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CULTURAL SAFETY IN HEALTH AND SOCIAL SERVICES

Towards Culturally Safe Care and Services for First Nations and Inuit

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PRODUCED BY

La Direction des communications du ministère de la Santé et des Services sociaux

Masculine pronouns are used generically in this document.

PRODUCTION

The Institut universitaire de première ligne en santé et services sociaux (IUPLSSS) of Centre intégré universitaire de santé et de services sociaux (CIUSSS) de l'Estrie – Centre hospitalier universitaire de Sherbrooke (CHUS) was tasked with facilitating the production and writing of this guide.

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FOREWORD

We have learned so much in the process of producing this guide. This process symbolizes a first step towards achieving culturally safe care and services for First Nations and Inuit.

From the beginning, it helped us see that the individual will to become aware of one's beliefs and knowledge is an invaluable starting place for working together to improve the care and services provided to First Nations and Inuit. To start, we met with Indigenous affairs officers from all institutions in the health and social services system (RSSS).[i] They shared what helped and what hindered their organizations in providing care and social services to First Nations and Inuit. Despite the wide variation in regional contexts these individuals described, all the people involved in this process had the same desire to learn from First Nations and Inuit culture to better serve those communities.

This experience has also taught us that the journey itself is just as important as the intended destination. Our conversations helped create more mutual knowledge and a better understanding of constructive ways to improve the health and well-being of First Nations and Inuit. They laid the groundwork for learning new ways of doing and being. They required time, dialogue, openness, and the ability to listen. We can see that these types of encounters have created new frames of reference between cultures and new ways of working together that are more rewarding for everyone and, most importantly, more equitable for First Nations and Inuit.

We also feel it is important to highlight the wide array of actions underway related to the health and well-being of First Nations and Inuit. We often took the opportunity during our meetings to examine regional, provincial, and federal projects concerning the health and well-being of First Nations and Inuit. Although we only touched on these projects, we got a glimpse of the wide-ranging needs and the many ongoing actions.

A lot remains to be done to restore equity for First Nations and Inuit, and this work presents colossal coordination challenges. This document builds on the work that many individuals and organizations from various backgrounds in Québec have been doing to make relevant contributions to the health and well-being of First Nations and Inuit.

Whether in the context of an intervention or the organization and governance of care and services, we all have a role to play in developing cultural safety. Each person's commitment, willingness, and actions are a significant and complementary contribution toward restoring equality among First Nations and Inuit in terms of health and well-being. Above and beyond the recommended practices described in this document, there are two message we hope you will take away. First is how important it is to be aware of our own, often ill-informed beliefs regarding First Nations and Inuit. Second is the importance of reaching out to First Nations and Inuit with respect so we can work together to develop culturally safe care and services.

Advisory committee members

i. Each RSSS health and social services institution has an Indigenous affairs officer. Data was collected through semi-structured interviews with 22 individuals from 22 RSSS institutions between November 2018 and January 2019. The institutions were spread across 12 regions of Québec..

GLOSSARY

In this document, the terms "Indigenous," "First Nations," and "Inuit" are used depending on the groups being discussed. The terms "First Nations" and "Inuit" have been used as much as possible because they more accurately represent the First Peoples in Québec.

Community

An inclusive term that encompasses the different types of land bases, including Indian reserves within the meaning of the Indian Act, lands reserved for the Cree, Naskapi, and northern villages of Nunavik[i], as well as Indian settlements and communities without a land base.

Culture

Culture is a system of knowledge created, learned, and shared by a group of people. Culture includes norms, values, symbols, material objects, and power structures—such as the arts, education, religion, and politics— in which our understanding of the world is shaped, reinforced, and challenged. Culture is learned, rather than inherited biologically, including through language, observation, and experience. It is not fixed, but often contested and it has many variations and subcultures (depending on region, age, gender, tastes, etc.).

Cultures adapt and change over time to meet the basic needs of the members who appropriate them (depending on the time, environment, and circumstances). This is why the norms, values, and associated power structures are often the subject of debate.[1]

Discrimination

A distinction, exclusion, or preference based on ethnocultural origin, skin colour, sex, gender identity or expression, pregnancy, sexual orientation, civil status, age (except as provided by law), religion, political convictions, language, social condition, disability, or use of a means to mitigate a disability.[2] Discrimination can be[3] :

- Direct when it is intentional
- Indirect when it stems from the application of a rule or practice that may appear neutral but negatively affects an individual or group

First Nations

The First Nations in Québec are represented by the Abenaki, Algonquin, Atikamekw, Cree, Ilnu/Innu, Maliseet, Mi'gmaq/Micmac, Naskapi, Huron-Wendat, and Mohawk nations.[ii,7]

Indigenous

A term used in Québec, the rest of Canada, and other countries to refer to the First Peoples.[iii]

The First Peoples in Québec are represented by First Nations and Inuit. First Nations and Inuit comprise a number of communities, each with its own cultural identity.

i. Inspired by RCAAQ.[98]
ii. Assembly of First Nations Quebec–Labrador. List of Communities and their Leader.[7]
iii. See Appendix A for a map of First Nations communities and Inuit villages in Québec.

Inuit

The first inhabitants of Inuit Nunangat of Canada, consisting of four Arctic regions, and their descendants. In Québec the Arctic region is Nunavik.[4]

The Inuktitut language distinguishes between the singular, dual, and plural. The term "Inuk" refers to the singular, "Inuuk" the dual, and "Inuit" the plural (three or more persons). The term "Inuit" is used as an invariable noun in this document, as it is used in Inuktitut.

Métis

The Métis trace their origins to the 1700s, when French and Scottish fur traders married Indigenous women, including Cree and Anishinabe (Ojibwe). Their descendants forged a distinct culture, a collective consciousness, and a common nation in northwestern Canada. The word "Métis" in Section 35 of the federal Constitution Act, 1982 refers to this nation. As such, the constitutionally recognized Métis Nation, does not include all people of mixed Indian and European ancestry.[i]

Prejudice

A preconceived attitude or opinion based on stereotypes. Prejudice can be negative or positive.[5]

Prejudice can be racist when it is historically linked with inequalities in power tied to economic and social differences between individuals and groups. Prejudice can also be racist when it is used to justify these inequalities.[6]

Stereotype

A belief or view that reduces an individual's identity to a few oversimplified traits thought to represent a group.

i. The Government of Québec acknowledges that historic Métis communities may exist within the province. But for such communities to be recognized, their existence must be clearly demonstrated, according to the criteria of the Supreme Court's Powley ruling. To date, no such demonstration has been made.

ACRONYMS

CBHSSJB	Cree Board of Health and Social Services of James Bay
CHU	Centre hospitalier universitaire (university hospital)
CISSS	Centre intégré de santé et de services sociaux (integrated health and social services centre)
CIUSSS	Centre intégré universitaire de santé et de services sociaux (integrated university health and social services centre)
FNQLHSSC	First Nations of Quebec and Labrador Health and Social Services Commission
INIHB	Insured/Non-Insured Health Benefits
INSPQ	Institut national de santé publique du Québec (Québec national institute of public health)
IUPLSSS	Institut universitaire de première ligne en santé et services sociaux (primary health care and social services university institute)
JBNQA	James Bay and Northern Quebec Agreement
MSSS	Ministère de la Santé et des Services sociaux (department of health and social services)
NIHB	Non-Insured Health Benefits
NRBHSS	Nunavik Regional Board of Health and Social Services
RCAAQ	Regroupement des centres d'amitié autochtones du Québec (Québec association of Friendship Centres)
RSSS	Réseau de la santé et des services sociaux (health and social services system)
RTS/RLS	Réseau territorial de services/Réseau local de services (territorial/local service network)
SAA	Secrétariat aux affaires autochtones (secretariat for Indigenous affairs)
SQIA	Southern Quebec Inuit Association

SUMMARY

While it is rooted in colonization, discrimination against First Nations and Inuit continues to be an issue in our societies, including in certain public services.[8]

In its report, the Viens Commission (2019) is clear about First Peoples mistrust in Québec's health and social services system: "[...] although it is impossible to generalize, many voices were heard to state that First Nations members and Inuit feel unsafe when they have to entrust their health to public services." [8]

This means that one obstacle to the health of Indigenous people is the system itself[9] because of the discrimination Indigenous people face in health and social services practices and in how the services are organized.

To address this issue, the development of culturally safe care and services is a path recognized and encouraged by First Nations and Inuit for their health and well-being.

Cultural safety is an approach that recognizes the injustices Indigenous people experience and strives to bridge those gaps through culturally safe practices. All stakeholders in Québec's health and social services system, from governments to front-line workers, have a role to play in developing culturally safe care and services. Each stakeholder must take steps to become aware of their beliefs and knowledge regarding First Nations and Inuit in order to promote appropriate behaviours and attitudes that support the health and well-being of Indigenous people.

The proposed model for developing culturally safe care and services is inspired by British Columbia's experience with implementing a health and social services system based on cultural safety.[10]

The model includes three levels of action through which leadership team members and managers can develop culturally safe care and services. These levels are interconnected and require simultaneous interventions.[10]

The model also includes four guiding principles that inform all practices with First Nations and Inuit:

- **a)** Continuously reflect on your beliefs and practices with respect to First Nations and Inuit
- **b)** Acknowledge past and current trauma and its impact on the health and well-being of First Nations and Inuit
- **c)** Respect the cultures of First Nations and Inuit
- **d)** Act with First Nations and Inuit as partners in their health and well-being

WHAT POLICY DIRECTIONS SPAWNED THIS DOCUMENT?

This guide is of a piece with the 2017–2022 Government Action Plan for the Social and Cultural Development of First Nations and Inuit and supports Measure 1.1.14: "Implement cultural safety strategies to enhance the service delivery of the health and social services network."[11]

It also contributes to the Viens Commission's (2019) various calls for action, notably Call for Action nº 75: "Encourage the health and social services network institutions to set up services and programs based on cultural safeguard principles developed for Indigenous peoples and in cooperation with them."[8]

WHO IS THIS DOCUMENT FOR?

This document is intended for members of boards of directors, members of the leadership team, and managers of RSSS institutions, who play a key role in creating conditions conducive to the development of culturally safe care and services for First Nations and Inuit.

This guide was also drafted in consideration of the individual responsibilities of everyone working in health and social services in terms of treating First Nations and Inuit with respect and equity, such as physicians and clinical and administrative services staff.

WHAT IS THE PURPOSE OF THIS DOCUMENT?

The purpose of this document is to help institutions develop culturally safe care and services for First Nations and Inuit. More specifically, it aims to:

- Promote awareness among leadership team members and managers of the importance of integrating the principles of cultural safety into care and services for First Nations and Inuit
- Define cultural safety and its principles
- Guide leadership team members and managers towards best practices for developing culturally safe care and services

WHERE DO THE SUGGESTED PRACTICES COME FROM?

The practices suggested in this document are derived from a combination of scientific, experiential, and contextual knowledge. This guide is the product of a process that brought together two committees of managers, front-line workers, and scientific advisors involved in organizing and providing care and services to First Nations and Inuit in Québec.

The organizations representing First Nations and Inuit were members of these two committees. The composition of the committees is outlined in the "Production" section of this guide. The process these committees followed as well as the main sources of knowledge that contributed to the development of this document are detailed in Appendix B.

OVERVIEW OF FIRST NATIONS AND INUIT IN QUÉBEC

The First Peoples of Québec are formed by Inuit and First Nations[7] (the Abenaki, Algonquin, Atikamekw, Cree, Huron-Wendat, Innu, Maliseet, Mi'gmaq, Mohawk, and Naskapi nations).[i] The Government of Québec recognizes the right of each of these First Peoples to shape and develop its own identity.[12]

> **"Diversity is a cornerstone of the Indigenous reality in Québec. It manifests in many ways—in languages, traditions, lifestyles, and beliefs—and is found in the specific identities of each nation."[13]**

An example of diversity are the nine languages and dialects are spoken in Québec: Inuktitut, Innu, Cree, Atikamekw, Algonquin, Mi'gmaq, Mohawk, Naskapi, and Abenaki. These are grouped under three main families (Iroquoian, Algonquian, and Eskimo-Aleut).[11]

Even so, common cultural traits emerge from this diversity and become emblematic of First Peoples culture and identity. Examples include:

- A "sense of interconnectedness and relationship to the land,"[14] (p.3) land being intrinsic to well-being
- A relationship to the community, i.e., extended family, friends, and the nation as a whole are central to well-being[8]
- Deep respect for elders[16]
- An understanding of health and well-being as a state encompassing multiple factors that go beyond the absence of illness[8,17]

i. See Appendix A for a map of First Nations communities and Inuit villages in Québec.

SOCIO-DEMOGRAPHIC STATISTICS

There are approximately 108,300 First Nations and Inuit in Québec who are registered in the federal register or in one of the provincial registers.[i,ii] Data on First Nations and Inuit is often subject to methodological challenges when it comes to comparing sources.[iii,8] However, certain key socio-demographic data has been determined:

- **The population is young**, with an average age of 36 compared to an average age of 41 for the Québec population as a whole. Inuit are the youngest, with an average age of 27.[20]
- **Families are larger**, with four to five times as many children as families in Québec as a whole.[20]
- **Demographic growth is significantly higher than among the Canadian population as a whole**. Between 2006 and 2016, the population of First Nations increased by 39%, that of Inuit living in Nunangat by 20%, and that of Inuit outside these Arctic regions by 62%.[21] The Canadian population as a whole increased by 5% and that of Québec by 3.3% between 2011 and 2016.[22]
- **The number and diversity of First Nations and Inuit living in urban areas is increasing every year.** [iv,23] This includes people born or living in cities and towns, temporarily staying there, or settling there permanently.
- **Montréal is home to the third-largest urban Inuit population in Canada**[21] and is among the most diverse cities in terms of Indigenous languages and cultures.
- **87% of Inuit and 37% of First Nations speak their mother tongue.**[21] The use of French and English varies among Inuit and First Nations. Some use English or French at home, while others only speak their Indigenous mother tongue.

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i. Secrétariat aux affaires autochtones, plus various estimates from the federal and Québec registers (register of Cree, Inuit, and Naskapi beneficiaries of the James Bay and Northern Quebec Agreement and the Northeastern Quebec Agreement[18] [data available online]: http://www.autochtones.gouv.qc.ca/nations/population_en.htm See Appendix A for a map of First Nations communities and Inuit villages in Québec.

ii. The official name of the federal register is the "Indian Register." It shows the people registered under the Indian Act and known by the federal government to have Indian status (Government of Canada, site accessed May 18, 2018).[19] The register of beneficiaries of the James Bay and Northern Quebec Agreement (JBNQA) and the Northeastern Quebec Agreement (CNEQ) is kept by MSSS. These registers include eligible Inuit, Crees, and Naskapi under the provisions of chapters 3 of the JBNQA and the NEQA.

iii. For example, Statistics Canada census data may contain inaccuracies and biases, due to self-reporting, allowing non-Indigenous people to declare Indigenous origin and leading some Indigenous people and communities to refuse to participate in census exercises.

iv. In this document, when we refer to First Nations and Inuit living or temporarily staying in urban areas, we mean any geographic location outside the community.

"Community" is an inclusive term that covers the various types of land bases, including Indian reserves within the meaning of the Indian Act, lands reserved for the Cree, the Naskapi, and the northern villages of Nunavik (inspired by RCAAQ, 2018), as well as Indian settlements and communities without a land base.

WHY ADAPT CARE AND SERVICES TO FIRST NATIONS AND INUIT REALITIES?

THE ORIGINS OF DISCRIMINATION

To some, colonization may seem like something from the bygone past that has little effect on modern society. However, the events that took place back then still have a major impact on many aspects of the lives of First Nations and Inuit today. Their governance system, education, economy and health and well-being have been and continue to be greatly affected. Many current laws and practices are rooted in a colonial perspective, perpetuating the individual and collective consequences on First Peoples.

For almost two centuries, the Canadian and Québec governments—according to their respective responsibilities—imposed measures that contributed to discrimination, exclusion, and racism with respect to First Nations and Inuit.

Over the past 30 years, and in particular the past five years, a number of public inquiries have examined the impacts of these measures. They have also addressed the underlying causes of human rights abuses, discrimination, and differential treatment that may exist in the provision of public services to Indigenous people[i]:

- The Royal Commission on Aboriginal Peoples (1996)[25]
- The Truth and Reconciliation Commission of Canada (2015)[26]
- The National Inquiry into Missing and Murdered Indigenous Women and Girls (2019)[27]
- The Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec: listening, reconciliation and progress (Viens Commission) (2019)[ii,8]

i. We would also mention the work of the Special Commission on the Rights of the Child and Youth Protection, whose mandate is "to investigate youth protection safeguards, in the various response networks concerned, in order to identify issues and obstacles and formulate recommendations on improvements to be made." More specifically, it must "take into account the reality of Indigenous peoples with respect to youth protection, referring in particular to the forthcoming studies of the Public Inquiry Commission on Relations Between Indigenous Peoples and Certain Public Services in Québec and the results of the National Inquiry into Missing and Murdered Indigenous Women and Girls."[24] The Special Commission must submit the findings of its report by April 30, 2021. https://www.csdepj.gouv.qc.ca/accueil/

ii. More specifically, the mandate of the Viens Commission was, among other things, "[...] to investigate, address facts and conduct analyses in order to make recommendations concerning concrete, effective, lasting remedial measures to be implemented by the Government of Québec and indigenous officials to prevent or eliminate, regardless of their origin or cause, all forms of violence, discriminatory practices and differential treatment in the delivery of the following public services to Québec's indigenous people." https://www.cerp.gouv.qc.ca/index.php?id=11&L=1

These inquiries have documented the repercussions of government actions on every sphere of life for individuals and communities. Although First Nations and Inuit have collectively been the target of assimilation, the measures to which they have been subjected differ. These differences, often rooted in legal and geographic realities, still exist today. Under the circumstances, the Indigenous peoples of Québec have shown remarkable resilience. However, two centuries of inequities, uprootedness, and marginalization have shaken these societies in many ways, and the scars are still present.[11] The following examples provide a partial overview of the severity of the government measures, as reflected in the experience of First Nations and Inuit.

FIRST NATIONS

Many measures affecting First Nations were sanctioned or continue to be sanctioned in the provisions of the Indian Act.[i] For example, a non-exhaustive list of strategies used includes the forced relocation of certain populations and the creation of reserves (controlled territories where colonial authorities restrict economic activity and impose their modes of governance), and the prohibition of gatherings of more than three people except in churches (limiting traditional ceremonies[29]). The notion of "emancipation" to mean renouncing one's status as an Indian and member of a band in exchange for rights such as Canadian citizenship, the right to vote in government elections, and access to higher education[ii] is another example that illustrates government authorities' perception of the "inferiority" of Indigenous groups.

The establishment of residential schools is also frequently cited as an illustration of the government's assimilation strategy, as their explicit mission was to assimilate Indigenous youth into Canadian society and erase any traces of their Indigenous origins.

Parents were forced to send their children to residential schools. Children were forcibly prevented from speaking their mother tongue, expressing their spirituality, and observing any practices related to their Indigenous culture and way of life. The ultimate objective of these institutions was to "kill the Indian in the child."[26] Numerous residents have testified about the mistreatment they experienced, including physical, psychological, and sexual abuse, poorly maintained buildings, poor nutrition, and a lack of medical care.[iii] Many deaths were reported among child residents of these schools.[26] Twelve residential schools operated in Québec from 1950 until 1991, when the Pointe-Bleue (Mashteuiatsh) residential school in Saguenay–Lac-St-Jean closed.[31]

INUIT

Inuit were also targeted for assimilation by being forced to attend residential schools. In 1964, nearly 75% of Inuit children age 6 to 15 were enrolled in such institutions. It is estimated that at least 3,000 Inuit survivors of residential schools are still alive today.[32] The Inuit experienced the colonization process differently from First Nations, among other things due to the short period in which it took place, which intensified the social upheaval. For example, there were about 40 children in residential schools in 1956, whereas barely 10 years later, there were 656.[33]

i. The terms "reserves," "Indian," and "member of a band" are used in this context because those are the legal terms in the Indian Act (R.S.C. (1985), c. I-5).[28] https://laws-lois.justice.gc.ca/eng/acts/i-5/

ii. For example, Indigenous people would have to wait until 1969 to exercise the right to vote in Québec without renouncing their Indian status, and Indigenous women until 1985 to gain the right to marry someone without Indian status without losing their own.[30]

iii. Many survivors made statements to the Truth and Reconciliation Commission of Canada (2015).[26]

One of the most significant traumas in the history of Inuit colonization was the slaughter of more than a thousand sled dogs by the Royal Canadian Mounted Police and Sûreté du Québec due to the shift toward an increasingly sedentary lifestyle.[8,34] "[...] This episode traumatized the population, whose identity was intrinsically linked to gimmiit (sled dogs) and who needed them to survive."[33] The impact of these events involving the police still weighs heavily on the Inuit community today.[35]

Nunavik's experience with epidemic tuberculosis, introduced by Europeans in the 20th century, is also central to the Inuit historical and collective experience. Many Inuit infected with this disease had to be transferred to sanatoriums in southern Québec in the 1950s for treatment. Still today, the region ranks ninth in the world, after Bangladesh and the Philippines, for the number of people affected by tuberculosis at any given time (prevalence rate).[36] These convalescent stays, averaging two years, had a major impact on Inuit patients cut off from their community and culture. Reintegration into the community was just as difficult. Some young patients lost their language and cultural references during their hospitalization. After recovery, patients were also repatriated to a community other than their home community or dressed in inappropriate clothing.[37] In addition, sometimes death notices were never sent to families. Although tuberculosis can now generally be treated in the community, this period in history has left Inuit resistant to screening.[38]

While not described in this document, other traumas have been inflicted on First Nations and Inuit, resulting in intergenerational repercussions on their individual and collective health and well-being.

INTERGENERATIONAL REPERCUSSIONS OF TRAUMA ON HEALTH AND WELL-BEING

These governmental laws and policies have led to major health disparities and social inequities for Indigenous populations.[39] One study shows there is a significant gap in human development indexes between Indigenous people and other Canadians, even though Canada is recognized internationally as one of the most advanced countries in terms of health and well-being.[40]

In Québec the many examples include the following:

- The life expectancy for Cree is 77 years old,[41] while it is nearly 83 years for the total Québec population.[42]
- Food insecurity affects 22% of First Nations people[43] and 55% of adult Inuit in Nunavik,[44] compared to 6% of Quebecers as a whole.[45]
- 27.6% of the Indigenous people who died by suicide between 2000 and 2011 were age 19 or younger.[46]
- The report rate at youth protection services for Indigenous youth is 4.4 times higher and the out-of-home care rate 7.9 times higher than for non-Indigenous children.[47]

Although the socio-economic situation of First Nations and Inuit can vary widely, a range of data nevertheless confirms the blatant inequalities in health and well-being that persist between Indigenous peoples and the rest of the Québec population. The experience of colonialism and discrimination, as well as self-determination initiatives, are among the factors recognized as having had a profound influence on the living conditions of Indigenous peoples.[48,49]

These major inequalities took root in the measures underlying colonization, but they have been perpetuated for generations.

For example, not only do Indigenous people who attended residential schools live with complex trauma, but their children and grandchildren may continue to experience that trauma in some form.[14,50,51] The repercussions of attending residential schools include a sense of loss of cultural identity, a significant decline in self-esteem, substance abuse, child neglect, violence, and abuse.[52] This intergenerational trauma must be appropriately addressed to mitigate the after-effects.[53]

In the face of all these historical and current challenges, First Nations and Inuit have shown remarkable collective resilience and a strong desire to assert their social and cultural identities.

CURRENT FORMS OF DISCRIMINATION IN HEALTH AND SOCIAL SERVICES

Discrimination is a current occurrence in public health and social services.

The death of Joyce Echaquan on September 28, 2020, in an RSSS hospital, in circumstances characterized by racist remarks made about her by staff members, was a reminder of the presence of sometimes discriminatory treatment of First Nations and Inuit in care and services.[54]

Discrimination and prejudice can take many forms. It may be a matter of treating people differently from others, for example by directing acts of violence against them.[9] Some individuals are not always aware that their actions reflect prejudices and that they have preconceived notions based on negative stereotypes. These prejudices can lead to false assumptions. Prejudices about alcohol and substance abuse are the most common.[9]

The Health Council of Canada study (2012) provides some examples of this: not prescribing pain medication due to a belief that patients will develop an addiction, attributing symptoms of diabetic coma to alcohol intoxication, keeping mothers and their newborns in hospital longer without reason to assess mothers' ability to care for their child, and excluding family members from care and service planning on the pretext that they would not understand.[9] Finally, blaming people for their health conditions is another practice to be eliminated, because it represents the same oppressive methods that have led to the need to develop cultural safety.[55] A lack of knowledge of Indigenous cultures and intergenerational trauma is often at the root of prejudice and discriminatory acts against Indigenous people.[9,56]

This is why, according to a cultural safety approach, each stakeholder in the health and social services system must reflect on their beliefs and knowledge regarding Indigenous people. This is a basic first step toward working more effectively and fighting inequality.

Efforts must also be made to re-establish bonds of trust between government institutions and Indigenous people. Public programs and policies have often failed to take into account Indigenous people's cultures and specific needs.[9,10,56,57,58] This lack of consideration has often led to the ineffectiveness of government initiatives meant to improve the living conditions of the most vulnerable populations.

A 2018 RCAAQ study found that cultural barriers—language, fear of being a victim of discrimination due to Indigenous origins, or a mismatch between the services offered and Indigenous values—inhibit access to care and social services. The survey also found that respondents in 10 of the 14 Québec cities surveyed had a negative perception of the health and social services system with respect to its understanding of Indigenous cultural specificities.

The study also showed that apart from adapting health and social services, there is the preliminary challenge of making existing services known. Three-quarters of respondents were not aware of the services available in the public service systems, and the majority felt that the systems in question did not offer the services they needed. Poor understanding of Québec's public service system thus leads to frustration and ultimately mistrust.

Current discrimination in health and social services has major impacts on the healthcare system, such as:

- The underuse of services
- An exacerbation and increase in the number of crisis situations
- Screening delays and, conversely, unjustified early screening and intervention
- Obstacles to care delivery, particularly in cases of chronic, serious, or fatal illnesses.[8]

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING IN FIRST NATIONS AND INUIT

Social determinants of health are social and health conditions that affect the overall health of individuals throughout their lives as well as the health of the community.[i]

First Nations and Inuit concepts of health are holistic and echo in many respects the conceptual underpinnings of the social determinant approach,[15,60] which recognizes that health is influenced by different spheres of individual and community life. This approach is considered essential to acting meaningfully on the factors that promote the health and well-being of these populations.[15,60]

Social determinants of health for Indigenous people can be grouped into three categories,[15,49] each of which can affect the determinants in another category[61]:

- Proximal determinants (e.g., the physical environment, food security, employment, income, education)
- Intermediate determinants (e.g., the health and education system, community capacity, cultural continuity)
- Distal determinants (e.g., colonialism, racism, social exclusion, and self-determination)

As mentioned above, distal determinants such as the experience of colonialism and racism have a profound influence on living conditions and modulate other determinants.[48] The geographic location of many communities, particularly Inuit communities in Nunavik, greatly influences a number of determinants. For example, limited access to air transportation has a significant impact on housing and food costs, which affects the cost of living.

i. Non-exhaustive list of social determinants: gender, sex, and sexual identity, race and experience of racism, ethnicity, Indigenous ancestry, colonization, migration experience, religion, culture, discrimination, social exclusion and social inclusion, education, literacy, health literacy, employment and working conditions, employment and job security, income and income security, early childhood development, disability and impairment, food and food security, affordable and quality housing, natural and built environment, social safety net, social protection, access to health care and services.[59]

Although First Nations and Inuit concepts of health both stem from a holistic perspective, they do have some differences:

- For First Nations, health is a state of balance between the physical, emotional, mental, and spiritual dimensions.[62] This concept is often illustrated by the medicine wheel.
- For Inuit, health is expressed across three dimensions[63]: the first closely linked to physical health, the second tied to a feeling of overall well-being (mental, physical, social), and the third involving relationships between people. A key dimension of the health experience for Inuit is the quality of relationships with others (family, friends, neighbours, etc.), including non-Inuit.

CULTURAL SAFETY IN HEALTH AND SOCIAL SERVICES

WHAT DOES CULTURAL SAFETY LOOK LIKE?

Cultural safety restores and sustains equity for Indigenous people. It recognizes the inequities they experience and strives to bridge those gaps through culturally relevant practices.[64]

Culturally safe care and services:

- Concern every group of actors in the health and social services system, from governments to front-line workers—each group has an important contribution to make
- Require everyone to reflect critically on their beliefs, behaviours and attitudes, and knowledge with respect to Indigenous realities[65]
- Promote egalitarian relations between Indigenous people and members of the health and social services system, whether in the context of an intervention or the organization and governance of care and services
- Consider the cultural dimension in interventions as in the policies that govern them[66]
- Make Indigenous people and their families, loved ones, and communities, as well as their realities and specific needs, central to care and services. This allows Indigenous people themselves to define what culturally safe care and services are[9,56,67,68,69,70,71,72,73,74,75]
- Recognize that the knowledge best suited to support the health and well-being of Indigenous people is rooted in the individual, their family, their friends, and their community.[10] Indigenous people are therefore part of the decision-making process regarding their health and well-being[9]
- Are a response to the needs of Indigenous individuals and communities that is co-constructed by Indigenous people and members of the health and social services system[64] in a way that respects and acknowledges the health and well-being practices of Indigenous people

Person-centred approaches have a number of components that go hand in hand with cultural safety. The partnership between users, their families, and health and social services stakeholders promotes a relationship built on complementarity and the sharing of respective knowledge, as well as the way in which the various partners work together.[76] As such, the principles of cultural security may also resonate with other cultural communities. However, cultural safety practices arose in response to the relationship of domination that resulted from colonization experienced by First Peoples, making it a more Indigenous-specific approach.[77] The issue of power dynamics is central to the concept of cultural safety.[66]

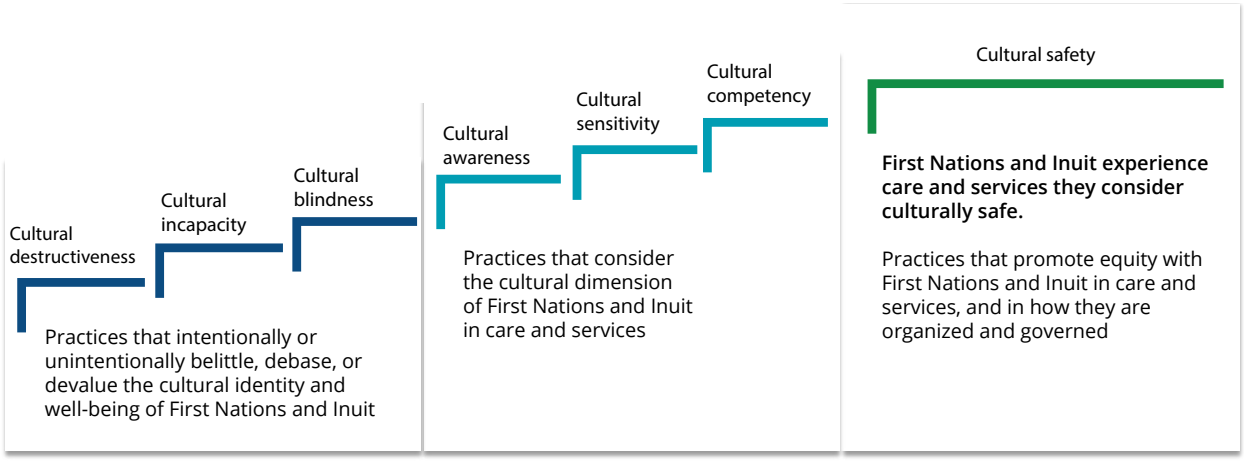
WHERE DOES THE CONCEPT OF CULTURAL SAFETY COME FROM?

"Cultural safety" is an approach to care and services initially developed by Irihapeti Ramsden, a Maori nurse from New Zealand, to address the health inequalities her people experienced.[78] Various factors argue in favour of implementing a cultural safety approach in Québec's health and social services system, including similarities in the impacts and trauma from colonization experienced by Indigenous people in New Zealand and in Québec and the fact that the care and services currently available are out of step with Indigenous realities.[71,79] It is for this reason that other Canadian provinces, including British Columbia[80] and Ontario,[81] are working to develop similar approaches with local Indigenous populations. In New Zealand, the Indigenous presence is primarily Maori. In Québec, it consists of First Nations and Inuit. This diversity creates a cultural context that is complex but extremely rich and important to consider and preserve.

THE STEPS TO CULTURAL SAFETY

Cultural safety is the outcome of a continuum of cultural competency. As members of the health and social services system progress through the continuum, they gain awareness of the power dynamics at play in their relations with First Nations and Inuit. They also become more capable of delivering relevant care and services to support Indigenous health and well-being, i.e., of putting the situations of each First Nations or Inuit person into context. They develop this ability in steps,[i] which are illustrated in figure 1.[ii,iii]

Figure 1. The steps to cultural safety



i. Also called "degrees of awareness."[64]

ii. This graphic is adapted from a variety of references: 64, 66, 75, 82, 83, 84, 85, 86, 87, 88, 89, and 90.

iii. A detailed version of the graphic can be found in Appendix C.

At the beginning of the continuum. These steps are characterized by practices that intentionally or unintentionally belittle, debase, or devalue the cultural identity and well-being of Indigenous people.[68,70,82,83] The roots of colonization and the beliefs that lead to discrimination are found at this end.[64]

In the middle of the continuum. These steps involve learning about Indigenous realities.[i,64] Participants develop greater sensitivity by acquiring knowledge about the realities of First Nations and Inuit, including their histories marked by colonization and trauma, the phenomenon of intergenerational trauma, and their cultures. This enables them to be more culturally competent and to act in more relevant ways.[85,86,87]

At the end of the continuum. Cultural safety is at the end of the continuum. This step, supported by the two previous ones, encourages participants to reflect critically on their own cultural beliefs and knowledge, and become aware of how these beliefs and knowledge influence their relationships with others. This step is characterized by Indigenous people's active, egalitarian involvement in relationships with members of the health and social services system, from governments to front-line workers.[64] Care and services can be regarded as culturally safe when an Indigenous person considers that their experience with the health and social services system, and with its members, has been culturally safe.

i. Some authors refer to a single step called "pre-competence."[64,82]

HOW TO DEVELOP CULTURALLY SAFE CARE AND SERVICES

A MODEL FOR DEVELOPING CULTURALLY SAFE CARE AND SERVICES FOR FIRST NATIONS AND INUIT[i]

The proposed model for developing culturally safe care and services for First Nations and Inuit is illustrated in the figure below.[ii] It is based on British Columbia's experience developing a culturally safe health and social services system.[iii,10] Putting the model into practice is an ongoing, evolving process.

The proposed model has three levels: environment, organization, and care and services. These levels are interconnected and require simultaneous interventions.[10] In other words, practices must be undertaken at all levels, even though they will vary in intensity. The recommended practices at each level are described on the following pages.

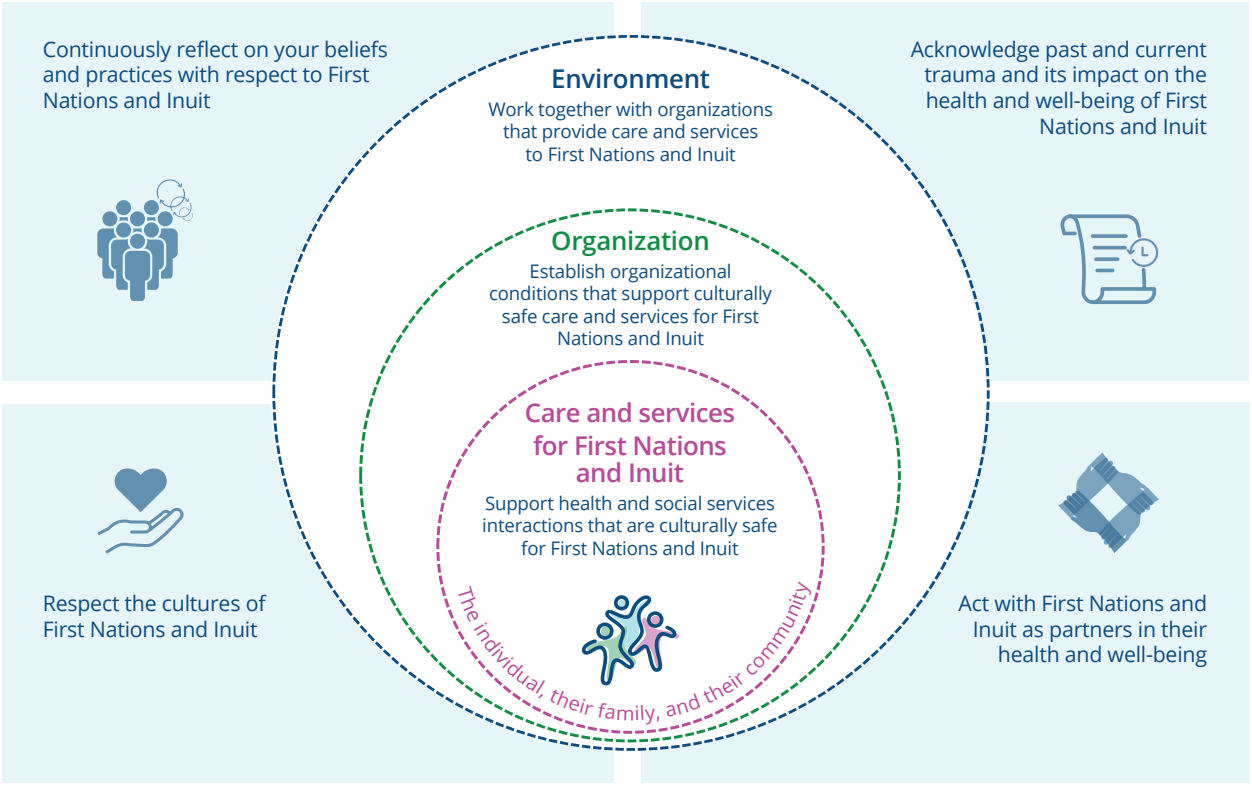
The model also includes four guiding principles: a) continuously reflect on your beliefs and practices with respect to First Nations and Inuit, b) acknowledge past and current trauma and its impact on the health and well-being of First Nations and Inuit, c) respect the cultures of First Nations and Inuit, and d) act with First Nations and Inuit as partners in their health and well-being. These guiding principles are described on the following page.

i. Inspired by Greenwood.[10]

ii. See Appendix D for the detailed version with the recommended practices at each level.

iii. Margo Greenwood is an Indigenous academic of Cree descent. She has many years of experience in child, family, and Indigenous community health and well-being. https://www2.unbc.ca/people/greenwood-dr-margo

Figure 2. A model for developing culturally safe health and social services for First Nations and Inuit[i]



GUIDING PRINCIPLES

The guiding principles are the key ingredients for achieving cultural safety in health care and social services. They inform all practices and apply to all three levels. These guiding principles complement one another and work together toward the goal of culturally safe care and social services.

Continuously reflect on your beliefs and practices with respect to First Nations and Inuit

Culturally safe interactions:

- Become possible when people become aware of their beliefs and knowledge about First Nations and Inuit and the power dynamics in their relations with First Nations and Inuit
- Arise from continuous assessment in order to improve and learn from experiences between First Nations and Inuit and the health and social services system

i. Inspired by Greenwood.[10]

Acknowledge past and current trauma and its impact on the health and well-being of First Nations and Inuit

Culturally safe interactions:

- Recognize and take into account the influence of past and current context on individual health and well-being[68,73,91]; this context includes historical, cultural, social, political, and economic aspects [9,69,71,72,73,79,92]
- Avoid blaming individuals for their health conditions, because the worker understands the complexity of the challenges they face[67,71] and is in a better position to show compassion and evaluate the behaviour in a broader context[14]
- Consider the transmission between generations of historical trauma[14]

Respect the cultures of First Nations and Inuit

Culturally safe interactions:

- Recognize the need to consider cultural differences to support health and well-being, so they take the individual's beliefs and values into account, as well as each community's specific norms for relationships and expression[9]
- Take into account the health determinants specific to First Nations and Inuit
- Encourage a personalized approach to care and services rather than an across-the-board approach used with all people of Indigenous descent by adapting to the context and specific experience of each person

Act with First Nations as partners in their health and well-being[i]

Culturally safe interactions:

- Ensure the individual and their family, friends, and community are actively involved in decisions related to their health and well-being[56,57,91,93,94]
- Seek to jointly carry out decision-making processes that affect the health of communities[64]
- Are based on building a partnership between First Nations and Inuit and the health and social services system

i. The partnership between users, their family and friends, and health and social services actors[76] can support the implementation of this principle.

LEVEL 1: ENVIRONMENT

This level refers to efforts an institution makes to work together with organizations that provide care and services to First Nations and Inuit.

These are primarily First Nations and Inuit organizations such as band councils, regional authorities such as the Nunavik Regional Board of Health and Social Services (NRBHSS), the Cree Board of Health and Social Services of James Bay (CBHSSJB), and the Naskapi CLSC, and community organizations outside the community such as Native Friendship Centres.[i]

In addition to these are all the other organizations in the local service network (RLS) or territorial service network (RTS) for which it the institution is responsible. This level also includes measures taken with government authorities such as MSSS to adapt care and services to local realities.

More specifically, the practices on this level involve members of the facility's senior management (for example, the CEO, deputy CEO, assistant general directors, directors, and assistant directors) as well as members of the board.

WHY IT'S IMPORTANT

- Institutions are responsible[95] for adapting care and services to the local residents they serve, particularly First Nations and Inuit, as part of their responsibility toward the population.[96] Such adaptation is orchestrated with all the RLS and RTS organizations that contribute to the health and well-being of First Nations and Inuit.
- The care and services provided by RSSS institutions are available to any First Nations or Inuit person who has a valid health insurance card, regardless of where they live, just like any resident of Québec.[97]
- Any RSSS facility can be called upon to provide care and services to First Nations and Inuit. Over 70% of Indigenous people living or temporarily staying in urban areas who took part in the 2018 survey by Regroupement des centres d'amitié autochtones du Québec (RCAAQ) have made one or more requests for care or services from a health and social services facility.[98]
- The commitment of the entire management team is essential because the organization of services and the clinical interventions are affected by the surrounding supportive or unsupportive conditions. Therefore, the management team must design policies and procedures that support and encourage cultural safety in the care and services their facility provides.
- Working with First Nations and Inuit organizations is essential to identifying needs and ensuring care and services are organized in a relevant way for the health and well-being of these populations.
- Formal partnership agreements may be important to ensure continuity of care and services for First Nations and Inuit, particularly those living in a community.

i. A variety of cities in Québec have community organizations that welcome Indigenous people. Organizations in Montréal include Projets autochtones du Québec, the Native Women's Shelter of Montreal, Chez Doris, The Open Door, the Southern Quebec Inuit Association, and the Montreal Indigenous Community NETWORK.

- Health and social services legislation is gradually evolving to help reduce the health inequalities faced by First Nations and Inuit, so it is important to understand and align our work with these changes (for example, Jordan's Principle[99] and the Inuit Child First Initiative[100] aim to ensure that all First Nations and Inuit children living in Canada can access the products, services, and support they need, when they need them).

POTENTIAL CHALLENGES

- The division of federal and provincial responsibilities regarding health and social services for First Nations and Inuit is complex.[101,102]
- The administrative and political organization of health and social services is not the same for all First Nations and Inuit communities. In addition, people with a different status may live in the same community (for example, Inuit and Cree live in Chisasibi, and their access to care and services will be based on rules and programs that may differ). Hence the importance of working with the organizations concerned.
- First Nations and Inuit are not covered by the public drug plan and must use a different drug list. Depending on the case, they use a program such as Non-Insured Health Benefits (NIHB)[103] or Insured/Non-Insured Health Benefits (INIHB).[104] Health and social services stakeholders, including physicians, are often unaware of these specifics, which creates significant obstacles to accessing health care and services.
- Identifying First Nations and Inuit contacts can be a challenge for institutions that do not have a community in the territory they serve or an Indigenous organization in an urban setting.

> **"The challenge is to get out of the expertise mindset and start from a position of humility. The service offering belongs to the RSSS, but if you can't go get people, what good does that do? This population [Indigenous people] doesn't come. They are the ones who can say what works. That's equality. Follow their lead and accept that the ultimate decision is theirs."**
>
> Indigenous affairs officer at a facility

BEST PRACTICES – ENVIRONMENT

There are four key practices around the environment that members of the leadership team and managers must take up to develop culturally safe care and services. A non-exhaustive list of proposed courses of action is suggested for these practices.

1. Develop links with First Nations and Inuit organizations[9,57]

- Reflect on your beliefs, knowledge, and attitudes regarding First Nations and Inuit as a member of the leadership team or as a facility manager.
- Reach out to leaders of First Nations and Inuit organizations with humility and a sincere desire to get to know them and work with them.[i]
- Visit care and social services facilities available to First Nations and Inuit in the region to get to know them.
- Communicate the institution's commitment to developing culturally safe care and services for First Nations and Inuit within the RLS/RTS.
- Raise awareness of the role of those responsible for liaising with First Nations and Inuit organizations within the RLS/RTS, such as the institution's Indigenous Affairs Officer, the Indigenous Liaison Officer (if applicable), especially when the person filling the role changes.
- Maintain frequent contact and working ties beyond specific projects.

2. Involve First Nations and Inuit organizations in decisions related to First Nations and Inuit health and well-being[9,57]

- Agree on mechanisms for discussion with First Nations and Inuit organizations.
- Identify opportunities for coordination between First Nations and Inuit organizations and other RLS/RTS organizations (e.g., issue tables on homelessness, seniors, addiction, intersectoral tables[ii]).
- Agree to an action plan to develop culturally safe care and services[9] with First Nations and Inuit organizations in the region.

3. Promote a continuum of care and services for First Nations and Inuit

- Encourage mutual understanding of the care and services offered through the RLS/RTS by the institution and by First Nations and Inuit organizations.
- Document specific needs with First Nations and Inuit organizations in the region.
- Share the information available on the health and well-being with First Nations and Inuit organizations.
- Discuss with First Nations and Inuit organizations what works and what doesn't in how care and services offered by the institution are organized.

i. "Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience."[105]

ii. In some regions these may include local urban Indigenous services accessibility tables cochaired by the local Native Friendship Centre and the regional CISSS or CIUSSS.

4. Formalize agreements to respond to local and regional realities[27]

- Formalize one or more partnerships with concerned First Nations and Inuit organizations as needed, depending on the situation.
- Respect the desire for autonomy among First Nations and Inuit organizations, and the related governance systems.[106]
- Provide information to the relevant government bodies (e.g., MSSS) on local and regional realities.
- Establish links with the region's educational institutions in order to share the importance of training future health and social services workers on cultural safety.
- Influence policy change related to First Nations and Inuit health and social services.

LEVEL 2: ORGANIZATION

This level refers to the organizational practices and conditions within the institution that support culturally safe care and services for First Nations and Inuit. These practices primarily involve the managers and leadership team of the organization.

WHY IT'S IMPORTANT

- Organizational practices serve to help or hinder the development of culturally safe care and services. Often workers will adapt their practices based on the organization's expectations and the tools available to them, such as training.
- A culturally safe environment seeks to co-construct with First Nations and Inuit individuals care and services that support their health and well-being.[9] A number of institutions have various means in place to support a partnership with users, which can provide initial impetus in this regard.
- Cultural safety requires profound changes that go beyond site design considerations, although the inclusion of First Nations and Inuit art and symbols can help First Peoples feel welcome, understood, and respected.[57]

POTENTIAL CHALLENGES

- The availability of human resources raises challenges on several fronts:
  - Freeing up practitioners so they can complete the facility's training module on cultural safety
  - Offering care and services in the person's home language, whether Inuktitut, English, or a First Nations language, such as through an interpreter
  - Maintaining stability and trust in relationships with First Nations and Inuit collaborators (individuals, organizations, etc.)
  - Developing the expertise to respond appropriately to First Nations and Inuit needs in partnership with these populations
  - Hiring First Nations and Inuit staff
- It can be difficult at times for facilities to access health data on First Nations and Inuit communities in their region, yet this information is important for planning what care and services to offer these populations.
- There is a lack of care and service programs specifically designed for First Nations and Inuit.
- The institutional capacity to integrate large-scale changes is known to be limited when such changes happen at the same time.[107] Depending on the context and support available to integrate practices, the facility could face a variety of challenges along its path to achieving culturally safe care and services.

> **"We're going to give a presentation to each department and then [the liaison officer] will help them choose what concrete measures to take to adapt their services. I've got some managers whose departments are called on more to provide services to Indigenous people. [The liaison officer] works closely with them but also supports all the managers so their employees adopt behaviours that make patients feel safe."**
>
> Indigenous affairs officer at a facility

BEST PRACTICES – ORGANIZATION

There are seven key practices around the organization that members of the leadership team and managers must take up to develop culturally safe care and services. A non-exhaustive list of proposed courses of action is suggested for these practices.

1. Commit to developing culturally safe care and services

- Mobilize managers around First Nations and Inuit health and well-being and communicate specific messages to them, for example, attitudes and behaviours of respect and equality in care and services.
- Create a working group or committee to prioritize improvements that will help the institution provide culturally safe care and services with First Nations and Inuit representatives.
- Agree on an institutional action plan involving the clinical and support departments with First Nations and Inuit representatives.
- Raise awareness of key roles within the institution, such as the Indigenous affairs officer, the Indigenous liaison officer, and the service navigator (if applicable).
- Raise employee awareness of the methods available to employees to learn more about cultural safety and the realities of First Nations and Inuit (e.g., training, list of references).

2. Increase representation of First Nations and Inuit within the facility

- Identify First Nations and Inuit representatives on the facility's various committees, including the board of directors and users' committee.[94] It is important to identify these representatives in cooperation with First Nations and Inuit organizations and to be sensitive to the fact that one person may not feel comfortable speaking for their entire community, or for all First Nations or Inuit.
- Represent First Nations and Inuit in the facility's public communications (posters, leaflets, etc.).
- Share information, news, and First Nations and Inuit initiatives that promote a positive and dynamic vision of First Nations and Inuit people and communities.[57]
- Hire First Nations and Inuit staff. [9,57]

3. Train facility staff on cultural safety in health and social services[27,57]

- Identify priority staff categories (e.g., workers, physicians, support staff, etc.).
- Identify people interested in becoming cultural safety resource persons that employees can call upon as needed.
- Offer a variety of training formats for skill development (e.g., online and in-person videos and training, documents, etc.).
- Promote experiential learning where learners can interact with First Nations and Inuit representatives (e.g., invite First Nations and Inuit representatives from the region to team meetings, support mentorship and sponsorship with First Nations and Inuit staff, do day-long internships in an Indigenous organization).
- Create conditions that support continuous uptake of knowledge (e.g., leading case studies with multidisciplinary teams, feedback, etc.).
- Create a network of knowledge brokers experienced in First Nations and Inuit realities that employees can call upon as needed.

4. Make the facility's care and services visible and accessible

- Publicize what care and services the facility offers and how to access them to First Nations and Inuit and the organizations representing them.[27]
- Create a position that guides First Nations and Inuit persons through their care and service experience.[i]
- Bring care and services to the people by offering care and services in locations perceived as culturally safe. This may mean, for example, a nurse or social worker located in a Native Friendship Centre, doctors travelling to a community's facilities.

5. Put in place the resources required for First Nations and Inuit to receive care and services in the language they speak at home

- Offer to translate documents into the person's and/or their family's and/or the community's home language in accordance with needs, contexts, and ministerial policies and guidelines.[109]
- Offer interpreting services with First Nations and Inuit interpreters who speak the person's home language or second language.[ii,110]
- Provide tools such as a glossary for Inuktitut and/or the most common First Nations language(s) in the RLS and RTS (glossaries can be a very useful tool, among other things, for reception staff at the facilities).

i. The concept of "patient navigator" is one example of support for First Nations and Inuit who receive care and services from an RSSS institution. This position would be tailored to the needs of the First Nations and Inuit population in the region (for example, acting as an interpreter, accompanying them to appointments, liaising with family and/or the community health centre when the person returns home, as applicable). This position is known to have a high success rate and to create opportunities to hire First Nations and Inuit staff.[108]

ii. See "Interpretating services" in Appendix E for references for further reading.

6. Adjust the facility's internal policies, rules, and procedures

- Adapt the physical premises taking into account First Nations and Inuit cultural aspects, and make sure they are big enough to accommodate large and extended families.
- Allow access to equipment to prepare traditional food in the facilities, wherever possible (for example, where there is access to a kitchenette for the public).
- Create procedures to facilitate the complaint process for First Nations and Inuit, including providing a response to those who use the process.
- Revise the facility's core documents, such as the code of ethics.

7. Assess cultural safety as an integral part of the quality and safety of care and services

- Monitor the action plan and priorities put in place as well as their outcomes.
- Establish times for taking stock and making improvements.
- Develop care and service quality indicators specific to cultural safety.
- Share indicator results with First Nations and Inuit organizations as a basis for discussing what improvements to pursue.
- Pay attention to evaluation methods to capture First Nations and Inuit satisfaction with care and services to ensure they are consistent with the principles of cultural safety.
- Involve First Nations and Inuit in the process of evaluating health and social services programs.
- Integrate dimensions of cultural safety into staff performance evaluations and hiring.

> **"The word dialogue is very important. You need time to hear what is said, build trust, and speak with transparency, humility, and openness about the limitations and constraints."**
>
> Indigenous affairs officer

LEVEL 3: CARE AND SOCIAL SERVICES

This level is where First Nations and Inuit interact with members of RSSS health and social services institutions. It is where First Nations and Inuit experience cultural safety most directly.[10] The steps in the cultural safety continuum matter a lot at this level, and whether members of the RSSS have become aware of their own attitudes, beliefs, and knowledge regarding First Nations and Inuit.

Practices at this level concern all members who interact with First Nations and Inuit, from leadership to front-line employees, including physicians, workers, and support staff.

WHY IT'S IMPORTANT

- After five years of political and organizational efforts, British Columbia's tripartite agreement concluded that racism tied to Indigenous origin within the health and social services system was the primary obstacle to the development of culturally safe care and services.[111]
- Misunderstanding of First Nations and Inuit is often the source of prejudice and discrimination and, as a result, culturally unsafe experiences.[8]
- Trust is built throughout the care and service experience. The attitudes and behaviours of the health and social services workers involved in this experience have a big impact on whether this trust is strengthened or diminished.
- A manager's ability to model expected behaviours and attitudes is often key to creating organizational change.[112]

POTENTIAL CHALLENGES

- Developing this new approach may make it seem like members of the health and social services system need to "know everything" about First Nations and Inuit. But that is not the case. Cultural safety asks us to become aware of our own cultural beliefs and knowledge regarding First Peoples, then to show humility as learners when it comes to understanding their experiences.[113]
- When someone takes the first steps toward cultural safety, they may develop a «folklorizing» reflex (for example, believing that a First Nations or Inuit person automatically wants to use traditional Indigenous medicines). This can lead to new experiences of discrimination. Everyone has their own cultural beliefs and knowledge. Listening and being open are good points of reference for identifying a person's needs.
- Progressing along the cultural safety continuum requires an openness and willingness to do the work that each member is individually responsible for.
- Such self-awareness requires support as well as time to reflect, time that is sometimes hard to find in one's work schedule or give to employees.

- New practices may conflict with existing organizational practices such as performance indicators and acceptance criteria, which may discourage certain initiatives. Instead, organizational practices must also be refreshed in keeping with cultural safety.
- Use of a second language and/or an interpreter can create distance in the relationship, make it more difficult to interact, or present challenges to completing certain tasks such as obtaining informed consent.
- Use of a third person as an interpreter may lead to breaches of confidentiality, particularly in communities with small populations (for example, when the interpreter and the individual reside in the same community).

> **"It's the best way to ensure people feel they will be treated like any other human being. You have to consider their journey in life, their history, and the impact on them and their descendants."**

> **"It means trying to serve with respect and empathy, while providing information and training to reduce negative discrimination and marginalization of Indigenous peoples."**

Indigenous affairs officers at two facilities

BEST PRACTICES – CARE AND SOCIAL SERVICES

There are four key practices around care and social services that members of the leadership team and managers must take up to develop culturally safe care and services. A non-exhaustive list of proposed courses of action is suggested for these practices.

1. Recognize the legitimacy of First Nations and Inuit cultural identities[114]

- Reflect on your personal beliefs.[9,57,72,75,94] For example: How do I perceive First Nations and Inuit? Where did I get this information? What are the potential biases in these sources of information?[56]
- Show humility and recognize the limits of your knowledge and understanding of First Nations and Inuit.[94]
- Know how to recognize discriminatory situations and intervene to correct them,[56] first by letting the person know they will not be tolerated and by using the methods put in place.
- Remember that the knowledge, experiences, practices, and beliefs of First Nations and Inuit are No. better or worse than others; they are simply different. Remember that difference is in the eye of the beholder.

2. Promote respectful dialogue[57]

- Allow plenty of time.
- Listen to the person.
- Welcome silences.[i]
- Be patient.
- Communicate using clear language.
- Make sure the person understands (for example, ask them to share their understanding).
- Take the time to explain situations or requests depending on the context.

3. Advocate for a personalized approach

- Be aware that First Nations and Inuit may distrust institutional services; work to build trust in your interactions.
- Explain why knowing certain information is important before asking for it.
- Allow the person to share their perspective.[94]
- Check with the person, their friends and family, and/or representatives of the community whether there are specific ways of being and doing things.
- Consider individual and family history, and more broadly the history of the community.
- Ask the person's permission to have their friends and family speak for them if needed, depending on the context.
- Take a holistic approach to interventions that includes the person's views of their own health and well-being.
- Respect beliefs around the traditional healing approaches of First Nations and Inuit,[27] and try to make connections between them and Western approaches to care and services.
- Include the extended family and the community according to the person's wishes, for example by calling on elders.[27,57]
- Choose locations where the person says they feel comfortable and safe, and organize them based on the needs expressed (for example, avoid having a desk between the worker and the person).

4. Constantly improve care and services

- Take a step back for perspective on interactions and interventions.
- Allow time for teams to reflect and share their experiences.
- Check in with different groups of stakeholders, including First Nations and Inuit.

i. Silences can be a time of reflection and can be associated with feeling comfortable with the person and the sincerity of the relationship. In addition, a person may sometimes wait to be asked to speak or give their opinion because this is often seen as a sign of respect and humility in Indigenous cultures.[115]

ILLUSTRATION OF A FACILITY'S FIRST YEAR OF WORKING TO DEVELOP CULTURALLY SAFE CARE AND SERVICES

Here is a fictitious example of a facility's first year of developing culturally safe care and services for First Nations and Inuit. It is inspired by numerous experiences recorded within the RSSS.i It is not an ideal, or a set of prescriptions. It is meant to inspire the leadership team and managers in their first steps towards culturally safe care and services.

The guide "Towards Culturally Safe Care and Services" provides a framework and a starting point for a new institutional approach.

In recent years a variety of incidents and even accidents have occurred in the care and services provided to First Nations and Inuit, including medical interventions conducted without the family's consent and procedures after death that were not consistent with the family's spiritual beliefs. The mistakes were acknowledged and reparations were made as best we could. The leadership team realizes that a more comprehensive step must be taken in the care and services provided to this population.

The leadership team and managers commit to contributing meaningfully to the health and well-being of First Nations and Inuit.

The leadership team meets with all the managers and explains the context leading up to the facility's commitment to reconsider its methods for providing care and services to First Nations and Inuit, to make real contributions to their health and well-being. They recognize that their understanding of the realities of First Peoples is limited, and that some of the organization's procedures and practices are not always helpful; they may even have a negative effect on health and well-being. They highlight initiatives by several managers and practitioners that others can use as inspiration, and underscore the need to create conditions that support existing and future initiatives.

They remind everyone about the role of the Indigenous affairs officer, while also sending a clear message that the changes required involve all departments, and that actions must be taken collectively along with First Nations and Inuit organizations in the region. Every person can make a difference in building trust with First Nations and Inuit who use the facility's care and services.

i. These experiences were captured through data collected in semi-structured interviews with 22 individuals from 22 RSSS institutions between November 2018 and January 2019. The institutions were spread across 12 regions of Québec.

> **"It takes one connection or one interaction to change everything, for good or for bad. For example, someone called me for an appointment. It wasn't part of my job. The person saw 'Indigenous' and called me. I helped them. It took time. I could have said they had the wrong number. But now that person will go off and say that someone helped them and they will come back."**
>
> Indigenous affairs officer at a facility

Soon the organization realizes it needs to better understand the realities of First Nations and Inuit.

A training session is organized with First Nations and Inuit organizations. Representatives speak to the facility's managers and talk about their reality. They explain the impacts of colonization on their peoples, the intergenerational trauma of residential schools, their current health needs, their experiences with discrimination, the frequent distrust of institutional settings such as health and social service facilities, and more. This conversation is the first time many managers have had the opportunity to get closer to the First Nations and Inuit experience.

> **"I took the training course with [cultural safety expert] and realized that I would never look at Indigenous realities the same way again.... I put myself in the shoes of an Indigenous person and now I understand how difficult it must be to trust the white community. We have to show humility."**
>
> Indigenous affairs officer at a facility

An interdepartmental action plan is developed where First Nations and Inuit are represented in the work being done.

At the same time, managers identify actions they can undertake with their teams. The commitment of the leadership team and the training on the realities of First Nations and Inuit spur the managers into action.

- They communicate the facility's commitment and the work underway.
- They remind everyone that First Nations and Inuit have the right to receive care and services from the facility regardless of where they live.
- They work with their teams to identify needs and what actions to take in the near and medium term.

The "baby steps" approach proves motivating. Alongside the training being offered across the facility, managers find other ways to support practitioners' learning, leading case studies for their teams and sharing knowledge between peers and with stakeholders from First Nations and Inuit organizations. First Peoples individuals and families are also involved in different ways to help others understand their realities.

Support departments also play a role. They develop indicators to incorporate the principles of cultural safety into performance metrics, add respect for First Nations and Inuit to hiring criteria, and review translations of documents for the population, for example.

> **"In order to provide care that meets their needs, you have to understand their culture. This has become a priority for us. We invite elders to team meetings to talk about their experience. […] The Friendship Centre gave us a glossary [in the community's language] for the people at the front desk. […] We have an Indigenous room in our office […] It's a welcoming space that belongs to Indigenous people. […] We added an interpreter at the hospital who speaks [the community's language]."**
>
> Indigenous affairs officer at a facility

After a year, a report on the initial developments shows that people have learned a great deal and a number of actions have been taken for the next steps.

Must-haves for cultural safety are now in place:

- First Nations and Inuit are better represented in the organization, on various internal and regional committees.
- Anyone who cannot speak French has access to interpreting services and public-facing documents are translated.
- Connections made with First Nations and Inuit organizations have made it possible to create a picture of the regional services available.
- First Nations and Inuit perceptions of their experiences with care and social services at the facility are considered in various relevant ways, with the collaboration of First Nations and Inuit organizations.

Innovative, relevant solutions based on the realities of different groups are identified to further the work the next year. The plan includes embedding service navigators to help the population access care and services and guide them through the experience.

> **"It's no longer just one person [the Indigenous liaison officer]—it's a real interdepartmental effort. If someone has difficulties, we're there to support them; [the leadership team] will travel there."**
>
> Indigenous affairs officer at a facility

> **"We've been working with them a long time. We weren't at the point of being able to say our services were culturally appropriate, but we were careful to build relationships, listen to their needs, and explain what our network is all about. […] What's important is knowing what they need, because they've developed all kinds of things. […] They know a lot about us, but we don't know much about them."**
>
> Indigenous liaison officer at a facility

CONCLUSION

This publication reflects the strong commitment of the Ministère de la Santé et des Services sociaux (MSSS) and the network institutions to restoring equity in the health and well-being of First Nations and Inuit. A collective movement is underway in Québec, and it comprises a number of initiatives and key approaches. MSSS wishes to play an active role in this movement.

Whether in the context of an intervention or the organization and governance of institutions, we all have a role to play in developing cultural safety. By creating and maintaining lasting ties of trust with Indigenous partners and improving our knowledge of the needs and realities of First Nations and Inuit, we can collectively contribute to improving their health and well-being through the development of relevant practices.

The release of this document paves the way for the implementation, starting now and going forward, of a cultural safety approach in the health and social services system in collaboration with First Nations and Inuit partners. It also marks MSSS's commitment to supporting institutions in making improvements to the quality, accessibility, and continuity of care and services for First Nations and Inuit—improvements that MSSS will be monitoring.

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APPENDICES

A – MAP OF FIRST NATIONS COMMUNITIES AND INUIT VILLAGES AND NATIVE FRIENDSHIP CENTRES IN QUÉBEC

The Indigenous presence in urban areas is rich and diverse, especially in Montréal, where many community organizations work with First Nations and Inuit.[i] Native Friendship Centres are identified on this map for information purposes and as an initial point of reference. We encourage you to go further and identify the Indigenous organizations in your region that can work with you.

www.autochtones.gouv.qc.ca

Original in French. Free translation.

i. A non-exhaustive list of organizations in Montréal includes Projets autochtones du Québec, the Native Women's Shelter of Montreal, Chez Doris, The Open Door, the Southern Quebec Inuit Association, and the Montreal Indigenous Community NETWORK.

B – CO-CONSTRUCTION APPROACH

In summer 2018, MSSS tasked the IUPLSSS Québec knowledge transfer projects team at CIUSSS de l'Estrie – CHUS with helping develop cultural safety in health and social services in the RSSS.

Managers and front-line workers involved in organizing and providing care and services for First Nations and Inuit were invited to form an advisory committee to consult on this work. Participants included primarily representatives of RSSS institutions, First Nations and Inuit organizations, and institutes with expertise in health and social services.

MSSS suggested that the first task of stakeholders be to co-construct a guide to support RSSS managers in developing culturally safe care and services for First Nations and Inuit. A steering committee was also created with Indigenous organizations to guide the approach and the deliverable according to Indigenous realities, and to facilitate connections with Indigenous communities.

The committees developed working principles to support this work, with the understanding that they would evolve over time according to the lessons learned:

- Promote respectful dialogue.
- Consider the experience of First Nations and Inuit as central to making RSSS-provided care and services safe.
- Recognize individual, organizational, and political responsibility in the development of culturally safer care and services.
- Promote knowledge derived from experience and research (without establishing a knowledge hierarchy) by translating it into evocative practices that guide stakeholders' actions.
- Foster partnership and cooperation throughout the process by involving as many stakeholders as possible, both from the RSSS and Indigenous organizations.
- Promote adaptation to specific realities, both for RSSS institutions and Indigenous organizations.
- Build on strengths and promote stakeholder autonomy.

MERGING KNOWLEDGE

Knowledge was merged in co-constructing this document in order to ensure it corresponded as closely as possible to the realities of the managers of RSSS institutions and respected the realities of First Nations and Inuit. This merging brought together scientific and grey literature and experiential and contextual knowledge.

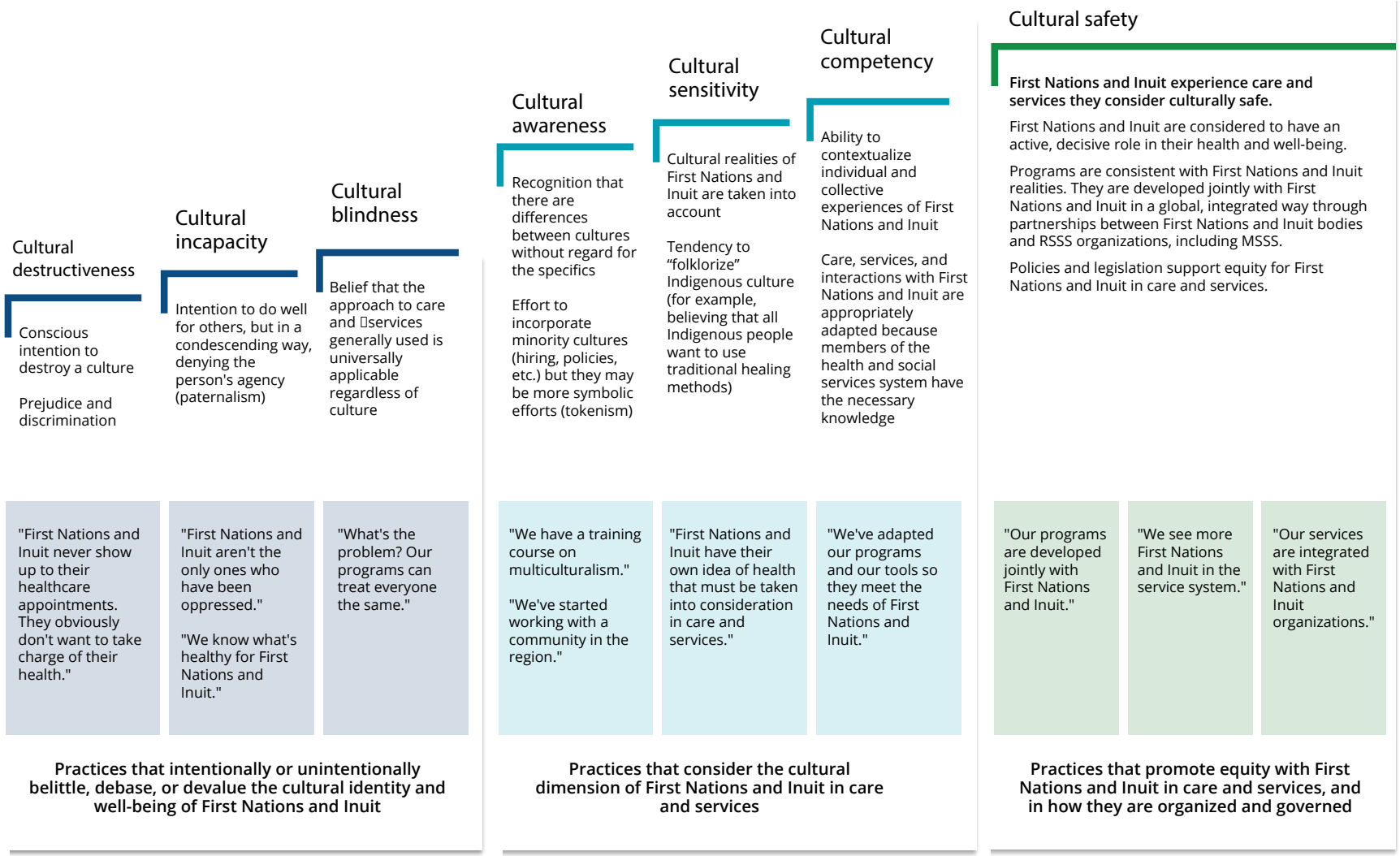
Knowledge from scientific and grey literature

A non-exhaustive literature search was conducted using the Autochtonia and iPortal Indigenous Studies Portal Research Tool databases and the Université de Sherbrooke library "discovery tool." The literature search was limited to the years 1990 to 2018, and the keywords used were "cultural safety" and "sécurisation culturelle." All stakeholders were also solicited to share scientific literature. INSPQ shared some of its internal research and some articles. INESSS shared the bibliographic list of an internal post on cultural safety, and FNQLHSSC shared articles specifically produced by First Nations authors like the one from Greenwood (2019).

Experiential knowledge

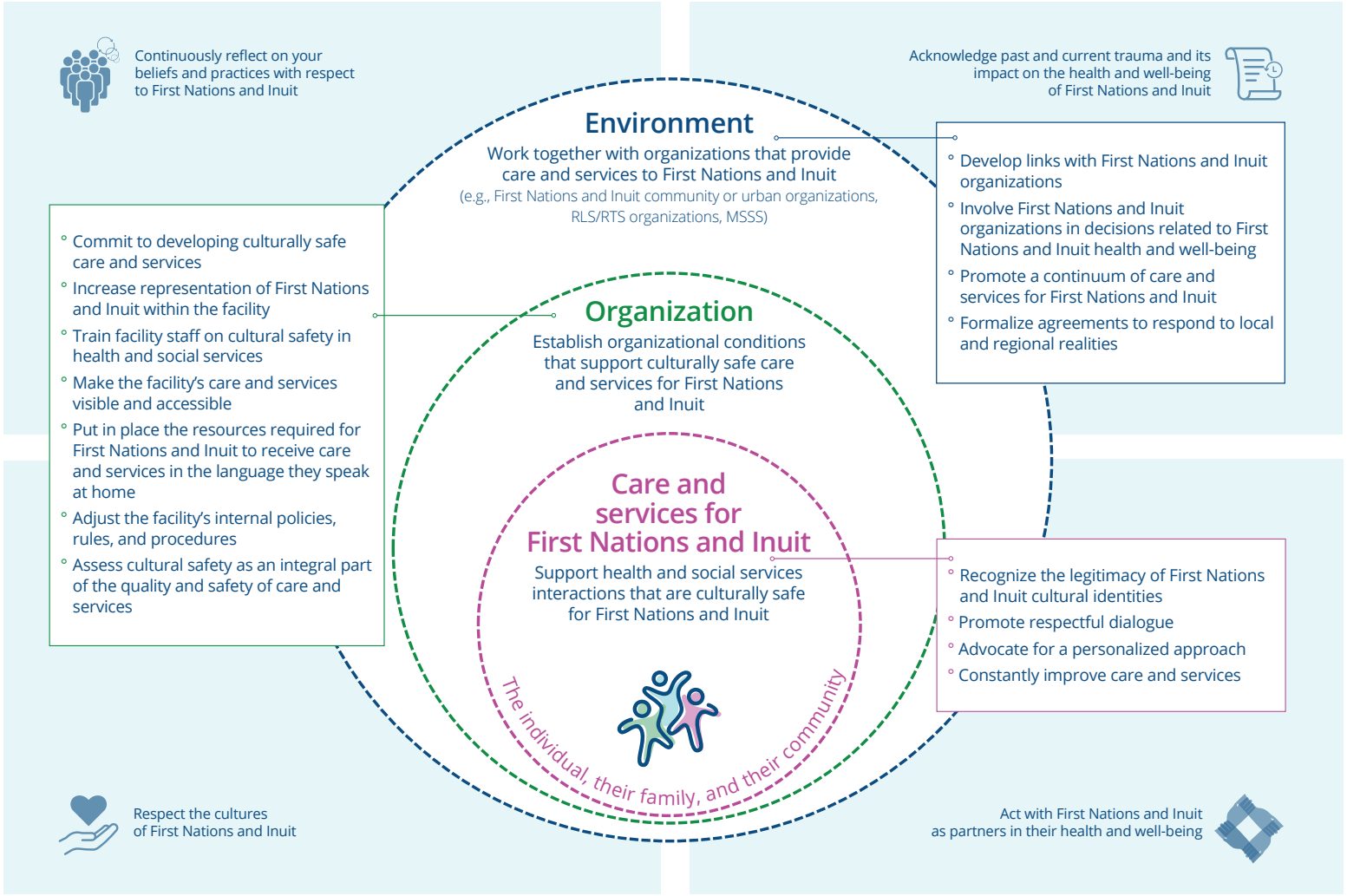
Knowledge derived from the experience of stakeholders involved in the co-construction of this document greatly enriched the drafting process. The steering committee created with Indigenous organizations met four times and the advisory committee met twelve times between 2018 and 2021. In the course of committee work, members had the opportunity to share their perspectives on cultural safety with one another through presentations and conversations. Finally, data was collected through semi-structured interviews with 22 individuals from 22 RSSS institutions between November 2018 and January 2019. The institutions were spread across 12 regions of Québec. The results captured the various realities across the province with respect to cultural safety in health and social services.

C – DETAILED STEPS IN THE CULTURAL SAFETY CONTINUUM[i]



i. This graphic is adapted from a variety of references: 64, 66, 75, 82, 83, 84, 85, 86, 87, 88, 89, and 90.

D – PROPOSED MODEL FOR DEVELOPING CULTURALLY SAFE HEALTH AND SOCIAL SERVICES FOR FIRST NATIONS AND INUITI – DETAILED VERSION WITH BEST PRACTICES FOR EACH LEVEL



i. Inspired by Greenwood.[10]

E – FURTHER READING

Resources to better understand First Nations and Inuit in Québec (in French)

- Information resources: https://www.autochtones.gouv.qc.ca/session-info/s_informer.htm
- Training resources: https://www.autochtones.gouv.qc.ca/session-info/se_former.htm

Investigations on the treatment of Indigenous people in public services in Québec (in French)

- Commission d'enquête sur les relations entre les Autochtones et certains services publics au Québec. Chapitre 10 – Constats relatifs aux services de santé et de services sociaux: https://www.cerp.gouv.qc.ca/fileadmin/Fichiers_clients/Rapport/Rapport_final.pdf
- Les autochtones en milieu urbain et l'accès aux services publics. Portrait de la situation au Québec: https://www.rcaaq.info/wp-content/uploads/2019/08/RCAAQ_Portrait_Provincial_FR.pdf

Social determinants of health for Indigenous people

- Health Inequalities and Social Determinants of Aboriginal Peoples' Health: https://www.ccnsa-nccah.ca/docs/determinants/RPT-HealthInequalities-Reading-Wien-EN.pdf
- Public Health for First Nations in Quebec. Shared Responsibility: https://files.cssspnql.com/index.php/s/Cfw7hRGpcod2LWI
- Social determinants of health and the future well-being of Aboriginal children in Canada: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3448539/#b2-pch17381

Intergenerational trauma

- Trauma Toolkit: http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf

Distribution of responsibilities for Indigenous health and social services between the federal and provincial government (MSSS)

- Particularités des services aux Premières Nations et aux Inuit (in French): https://www.msss.gouv.qc.ca/professionnels/soins-et-services/particularites-des-services-aux-communautes-autochtones/
- Delivery and Funding of Health Services and Social Services for Aboriginal People (First Nations and Inuit): https://publications.msss.gouv.qc.ca/msss/fichiers/2007/07-725-02A.pdf

Interpreting services (in French)

- Banque interrégionale d'interprètes: https://santemontreal.qc.ca/professionnels/services-et-outils/banque-interregionale-dinterpretes/
- Orientations ministérielles concernant la pratique de l'interprétariat: https://publications.msss.gouv.qc.ca/msss/fichiers/2018/18-406-03W.pdf
- Politique du ministère de la Santé et des Services sociaux relative à l'emploi et à la qualité de la langue française: https://publications.msss.gouv.qc.ca/msss/fichiers/2016/16-121-03W.pdf

Non-insured health benefits

- Health Canada – About the Non-Insured Health Benefits program: https://www.sac-isc.gc.ca/eng/1576790320164/1576790364553

- FNQLHSSC – Non-Insured Health Benefits: https://www.cssspnql.com/en/areas-of-intervention/health/access-to-services/non-insured-health-benefits
- AN INFORMATION BOOKLET FOR SOUTHERN QUEBEC INUIT: https://qanuikkatsiqinirmiut.ca/wp-content/uploads/2019/06/HEALTH-BOOKLET.pdf

Québec

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