Cultural Safety

Bridging Historical Trauma, Trauma Informed Care and Structural Change for American Indian/Alaskan Native Healthcare

Introduction

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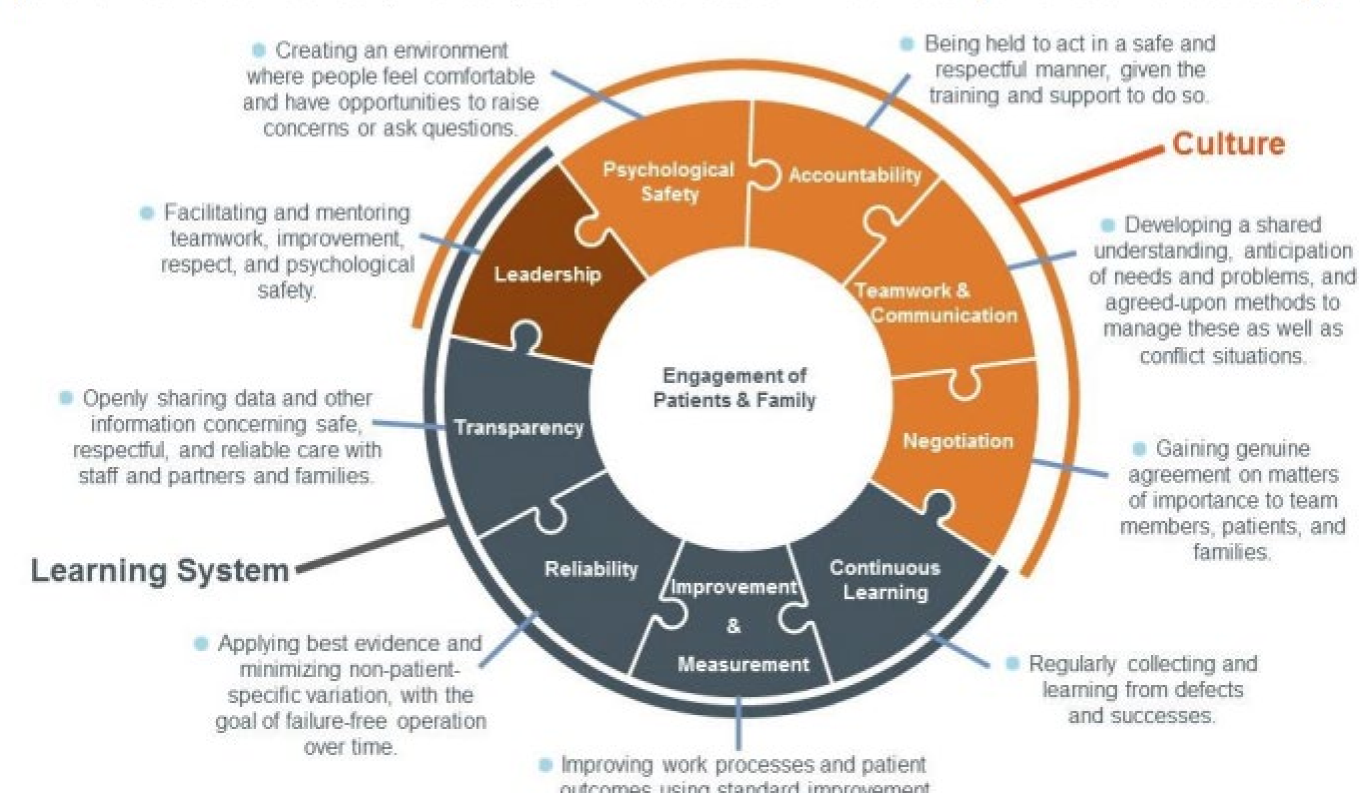
Disclosures

- This presenter has no financial or commercial disclosure for this presentation.

Culture of Safety in Healthcare



- Frankel A, Haraden C,, et. Al (2017) outlined the framework for patient safety to improve quality in healthcare.

Culture of Safety in Healthcare

- At the IHI's National Forum in December 2016, Derek Feeley, President and CEO proposed six patient safety "resolutions" outlined in the 2017 white paper:

  1. Focus on what goes right as well as learning from what goes wrong;

  2. Move to greater proactivity;

  3. Create systems for learning from learning;

  4. Be humble — build trust and transparency;

  5. Co-produce safety with patients and families; and

  6. **Recognize that safety is more than the absence of physical harm; it is also the pursuit of dignity and equity.**
     - **This is where we can begin to examine the role of Cultural Safety as the underpinning for the Culture of Safety.**

Trauma

- Trauma is defined as an event, or series of events, or circumstances that can have long lasting adverse effects on an individuals physical, emotional, social, cognitive and spiritual functioning.

Role of Trauma and Trauma Response during Medical Care

- Brown, Ashford et al. (2022) write regarding trauma response during medical care that trauma response can interfere in treatment, or retrigger trauma:
  - "For some survivors of trauma, the experience of the ED may be re-traumatizing or trigger past experiences.
  - Survivors of trauma may experience **emotional dysregulation** (ie, trouble controlling strong emotions) or hypervigilance (ie, increased threat perception and **reactivity**).
  - The close interplay between executive functioning and emotional regulation **may impact both the patient and the care team's navigation** of the encounter.
  - Similarly, hypervigilance could make the often-hectic environment of the ED, as well as **interventional procedures, harder to tolerate**."

Trauma and Healthcare Utilization

- "Yet, current results suggest patients who are perceived to be less engaged in their healthcare may in fact have significant trauma histories, previous poor experiences with healthcare, and perhaps understandable decreased trust in healthcare providers.
- In this context, pathologizing patients' decreased healthcare engagement and labeling:
  - "Difficult"
  - "Non-compliant"
  - "Non-engaged"
  - "Left without being seen"
  - "Left against medical advice"
- Can be considered a form of re-traumatization.

Selwyn, Lathan, Richie et al (2021)

Trauma Treatments

- Cognitive Behavioral Therapy
- Cognitive Processing Therapy
- Prolonged Exposure
- Eye Movement Desensitization
- Narrative Therapy
- Medication

- Still predominately focused on the individual, and individual response

TRAIL OF TEARS

9 STATES

5045 MILES OF TRAIL OVER LAND AND WATER

SUPPORTED BY PRESIDENT ANDREW JACKSON CONGRESS PASSED THE INDIAN REMOVAL ACT OF 1830

MAJOR 5 TRIBAL NATIONS

87964

other Wounded Knee cases remain to be tried.

Sterilization Is Genocide

Investigations and hearings are in the offing following charges growing since June of wide-spread **sterilization of young Native American women** in the US operated Indian Health Service hospital in Claremore, Okla.

According to Dr. Connie Uri, a Native Am-

Native American Deaths from COVID-19 Highest Among Racial Groups

Historical Trauma

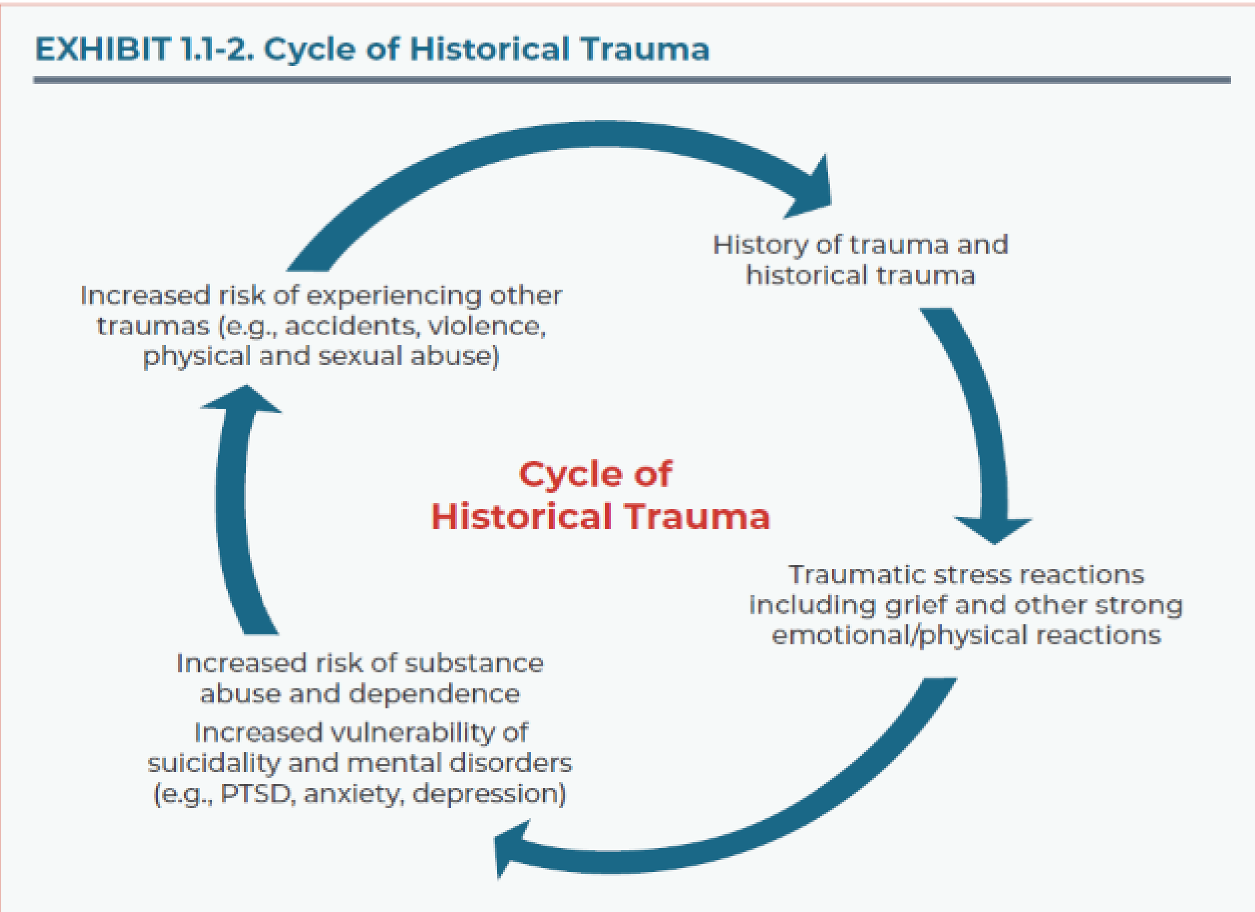
- Dr. Maria Yellow Horse Brave Heart defined Historical Trauma is defined as: The cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma

- Her seminal work has helped define not only the concepts of historical trauma; but the long ranging impacts of trauma histories.

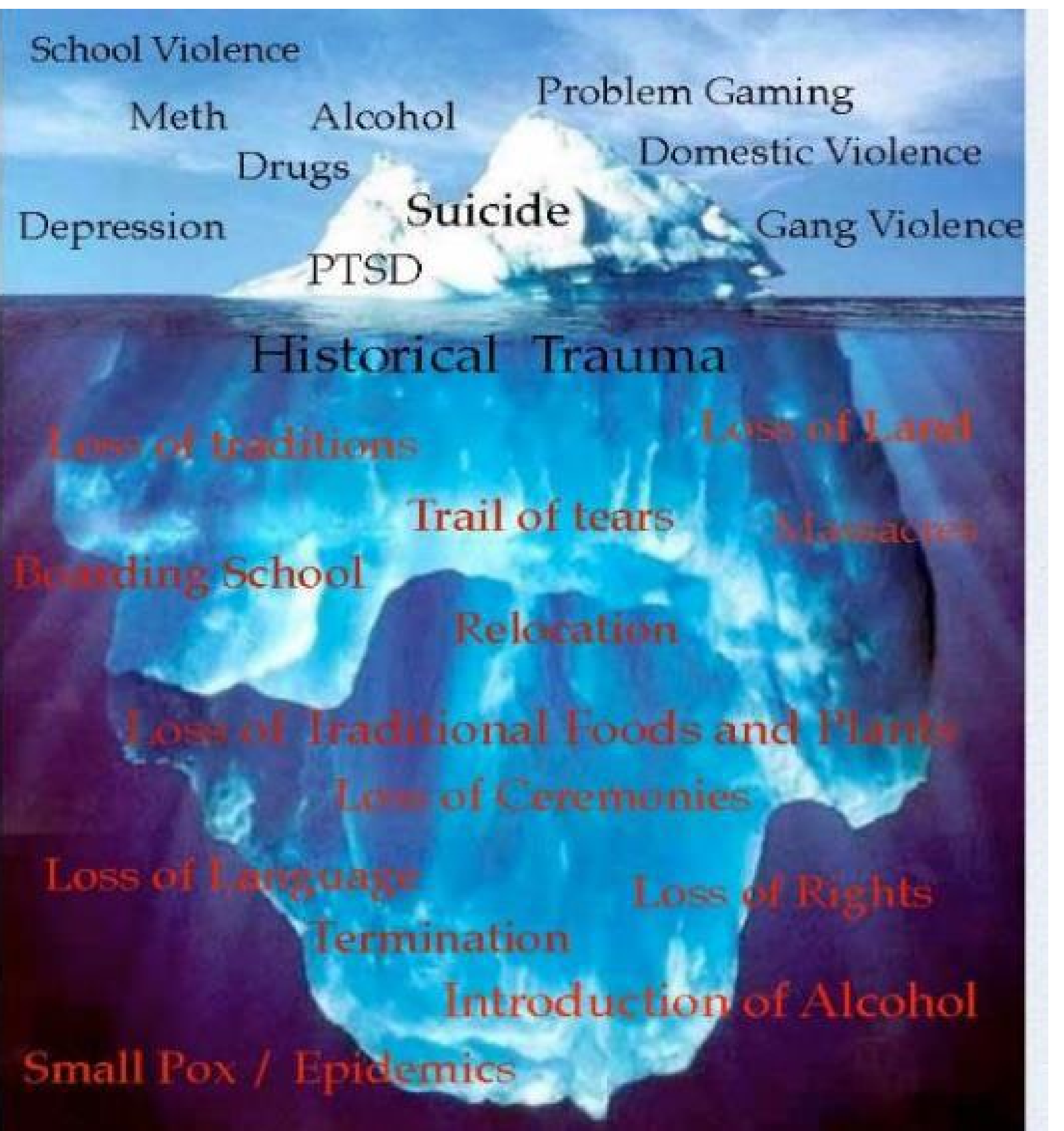
Brave Heart-Jordan, M. Y. H. (1995). The return to the Sacred Path: Healing fromhistoricaltraumaand historical unresolved grief among the Lakota. Doctoral dissertation,Smith College School for Social Work, Northampton, MA.

Role of Trauma and Historical Trauma

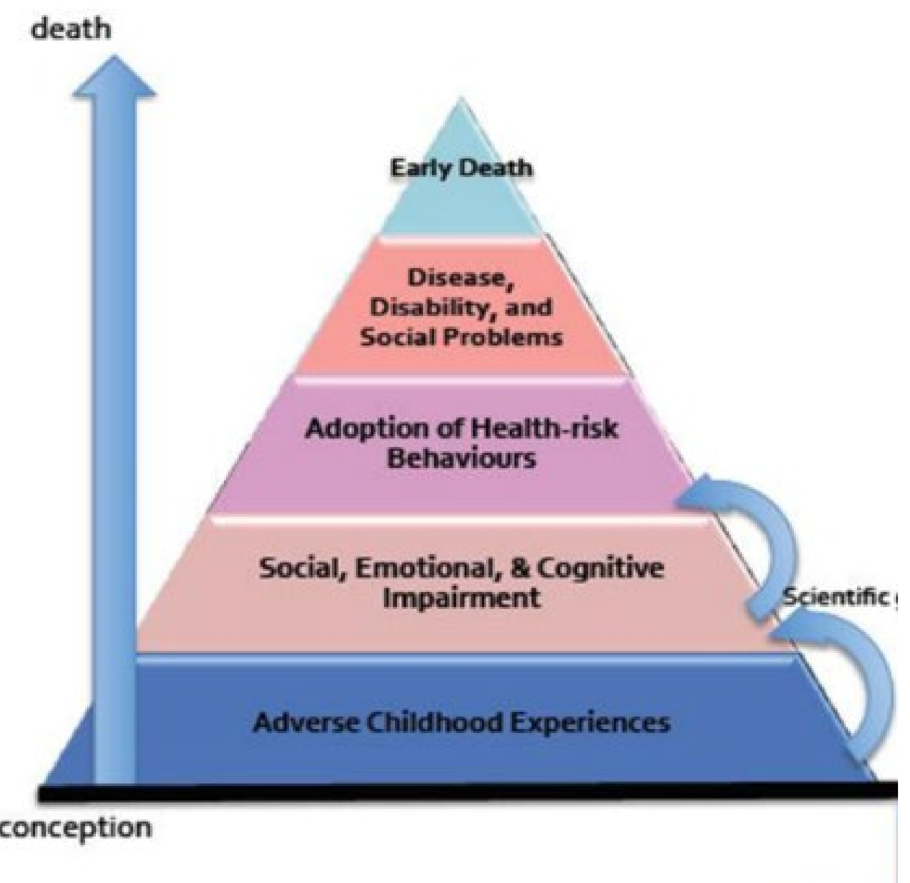
- Historical Trauma is defined as: The cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma
- Historical trauma response: can include suicidal thoughts and acts, IPV, depression, alcoholism, self-destructive behavior, low self-esteem, anxiety, anger, and lowered emotional expression and recognition



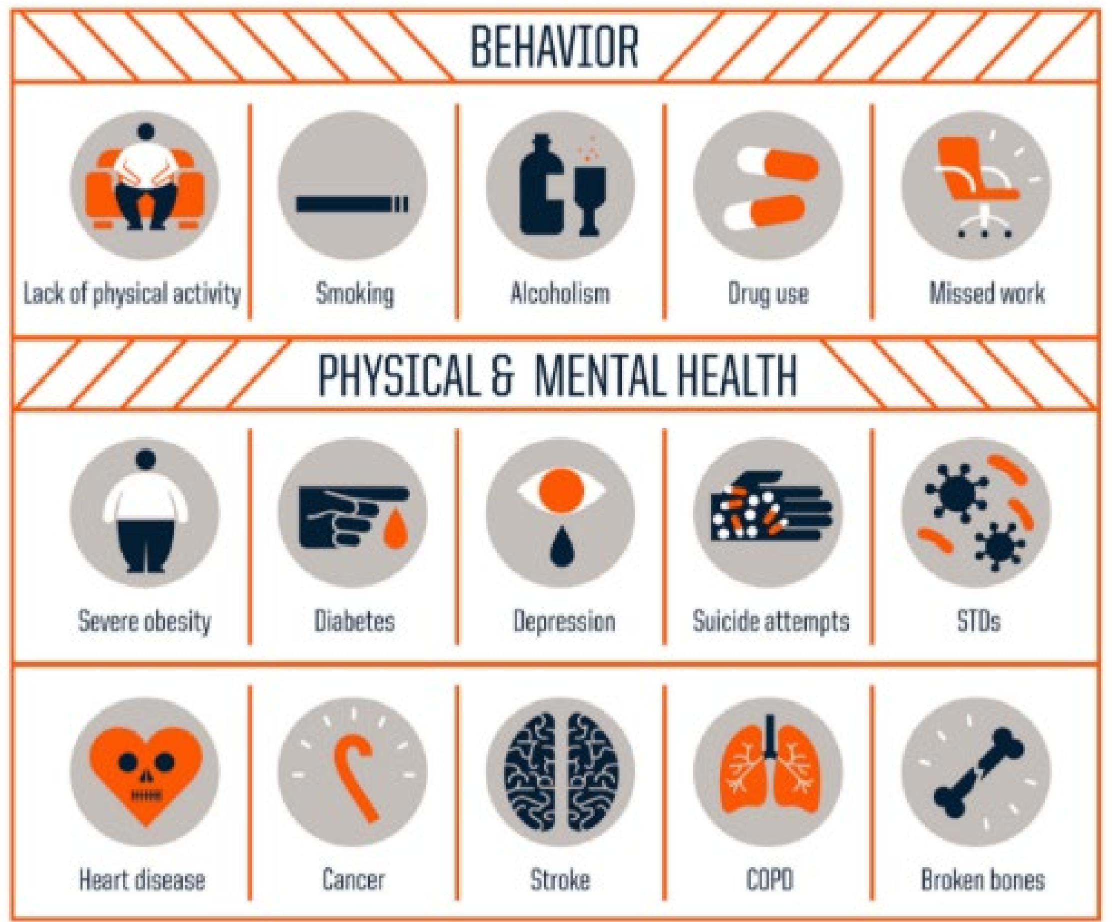
SAMHSA TIP 61, 2019



Adverse Childhood Experiences



Ryse Center, 2015



Source: Centers for Disease Control and Prevention

Credit: Robert Wood Johnson Foundation

Ryse Center, 2015

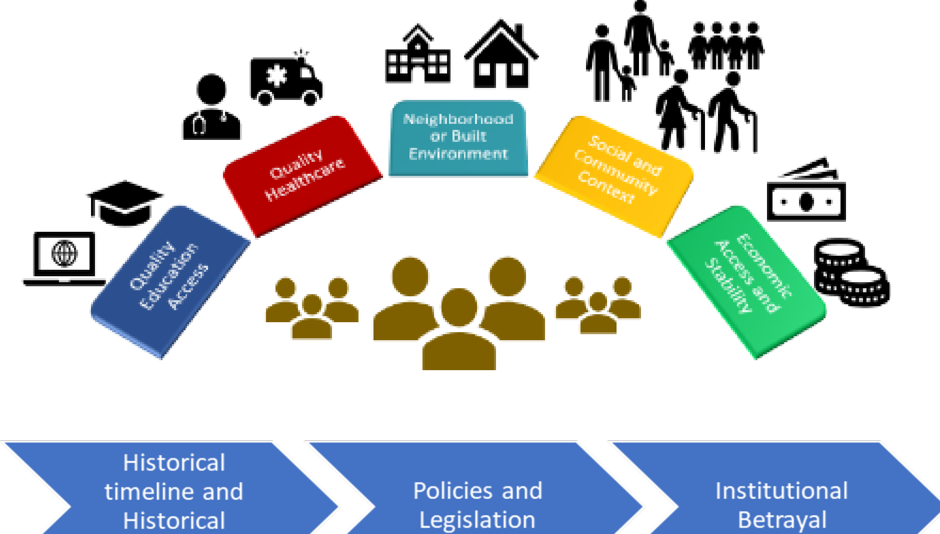
Carlisle Student Body, 1884. John N. Choate. Carlisle Indian School Digital Resource Center. Dickinson.edu

Historical Oppression

- McKinley and colleagues (2017) posit that Historical Trauma does not fully explain the pervasive and chronic oppression that Indigenous populations continue to experience,
- The concept of Historical Oppression is described as
  - "the chronic, pervasive, and intergenerational experiences of oppression that, over time, may be normalized, imposed, and internalized into the daily lives of many Indigenous peoples (including individuals, families, and communities)"
- Historical oppression includes both historical and contemporary forms of oppression

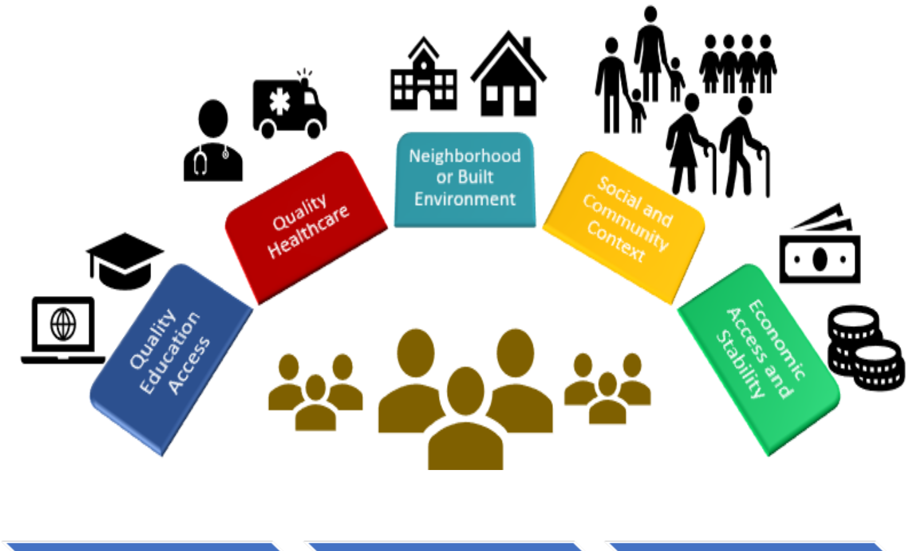
Social Determinants of Health and Structural Violence

- The term Structural Violence or structural racism is increasingly understood in population & public health as a major determinant of the distribution and outcomes of social and health inequities.
- Structural violence refers to the multiple ways in which **social, economic, political, and systems structures expose particular populations to risks and vulnerabilities leading to increased morbidity and mortality**.
- Structural violence creates the conditions which sustain the proliferation of health and social inequities.



Social Determinants of Health and Structural Violence

- However the term Structural violence is increasingly understood in population & public health as a major determinant of the distribution and outcomes of social and health inequities.
- Encompasses historical timeline, policy implementation
- Helps to define the context in which inequities occur.



Historical timeline and Historical Trauma → Policies and Legislation → Institutional Betrayal

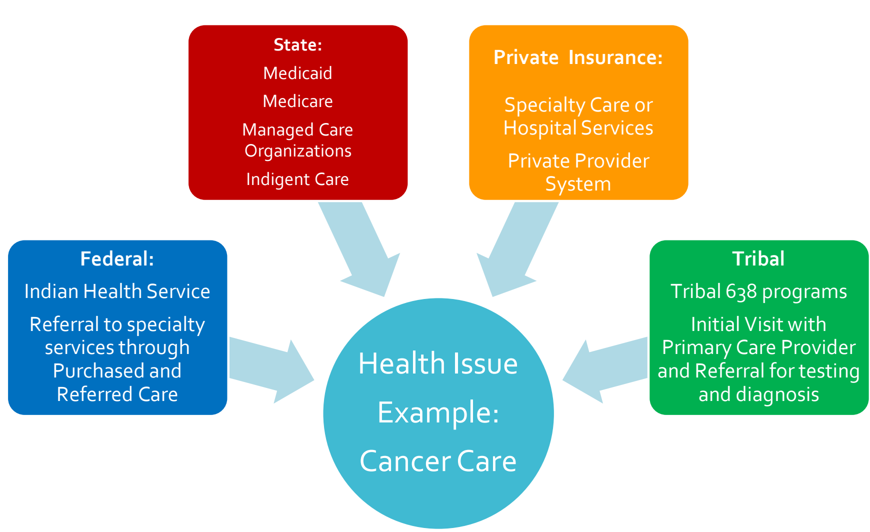
- Stereotypes and dismissal of historical trauma can also contribute to structural violence and result in harm on a regular basis including but not limited to discriminatory treatment, and disparate pain treatment

American Indian SDH Disparities

- Housing and Income:
  - In 2017, 88% of tribal housing officials reported homelessness was a problem in their community—not to mention the number of individuals staying in overcrowded conditions
  - 28.3% of Natives live in poverty, nearly twice the national rate of 15.5%, and the highest of any racial or ethnic group;
    - the median Native household income is $37,227, compared to $53,657 for the nation as a whole;
- 58 out of every 1,000 Native American households lack complete plumbing, as opposed to three out of every 1,000 white households
- Digital access:
  - In 2020, 34% of AI/AN households had no high speed internet access at home, and almost 16% with out a computer.
- Educational Attainment:
  - Lawsuits against State and Federal government by Tribes has been one means by which Tribal nations have sought to seek accountability for educational support for tribal children.
    - Yazzie/Martinez lawsuit in NM is one example

Examples of Institutional Betrayals in AIAN Healthcare

- Hoops to access care
- Lack of PRC funds to support specialty care needs
- PRC restrictions
- Lack of I.H.S funding to meet need
- Non-consented sterilizations of AIAN women (I.H.S, 1970s)
- Policies separating Indigenous babies from mothers during COVID
- Lack of follow up care
- Bias in care resulting in disparate treatment.



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Racial Justice Labor Health Care Criminal Justice More... Series Video

CORONAVIRUS

A Hospital's Secret Coronavirus Policy Separated Native American Mothers From Their Newborns

Pregnant Native American women were singled out for COVID-19 testing based on their race and ZIP code, clinicians say. While awaiting results, some mothers were separated from their newborns, depriving them of the immediate contact doctors recommend.

by Bryant Furlow, New Mexico In Depth, June 13, 2020, 5 a.m. EDT

Slide courtesy Jennifer S. Nanez, MSW, LMSW

Implicit and Explicit Bias

- Years of exposure to structural and cultural racialization and privilege have embedded stereotypes and biases in our individual psyches and the broader culture.
- Because of the link among cultural stereotypes and narratives; and systemic policies, practices, and behaviors; implicit bias is one part of the system of inequity that serves to justify inequitable policies, practices, and behaviors.

- Puumula, Burgess, et al. (2016) write regarding American Indian Children's utilization of ED;s:
- Their study of both implicit and explicit bias of providers in 5 Eds across both rural and urban centers, both servicing large urban American Indian and on reservation American Indian populations, found that 22-32% of providers surveyed believed:
  - "American Indian children were seen as increasingly challenging and parents/caregivers less compliant as the proportion of American Indian children seen during a typical shift increased."

What is Trauma informed care:

- Trauma-Informed Care (TIC) is an approach in the human service field that assumes that an individual is more likely than not to have a history of trauma.
- Trauma-Informed Care recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life.
- On an organizational or systemic level, Trauma-Informed Care ***changes organizational culture*** to emphasize respecting and appropriately responding to the effects of trauma at all levels.

Four R's

- ***Realizes*** the widespread impact of trauma and understands potential paths for recovery
- ***Recognizes*** the signs and symptoms of trauma in clients, families, staff and others involved in the system
- ***Responds*** by fully integrating knowledge about trauma into policies, procedures and practices
- Seeks to actively ***Resist re-traumatization***

Kunesh, P. (2021) National Native Children's Trauma Center

https://opentextbc.ca/peersupport/chapter/samhsas-definition-of-trauma-informed-care/

Historical Trauma Informed Care

- Historical Trauma Informed Care includes integration of recognition of tribal culture and history and the impact up to the present. Both must be incorporated in assessment, rapport building and treatment approaches.

SAMHSA TIP 61, 2019

6 GUIDING PRINCIPLES TO A TRAUMA-INFORMED APPROACH

The CDC's Office of Public Health Preparedness and Response (OPHPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for OPHPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA'S six principles that guide a trauma-informed approach, including:

Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by OPHPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

Trauma and Healthcare Utilization

- Selwyn, Lathan, Richie et al (2021) write regarding a framework called 'BITTEN" that examines histories of trauma and institutional betrayals and its impact on healthcare engagement.
  - **B**-institutional and personal betrayals and trauma exposure
  - **I**-indicator for healthcare engagement (presenting symptoms)
  - **T**-triggers for trauma symptoms (trauma responses)
  - **T**-trust in Healthcare Providers (power differential, past experience, present experience)
  - **E**-patient expectations (expectation of service provision or treatment)
  - **N**-patient need for healthcare services (acute, urgent, chronic, regular, preventative)

- "Without the ability to view the patient's current behavior in light of their previous experiences, the provider may instead attribute the behavior to a "dispositional attribute" of the patient (e.g., laziness) rather than situational factors (i.e., fundamental attribution error; (Croskerry et al., Citation2010).
- Once perceived as "difficult," these patients tend to evoke aversive emotions from their providers including discomfort, frustration, and incompetence (Robiner & Petrik, Citation2017)."

Selwyn, Lathan, Richie et al (2021)

Slide courtesy Jennifer S. Nanez, MSW, LMSW

The Body Politic

- "Sickness is not just an isolated event, nor the unfortunate brush with nature. It is a form of communication-the language of the organs-through which nature, society and culture speak simultaneously. *The individual body should be seen as the most immediate…where social truths and social contradictions are played out."*
- "Our body,…is, in fact, a talkative, social and political construction but in it – and in every socio-cultural order – the three dimensions of experience (social, political and individual) are not divided."
- *"According to this point of view, pathology in the backgrounds of poverty and social discrimination, is …both the overflowing effect of **biopolitics** and of **biopowers** on our body…"*

American Indian & Alaska Native Health Inequities Compared to Non-Hispanic Whites

Racial and ethnic health inequities are undermining our communities and our health system. American Indians and Alaska Natives are more likely to suffer from certain health conditions, and they are more likely to get sicker, have serious complications, and even die from them. These are some of the more common health inequities that affect American Indians and Alaska Natives in the United States compared to non-Hispanic whites.

AMERICAN INDIAN & ALASKA NATIVE HEALTH INEQUITIES: ADULTS

depression
37%
more likely to feel hopeless all or most of the time[1]

tuberculosis
x9
as likely to have tuberculosis[2]

liver cancer
64%
more likely to die from liver cancer[2]

heart disease
40%
more likely to have heart disease[1]

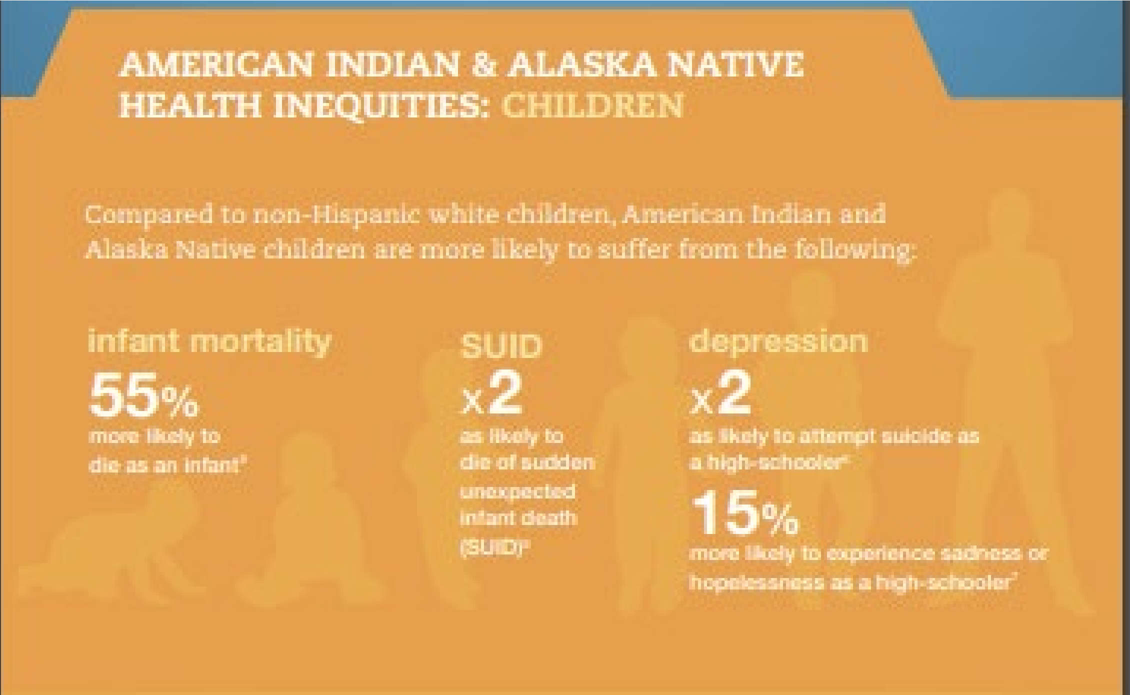
liver disease
x3.5
as likely to die from liver disease or cirrhosis[2]

obesity
33%
more likely to be obese[1]

stomach cancer
48%
more likely to die from stomach cancer[2]

diabetes
x2
as likely to be diabetic[1]
50%
more likely to have end-stage renal disease[2]
x2.4
as likely to die from diabetes[2]

HIV
x2
as likely to be diagnosed with HIV[3]
x2
more likely to die from HIV[2]



- Disparities in AI/AN health are well documented.
- Indigenous health post colonization has been influenced by histories of trauma, policy and institutional betrayals.

https://familiesusa.org/wp-content/uploads/2018/11/HSI-Health-disparities_american-indian-infographic.pdf

CULTURAL SAFETY

Structural systemic change and Indigenous lens

Indigenous View of Health

- Relational, Collective
- Anchored in Identity, Culture including historical and traditional knowledge, language, ceremony, tradition, belief, story, art
- Tied to the land and environment.
- Based in core cultural values of what it means to take care of each other and promote cultural perpetuity.

Cajete, 2000
Greenwood and Lindsay, 2019

Origins of Cultural Safety

- Developed in 1989 by Irihapiti Ramsden, A Maori nurse researcher.
- Ramsden wrote: "Maori people no longer accept that our world is a perspective on the reality of anyone else. We have our own whole, viable, legitimate reality…We insist *we are not a perspective*"
- "This leads to the question of choices in service delivery. The data on Maori mortality and morbidity and empirical experience has made it quite clear…The health service is not and has not ever been culturally safe for Maori people."
- ***"The service has not been designed to fit the people, the people have been required to fit the service"***

Definition of Cultural Safety

Cultural Safety is:

- an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system.
- ***Safety is defined by those receiving care,*** not by those who provide it.
- Turpel et al. (2020) further defined cultural safety as occurring when:
  - "[an] environment is physically, socially, emotionally and spiritually safe. There is recognition of, and respect for, the cultural identities of others, without challenge or denial of an individual's identity, who they are, or what they need.
  - Culturally unsafe environments diminish, demean or disempower the cultural identity and well-being of an individual. "

- Cultural Safety encompasses cultural humility, but also considers those historical timelines, trauma histories, inequities, and **takes on an active social justice and health justice stance.**
- It is inherently actively Anti-Racist in its basis.
- **It examines the aspects of constructs that impact health outcomes; actively transfers power to the patient and seeks to create systems that support safety and equity.**

Examines and confronts Structural Violence in systems of care and creates equitable access

Examines and confronts implicit bias

Centers cultural connection as supportive and cultural knowledge of a patient as valid and important to healing

Working in collaboration with a patient versus Working on.

Cultural Safety

Historical Trauma Informed Care

Historic and Gender Issues

Collaboration and Mutuality

Empowerment and Choice

Trauma Informed Care

Safety

Peer Support

Trustworthiness/ Transparency

Examines and confronts institutional betrayal in systems of care.

Examines and confronts power differentials and creates space free from judgement, racism, stereotyping

Understands historical context of population and historical context of care including hurtful or detrimental issues in care.

Sees care in the context of the impact of trauma and the need for safety and connection

Cultural Safety creates safe care

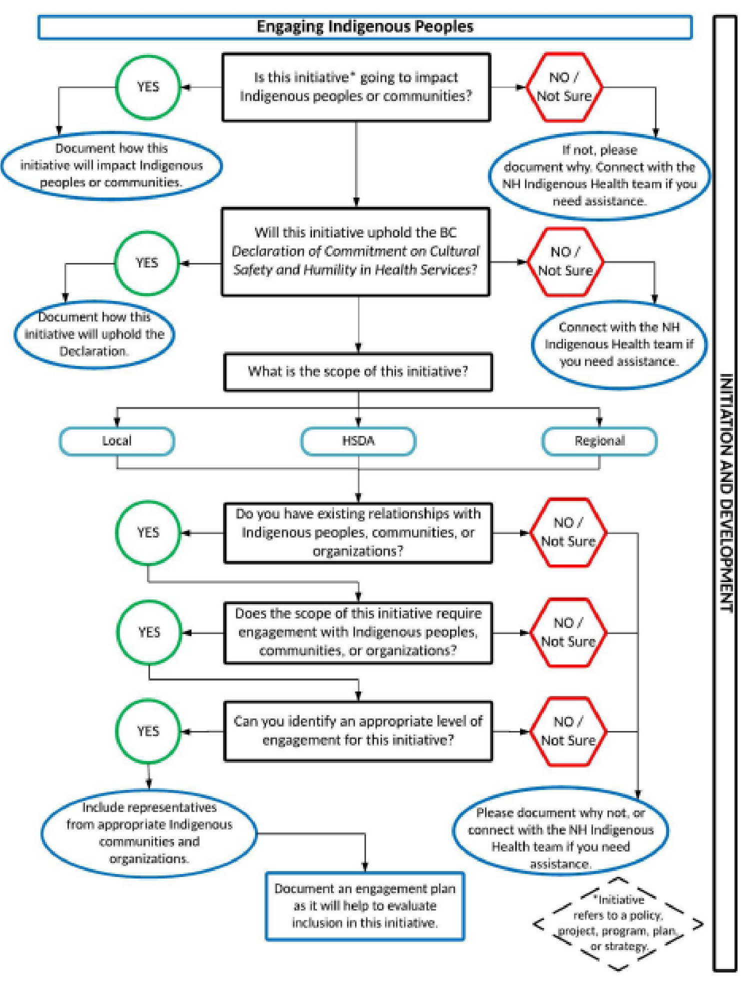
- Individuals seeking care are coming sometimes at the most vulnerable moments of their lives.
- Yet perceptions of biases, power differentials, and history of betrayals in care keep our relatives from sharing information about their health struggles
  - And their loss of health can create trauma
- Creating safe, respectful spaces for healthcare can create generations of impact

Operationalizing Cultural Safety: Turning to our Relatives for support.

NORTHERN HEALTH CULTURAL SAFETY AND SYSTEM CHANGE: An Assessment Tool

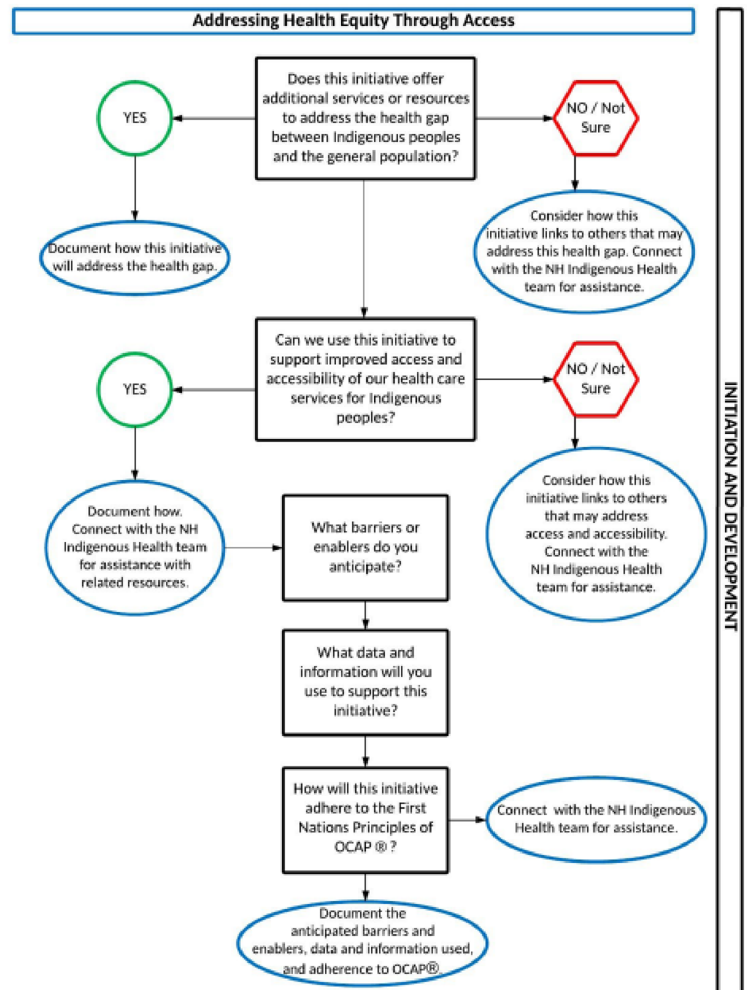
3.1 ENGAGING INDIGENOUS PEOPLES

Engaging Indigenous peoples is arguably the most important action area to support respectful, inclusive, and equitable initiative development. This decision-making tree includes screening questions and prompts to: 1) assess whether the initiative will impact Indigenous peoples or communities; 2) determine whether the initiative upholds the *Declaration of Commitment*[xi], 3) determine the scope of the initiative; 4) assess whether established relationships with Indigenous peoples, communities, or organizations exist; 5) determine whether to engage Indigenous peoples, and 6) identify an appropriate level of engagement. See Section 4.1 for expanded questions and considerations in applying this tool and decision-making tree.



3.2 ADDRESSING HEALTH EQUITY THROUGH ACCESS

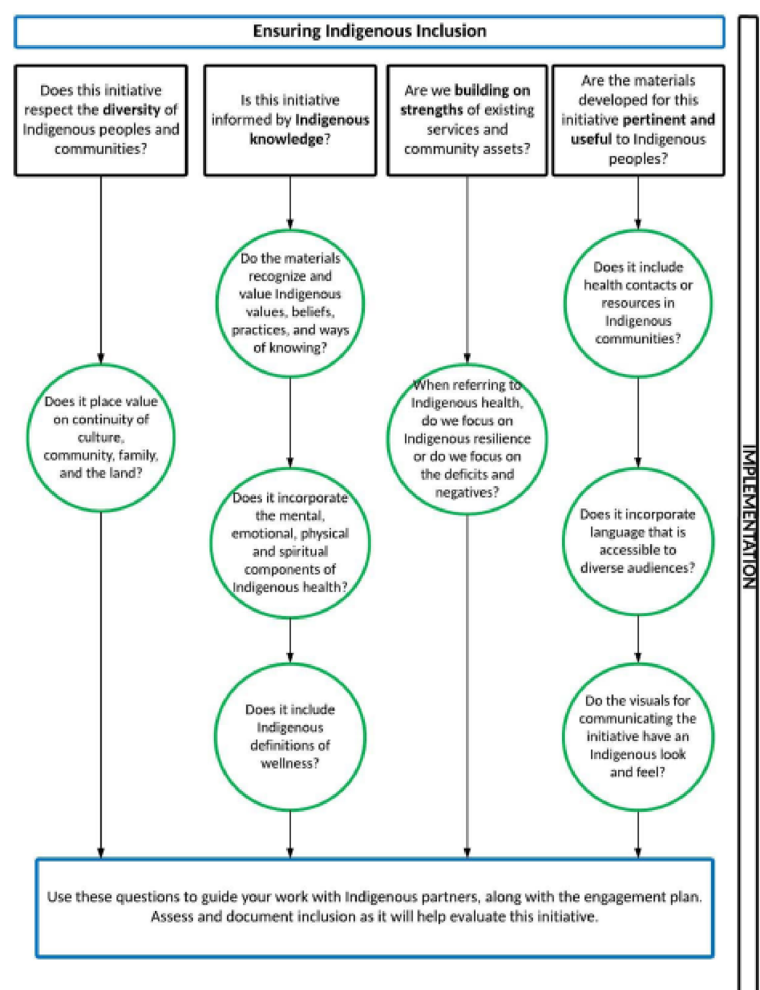
It is important to remember that working on even a single practical change to an initiative is always more powerful and effective than making plans to do so in the future. This decision-making tree provides end users and their partners opportunities to address health equity for Indigenous peoples by focusing on access and accessibility. The decision-making tree prompts consideration of how the initiative will adhere to the First Nations Principles of OCAP® [iii] to ensure the ethical collection, management, and use of Indigenous people's data. See Section 4.2 for expanded questions and considerations in applying this tool and decision-making tree.



NORTHERN HEALTH CULTURAL SAFETY AND SYSTEM CHANGE: An Assessment Tool

3.3 ENSURING INDIGENOUS INCLUSION

Ensuring that Indigenous peoples can see themselves reflected in initiatives is important. Ultimately, First Nations, Inuit, and Métis people, communities, organizations, partners, and nations will determine whether any given initiative has met its goals and objectives in relation to inclusivity. This decision-making tree provides a series of questions and prompts for partners to assess how the initiative respects and recognizes Indigenous peoples, including their definitions of health and wellness. See Section 4.3 for expanded questions and considerations in applying this tool and decision-making tree.



3.4 INFORMING EVALUATION

Reciprocal accountability is central to true partnership and includes seeking and following up on feedback, as opposed to conducting a one-time consultation without further contact. This decision-making tree focuses on informing a self-evaluation of the initiative through documenting the actions outlined in the preceding decision-making trees. It is important to ensure that evaluation processes adhere to the OCAP® principles[iii], thus safeguarding the ethical use of Indigenous-specific data. See Section 4.4 for expanded questions and considerations in applying this tool and decision-making tree.

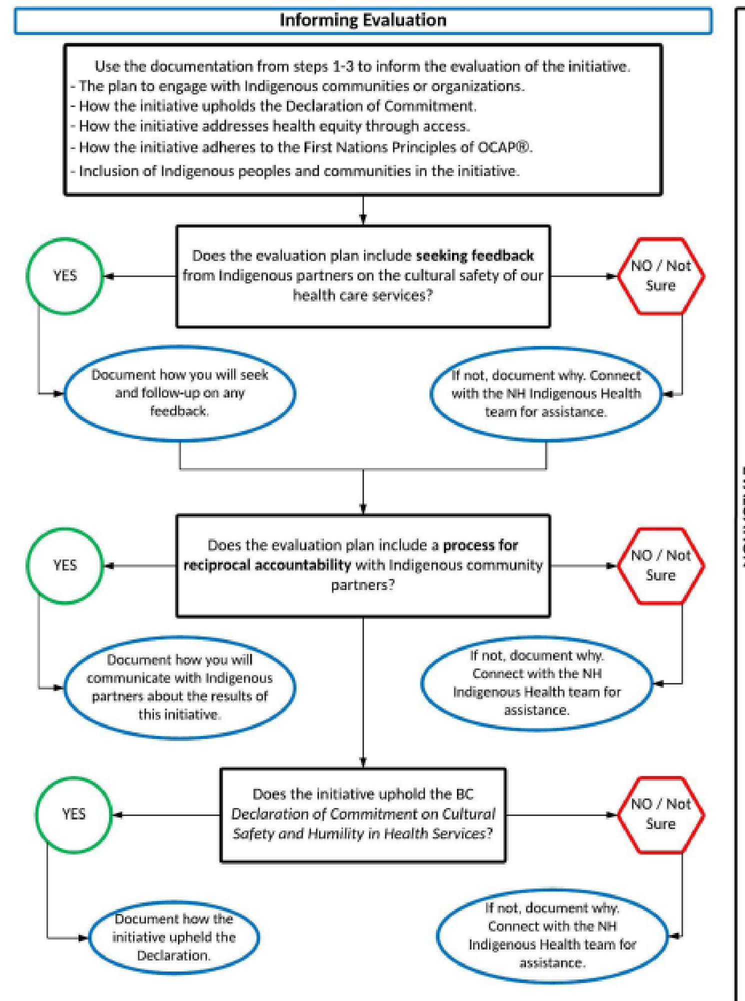


Table 2: Cultural safety in public policy—analysis framework

Main concepts of cultural safety	Themes for critical analysis
	Policy (discourse/structure/process) does/does not address:
Reflexivity	• Recognition: (of) e.g. impacts of colonization; respect for cultures • Reflection and learning: (about) e.g. privilege, power; implicit bias • Accountability: (for) e.g. effects of policy inconsistency
Dialogue	• Partnership: e.g. policy partnership; resourcing organizations • Relationship building: (between) e.g. non-Indigenous policy actors and Aboriginal or Torres Strait Islander leaders or community members • Listening: Respectful, receptive, reflexive listening
Power differences reduced	• Support for leadership: e.g. fund representative organizations; role of elders in community • Empowerment: e.g. increased regional control over resources • Reduce disempowerment: e.g. 'business-as-usual' policy practices
Decolonization	• Self-determination and rights: (support) e.g. treaty, Indigenous rights • Cultural identity: (support) e.g. connection to country, maintaining language • Address racism: e.g. demonstrate leadership, anti-racism campaigns • Interface thinking: creative exchange between knowledge systems • Processes of colonization: (question and change) e.g. dispossession; assimilationist, paternalist or discriminatory policy; dominant worldviews
Regardful care	Publically funded programmes and services value/address: • Indigenous knowledges: e.g. respond to local context and culture • Culturally safe healthcare: e.g. community-controlled services • Action on social determinants of Indigenous health: • Strength-based approaches: e.g. strong cultural identity • Healing: e.g. acknowledge and address burden of trauma • Transparency and evidence: e.g. evidence-based approach • Lack of regard: e.g. multiplication of deficit-focused interventions delivered by non-Indigenous NGOs or private companies

Mackean, T., Fisher, M., Friel, S., & Baum, F. (2020). A framework to assess cultural safety in Australian public policy. Health promotion international, 35(2), 340-351.

Operationalizing Cultural Safety: Turning to our Relatives for support.

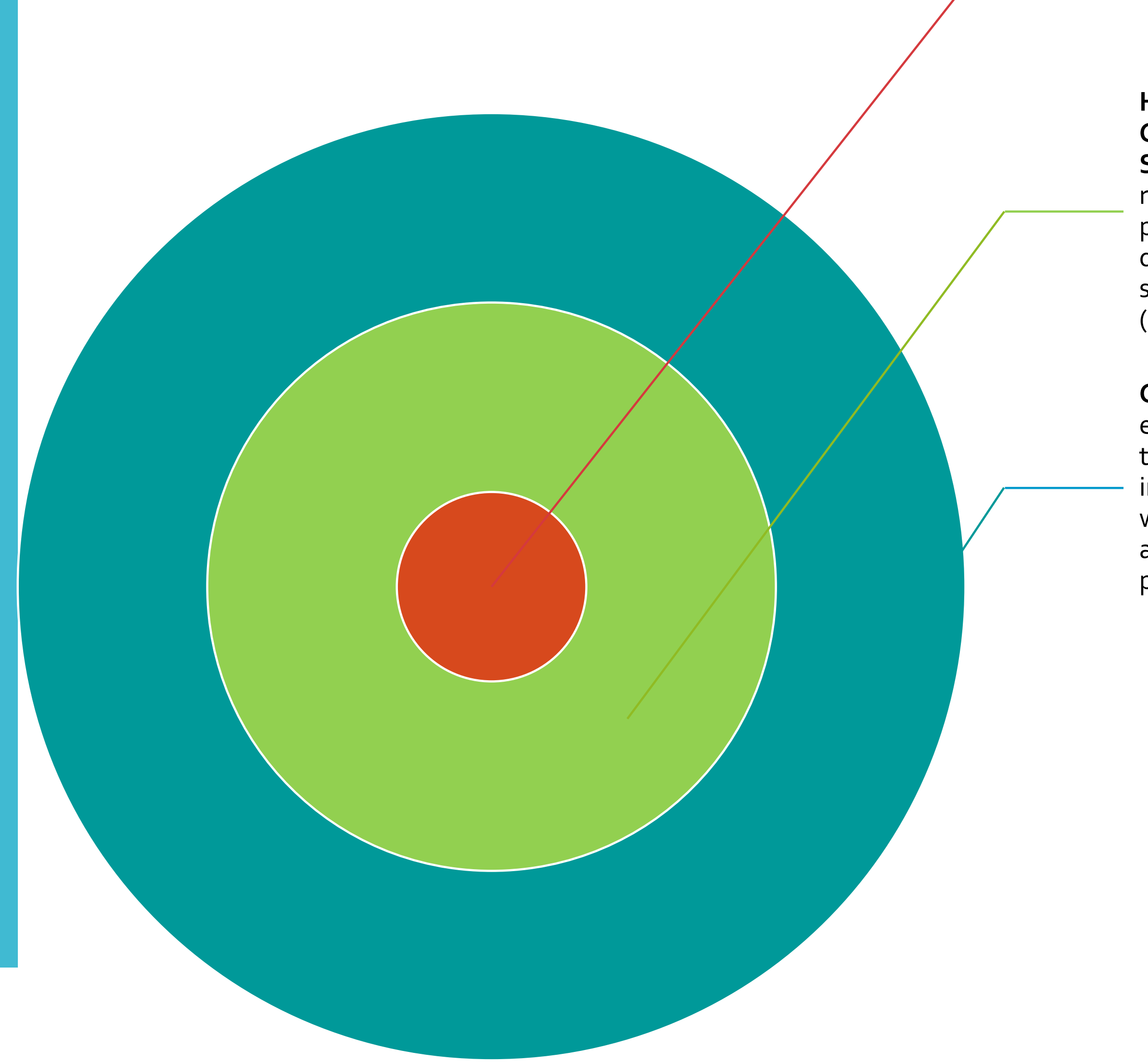
- Dell, Firestone et al (2015) draw on previous work in Canada and Australia to pose four overarching principles and possible resulting actions to address cultural safety in ED care.
  - The patient's way of knowing and being is valid—
    - We need to be able to listen to our patients and their understanding and story of their medical issue/trauma and needs even in this emergency medicine space
  - The patient is a partner in the healthcare decision making process
    - What information can we share and what choices can we provide
    - Understand that the decisions around care are often being considered in the broader context of family, community and even traditional ceremony and constructs and time
  - Recognize the impact of complex intergenerational traumas on health and access to health services
    - Building trust is still key, even in this emergency medicine space—introductions, asking permission, understanding hesitancy and reactivity and mistrust may be related to prior experiences and our work is to bridge to a new positive experience.
  - The patient determines whether the care they have received is culturally safe

  - We come with our whole selves, yes our whole traumas and histories and experiences, but we also come with our whole resilience—and when fostered, supported and recognized as valid in our own healthcare, then we see the patient as a whole being.

A few more “R’s” Cultural Safety

- **Replenish:** engaging in your own self care as a provider, and recognizing and addressing burnout and compassion fatigue
  - “Self care is an ethical imperative.” (Tujague and Ryan,2023)
- **Reflect and Re-evaluate (Reflexivity)**: on what we know, and how we put that knowledge into practice.
- **Resilience** expands on trauma informed care concepts and includes narratives and strategies deeply rooted in community well being.
  - Draws on cultural connection, traditional cultural healing and strengths based approaches.
- **Regenerate and Revive**: Tujague and Ryan (2023) note that our goal as partners and collaborators in our patient populations care, is to encourage and support our {Indigenous} populations engagement in our own local healing frameworks;

Intersection of Cultural Safety, Trauma Informed Care and Culture of Safety.



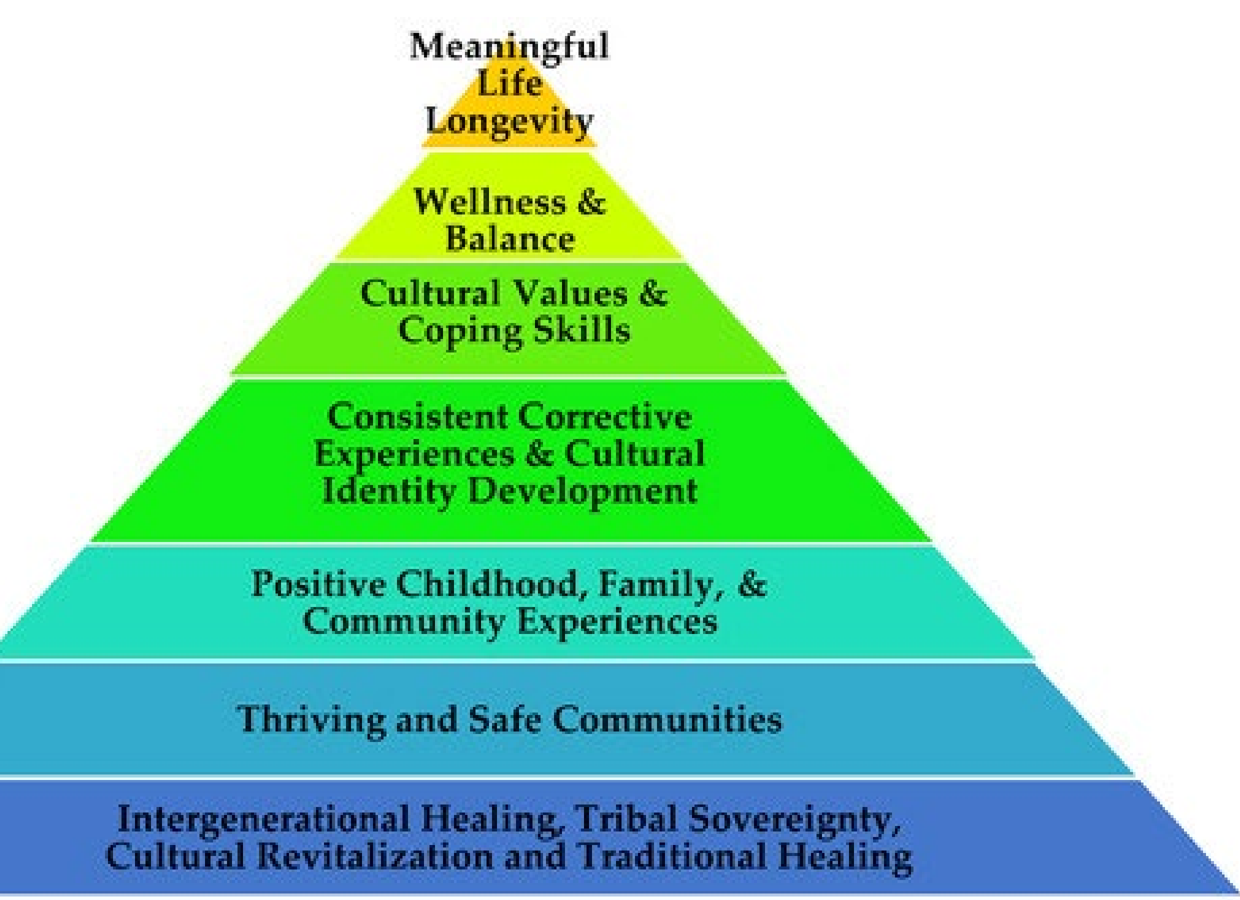
CULTURE OF SAFETY: how we create safety in healthcare service delivery in the day to day processes and procedures (Service Delivery Change)

HISTORICAL TRAUMA INFORMED CARE/TRAUMA INFORMED SYSTEMS OF CARE: How we recognize the intersection of a population and the history and present day interaction with the health care system and other systems of care. (System change)

CULTURAL SAFETY: How we examine and create systems of care that actively create safety, cultural inclusion, collaborative relationship with patients both in service delivery and in service creation, and minimize power differential (Structural Change)

Our Goal

Our Goal



Rides At The Door and Shaw, 2016

How can you create culturally safe care for American Indian and Alaskan Natives?

References and Resources

- Anderson, E. S., & D'Andrea, S. (2017). Emergency medicine and the Indian Health Service: overburdened and understaffed. *Annals of Emergency Medicine*, *69*(6), 711-713.
- Arabena, K., Somerville, E., Penny, L., Dashwood, R., Bloxsome, S., Warrior, K., Pratt, K., Lankin, M., Kenny, K. & Rahman, A. 2020, Traumatology Talks – Black Wounds, White Stitches, KCT Publishing, Melbourne.
- Barnes, D., Phillips, G., Mason, T. and Hutton, J. (2022), Working towards equity: An example of an emergency department project for Aboriginal and Torres Strait Islander health and cultural safety. Emergency Medicine Australasia, 34: 644-647. https://doi.org/10.1111/1742-6723.14003
- Berg, K., McLane, P., Eshkakogan, N., Mantha, J., Lee, T., Crowshoe, C., & Phillips, A. (2019). Perspectives on Indigenous cultural competency and safety in Canadian hospital emergency departments: A scoping review. *International Emergency Nursing*, *43*, 133-140.
- Bernard, K., Hasegawa, K., Sullivan, A., & Camargo, C. (2017). A profile of Indian Health Service emergency departments. Annals of Emergency Medicine, 69(6), 705-710.
- Brown T, Ashworth H, Bass M, Rittenberg E, Levy-Carrick N, Grossman S, Lewis-O'Connor A, Stoklosa H. Trauma-informed Care Interventions in Emergency Medicine: A Systematic Review. West J Emerg Med. 2022 Apr 13;23(3):334-344. doi: 10.5811/westjem.2022.1.53674. PMID: 35679503; PMCID: PMC9183774
- Bryan, J.M., Alavian, S., Giffin, D. *et al.* CAEP 2021 Academic Symposium: recommendations for addressing racism and colonialism in emergency medicine. *Can J Emerg Med* **24**, 144–150 (2022). https://doi.org/10.1007/s43678-021-00244-2
- Bourgois P, Holmes SM, Sue K, Quesada J. Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care. Acad Med. 2017 Mar;92(3):299-307. doi: 10.1097/ACM.0000000000001294. PMID: 27415443; PMCID: PMC5233668.
- Christensen, L., & Damon, S. (2022). Social determinants of health and response to disease associated with health outcomes of American Indian and Alaska native patients. *JAMA Network Open*, *5*(3), e224827-e224827.
- Curtis, E., Jones, R., Tipene-Leach, D. et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 18, 174 (2019). https://doi.org/10.1186/s12939-019-1082-3

References and Resources

- Dell, E., Firestone, M., Smylie, J., & Vaillancourt, S. (2016). Cultural Safety and Providing Care to Aboriginal patients in the Emergency Department. CJEM, 18(4), 301-305. doi:10.1017/cem.2015.100
- Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017.
- Gadsden, T., Wilson, G., Totterdell, J. *et al.* Can a continuous quality improvement program create culturally safe emergency departments for Aboriginal people in Australia? A multiple baseline study. *BMC Health Serv Res* **19**, 222 (2019). https://doi.org/10.1186/s12913-019-4049-6
- Grace, S. G. (2020). Emergency department: A sociological perspective. *Emergency Medicine Australasia*, *32*(5), 875-876.
- Greenwood M. Modelling change and cultural safety: A case study in northern British Columbia health system transformation. Healthcare Management Forum. 2019;32(1):11-14.doi:10.1177/0840470418807948
- Greenwood, M and Lindsay N. (2019) A commentary on land, health, and Indigenous knowledge(s) Global Health Promotion. 2019;26(3_suppl):82-86. doi:10.1177/1757975919831262
- Horrill, T. C., Martin, D. E., Lavoie, J. G., & Schultz, A. S. (2021). Nurses as agents of disruption: Operationalizing a framework to redress inequities in healthcare access among Indigenous Peoples. *Nursing inquiry*, *28*(3), e12394.
- Lokugamage AU, Rix E, Fleming T, et al. Translating Cultural Safety to the UK. Journal of Medical Ethics Published Online First: 19 July 2021. doi: 10.1136/medethics-2020-107017

References and Resources

- Mackean, T., Fisher, M., Friel, S., & Baum, F. (2020). A framework to assess cultural safety in Australian public policy. Health promotion international, 35(2), 340-351.
- McKinley, C. E., Boel-Studt, S., Renner, L. M., Figley, C. R., Billiot, S., & Theall, K. P. (2020). The Historical Oppression Scale: Preliminary conceptualization and measurement of historical oppression among Indigenous peoples of the United States. Transcultural Psychiatry, 57(2), 288–303. https://doi.org/10.1177/1363461520909605
- Mkandawire-Valhmu, L. (2018). *Cultural safety, healthcare and vulnerable populations: A critical theoretical perspective*. Routledge.
- Owens, A., Holroyd, B. R., & McLane, P. (2020). Patient race, ethnicity, and care in the emergency department: a scoping review. Canadian Journal of Emergency Medicine, 22(2), 245-253.
- Rides At The Door M, Shaw S. The Other Side of the ACEs Pyramid: A Healing Framework for Indigenous Communities. International Journal of Environmental Research and Public Health. 2023; 20(5):4108. https://doi.org/10.3390/ijerph20054108
- Treatment Improvement Protocol (TIP) Series 61. HHS Publication No. (SMA) 18-5070. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.
- Tujague, N., & Ryan, K. (2023). Billabong of Culture and Healing. In Cultural Safety in Trauma-Informed Practice from a First Nations Perspective: Billabongs of Knowledge (pp. 243-280). Cham: Springer International Publishing.
- Turpel, M. E., & White-Hill, E. British Columbia Ministry of Health.(2020). In plain sight: Addressing Indigenous-specific racism and discrimination in BC Health Care.
- Weber, T.L., Ziegler, K.M., Kharbanda, A.B. *et al.* Leaving the emergency department without complete care: disparities in American Indian children. *BMC Health Serv Res* **18**, 267 (2018). https://doi.org/10.1186/s12913-018-3092-z

References and Resources

- Cultural Safety: Respect and Dignity in Relationships (2017). Northern Health BC. https://www.youtube.com/watch?v=MkxcuhdgIwY
- Indigenous Engagement and Cultural Safety Guidebook: A resource for primary care networks. British Columbia Ministry of Health. (2019) https://www.pcnbc.ca/media/pcn/PCN_Guidebook-Indigenous_Engagement_and_Cultural_Safety_v1.0.pdf
- Introduction to Cultural Safety. Frontier Nursing University, Versailles, Kentucky. https://ceu.catalog.instructure.com/courses/introduction2cultural-safety
- Northern Health Cultural Safety and System Change: An Assessment Tool (2020) https://www.indigenoushealthnh.ca/sites/default/files/cultural-safety/documents/NH-Cultural-Safety-System-Change-Assessment-Tool-Jan2020.pdf
- Traumatology Talks: Black Wounds, White Stitches: https://static1.squarespace.com/static/5c63ec48840b162eb5d34b2d/t/5fd2b78e9f7c8079a6b4f049/1607645257088/TraumatologyTalks_ACEM_Report_FINAL.pdf