Toward Culturally Safe Evidence-informed Decision-making for First Nations and Inuit Community Health Policies and Programs

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Abstract

Objective: Public program and policy decisions affecting First Nations and Inuit communities must consider both Aboriginal and mainstream sources of knowledge. This study focuses on an evidence review to identify core characteristics of cultural safety relevant to decision making in the organizational context of the First Nations and Inuit Health Branch (FNIHB) of Health Canada.

Methods: References were identified through three approaches: requesting sources from Aboriginal and other partners, professional contacts, and networks; performing systematic searches using several electronic search engines; and identifying grey literature through online searches, and consultation of pertinent websites and reference lists.

Results: Core characteristics of cultural safety were identified as relevant to FNIHB decision making.

Conclusion: This review of evidence identifies a series of key cultural safety principles that could support program and policy-related processes. Feedback thus far suggests these principles may be helpful for FNIHB decision making contexts.

Key words: cultural safety, cultural competence, community programs, health policy, First Nations, Inuit, Aboriginal, evidence informed decision making

Introduction

Few would disagree that there is merit in basing government program and policy decisions on the best available evidence. More challenging, however, are the questions of how to identify and use this evidence — questions that are highly pertinent to the work of employees of Health Canada's First Nations and Inuit Health Branch who develop programs and policies for government supported health services in First Nations and Inuit communities.

Health Canada recognizes that decisions affecting First Nations and Inuit communities must consider both Aboriginal and so-called mainstream sources of knowledge. First Nations and Inuit communities' strengths and needs may differ from those of non-Aboriginal communities, and the lessons learned from experiences in non-Aboriginal communities may not be appropriate for application in First Nations or Inuit contexts.

An opportunity to reflect on and respond to our practical, daily challenges as FNIHB employees was provided through participation in the Executive Training in Research Application (EXTRA) pro-

We, the authors, are non-Aboriginal employees of Health Canada who wrote this paper in the context of working at First Nations and Inuit Health Branch. We make no claim of writing from an Aboriginal perspective. In keeping with Health Canada's mandate, we work primarily in partnership with First Nations and Inuit communities. (Appendix A provides further information.) With this article, we hope to contribute to dialogue on how best to help facilitate the conditions necessary for communities to define and foster their own wellness.

We would like to express our gratitude to Winona Polson-Lahache and Sarah MacDonald from the Assembly of First Nations (AFN) and Jim Cincotta from Inuit Tapiriit Kanatami (ITK) for their feedback on the process of this work; and to First Nations and Inuit colleagues and other partners for their contributions to the evidence review. The opportunity to develop this focus into a paper came about through participation of Patricia Wiebe, Kathy Langlois, and Eric Costen in the Executive Training in Research Application program of the Canadian Foundation for Healthcare Improvement. We thank the following individuals for reviewing preliminary drafts of this paper: Elizabeth Ford and Jim Cincotta from Inuit Tapiriit Kanatami; Jonathan Thompson, Sarah MacDonald, and the National First Nations Health Technicians Network, from the Assembly of First Nations; Paula Goering from the Centre for Addiction and Mental Health; and Louise Poulin and Samir Khan from Health Canada.

The views expressed in this paper are those of the authors and do not necessarily represent the views of the authors' affiliated organization, Health Canada.

gram of the Canadian Foundation for Healthcare Improvement, a program specifically designed to help participants become more skilled in evidence-informed decision making (EIDM). As defined by the National Collaborating Centre for Methods and Tools (2013), EIDM

> recognizes that important evidence comes from a variety of sources: community health issues and local context; public health resources; community and political climate; and the best available research findings. Decision makers must draw on their explicit and tacit public health knowledge and expertise to incorporate all the relevant factors into the final decision, conclusion or recommendation.

The EXTRA training program allowed us to explore the principles of cultural safety — closely related to the more broadly known concept of cultural competence — and to consider how these principles could be applied in a program and policy development context, a process we coined "culturally safe evidence-informed decision-making."

Cultural safety was developed as an educational framework for the analysis of power relationships between health professionals and those they serve. It originated in New Zealand during the 1980s in the context of Maori people's dissatisfaction with nursing services (Ramsden, 2002). The concept of cultural safety is inspiring new approaches to service delivery internationally (Ramsden, 2002; Smye et al., 2010), and is helping to guiding FNIHB's activities. As defined by The Nursing Council of New Zealand (NCNZ), cultural safety is:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.
>
> The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual. (NCNZ, 2009, p. 4).

While cultural safety was derived from clinical situations, over the past decade it has gained international influence in a variety of contexts, and also provides a much needed lens for addressing health policy and service delivery (Smye et al., 2010).

The main focus of our work undertaken for the training program was an evidence review to establish what has been learned in other organizational contexts. This paper focuses on that evidence review. It is hoped that the process of sharing what we have learned might contribute to ongoing striving by organizations such as FNIHB toward increased cultural safety in program development and delivery.

Evidence Review

Purpose

The following evidence review, completed in 2009, aims to inform thinking on how cultural safety may be realized in EIDM in federal government contexts involving First Nations and Inuit communities. It focuses specifically on what has been learned from the processes of designing and/or implementing cultural safety guidelines, tools, protocols, etc. in other contexts in Canada and internationally. This may help the authors' organization achieve similar objectives.

The literature was selected on the basis of relevance to the development of principles to inform decision making. It is important to note that this review did not necessarily address related approaches for ensuring cultural safety, such as cultural orientation programs for staff members and other knowledge exchange strategies.

Methods

In conducting this review of evidence, three approaches were used to identify potentially pertinent references.

First, Aboriginal and other partners, professional contacts, and networks were contacted through in-person meetings, by telephone, or by e-mail, to ask for sources that might inform this review. The purpose of our initiative was explained to each of these partners at the time when the request was made.

Second, searches were performed on a number of electronic search engines, using the follow-

ing key search terms in isolation and/or in combination: cultural safety; cultural competence; Aboriginal/Indigenous/Native/First Nations/Inuit; policy/program/research/evaluat*/administrat*/ decision-mak*; tool*/guide*/ protocol/framework. These terms were determined using Medical Subject Headings (MeSH) or adapted from terms used in the articles reviewed.

Using the filter for systematic reviews, a PubMed Health Services Research Queries search for "cultural safety" produced 2 results. Substitution of the related concept — and MeSH term — "cultural competency" produced 31 results. A PubMed basic search for "cultural safety" rendered 76 results. A search of the Cochrane Library, based on the term "cultural safety" produced no results, but the term "cultural competence" produced 8 references.

EBSCO *host* was also used for a search. The following sources yielded at least one result: Psychology and Behavioural Science Collection, Nursing and Allied Health Collection, Biomedical Reference Collection, CINAHL Plus, and MEDLINE. Filtering for peer-reviewed results, this search produced 229 references for "cultural safety." A quick scan of the titles showed that many references were not pertinent to our investigation as described above. The search was subsequently further limited to items that included the words Aboriginal, Indigenous, Native, First Nations, or Inuit. This resulted in 89 references.

From the combined search results, duplicates and items that were found to be unrelated to our topic were removed. This resulted in 79 references for closer review.

The third approach used to identify potentially useful resources focused on grey literature. Google searches were conducted using the search terms mentioned above; and websites of organizations which focused on Aboriginal wellness and mental wellness research, and reference lists contained within the accessed literature were consulted. A particularly large number of guidelines and protocols for conducting research involving Aboriginal peoples were identified in this manner. Among the sample tools collected, gender-based analysis tools were most common.

The critical review below summarizes references found to provide pertinent empirical evidence (based on qualitative or quantitative studies), as well as references judged to provide relevant theoretical, experiential, or cultural evidence.

Critical Review

No systematic reviews of literature on cultural safety were identified. Systematic reviews of literature on interventions aimed at enhancing cultural competence indicate a dearth of rigorous empirical studies in this area (Anderson, L.M. et al., 2003; Bhui et al., 2007; Chipps et al., 2008; Price et al., 2005). The relatively recent introduction of this concept is identified as one explanation (Minore et al., 2007). In a literature review of Aboriginal community-based alcohol and substance abuse programs, Jiwa et al. (2008) caution that impacts on community development in the form of self-esteem, community spirit, and leadership are difficult to measure and may take years to realize.

According to Price et al. (2005), many studies focus on evaluating personal attitudes and knowledge but stop short of assessing behavioural changes. According to Engebretson et al. (2008), cultural competence is a "dynamic process requiring growth rather than an attainable static point" that involves checking off a set of competencies. In his review of various US health care training reform initiatives, Thrall (2006) notes that some recent initiatives have already reflected a "shift from a descriptive approach, which is focused on finite curricular elements, to an outcomes approach, which is focused on values." Minore et al. (2007) draw attention to models of care that conceptualize cultural competence as an "ongoing process" of knowledge and skills development involving nonjudgmental, meaningful consultation or participatory interaction with clients, traditional healers, and communities at large.

Cultural safety/relevance is included among the guiding principles and recommended practices identified by Smye and Mussell (2001) on the basis of a review of successful interventions. For the authors, it is "essential" that service providers and administrators understand the impacts of "history, traditions, values and forces on families and com-

munities" and those of their own social position, on the development and delivery of programs and services. The literature review conducted by Minore et al. (2007) suggests that cultural competence requires that practitioners have a "reflective self-awareness" regarding the nature and impact of their own belief system. According to Anderson J. et al. (2003), cultural safety allows postcolonial discourse to be introduced into clinical practice,

> not as a set of concrete standards for practice, but as a way of questioning how we are positioned in relation to our patients and in relation to the system of health care delivery that we practice.

According to White (2007), critical reflection, rendering a detailed and contextualized account of the self, heightens awareness of the way social meanings are shaped by language, "qualifies ... knowledge as local, contingent, and partial," and favours "more open, relational, collaborative and accountable practices." Exploring questions regarding, for instance, one's knowledge, role, motivations, and ways of engaging clarifies, for oneself and others, one's perspective as having a history and a subjectivity. Asking individuals and communities generative questions from this starting point and giving their cultural meaning system preference can bring to the fore preferred storylines, assist collaborative meaning-making, and help overcome tensions between empirically based and local, traditional Indigenous knowledge.

Cultural safety is central to the core competencies in First Nations, Inuit, and Métis health that were developed for Canada's medical schools by the Indigenous Physicians Association of Canada (IPAC) and the Association of Faculties of Medicine of Canada (AFMC) in partnership with representatives of First Nations, Inuit, and Métis. Self-reflection and understanding of power imbalances are considered critical to cultural safety. It is emphasized that a fundamental principle of cultural safety is that the patient defines what culturally safe services entail (IPAC and AFMC, 2009).

Numerous reports stress the importance of recognizing the diversity of Aboriginal cultures (Inuit Tapiriit Kanatami and Nunavut Research Institute, 2007; Minore et al., 2007; National Aboriginal Health Organization, 2008; Registered Nurses Association of Ontario, 2007; Smye and Mussell, 2001). A research report commissioned by Pauktuutit, which is a national organization representing Inuit women in Canada, and the Women's Health Bureau of Health Canada on the Inuit Gender-Based Analysis (GBA) Framework (Guillou and Rasmussen, 2007) stresses the need for health strategies to recognize differences between Inuit and the general Canadian population and between Inuit and other Aboriginal populations, even within the same region, in terms of health concepts and patterns. They note that Western indicators of wellbeing may not be appropriate for Inuit.

Chandler and Lalonde (2004) argue that generalizations about Aboriginal peoples based, for instance, on statistical averages, result in "actuarial fictions" that fail to provide meaningful information regarding any specific group or community. They note that knowledge transfer is often conceived of as involving social scientists and health professionals, with information flowing from positions of higher to lower status and very little information moving "up" from the community level. They argue that the "top-down" approach, which "illegitimizes and disqualifies" Indigenous community knowledge, should be replaced by lateral knowledge transfer practices that give due recognition to the rich sources of knowledge and expertise that reside within communities.

Guillou and Rasmussen (2007), authors of the report on the Inuit GBA Framework, advise against stereotyped references to the concepts "modern" and "traditional," noting that although practices of southern Canadians — such as democratic elections — may also have ancient roots, they are generally not described as "traditional." They argue that the "modern-traditional" dichotomy parallels the "civilized-primitive" conceptualization, with traditional constituting a misleading notion that might imply associations with "backwards" or "old-fashioned." They similarly recommend against "linear notions of Progress" and, conversely, "golden age romanticism." According to the authors,

> [t]o speak of Inuit tradition, is actually to speak of adaptability and openness to incorporate technological changes and some parts of Euro-Canadian

> customs without abandoning Inuit worldviews and ethics.

A systematic review conducted by Kumas-Tan et al. (2007) to examine underlying assumptions of quantitative measures of cultural competence shows that instruments generally imply a conceptualization of culture as limited to ethnicity and race, and as "an attribute possessed by the ethnic or racialized Other," who "is/has the problem." Power relations based on social inequality are ignored and personal knowledge of the "Other" is assumed to be sufficient for change.

Engebretson et al. (2008) identify a number of challenges in the application of cultural competence in the clinical setting, some of which find similar expression in the policy-making context. The authors note the danger of essentializing, which may lead to stereotyping and lack of attention to care providers' cultural orientation and the health care system's culture. Anderson, J. et al. (2003) situate the concept of cultural safety within the "postcolonial project" directed at the

> unmasking of colonizing practices to show how race and culture have been constructed as 'rational' categories to locate non-European peoples as the essentialized, inferior, subordinate Other.

Browne et al. (2005) caution against binary conceptualizations that, by imposing categorical oppositions such as "colonizers and colonized," fail to recognize complexity, dynamics, human agency, and resistance, thereby reinforcing existing power relations. They point out that collaborative research involving "speaking with" can imply an "us and them." The notion "speaking from" encourages awareness of one's own sociohistorical and professional location, motivations, and position within power relationships. Locating health and social trends in historical and structural contexts can help avoid the reinforcing of stereotypes often associated with discussions of research findings.

A number of organizations representing Aboriginal peoples have developed detailed guidelines for researchers working with Aboriginal communities. Inuit Tapiriit Kanatami (ITK) and the Nunavut Research Institute (NRI) have described various levels of community involvement that may be appropriate for the three stages of research design — i.e., project design, data collection, and analysis — depending on the nature of the study. Researchers are asked to consider the following questions: "What level of involvement do I envision as working best for my project? How can the level of involvement desired by the community be incorporated into my project? How will this level of involvement vary in different research stages?" (ITK and NRI, 2007).

In recognition of the diversity among communities, a review by Chouinard and Cousins (2007) of empirical literature on culturally competent evaluation practices in Aboriginal settings recommends participatory methodologies that firmly base evaluations in local cultural contexts. On-going dialogue with communities — and not only individuals in positions of leadership — is identified by Minore et al. (2007) as key to cultural competence. Advocating the development and implementation of an ethical framework for mental health and addictions programming, Tait recommends that a mandate for such an initiative be sought from First Nations, Métis, and Inuit health leaders; involve broad consultations with representatives of Aboriginal peoples regarding ethical problems experienced in the context of program and service delivery; be informed by a survey of pertinent literature produced by Aboriginal scholars, as well as medical and government literature; and involve an advisory board comprising Aboriginal and other stakeholders to synthesize and analyze information (Tait, 2008). IPAC and the Royal College of Physicians and Surgeons of Canada (RCPSC), which have extended the core competencies curriculum for postgraduate and continuing medical education programs, attribute the success of the curriculum initiative to collaborative project governance structures and consultative methodologies; integration of Indigenous protocols and ceremonies; recognition that medical educational practices require support from Indigenous community personnel and resources; strong volunteer commitment from participants; and broad stakeholder representation on working groups (RCPSC et al., 2009).

Based on extensive research on mental health human resources issues facing Aboriginal com-

munities — including a systematic review of the literature complemented by interviews and a scan of training programs in Ontario — Minore et al. (2007) conclude that culturally competent mental health programs require supporting policies and workplace training.

Based on a literature review, Yamanda and Brekke (2008) identify a number of reasons why cultural competence training may not affect psychosocial rehabilitation services. These factors — which could have similar effects on the policy decision-making process — include the following: (1) cultural competence is perceived as a distinct skill, not as an integrated element of care practices; (2) a very limited range of topics is covered; (3) training is restricted to descriptions of cultural groups and does not cover the intersection of social issues and cultural beliefs, values, and attitudes; (4) those who most need the training do not get it; (5) consumers are not consulted in development of training programs; (6) training programs often do not reflect effective teaching methods aimed at learning and behaviour change; and (7) training programs do not address the organizational context necessary to sustain change in providers' practices. The authors also observed that providers are better able to offer culturally relevant evidence-based services when they are aware of their own culturally based beliefs, values, and biases.

The Maritime Centre of Excellence for Women's Health and the department of Indian and Northern Affairs Canada — now known as Aboriginal Affairs and Northern Development Canada — identify barriers to successful tool implementation in evaluating gender-based analysis policies and tools. These barriers were often attitudinal (resistance, hostility, and dismissiveness), operational (time, money, expertise, staff turnover, competing priorities, information sources), or theoretical (poorly designed or inappropriate tools). Operational barriers were mitigated by high-level political and bureaucratic support, accountability mechanisms, awareness, and a changing political environment favouring public consultation and participation. Ongoing access to educational resources, training, and experts helped overcome operational barriers. Participation by individuals with first-hand knowledge of the organization's policy-making context was crucial for the design of an effective tool, as was customizing tools to the specific needs of distinct target groups. Tools that were too long or complicated were found to be ineffective (Skinner, 1998; Indian and Northern Affairs Canada, 2008).

In its position statement on cultural competence and safety in health care and education, the National Aboriginal Health Organization (2008) identifies many of the previously noted requirements pertaining to, for instance, awareness, including self-awareness; respect for differences regardless of one's personal views; recognition of power relationships; recognition of persons as "experts" about themselves; understanding of the inadequacy of health services provided to many Aboriginal peoples, and recognition of negative attitudes and stereotypes. NAHO advocates practices that enhance relationship building and team work; culturally safe ways of communicating; and mindfulness of diversity.

In the report, *Negotiating Research Relationships with Inuit Communities: A Guide for Researchers*, ITK and NRI (2007) identify concerns about research conducted in communities. Many of these concerns relate to practices such as: token or cursory inclusion of local expertise; lack of recognition or compensation; generalization/decontextualization of local knowledge; appropriation of expertise and knowledge; lack of local data ownership; and inadequate reporting back to the communities. Local involvement and respecting local knowledge in all project phases was recommended.

The report on cultural competence guidelines produced by the Registered Nurses' Association of Ontario includes numerous recommendations. Recommendations at the individual level include strategies focused on self-awareness, communication skills, and learning. The report calls on governments to develop and enforce accountability expectations for employers; determine communities' cultural makeup; ensure opportunities for broad community and patient input; accommodate racial/ethnic and language preferences in data collection systems; acknowledge population diversity; and ensure cultural competence throughout the health care system (RNAO, 2007).

Key Findings: Core Characteristics of Cultural Safety

On the basis of the information gathered from the evidence review and consultations, the following core characteristics of cultural safety were identified as relevant to EIDM processes in FNIHB's organizational context. Culturally safe EIDM strives toward:

- Ongoing personal and organizational growth toward the integration of cultural safety principles in decision making processes, and a focus on principles and outcomes rather than a finite number of concrete practices.
- Reflection, including self-reflection, towards understanding the way cultural backgrounds, historic and structural contexts, social inequality and positions within power relationships may influence personal and organizational perspectives, interests, values, priorities and behaviours, and actions.
- Recognition of diversity among and within Aboriginal communities.
- Guarding against stereotyping and essentializing.
- Building and maintaining relationships of trust through open communication and work in partnership with Aboriginal communities, including at the local level, and recognizing community members as experts on their communities.

The evidence review further suggests that successful uptake of these elements requires:

- Supporting policies, training for all, leadership and funding.
- Integration in all stages of decision-making so that it becomes "second nature" rather than "an afterthought."
- Adjustments in response to distinct organizational contexts.

The review of evidence on cultural safety indicates a series of key cultural safety principles that can assist culturally safe program and policy development.

Our findings underscore that culturally safe EIDM is not a simple checklist, but rather an ongoing, dynamic process of growth, that occurs at personal and organizational levels. From this work, we have come to consider cultural safety not as a lens to look through at an Other who is or has the problem (Anderson, J. et al., 2003), but rather as a mirror to hold up to oneself and one's organization, with an awareness of power relationships and all their broad impacts. It involves being mindful, personally and as an organization, that one will always have "blind spots," and therefore it is essential that our First Nations and Inuit partners and communities, not our organization, define whether our services and policies are experienced as culturally safe. Engaging in culturally safe dialogue necessitates striving toward relationships of trust, open communication and partnership, and meaningfully recognizing the importance of diversity, local context, and community engagement when working toward developing programs and policy.

Implications

This evidence review highlighted the relational nature of cultural safety, including the importance of working in partnership with First Nations and Inuit. It is hoped that the identified principles are helpful in policy and program decision-making contexts across Health Canada and also within other governmental and nongovernmental organizations that address Indigenous issues.

Appendix A

Canada's Constitution Act (1982) recognizes three groups of Aboriginal peoples: Indians (or First Nations), Inuit, and Métis. These are three separate peoples with unique cultures, languages, political, and spiritual traditions.

- First Nations include those registered under Canada's Indian Act. First Nations are a diverse group of approximately 765,000 citizens living in 603 First Nations communities, as well as rural and urban areas (Assembly of First Nations, 2007).
- Inuit are the Aboriginal people who inhabit Arctic Canada. There are approximately 45,000 Inuit living in the 53 Arctic communities in four geographic regions: Nunatsiavut (Labrador); Nunavik (Quebec); Nunavut Territory; and the

Inuvialuit Settlement Region of the Northwest Territories (Inuit Tapiriit Kanatami, 2007).

- Métis are persons of mixed Aboriginal and European ancestry who identify themselves as Métis. The Métis people have their own unique culture, traditions, language (Michif), way of life, collective consciousness, and nationhood (Métis National Council, 2011).

Health services are provided to all Canadian citizens by their respective provincial or territorial governments; however Canada's Constitution Act (1867) charges Canada's federal government with the responsibility for Indians and Inuit and this responsibility has included the provision of health services. (Adapted from Langlois, 2008)

Organizational Mandate and Structure

FNIHB is responsible for provision of public health and primary health care services, and Non-insured Health Benefits. This branch of the federal government shares responsibility for health care delivery with provincial and territorial governments, and with First Nations and Inuit organizations.

The health services that fall within FNIHB's mandate generally focus on First Nations on reserve, First Nations north of the 60th parallel of latitude, and Inuit in Inuit communities. Non-insured Health Benefits are provided to First Nations and Inuit regardless of residence.

FNIHB is one of the nine branches of Health Canada. FNIHB comprises a national office, located in Ottawa, and regional offices located across Canada.

References

Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Khan, K.B., Reimer Kirkham, S., Lynam, J., Semeniuk, P. and Smye, V. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project toward new epistemologies of healing. *Advances in Nursing Science*, *26*(3), 196–214.

Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., Fielding, J.E., Normand, J., and Task Force on Community Preventive Services. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, *24*(3 Suppl), 68–79.

Assembly of First Nations (2007). Fact Sheet—First Nations Population. Retrieved 10 December 2007 from http://www.afn.ca/articl.asp?id=2918.

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

Browne, A.J., Smye, V.L., and Varcoe, C. (2005). The relevance of postcolonial theoretical perspectives to research in Aboriginal health. *The Canadian Journal of Nursing Research — Revue canadienne de recherche en sciences infirmieres*, *37*(4), 16–37.

Chandler, M.J. and Lalonde, C.E. (2004). Transferring whose knowledge? Exchanging whose best practices? On knowing about Indigenous knowledge and Aboriginal suicide. In D. Beavan and J. White, eds., *Aboriginal Policy Research*. London, ON: Althouse Press.

Chipps, J.A., Simpson, B., and Brysiewicz, P. (2008). The effectiveness of cultural-competence training for health professionals in community-based rehabilitation: A systematic review of literature. *Worldviews on Evidence-Based Nursing/Sigma Theta Tau International, Honor Society of Nursing*, *5*(2), 85–94. doi:10.1111/j.1741-6787.2008.00117.x

Chouinard, J.A. and Cousins, J.B. (2007). Culturally competent evaluation for Aboriginal communities: A review of the empirical literature. *Journal of Multidisciplinary Evaluation*, *4*(8), 40–57.

Engebretson, J., Mahoney, J., and Carlson, E.D. (2008). Cultural competence in the era of evidence-based practice. *Journal of Professional Nursing: Official Journal of the American Association of Colleges of Nursing*, *24*(3), 172–178. doi:10.1016/j.profnurs.2007.10.012

Guillou, J. and Rasmussen, D. (2007). *Inuit Gender-based Analysis Framework — Excerpts from a Report on the Health of Pauktuutit Inuit Women of Canada.* Paukuutit Inuit Women of Canada and the Women's Health Bureau of Health Canada.

Indian and Northern Affairs Canada. (2008). *Evaluation of the Implementation of INAC's Gender-based Analysis Policy* No. CIDM#1420188. Ottawa: Indian and Northern Affairs Canada.

Indigenous Physicians Association of Canada [IPAC] and Association of Faculties of Medicine of Canada [AFMC]. (2009). *First Nations, Inuit, Métis Health Core Competencies — A Curriculum Framework for Undergraduate Medical Education.* Indigenous Physicians Association of Canada and The Association of Faculties of Medicine of Canada.

Inuit Tapiriit Kanatami [ITK] (2007). Backgrounder: Inuit Tapiriit Kanatami. Retrieved 10 December 2007 from http://www.itk.ca/media/backgrounder-itk.php.

Inuit Tapiriit Kanatami [ITK] and Nunavut Research Institute [NRI]. (2007). *Negotiating Research Relationships with Inuit Communities — A Guide for Researchers.*

Jiwa, A., Kelly, L., and St. Pierre-Hansen, N. (2008). Healing the community to heal the individual: Literature review of Aboriginal community-based alcohol and substance abuse programs. *Canadian Family Physician, 54*(7), 1000–1000.e7.

Kumas-Tan, Z., Beagan, B., Loppie, C., MacLeod, A., and Frank, B. (2007). Measures of cultural competence: Examining hidden assumptions. *Academic Medicine: Journal of the Association of American Medical Colleges, 82*(6), 548–557. doi:10.1097/ACM.0b013e3180555a2d

Langlois, K. (2008). First Nations and Inuit mental wellness strategic action plan. *International Journal of Leadership in Public Service, 4*(1), 7–12.

Métis National Council (2011). The Métis Nation. Retrieved 22 April 2011 from http://www.metisnation.ca/index.php/who-are-the-metis.

Minore, B., Hill, M.E., Boone, M., Katt, M., Kuzik, R., Gauld, T., and Lyubechansky, A. (2007). *Community Mental Health Human Resource Issues Pertaining to Aboriginal Clients.* Thunder Bay, ON: Centre for Rural and Northern Health Research, Lakehead University.

National Aboriginal Health Organization. (2008). *Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators.* No. 978-1-926543-01-7. Ottawa: National Aboriginal Health Organization.

National Collaborating Centre for Methods and Tools. (2013). Glossary. Retrieved 18 January 2013 from http://www.nccmt.ca/glossary/all_terms-eng.html.

Nursing Council of New Zealand. (2009). *Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice.* Wellington, NZ: Nursing Council of New Zealand.

Price, E.G., Beach, M.C., Gary, T.L., Robinson, K.A., Gozu, A., Palacio, A., Smarth, C., Jenckes, M., Feurerstein, C., Bass, E.B., Powe, N.R., and Cooper, L.A. (2005). A systematic review of the methodological rigor of studies evaluating cultural competence training of health professionals. *Academic Medicine: Journal of the Association of American Medical Colleges, 80*(6), 578–586.

Ramsden, I.M. (2002). Cultural safety and nursing education in Aotearoa and Te Waipounamu (Doctoral dissertation). Victoria, NZ: University of Wellington.

Registered Nurses' Association of Ontario. (2007). *Healthy Work Environments Best Practice Guidelines — Embracing Cultural Diversity in Health Care: Developing Cultural Competence.* Toronto: Ontario Ministry of Health and Long-Term Care.

Royal College of Physicians & Surgeons of Canada [RCPSC], Indigenous Physicians Association of Canada [IPAC], Clearsky, L., Sandham, D., Kennedy, M., Arsenault, P., Stevenson, B., and McComber, A.M. (Undated) *Medical Education to Improve Health Care for First Nations, Inuit and Métis (Indigenous) People in Canada.* Ottawa: Health Canada.

Skinner, E. (1998). *Lessons from the Field: Policy Makers and Gender-based Analysis Tools in Canada.* Third edition. Halifax: Maritime Centre of Excellence for Women's Health.

Smye, V., Josewski, V., and Kendall, E. (2010). Cultural safety: An overview. Prepared for the First Nations, Inuit and Métis Advisory Committee, Mental Health Commission of Canada.

Smye, V. and Mussell, B. (2001). *Aboriginal Mental Health: 'What Works Best'.* Vancouver, BC: University of British Columbia, Mental Health Evaluation & Community Consultation Unit.

Tait, C.L. (2008). Ethical programming: Towards a community centred approach to mental health and addiction programming in Aboriginal communities. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 6*(1), 29–60.

Thrall, J.H. (2006). Education and cultural development of the health care workforce: Part II. Opportunities for nonprofessional workers. *Radiology, 240*, 311–314.

White, J. (2007). Working in the midst of ideological and cultural differences: Critically reflecting on youth suicide prevention in Indigenous communities. *Canadian Journal of Counselling, 41*(4), 213–227.

Yamada, A.M. and Brekke, J.S. (2008). Addressing mental health disparities through clinical competence not just cultural competence: The need for assessment of sociocultural issues in the delivery of evidence-based psychosocial rehabilitation services. *Clinical Psychology Review, 28*(8), 1386–1399. doi:10.1016/j.cpr.2008.07.006

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