embarrassment or self-loathing as a result of internalizing the negative perceptions around them.

Actions that work **to combat stigma** include: public education, proximity and interpersonal connections, support consumer empowerment and family organizations, develop an integrated network of sensitive services and supports.

Opening Minds is an initiative of the Mental Health Commission of Canada to combat stigma. The information on Opening Minds includes a summary of the experience of stigma and the results which include inequality in employment, housing, education and other opportunities; loss of friends and family members (the social and support network); and self-stigma created when someone with mental illness believes the negative messages.

Reference – www.mentalhealthcommission.ca/English/Pages/OpeningMinds.aspx accessed May 1, 2011

Large Group Discussion – open discussion or circle talk

Share your thoughts on the experience of stigma and how it acts as a barrier to accessing treatment and living a good quality life

Content Presentation: FNIM experiences of multiple stigmas

Multiple stigmas are discussed in the context of First Nations, Inuit and Métis realities.

First Nation, Inuit and Métis people are often stigmatized due to race. Additional sources of stigma are poverty and rural / remote places or residence – being from the “bush” which assumes a lack of understanding of modern living. In addition to mental health, sources of stigma may include addictions, overweight, a history of incarceration or criminal behavior, violence and low educational levels. Land and nature based spiritual beliefs may be ridiculed as heathen by some religious groups. A history as part of a family with problems or in the child welfare system may also lead to low self esteem and self stigma related to being an outsider without a sense of belonging to anyone. The individual stigma is accentuated by collective stigma as a result of being from a First Nation, Inuit or Métis community that is often subject to stigma associated with the entire cultural group.

Individuals in other groups often overcome stigma by close relationships marked by cultural and community pride. These mediating factors that contribute to resilience have been heavily impacted in some FN, I, M populations by a history of colonization and resulting family and community breakdown due to alcohol, drugs, other addiction, lateral and other forms of violence and child welfare interventions.

Large Group Discussion - roundtable / circle talk

- 1) How do the intersecting multiple stigmas complicate the experience of a First Nation, Inuit or Métis individual and family living the experience of mental illness?
- 2) How does stigma need to be dealt with differently when the objective is social inclusion of groups that also experience racially based stereotyping and other stigmas?

Content Presentation: A Young First Nation Man's Experience with Stigma

The following case study is read by a volunteer from the group:

Service Provider, Saskatoon Focus Group #1:

"I have a BA in Native Studies, and am an LPN, employed five years at City Hospital. I have had FNIM patients. Last week, I had a patient with mental issues, a young guy, same age as me. He was Hep C, HIV positive. The nurses just treated him so differently. I don't know if it was because of his issues, like Hep C and HIV or if it was to do with the fact he was native. Actually, I think it was a bit of both. When I came on night shift, he could see I am visibly Native, and he was more in tune to talk to me. When we did sit and talk, he told me of the mistreatment he was experiencing at the Hospital for the last few days from the nursing staff. One of the nurses said, "He is just a drug seeker" when he was in a lot of pain. He was in the Hospital because he had to have surgery done on his knee and it was very painful. These nurses instead of taking into consideration his whole history, his mental history, his physical, his emotional, everything, they just started making these judgments on him and he heard them. They didn't realize he was shutting the door on them because he could hear them and they made him angry. They didn't realize it was his own doing the way he was responding to them. So they were saying he was crazy. But no, it was their lack of professionalism that created this whole...produced his behaviour. By the morning, he was fine and the nurses coming on shift asked me what I had done. Talk to him; treat him like a human being. The Nurses were trying to put masks and a gown on to give him his pills. He does have Hep C so you do need to protect yourself, but you don't need a mask and a gown to go in and give him his pills. They created so much reactive anger. They got him twisted right up. By the end of my shift, he was fine. I got him in the bath, the shower, he thought I was just his best friend. It kind of took only a few minutes to undo their stuff. I confronted them in the morning. I asked both of them, I said can you guys please keep your opinions to yourself, this gentleman heard what you said about him. They were embarrassed and sheepish and rightfully so. I don't know how his day went because I haven't been back since.

This man was covered in tattoos head to toe, so all the nurses were horrified of him. He had Hep C because he was using needles, had HIV because he had contracted it working on the street. He is still somebody, he belongs to somebody, he is important to somebody. He may not be to us as nursing staff but he is to somebody.

I have seen it so many times, the racism and discrimination."

Small group discussion and report back to large group on the following questions:

1. What are the ethical implications of staff members speaking about a patient in negative terms, in a public place close enough to the patient to be overheard?
2. What judgments have been made about this young man?
3. What information do staff members not have about this young man and the circumstances of his life?
4. What would a more culturally competent, compassionate response look like – a relationship that is not obscured by stigma?
5. How do you account for the ability of the aboriginal LPN to intervene as she did?
6. How does the idea of the “self-fulfilling prophecy” apply in this situation to maintain the status quo?
7. What supports may be needed in the workplace to provide appropriate policy, education, debriefing and other supports to both the Aboriginal and non-Aboriginal staff members?
8. What changes are necessary in professional training, in the client/practitioner interface, in the health care system, in public policy, to contribute to culturally safe care for everyone, whatever their “differences”?

Alternative Exercise:

View “Glimpses of Light” as a case study of stigma

Pre-viewing questions:

1. What types of stigma are evident in the DVD?
2. What is the impact of these kinds of stigma on people and their motivation to seek help?
3. In what ways might stigma be detrimental to the person stigmatizing as well as to the person who is stigmatized?
4. What helps people to overcome stigma?
5. What more could be done to reduce/eliminate stigma?

Small group discussion:

Share your thoughts and feelings about the pre-viewing questions.

Report group’s “best thinking” to the large group and discuss.

Closing Round Table/Circle on reducing stigma

1. What insights are you taking from this workshop?
2. How could you contribute to the elimination of stigma in your work and personal life?

Appendix A

“Interactive session” describes a facilitated discussion that preferably takes place within a circle. To maximize communication, it is important that participants are able to see, interact with, and serve as teachers/learners to one another, as is possible in a circle.

Each Module can be covered in a ½ day (3 working hours) or a whole day (6 working hours) for a more comprehensive session. The following provide examples of time allocations for each format.

Module I: Holding Space for Experiential Learning: Groups and Circles

½ Day Session

Activity	Format	½ day 3 hrs.	Total time
Purpose and Objectives of Session	Facilitator(s)	5 min	9:05
Introductory Exercise: meeting each other	In Circle	25 min	9:30
Presentation on values and guiding principles	Facilitator(s)	20 min	9:50
Group discussion (values and guiding principles)	Interactive Session	30 min	10:20
Refreshment Break		20 min	10:40
Presentation on reflective practice, relational practices and cultural competence	Facilitator(s)	20 min	11:00
Group discussion (relational practice and cultural competence)	Interactive Session	20 min	11:20
Presentation on ethical space and ethical engagement	Facilitator(s)	10 min	11:30
Closing Round Table—reflections on process and content of session.	In circle	30 min	12:00

One Day Session

Activity	Format	1 day 6 hrs.	9:00
Purpose and Objectives of the Session	Facilitator(s)	10 min.	9:10
Introductory Exercise: meeting each other	In circle	35 min.	9:45
Presentation on values and guiding principles	Facilitator(s)	20 min.	10:05
Group discussion on values and guiding principles	Interactive Session	30 min.	10:35
Refreshment Break		20 min.	10:55
Presentation on reflective practice, relational practice and cultural competence	Facilitator(s)	30 min.	11:25
Group discussion on reflective practice, relational practice and cultural competence	Interactive Session	35 min.	12:00
Lunch break		1 hr.	1:00
Presentation on ethical space and ethical engagement	Facilitator(s)	30 min.	1:30
Group discussion on ethical space and ethical engagement	Interactive Session	60 min.	2:30
Refreshment Break		20 min.	2:50
Closing Round Table—reflections on process and content of session	In circle	70 min.	4:00 p.m.

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