Evidence Brief: Wise Practices for Indigenous-specific Cultural Safety Training

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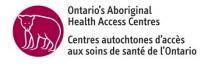
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Background

As a result of the intersections between colonialism, racism, sexism, and their legacies, striking Indigenous/non-Indigenous health inequities persist across Canada (Adelson, 2005; Allen & Smylie, 2015; Bourassa, McKay-McNabb, & Hampton, 2004; Browne, Smye, & Varcoe, 2005). The health disparities that stem from these inequities not only cut across almost every major health outcome, health determinant, and measure of access, but have also been exacerbated by institutions such as the Canadian healthcare system (Loppie Reading & Wein, 2009; Smylie, Fell, Ohlsson, & Joint Working Group on First Nations, Inuit, and Métis Infant Mortality of the Canadian Perinatal Surveillance System [JWG], 2010; Smylie et al., 2011; Firestone, Smylie, Maracle, Spiller, & O'Campo, 2014).

Recently, the impact of the healthcare system on Indigenous health and well-being has moved to the forefront of discussions on health equity following the inquest into the death of Brian Sinclair (The Provincial Court of Manitoba, 2014), the publication of the *First Peoples, Second Class* Treatment report (Allen & Smylie, 2015), and the release of the *Truth and Reconciliation Commission of Canada's (TRC)* calls to action (2015). Emerging from these reports is the urgent need to bridge the gap between Indigenous patients and non-Indigenous healthcare providers (HCPs) and other healthcare workers. The gap between Indigenous patients and non-Indigenous healthcare workers has been well documented in the literature; many First Nations, Inuit, and Métis peoples have reported being ignored, belittled, mocked, disrespected, and discriminated against by a HCP in the mainstream Canadian healthcare system (Browne, Fiske, & Thomas, 2000; Benoit, Carroll, & Chaudhry, 2003; Kurtz, Nyberg, Van Den Tillaart, Mills, & The Okanagan Urban Aboriginal Health Research Collective, 2008; Møller, 2010; Wesche, 2013; Denison, Varcoe, & Browne, 2014). The problem with these attitudes and behaviours – which may be unconscious, reflecting entrenched and unchallenged assumptions about Indigenous peoples based on colonial narratives (Burgess, van Ryn, Dovidio, & Saha, 2007) – is that they are causing harms that can include the delay and/or denial of treatment resulting in sub-standard care, negligence, worsened health conditions, and even death (Allen & Smylie, 2015).

One strategy that has been widely used in the U.S., Australia, New Zealand, and most recently, in Canada, is the implementation of *cultural competency* or *cultural safety* training for healthcare and other service providers. Even though there is a tendency to use the terms interchangeably, *cultural competency and cultural safety* are distinct.

The Health Council of Canada (2012) defines **cultural competency** as being:

> *"…about creating a health care environment that is free of racism and stereotypes, where Aboriginal people are treated with empathy, dignity, and respect. Culturally competent health care providers are more likely to recognize the effects of history on Aboriginal people and to adapt the way care is provided to more effectively meet their patients' distinct needs."* (p.5)

Cultural safety, on the other hand, is a concept that was developed by Maori nurse Irihapeti Ramsden in *Aotearoa*/New Zealand as a response to the mainstream healthcare system's failure to meet the needs of the Maori community (Ramsden, 2002). Cultural safety is both a direct departure from and an extension of cultural competency (Brascoupé & Waters, 2009), being positioned at one end of a continuum that begins with cultural awareness, moves through cultural sensitivity and cultural competency, and ends with cultural safety as a step-wise progression (Ramsden, 2002; Koptie, 2009). The differences between each of these concepts are presented in Table 1 below.

Table 1. Differences between cultural safety and related concepts (from Ward, Branch, & Fridkin, 2016, p.30)

Cultural Awareness	An attitude that includes awareness about differences between cultures
Cultural Sensitivity	An attitude that recognizes the differences between cultures and that these differences are important to acknowledge in health care
Cultural Competency	An approach that focuses on practitioners' attaining skills, knowledge, and attitudes to work in more effective and respectful ways with Indigenous patients and people of different cultures
Cultural Humility	An approach to health care based on humble acknowledgement of oneself as a learner when it comes to understanding a person's experience. A life-long process of learning and being self-reflective
Cultural Safety	An approach that considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences. Practitioners are self-reflective/self-aware with regards to their position of power and the impact of this role in relation to patients. "Safety" is defined by those who receive the service, not those who provide it.

The defining feature of cultural safety is that is that it "turns the focus… away from the cultural understanding and knowledge of the health care worker and onto the power inherent in their professional position" (Brascoupé & Waters, 2009, p. 11). Cultural safety can also only be measured or defined by those who receive care (i.e. clients or patients). The Health Council of Canada (2012) defines cultural safety as:

> *".. an outcome, defined and experienced by those who receive the service—they feel safe; … based on respectful engagement that can help patients find paths to well-being; … based on understanding the power differentials inherent in health service delivery, the institutional discrimination, and the need to fix these inequities through education and system change; and requires acknowledgement that we are all bearers of culture—there is self-reflection about one's own attitudes, beliefs, assumptions, and values."* (p.5)

Proponents of cultural safety argue that the concept, given its focus on inequities, power structures, and forces like racism and colonialism, are particularly valuable to education programs. Programs that are oriented towards *cultural awareness*, *cultural sensitivity*, and even *cultural competency* have been critiqued because they tend to reduce culture to food, dress, and ceremonies, and in doing so, unintentionally increase stereotyping by conflating *race* with *culture* and by rendering structural and systemic forces invisible (Brascoupé & Waters, 2009; Diffey & Lavallee, 2014; Ramsden, 2002;

Downing & Kowal, 2011). However, cultural competenc*ies* are relevant to healthcare providers; the hope is that through cultural safety training, healthcare providers can develop the cultural competencies that are necessary to deliver culturally safe care (Jacklin et al., 2017). Here, it is important to note that cultural competencies are not a simple checklist; rather, they span multiple dimensions. At the client/patient level, cultural safety is about Indigenous clients/patients feeling comfortable, respected, and able to be themselves in a care setting (Churchill, 2015). At the healthcare provider level, cultural safety involves providers delivering high-quality health services that are responsive to needs of Indigenous clients/patients. At the systems level, cultural safety involves a commitment to delivering high-quality, equitable care to Indigenous communities and effectively responding to attitudinal and institutional racism affecting care settings (Browne et al., 2016; Wyatt et al., 2016).

Current Landscape

In recent years, the number of Indigenous cultural safety (ICS) training programs and the number of organizations committed to mandating ICS training have significantly increased across the country. In the Ontario context, for example, there are now more than 15 different ICS training programs (D. Smylie, personal communication, April 30 2017), and major employers such as the Government of Ontario have committed to mandating ICS training for all of their employees (Government of Ontario, 2015).

The Ontario Indigenous Cultural Safety Program, which is administered by the Southwest Ontario Aboriginal Health Access Centre (Ontario ICS Program), is one of the largest programs in the province. Over 8,000 Ontarians who work in health care have completed the training, which includes modules that were specifically developed for Ontario and are offered in partnership with the San'yas Indigenous Cultural Safety Training Program (see box 1).

Box 1. San'yas Indigenous Cultural Safety Training Program: A case study.
The San'yas Indigenous Cultural Safety Training Program is a leading approach in Indigenous-specific cultural safety training in Canada because of its theoretical grounding in anti-racist and transformative learning pedagogy, effective model of online cross-racial facilitation, and multi-faceted support for Indigenous staff and participants (Ward et al., 2016). It was developed by Indigenous women leaders through the Provincial Health Services Authority of British Columbia. San'yas has worked in collaboration with Indigenous stakeholders in both Manitoba and Ontario to design training that is responsive to the unique contexts and histories of Indigenous people in each of these provinces. Approximately 40,000 people across Canada have now been trained using the San'yas platform and approach to ICS training. Modules have been co-developed with San'yas for a variety of service sectors, including child welfare and justice. In Ontario, more than 8000 people working in healthcare have taken this core training.

The renewed interest in ICS training in Ontario may have been motivated by a number of factors, including the release of the Truth and Reconciliation Commission of Canada's Final Report and Calls to Action in December 2015 – a highly influential policy initiative that called for cultural competency training and the development of anti-racism skills across sectors (see Table 2) - and the success of existing cultural safety initiative such as the San'yas Indigenous Cultural Safety Training Program in British Columbia (2016). However, both of these initiatives are only the most recent responses to a long history of policy initiatives geared towards improving healthcare for Indigenous peoples in Canada, including but not limited to the Report of the Royal Commission on Aboriginal Peoples (2000), the Kelowna Accord (2005), the Blueprint on Aboriginal Health: A 10-Year Transformative Plan (2005), and the Ontario Aboriginal Health and Wellness Strategy (developed in 1994).

Table 2. Calls to Action from the Truth and Reconciliation Commission of Canada's Final Report that relate to cultural competency training (2015)

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TRC Calls to Action	
Health	
23.	We call upon all levels of government to: iii. Provide cultural competency training for all health-care professionals.
24.	We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism
Justice	
27.	We call upon the Federation of Law Societies of Canada to ensure that lawyers receive appropriate cultural competency training, which includes the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal–Crown relations. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.
Professional Development and Training for Public Servants	
57.	We call upon federal, provincial, territorial, and municipal governments to provide education to public servants on the history of Aboriginal peoples, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal–Crown relations. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.
Business and Reconciliation	
92.	We call upon the corporate sector in Canada to adopt the United Nations Declaration on the Rights of Indigenous Peoples as a reconciliation framework and to apply its principles, norms, and standards to corporate policy and core operational activities involving Indigenous peoples and their lands and resources. This would include, but not be limited to, the following: iii. Provide education for management and staff on the history of Aboriginal peoples, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal–Crown relations. This will require skills based training in intercultural competency, conflict resolution, human rights, and anti-racism.

While this heightened interest and investment in Indigenous cultural safety training is promising, the development and implementation of training must be done carefully to ensure that they do not cause more harm to Indigenous peoples and communities, and effectively address the root causes of health disparities, including structural racism and discrimination (Downing & Kowal, 2011; Lalich, 2016).

Purpose

The purpose of this Evidence Brief is to present the *lessons learned* from both the peer-reviewed and grey literature with regards to designing and implementing Indigenous cultural safety training for healthcare professionals (HCPs) in Ontario. We hope that this Evidence Brief will assist policy-makers and program leaders who are responsible for coordinating or implementing Indigenous cultural safety training to develop programs that effectively address the root causes of Indigenous/non-Indigenous inequities and the resulting harms to Indigenous peoples' health and well-being.

Methods

This Evidence Brief builds on a document that was originally produced for the Toronto Central Local Health Integration Network (TC LHIN). The articles included in this Evidence Brief (see Table 3) were purposively selected from a list of resources identified from a scoping review conducted by Michèle Parent-Bergeron (Ontario Indigenous Cultural Safety Program, Southwest Ontario Aboriginal Health Access Centre). This scoping review was conducted to map the key research areas and gaps in the literature on cultural competency and/or cultural safety training for Indigenous peoples. The inclusion criteria for the scoping review were articles published in the past 5 years in academic peer-reviewed journals. Consulted databases included: Medline, CINAHL, Proquest, and PubMed. Key words included: Australia, Canada, United States, New Zealand, racism, discrimination, prejudice, coping responses, Aboriginal, Indigenous, Whiteness, intervention, Indigenous cultural training, cultural competence, and equity; perceived racism, racism, racism instruments, perceived discrimination, implicit, implicit association test, and explicit racism.

Because this Evidence Brief was originally conducted to identify *best practices* in cultural competency and/or cultural safety training, we selected papers from our established resource list that were: systematic reviews, environmental scans, meta-analyses, or additional scoping reviews. This process generated **seven review articles** (see Table 3).

Due to the limited number and quality of existing reviews, we consulted our colleagues for guidance: Alycia Fridkin (PhD-prepared and Policy and Research Analyst, BC Provincial Health Services Authority, and San'yas Indigenous Cultural Safety Training Program) and Cheryl Ward (Director, Indigenous Health, BC Provincial Health Service Authority; Director, San'yas Indigenous Cultural Safety Training Program). We also cross-referenced our articles with literature reviews that were completed by Mackenzie Churchill, Research Coordinator, Well Living House, and Kristina Klopfer, PhD candidate, Ontario Institute for Studies in Education, University of Toronto for the Well Living House's *Reconciling Relationships* Indigenous cultural safety training research project.

We gathered **additional resources from the peer-reviewed and grey literature that were informed by critical theoretical perspectives,** including critical race theory, transformative education, and decolonizing anti-racist pedagogy. These resources filled key gaps identified during a preliminary analysis of the seven review articles because they oriented our analysis towards the theoretical and

contextual underpinnings of cultural safety, and provided insight towards how training could shift individual and organizational practices. Reading these resources in relation to the seven articles we included from the scoping review, we developed what we refer to as *wise practices for developing and implementing Indigenous-specific cultural safety training*.

We opted for the term *wise practices* because it has been widely used in Indigenous contexts (Wesley-Esquimaux & Calliou, 2010; Wesley-Esquimaux & Snowball, 2009; Thoms, 2007) and has been defined as "locally appropriate actions, tools, principles or decisions that contribute significantly to the development of sustainable and equitable conditions" (Wesley-Esquimaux & Calliou, 2010, p.19). We opted for *cultural safety training* rather than cultural competency *and* cultural safety training because cultural safety implies that the curriculum covers power and privilege, and to shift the focus away from cultural competency as a goal to cultural competen*cies* as skills that can be learned, strengthened, and refined through cultural safety training.

Findings: Wise Practices for Developing and Implementing Indigenous-Specific Cultural Safety Training

The seven review articles that were included in this Evidence Brief are summarized in Table 3. The reviews suggest that the majority of the cultural safety literature comes from United States, Australia, and to a lesser extent New Zealand; very few publications include Canadian content or were conducted in Canada. Two of the seven reports were situated within a Canadian context (Baba, 2013; Guerra & Kurtz, 2016). Both articles conclude that in spite of the renewed interest in Indigenous cultural safety, few programs have been successfully implemented across Canada. Clifford, McCalman, Bainbridge, and Tsey (2015) speculate that the abundance of American studies may be partially attributed to the existence of policy/legal requirements for reporting cultural competency considerations that do not exist in other countries such as Canada.

Reflecting on the insights drawn from the literature reviewed, we offer the following *wise practices* for consideration:

Wise Practice #1: Cultural safety training needs to be evaluated

The review of the literature suggests that the number of papers evaluating cultural safety training is limited, and those that do exist lack methodological rigor (Clifford et al., 2015; Gallagher et al., 2015; Guerra & Kurtz, 2016; Horvat et al., 2014; Lie et al., 2010; Truong et al., 2014). With so few evaluations, it is difficult to identify which types of training are most effective.

There is also a call to expand the number and nature of outcomes that are being assessed when cultural safety training is implemented. Existing evaluations tend to measure effectiveness based on provider-defined, self-reported outcomes (Truong et al., 2014; Clifford et al., 2015). Client/patient

outcomes also need to be measured both in the short-term and long-term (Durey, 2010) in order to accurately assess the extent to which the cultural safety training program improves how Indigenous peoples are treated by healthcare providers.

There is also a need for improved evaluation tools and instruments (Clifford et al., 2015; Truong et al., 2014). Promising measures and instruments include the Implicit Association Test and Indigenous standardized patients (Ewen, Pitama, Robertson, & Kamaka, 2011); these two types of measures will be used in the *Reconciling Relationships* research project (Well Living House, 2017) to assess and compare the effectiveness of three types of cultural safety training for healthcare professionals. Policy-makers, scholars, and programs can look to the *Reconciling Relationships* research project and the framework for evaluation proposed by Lie and colleagues (2010) for guidance.

Wise Practice #2: Cultural safety training needs detailed program descriptions in order to be consistently and reliably implemented and evaluated

Incomplete or sparsely detailed program descriptions can make it hard to know whether cultural safety training is being consistently and reliably implemented and evaluated over time and across contexts. Gaps in reporting can also make it difficult to reach conclusions about what types of cultural safety training work best and why. The articles that report on evaluations of cultural safety training have been criticized for these very gaps. Existing evaluations lack information and clarity about the type of curriculum and pedagogy used in the program, the structure and delivery of the program itself, and the definitions of "cultural safety" or "cultural competency" upon which the program was based (Baba, 2013; Gallagher et al., 2015; Horvat et al., 2014; Truong et al., 2014). Authors like Clifford and colleagues (2015) have called on scholars to improve how the evaluations of cultural safety training are described and reported, so decision-makers can draw meaningful conclusions from their findings. As we will explain below, detailed descriptions are particularly important because they can confirm whether the program was indeed oriented towards cultural safety, and not – whether intentionally or unintentionally – towards cultural awareness.

Wise Practice #3: Cultural safety training would benefit from curriculum that focuses on power, privilege, and equity; is grounded in decolonizing, anti-racist pedagogy; and is based on principles from transformative education theory

One of the strongest findings that emerged from the review papers and the additional resources was the importance of incorporating power, privilege, equity, settler colonialism, race and racism, and other structural forces into the curriculum (Brascoupé & Waters, 2009; Canadian Association of Schools of Nursing, 2013; Diffey & Lavallee, 2014; Guerra & Kurtz, 2016; Kowal, Franklin, & Paradies, 2013; Lavallee et al., 2009; Truong et al., 2014). Many cross-cultural training programs have been

critiqued for reducing or *essentializing* culture to food, worldviews, customs, etc. and ignoring the impacts that power structures and inequities have on the health, well-being, and lived realities (Diffey & Lavallee, 2014; Reitmanova, 2011; Truong et al., 2014). These types of approaches have been shown to reinforce stereotypes and perpetuate inequities by failing to challenge and change the status quo (Gregg & Saha, 2006; Gregory, Harrowing, Lee, Doolittle, & O'Sullivan, 2010).

The evidence also indicates that cultural safety training must be grounded in decolonizing, reflexive, anti-racist pedagogy to enable critical self-reflection, orient the curriculum towards the root causes of Indigenous health inequities (e.g. intersections of racism, sexism, colonialism), and to prevent multiculturalism discourses from silencing the realities and experiences of Indigenous peoples (Browne et al., 2016; Diffey & Lavallee, 2014; Kowal et al., 2013; Lawrence & Dua, 2005; St. Denis, 2011).

Equally important to the development and implementation of cultural safety training is their structure and delivery (Gallagher et al., 2015). Here, program developers should look to transformative education theory, which has been widely used in adult education. Transformative education theory argues that the discomfort and disruption that can arise from discussing topics such as racism and colonialism can lead transformative learning (Czyzewski, 2011; Mezirow, 2000a, b). Advances in the field of transformative adult education have also shown conventional didactic, lecture-style methods may not be as effective as interactive, multi-faceted, and facilitated web-based approaches to training (Mezirow 2000b). Meyers (2008), for example, found that many adults were more comfortable sharing information and voicing their true perspectives in interactive, multi-faceted, small-size, facilitated online spaces, possibly due to the less formal, more anonymous nature of online versus in-person learning.

Wise Practice #4: Cultural safety training must be led by trained facilitators

While not made explicit in the review papers, several of the additional resources made reference to the importance of ensuring cultural safety training is led by trained facilitators. Individuals who facilitate cultural safety training must be trained in delivering the curriculum; supporting decolonizing, anti-racist, reflexive pedagogy; and managing resistance from non-Indigenous – often White – participants (Czyzewski, 2011; Kowal et al., 2013; Okun, 2010).

There is also a body of evidence supporting inter-racial facilitation models. Having facilitators/educators of different racial identities can improve training effectiveness because participants interpret messages delivered by White facilitators and Black facilitators, for example, differently, and because facilitators can support each other (Liberman, Block, & Koch, 2011). Similarly, Kowal and colleagues (2013) found that having two facilitators of differing racial identities enabled participants to have more honest, open, and reflexive discussions about diversity.

Wise Practice #5: Cultural safety training must be offered in effective learning spaces that both challenge resistance from non-Indigenous peoples, and support non-Indigenous peoples to learn from their discomfort

Cultural safety training should not make conversations about racism, colonialism, and power inequities *more palatable* for non-Indigenous learners by focusing on culture because "this is a privilege that has never been afforded to the racially oppressed" (Diffey and Lavallee, 2014, p. 3). Although finding the balance between preventing non-Indigenous learners from disengaging from the content due to negative emotional responses and not "coddling" or shifting the focus to settler feelings can be challenging, cultural safety training need to find this balance. Strategies that have been proposed to achieve this balance include acknowledging that stereotyping and biases are normal, acknowledging that cognitive dissonance and discomfort are a normal process of un-learning (Mezirow, 2000a, 2000b), giving examples of strategies to challenge and change biases, and providing resources. Unpacking and acknowledging the differences between White second generation Canadians and racialized refugees (Lawrence & Dua, 2005) are also critical – although under-examined – topics that should be covered in order to consider intersectionality (Dhamoon, 2010; Hankivsky, 2014) and to better communicate the roles that individuals, groups, organizations, and systems play in being complicit and driving Indigenous health inequities.

Wise Practice #6: Cultural safety training needs to prioritize support for Indigenous learners

As mentioned, culturally-related trainings are not always a safe place for Indigenous learners and Indigenous facilitators. Comments and behaviours from classmates who are non-Indigenous can be extremely harmful. Discussions about residential schools, forced adoptions, and other colonial realities can also be triggering, re-traumatizing, and/or shocking, especially if it is the Indigenous person's first exposure to the content. Facilitators must prioritize the needs of Indigenous learners within the program, but without singling them out or assuming that they are *experts* because they self-identify as Indigenous. To mitigate the potentially harmful impacts of participating in cultural safety training and to support the specific needs of Indigenous learners, facilitators should acknowledge the participation of Indigenous learners throughout the program, intervene in situations where other non-Indigenous participants might cause harm, and offer Indigenous-specific supports during and after the training program (e.g. support from an Elder, personal check-in phone calls; Grosland, 2013; McLoughlin & Oliver, 2000; Ranzijn et al., 2008). The San'yas Indigenous Cultural Safety Training Program, for example, also offers Indigenous-only cohorts.

Wise Practice #7: Cultural safety training cannot work in isolation; system-level support is required for accountability and organizational transformation

There is broad consensus that cultural safety training will have little long-term impact on HCP behaviours, patient outcomes, organizational transformation, and health inequities if they are developed and implemented without organization-wide and system-level support (Baba, 2013; Browne et al., 2015; Durey, 2010; Guerra & Kurtz, 2016). According to Guerra & Kurtz (2016), cultural safety training is "futile if these practices are not mandated within healthcare organizations, authorities, and all levels of government" (p. 12). If cultural safety training is to effectively address the root causes of Indigenous health inequities, HCPs and organizations must be held accountable for their actions; provider and organizational accountability cannot be integrated or enforced without system-level support.

Table 3. Review papers examining best practices in cultural competency and/or cultural safety training.

Authors, Year	Study Type	Sample	Objectives	Key Findings
Lie et al., 2010	Systematic review, plus qualitative synthesis and analysis of results (N=7)	Studies measuring the impacts of CC training for several types of HCPs on patient outcomes (mostly USA)	To examine the impacts of HCP CC training on patient outcomes	• There is a limited evidence showing a positive relationship between CC training and patient outcomes. However, high-quality evidence is lacking. The authors also predict that CC training alone is insufficient to improve outcomes. • The authors present an "algorithm" or framework that researchers can follow when evaluating the impact of CC training on patient outcomes.
Baba, 2013	Environmental scan	Articles documenting existing HCP education and CC & CS training across Canada (plus some USA)	To provide an overview of curriculum and initiatives implemented by governments, universities, and agencies to improve CC & CS of HCP	• Findings were divided into seven sections: (1) definitions of CC & CS, (2) core competencies for HCP in Canada, (3) CC curriculum in HCP education programs, (4) accreditation standards in the USA, (5) professional training and continuing education programs, (6) the implications of the Tripartite First Nations Health Plan in British Columbia on CS, and (7) recent Health Canada-related CC and CS programs. • The authors cannot effectively evaluate existing trainings because there are no curriculum standards or standardized assessment criteria. The authors call for the development of these standards/criteria and for increased support from people in power (e.g. senior leaders, executives) to bring about tangible change.
Horvat et al., 2014	Systematic review (N=5)	Randomized controlled trials evaluating CC training in the USA (3), Canada (1), and the Netherlands (1)	To examine the impacts of HCP CC training on patient outcomes, HCP outcomes, and organizational outcomes	• There is some evidence showing a positive relationship between CC training, patient outcomes, HCP outcomes, and organization outcomes (e.g. patients in the Netherlands more likely to attend follow-up appointments). However, there is a lack of high-quality evidence and a lack of consensus on what constitutes "cultural competency" and how it should be defined. The results are promising but not generalizable.
Truong et al., 2014	Systematic review of reviews (N=19)	Studies evaluating the impacts CC training on outcomes in the USA	To examine the impacts of HCP CC training on patient outcomes, HCP outcomes, and organizational outcomes	• Most of the studies examining CC training and HCP outcomes found evidence of improvements in knowledge and skills related to CC. Most of the studies examining CC training and patient outcomes found some evidence of improvements. Most of the studies examining CC training and service utilization outcomes found some evidence of improvements. • However, the findings are limited due to a lack of: (1) high-quality evidence, (2) training standards, and (3) assessment criteria and evaluation instruments. • The authors call for assessments that move beyond self-reporting of HCPs. • The authors criticize the tendency of CC training to essentialize culture and promote "cultural awareness" rather than competency and safety. They recommend that more programs explicitly focus on culture, racism, and privilege.

Authors, Year	Study Type	Sample	Objectives	Key Findings
Gallagher et al., 2015	Meta-analysis (N=25)	Studies evaluating outcomes associated with CC training for nurses (mostly USA)	To examine whether CC training enhances the cultural competence of nurses and nursing students, and if so, why	• The authors demonstrated that training had a positive, but not statistically significant, effect on measures of cultural competence. • Supportive of CC training, the authors identified a lack of methodological rigor and information about curriculum/pedagogy as challenges that need addressing to improve the evidence base. • Most studies used immersion or simulation techniques to change HCP behaviours, rather than didactic models. More research is needed to determine which approach is more effective.
Clifford et al., 2015	Systematic review (N=16)	Evaluations of intervention to improve CC in healthcare for Indigenous peoples; USA (11), Australia (5)	To identify strategies to improve Indigenous-specific, and to examine impacts of strategies on Indigenous peoples	• The authors confirm that CC & CS training is one of the most commonly used strategies to improve CC & CS for Indigenous peoples. • After examining the evidence evaluating CC & CS training, the authors find that effectiveness is typically assessed based on HCP outcomes (e.g. knowledge, confidence, attitudes, and skills). The authors also note that high-quality evidence is lacking so it is difficult to determine which types of training are best. • The authors call for improvements in CC & CS training design, evaluation, and reporting (e.g. via use of clinical audits and incorporating patient outcomes in assessments)
Guerra & Kurtz, 2016	Scoping review (N=26)	Programs in Canada	To determine the extent, range, and nature of CC & CS education and training in Canada to better understand the current landscape	• The authors demonstrate that although there is an increased awareness and interest in CC & CS training in Canada, few trainings have been successfully implemented. There have also been very few evaluations. • Leaders/promising practices include: Aboriginal Nurses Association of Canada (now: Canadian Indigenous Nurses Association) and the Innulitsivik Inuit midwifery program in Nunavut. • The authors call for further research, particularly into experiential learning and moving CC & CS training beyond the classroom and into community. • The authors warn that CC & CS training are *"futile if these practices are not mandated within healthcare organizations, authorities, and all levels of government"* (Guerra & Kurtz, 2016, p. 12).

Discussion

In this Evidence Brief, we argue that the existing evaluative literature on cultural safety training is limited in number and in rigor, both in Canada and abroad. These limitations pose significant challenges to compiling a comprehensive set of *best practices* for Indigenous-specific cultural safety training. As such, we recommend that research and ongoing evaluation become top priorities for policy makers, program developers, evaluators, and scholars involved with the development and implementation of any Indigenous-specific cultural safety training program.

In addition, as presented above, the scant peer-reviewed literature can be read in relation to the literature of critical race theory, transformative education, and decolonizing anti-racist pedagogy to arrive at seven evidence-based *wise practices* on Indigenous-specific cultural safety training.

- Wise Practice #1: Cultural safety training needs to be evaluated.

- Wise Practice #2: Cultural safety training needs detailed program descriptions in order to be consistently and reliably implemented and evaluated.

- Wise Practice #3: Cultural safety training would benefit from curriculum that focuses on power, privilege, and equity; is grounded in decolonizing, anti-racist pedagogy; and is based on principles from transformative education theory

- Wise Practice #4: Cultural safety training must be led by trained facilitators.

- Wise Practice #5: Cultural safety training must be offered in effective learning spaces that both challenge resistance from non-Indigenous peoples, and support non-Indigenous peoples to learn from their discomfort

- Wise Practice #6: Cultural safety training needs to prioritize support for Indigenous learners

- Wise Practice #7: Cultural safety training cannot work in isolation; system-level support is required for accountability and organizational transformation.

While these *wise practices* are certainly an excellent starting point, we urge policy makers, program developers, evaluators, and scholars to be extremely careful when developing Indigenous cultural safety training. As we have briefly discussed, poorly and uncritically designed training - good intentions notwithstanding – can actually reinforce the marginalization of Indigenous peoples as both patients/clients and training participants and reinforce organizational resistance to addressing the structural racism that is embedded within workplace policies and practices.

There is also an emerging critique of the renewed interest in developing and implementing such programs within the spirit of *reconciliation* (Coulthard, 2014). Even though the *Truth and Reconciliation Commission of Canada* has been a highly influential policy initiative refocusing the

spotlight on Indigenous inequities, non-Indigenous and mainstream organizations need to critically reflect on their motives for developing and implementing Indigenous cultural safety training. Reconciliation should not be reduced to a tick box that can be *checked* or a goal that can be achieved once an organization develops, implements, and even mandates Indigenous cultural safety training. Reconciliation is an ongoing, multi-dimensional, and complex process that can indeed be initiated or furthered by ICS training, but only if policy makers, program developers, evaluators, and scholars move beyond superficial commitments (Czyzewski, 2011).

Conclusion

The wise practices presented in this document are offered as insights for policy makers, program developers, evaluators, organizations, and scholars who are involved in the development and implementation of Indigenous-specific cultural safety training. We hope that these wise practices will be critically and thoughtfully applied when designing, implementing, and evaluating Indigenous cultural safety training, so that the training effectively addresses the root causes of Indigenous health inequities, reduces the barriers that Indigenous peoples face in accessing high-quality culturally safe care, and contributes to a wider systemic shift towards safer, more equitable experiences and outcomes for Indigenous peoples at all levels in the Canadian healthcare system.

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