Primary Research

It's a Journey Not a Check Box: Indigenous Cultural Safety From Training to Transformation

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ABSTRACT

Indigenous Peoples in Canada continue to experience racism and discrimination when accessing health care. Competencies of health care staff urgently need to be improved through cultural safety education and training programs to inform culturally appropriate and safe care practice among care providers serving Indigenous individuals and families. This paper explores current educational strategies, the perspectives of Indigenous and non-Indigenous care providers on training approaches, and recommendations for improving training. Qualitative semi-structured interviews were conducted with 31 participants to explore the current provision of culturally appropriate and safe care. Interviews were voice recorded and transcribed verbatim, and a thematic analysis was completed. The three key themes related to training that emerged from data analysis were (a) addressing the knowledge gaps, (b) challenges of current training approaches, and (c) recommendations for improvements in training. Each key theme had three subthemes that were further explored. Cultural safety training is a long and iterative process that has the potential to change care providers' behaviours and attitudes. Various challenges to existing education and training included issues with implementation, limited follow up with health care staff to support practice changes, and/or limited commitment from senior leadership to change organizational policies and practices. As such, there is a clear need for systemic change within health care institutions to support staff participating in cultural safety training and to put that training into practice to create a culturally safe space for Indigenous individuals seeking health care.

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Introduction

Indigenous people face significant barriers in the health care system. One of the main challenges is the lack of culturally appropriate and respectful health services (Benoit et al., 2003; Browne & Smye, 2002; Browne et al., 2005). In Canada, research has demonstrated that this is not simply due to accessibility challenges, but is also the result of systemic racism and discrimination (Allan & Smylie, 2015; Wylie & McConkey, 2019). Poor attitudes about Indigenous people reflect negative stereotypes that health care providers carry, combined with a lack of understanding about history and the everyday lived experiences of Indigenous people. Colonialism and ongoing discrimination in policy and practice lead to poverty, poor access to basic goods and services, racism, and loss of identity (Browne et al., 2005; de Leeuw et al., 2015; Reading, 2015). This article is part of the *Engaging for Change* study, a project taken up to assess the inequities in health care access and experiences of Indigenous people in a major urban centre in Southwestern Ontario. Earlier publications from this study identified that negative experiences are a direct result of widespread anti-Indigenous racism in the health system, where stereotypes shape provider attitudes and clinical decision making (Wylie & McConkey, 2019), and structural racism shapes health policy and systems (Wylie et al., 2019). Health care providers noted that they regularly witnessed Indigenous peoples' concerns being dismissed, and patients were often blamed for their health issues. Other cases have shown that this problem is not new, nor limited to Ontario.

In September 2020, Joyce Echaquan, a First Nations woman from Atikamekw First Nation, livestreamed on Facebook a video showing her being subjected to racist taunts from hospital staff as she was dying in a hospital in the province of Quebec. She had raised concerns about being given drugs she was allergic to. Joyce Echaquan's was not the first high-profile case where racism led to the death of a First Nations person in health care. In 2008, Brian Sinclair, an Indigenous man referred to the emergency room in Winnipeg, Manitoba, by his doctor, was "ignored to death" over the course of 34 hours (Brian Sinclair Working Group, 2017). Together these cases provide dramatic examples of how systemic and interpersonal racism not only lead to neglect and dismissal of Indigenous people in the health care system, but are also a matter of life and death.

Examples like this demonstrate that the health care system and those working within it are failing to provide the basics of care for Indigenous people. In addressing this challenge, strategies must be developed to tackle these discriminatory practices from within the health care system itself. As identified in Call to Action 23 (iii) of the Truth and Reconciliation Commission of Canada (TRC, 2015), a key strategy is to improve the competencies of health care staff

through education and training so they can provide culturally appropriate and safe care for Indigenous people. In this article, we explore the perspectives of Indigenous and non-Indigenous care providers who have had experience with existing training programs. The aim is to identify the promising practices, continuing challenges, and recommendations that directly address racism and discrimination in health care and that ensure education and training lead to changes in the behaviours and practice of those providing health services for Indigenous people.

Background

Growing awareness of the poor experience of Indigenous people in the health care system has resulted in an expansion of cultural training programs for health professionals to address these challenges over the past decade. From the First Nations health governance changes in British Columbia (BC), Canada, in 2011 (O’Neil et al., 2016) to the Calls to Action in the TRC (2015), the political climate has raised Canada’s national consciousness about the need to address health system barriers and ensure that care providers have knowledge of Indigenous health. Indigenous cultural training programs for health professionals have been rolled out across Canada in response. Significant variation in uptake and expectations of cultural safety training is seen across the country. The trilateral framework agreement of 2011 between the federal government, the BC provincial government, and First Nations in BC, which resulted in the creation of the First Nations Health Authority, explicitly called for the creation of a cultural competency curriculum. In response, the Provincial Health Services Authority in BC worked with Indigenous educators to provide an online cultural safety training program, now called San’yas; there has been significant uptake of San’yas in BC, as there are mandates in place to ensure the training of health care providers (Provincial Health Services Authority, 2019). Uptake across the rest of the country has been less consistent. The province of Ontario did introduce its own version of the San’yas Indigenous Cultural Safety training program, but this training has not been mandated as it was in BC, and thus fewer health professionals have taken it.

The TRC (2015) also put forward a Call to Action for cultural competency training of health professionals. In response, more training programs have been developed, including through Cancer Care Ontario and Aboriginal Awareness Canada. Both of these provide “knowledge about the history and culture of First Nations, Inuit and Métis people and communities” (Cancer Care Ontario, n.d.), and content to help participants “learn about Canada’s Indigenous People and to help non-Indigenous Canadians and Indigenous Peoples move toward reconciliation” (Aboriginal Awareness Canada, n.d.). The purpose of training is to address not only the poor experiences that Indigenous people face, but also their overall health outcomes. Other training, such as the Fundamentals of OCAP®,¹ created by the First Nations Information Governance Centre (FNIGC), has been developed to give individuals a better understanding of the need to respect the data sovereignty and information governance of First Nations (FNIGC, 2020). Unfortunately, it is hard to accurately track the delivery of training being provided across

¹ Standing for ownership, control, access, and possession, OCAP® is a registered trademark of the First Nations Information Governance Centre (<https://fnigc.ca/ocap>).

Canada as institutions are constantly changing what training is being provided and/or are not publicly reporting on the training they provide, resulting in a piecemeal picture of training programs and their impact. As such, it is imperative that opportunities to publicly mandate training are explored. It is also important to examine how health care providers have been able to act on what they are learning in these online training programs.

Methodology

There has been significant research and many recommendations over the past two decades on how to rectify the situation of Indigenous Peoples' health care experiences through the education of health care providers. From the foundational literature in the 1990s on cultural safety (Papps & Ramsden, 1996) and cultural competency (Leininger, 1997), to the focus on respect (Smylie et al., 2000), cultural humility (Lamiani, 2008) and cultural security (Lumby & Farrelly, 2009) in the 2000s, researchers have grappled with the philosophical foundations of training health professionals in order to change their practice. The Engaging for Change project was informed by Charlotte Reading's model of structural determinants of Indigenous health (Reading, 2015), which draws our attention to historical, political, social, and economic factors and their interrelationship, as guided by critical theory (Lincoln et al., 2011). By embedding Indigenous health outcomes within the broader context, we are able to see how structural violence shapes the everyday reality of Indigenous people. Large-scale social, economic, and political structures perpetuate inequities and must be analysed in order to inform strategies for overcoming them (Farmer, 2004). Therefore, meaningful change needs to address structural issues, along with provider attitudes.

One of the challenges with the focus on individual-level training is that often institutions tend not to evaluate the training in ways that assess behavioural change, nor is adequate attention focused on the resources or supports needed to practise in a culturally safe way in the health care system. Instead, a tick box approach of tracking is used to note the numbers of people who have completed the training. Reviews of the impact of these various models of training on actual changes in health care practice are not particularly encouraging. A review of cultural education programs in Australia concluded that although the evaluations of cultural training programs have shown positive impact on attitudes, these have not led to sustained changes in either behaviours or practice (Durey, 2010). A key challenge, according to Durey (2010), is "that a lack of methodological rigour limits the evidence for the impact of cultural competence training on the quality of care" (p. 90). Downing et al. (2011) assert that this lack of methodological rigour creates challenges in assessing the impact, and the limited evidence only demonstrates improved knowledge, attitudes, or skills of care providers; "virtually nothing is known about any changes in the health and wellbeing" of Indigenous people (pp. 250–254), or if the training is effectively tackling anti-Indigenous racism within health care organizations, policy, and practice.

Nearly a decade later we seem to be in the same position. An extensive review of Indigenous experiences in health care in Canada found that widespread racism and discrimination continue to undermine the quality of care provided to Indigenous people (Allan & Smylie, 2015). Other research showed that although training was available, there was limited

uptake, and health care providers continued to make clinical decisions based on racism and stereotyping of Indigenous people (Wylie & McConkey, 2019). Part of this gap is based on the way Indigenous cultural training is conceptualized and rolled out. Downing et al. (2011) provide an extensive review of six different models, noting that a cultural awareness approach only focuses on teaching participants about the “other cultures” of people seeking their care. The culture of participants (health workers) and the culture of the health system itself remain unexamined and are thereby implicitly positioned as the norm (p. 254). Fundamental transformation is going to require training that goes beyond “other cultures” to focus on the ways the culture within health care perpetuates racism, discrimination, and inequity.

Contribution and Focus

As part of an overarching research project to explore the experiences of health care staff and their capacity to provide quality care for Indigenous people, this article presents the results that focused on the education and training experiences and the recommendations from health care providers. Most research on barriers to health services and discrimination among Indigenous Peoples focuses on the perspective of Indigenous patients. Adding to the current literature, this research explores two narratives: those of both non-Indigenous and Indigenous health and wellness practitioners working in mainstream or Indigenous organizations. Including the voices of Indigenous people working in health care offers a unique wholistic understanding of the current barriers and gaps in health care services for Indigenous Peoples. In addition, these insider voices are well positioned to make recommendations for realistic and tangible improvements in care for Indigenous people accessing health services. In order to elicit recommendations for education and training, the line of inquiry explored in this paper sought to understand how health care staff had learned and how they wanted to learn about ways to improve care for Indigenous people. This article discusses what Indigenous health training the practitioners had taken, the benefits and challenges, and recommendations from health providers on strategies for successful training that would improve staff abilities and confidence in providing quality health care for Indigenous people and families.

Methods and Relationships

Community Engagement

Before commencing the study, the first author engaged with Indigenous health professionals working in both urban centres and First Nations communities in southwestern Ontario. Indigenous people working in hospitals and health centres shared their knowledge of the first-hand experiences of Indigenous people in the health care system. A number of concerns were raised about the provision of culturally safe care for Indigenous Peoples. These individuals expressed an urgent need to explore the barriers that undermine the provision of culturally safe, quality health care for Indigenous Peoples in local mainstream health care services. These Indigenous health professionals urged the researcher, as an insider, to find out what was happening inside the health care system locally. In response to these recommendations from

local Indigenous health care professionals and leaders, the Engaging for Change research project was initiated in 2014.

Data Collection

Ethics

Ethics approval was granted by Western University's Health Sciences Research Ethics Board and the ethics committee of Lawson Health Research Institute, responsible for hospitals and community-based health services. Participants provided informed consent prior to data collection. Ongoing partnerships with Indigenous communities have ensured that knowledge translation and mobilization were focused on Indigenous community members' expectations. The project produced health care navigation guides, service mapping, reports, and posters on key findings, and recommendations for practice changes. The research team included four graduate students from Anishinaabe and Haudenosaunee communities in the region. The second author is Indigenous and has been involved in the project throughout. The next stage of this research, in partnership with First Nations local and provincial organizations, is to advance improvements in health care by facilitating dialogue between local First Nations, health care providers, and the research team. Additional communities have joined as the project expands in scope, including an Indigenous co-lead in Northern Ontario.

Research Methods

Purposive sampling was used to recruit participants who hold knowledge on the research topic of interest (Sandelowski, 1995). The interdisciplinary sample (N=31) was composed of physicians, nurses, social workers, patient navigators, patient experience specialists, community-based support staff, and departmental directors/leaders. Respondents included eight Indigenous people and 23 non-Indigenous people, one of whom worked for an Indigenous organization. The research lead and two Indigenous research assistants recruited participants for this qualitative study. Qualitative description was chosen, as the process of asking questions informed by this methodology facilitates relationship building between researchers and participants, which is particularly valuable when conducting Indigenous health research (Laycock et al., 2011).

Participants engaged in a 1- to 1.5-hour semi-structured interview to explore the provision of culturally sensitive care for Indigenous Peoples in their respective organization, as well as the barriers preventing the enhancement of health care services for Indigenous Peoples. The interview guide is an adapted instrument, based on previously validated cultural, linguistic, and multicultural counselling competency assessment tools (Sheu et al., 2012; Goode, 2013). Specific questions that evoked responses about education and training included the following:

- What could ensure the provision of culturally sensitive services for Indigenous people?
- What was needed to help staff provide culturally sensitive services?
- Did their employees have intercultural communication and/or Indigenous cultural training?

- Did their organization provide on-the-job training in cultural competence/sensitivity/safety? If yes, how often?
- Were they aware of any policies/protocols for facilitating the inclusion of Indigenous perspectives on improving health services?
- What types of policies/protocols could improve access and experiences of Indigenous people in the health care system?

Data Analysis

The interview transcripts were coded by the research team (including two Indigenous researchers) on NVivo 10 Software using inductive thematic analysis (Braun & Clarke, 2014). The team discussed emerging codes to ensure triangulation of the data and stopped coding once saturation was achieved (Bowen, 2008). The codes were sorted into clusters to generate themes and subthemes based on their relationships to each other (Hsieh & Shannon, 2005).

Results

The results from this data on education and training of health care professionals are organized around three themes: (a) addressing the gaps, (b) challenges of current training approaches, and (c) recommendations for improvements in training. Table 1 presents the subthemes in each of these areas, which are discussed next.

Table 1

Themes and Subthemes

Themes	Subthemes
Addressing the gaps	<ul style="list-style-type: none"> • Knowledge gaps • Desire to improve • New training initiatives
Challenges of current training approaches	<ul style="list-style-type: none"> • Training scope limitations • Learning modes limitations • Implementation gaps
Recommendations for improvements in training	<ul style="list-style-type: none"> • Learning from lived experiences • Multifaceted approaches needed • Mandates and accountabilities

Addressing the Gaps

Knowledge Gaps

Overall, most participants understood the importance of Indigenous cultural safety training for health care professionals. There is a significant gap in knowledge about Indigenous Peoples, their history, and their current reality. Indigenous respondents noted that “you have to have that history piece” (H05S), and that “they need to teach the history the right way, instead of the victor’s point of view. ... They just assume everything is what they learned in history

class. ... Nobody knows anything about our Native history and that upsets me” (FG01). Other Indigenous participants asserted that health care providers “need to be educated, they don’t know” (CR6S), and “you have to re-educate all of these people” (FG01). A physician respondent stated, “Hospital personnel ... tend to be very, you know, clinically oriented. ... There is very limited understanding and appreciation of cultural-social needs” (H23P). A counsellor noted the importance of health care providers, particularly mental health providers, learning about intergenerational trauma (A19P). A physician said that education needed to include Indigenous practices, and information on the types of coverage provided by non-insured health benefits (NIHB). Health providers “aren’t even aware if they are prescribing something that is covered or not” (AH23P).

Care providers were unaware of the types of issues that Indigenous people faced in everyday life in their communities. Training on Indigenous health also need to “educate them on the logistics of where people live. ... I don’t think people know about those things. And how do you know them if you’ve never lived them” (H05S). An Indigenous respondent emphasized that medical students need to be taught “that we are not the same. We need to stop going by what they made for the white man and putting that on us. Because we are not the same, we are different,” and “we haven’t gone through the same things” (FG01). A physician leader noted that we often miss the nuance, “we do tend to lump all Aboriginal people together, but they come from quite different backgrounds” (H14P).

Desire to Improve

There was a general willingness among health care professionals to participate in training initiatives. The trend toward advancing patient-centred care was seen as helpful for advocating for improvements for Indigenous people, given that “we are very concerned about what we call the patient experience” (A12L). This sentiment has created an impetus for cultural training. The uptake for Indigenous cultural safety training in a local health organization was “close to hitting more than 3/4 of the staff taking the course since it was launched. That’s a pretty good number” (H06L). Another leader emphasized the value of training to ensure staff were able to meet Indigenous Peoples’ expectations; education can raise issues for staff “to pay attention to. People may want things that are outside the traditional path of care plan that we might normally see” (A03L).

New Training Initiatives

Most participants were aware of Indigenous cultural safety training tools and materials that were starting to be introduced for health care providers locally. One respondent highlighted that the Royal College has mandated that “obstetricians and gynaecologists have some training in the ... provision of care for Aboriginal Peoples” (A09P-FG). New curriculum was being rolled out in health professional education, with a respondent in nursing noting, “This is the first time I have seen them talk about residential school” (H05S). Participants in senior leadership roles shared that when they learned of the new cultural safety modules online, they sent information out to all “staff and physicians and encouraged them to do it. And we began making it a

mandatory requirement for the leadership team to complete” (A22L). Participants also shared that they knew of colleagues who were asked to complete mandatory training when they were reprimanded. One participant shared, “It happens a bit. ... I know that if you give the wrong comment, or get in trouble or complain you can get sent for sensitivity training” (A04P).

Challenges of Current Training Approaches

Participants were open to sharing their experiences and providing recommendations about Indigenous health training.

Training Scope Limitations

Some participants shared that they participated in some form of Indigenous cultural training but expressed the opinion that existing education efforts from their organizations had felt very surface level, lacking depth or the potential to have a meaningful impact. One participant explained their organization “had information sessions that were for all the teams but it was just a generalized information session about what health equity is” (H17L). Sessions that only provided general information and definitions of concepts were problematic, as they lacked training related to Indigenous Peoples. A challenge stemmed from the fact that “there is not always agreement on the best practice or the minimum standards” (H06L).

Among participants who had not completed Indigenous health training, some perceptions, and perceived barriers to completing training, were shared. Participants were less optimistic about cultural safety courses that they could complete at work. To begin, some participants believed that they would be unable to achieve anything more than general awareness. One participant stated that the outcome of these cultural safety courses are “just in general to be aware of many diverse cultures and to be sensitive to them is about as far as we could realistically go” (A01P).

Learning Modes Limitations

Participants also shared their perceived barriers for not participating in such training and provided recommendations to facilitate their learning. Some felt that that online training alone was not ideal to achieve an impact on health provider practice. A participant explained, “I don’t think it’s just a matter of taking an 8-hour module, I don’t know if that’s going to change my mind in the way that I’m going to perform care” (H05S). A physician noted that although didactic education is “worth doing. ... Maybe a more hands-on session is better” (H14P). In addition, other participants highlighted that although they would like to complete the cultural safety courses, they were resistant due to the significant amount of time they took to complete. One participant shared that staff “have some online training that is available but there is resistance to that ... like everyone wants to do it ... but the staff have at least 15 other courses when they start, and every year” that continues to increase (A08L).

It was also noted that preparatory work needed to be done with health care staff to have them ready to engage in difficult learning around Indigenous health, as running a short information session and expecting staff to be ready to act on it “was kind of putting the cart before the horse. It was too fast and people didn’t get it” (H17L).

Implementation Gaps

The challenge with making training mandatory is that it then becomes about checking a box instead of having follow-up with managers and/or employers to debrief and discuss learnings. It was identified that Indigenous cultural safety training was not viewed as a priority among some health care providers, as there are a number of competing training courses. Indigenous cultural safety training was not mandatory, and it was unevenly implemented across community health centres and hospitals, so a lack of awareness and understanding among many care providers persists. Another respondent noted that even when the training is mandated, it is not being implemented (H05S).

Some participants believed that an online module would facilitate their understanding of Indigenous Peoples and their worldview and history, but were hesitant to believe that it would impact their practice. As an Indigenous respondent asked, “Are they going to honour what they’re learning? Because we’re tired of lip service. Truly. Words are wonderful, but actions speak louder than words. Truth and reconciliation call to action. Miigwetch to that statement. That’s powerful” (CR6S). Evaluation of changes in behaviour pre- and post-training is required as evidence of the impact of various training approaches on practice changes.

Another Indigenous respondent highlighted that staff can have a difficult time implementing what they have learned and moving from knowledge to practice:

If you don't have the opportunity to actually practice and to, to get better you know? ... Some people are just trying and I think that's a tough thing. Like if you're trying but you don't have the support, you don't have that knowledge, you don't have the, the education piece that you really need to do a better job.
(CR5S)

Recommendations for Improvements in Training***Learning from Lived Experiences***

Participants made recommendations for educational opportunities that would better support them in building cultural competence. In particular, “interacting with First Nations people and interacting with the reserve” (H14P) was seen as most helpful in understanding Indigenous Peoples’ cultures and informing their practice. Interacting with the community first would actually better prepare individuals for courses in cultural competency: “you have to have knowledge and understanding and some interaction with community, and it is more than just reading, and it is like involvement with people and learning from them” (A19P). This participant went on to share that although they received formal education in counselling,

I got my education from the people I worked with, right? I had a good background in the Western psychology and counselling and I had a

compassion for the struggles, but I had no idea [laughs] really until I began to work with people. (A19P)

Community placements were seen as a particularly valuable learning experience, as a physician shared:

When I was in medical school ... I went to ... northern Ontario, and that was probably my most valuable clinical experience with respect to meeting and treating the Aboriginal population. ... Identifying reserves in the more immediate area surrounding academic schools and residency training would be useful so that people get a better idea of how health services function close by or on reserve specifically, and get a better idea of the interactions and the access and how things actually work. ... You may not have ever had any exposure or idea. (A01P)

Participants said that meeting with Indigenous Peoples and hearing their negative and positive experiences would also be helpful, and would provide staff the opportunity to discuss what they are learning together, which was not possible for individual online learning. A health care leader noted that having “that online for the background, but experientially of actually living in the same environment has been very eye-opening” for their team (A22L). Acknowledging that Indigenous people knew more about their own challenges would ensure care providers value the knowledge that Indigenous people bring to the clinical encounter to support their health care journey. One participant shared,

I think one of the most powerful ways for students to really open their minds is to have first-hand experiences, so meeting with people who have had interactions with the health care system both negative and positive, to be able to describe their stories. (AB10P)

Participants also identified the need for more Indigenous health care professionals in the system, “whether it be nurse practitioner or allied health or a physician, and to have those individuals then in the community ... practicing” (A09P-FG). Another respondent noted the value of having “someone who can speak from personal experience going through the health care system, and someone who can meet health professionals ... on their level” as a clinician (A18L). The importance of Indigenous liaisons was also identified. One participant suggested getting “a person who has established trust from their own community who then liaises with the hospital” (A09P-FG) to create a welcoming environment and support Indigenous Peoples’ access.

Multifaceted Approaches Needed

A clear message from respondents was that there was not one single right way to train staff about Indigenous health and health care issues. “It’s just recognizing that it’s not a one-off and it’s something that has to be continued” (H06L). Indigenous health training should be a journey that is ongoing throughout a health professional’s career to inform their practice. An Indigenous

respondent asserted that Indigenous-specific training needs to be part of the curriculum for training health professionals, catching them “as soon as possible ... not waiting until they are already doctors and nurses in hospitals” (CR5S). Medical school training was seen as a place to integrate Indigenous health issues into clinical training. One person noted that if they were giving a lecture on diabetes, it would include information about Indigenous-specific diabetes issues (A13P). A physician suggested “a one-day workshop ... integrated into primary care forums ... for family physicians ... where everyone attends, geared toward Aboriginal community health” (AH11P). A physician also suggested that Indigenous cultural training should be part of the physician “maintenance competency program” required for ongoing professional development (A04P). A physician and a support staff person both recommended that grand rounds could be focused on Indigenous health (AH13P, H05S). In addition to experiential learning, care providers appeared enthusiastic about participating in case-based learning opportunities. One participant shared,

Everybody groans when anything is mandatory. It is always interesting to hear about cases and why cases didn't go well, so if the cultural training program would make everybody groan, but if you said “this guy was in emerg and this is what happened and he died or had this bad outcome, because of this.” ... But I think that if you had a case-based, kind of real cases where things have not gone as well as they could have and showing, you know, options that are available, I think that would be valuable. (A04P)

To meet the needs of care providers who work shift work, one participant explained it would be ideal to offer multiple sessions at different dates and times. Specifically, they said,

The way that training is generally provided in ER setting is to offer multiple sessions and to organize the schedule and people have to sign up and go in small groups, because everyone is working shift work. A whole lot of people would not be available at one time, so you would have to offer a planned, multi-session, small group sessions really. (A01P)

Online training and case-based learning opportunities were viewed as a great introductory-level of Indigenous cultural safety training. However, there was a general understanding among participants that a one-time introduction to Indigenous cultural safety training was not enough to support health care providers to implement culturally safe practice. An Indigenous leader shared their perspective of continuing Indigenous cultural safety training:

It's kind of the next step and it's really building on the knowledge, the skills, and enhancing awareness. To me, that's a necessary next step that will translate the education and learnings from an individual level to a more organization level and really start looking at how to integrate that knowledge into practice ... recognizing that we do need to have the initial training and

then we need to start planning for other ways to support staff so that knowledge is used and not lost and it's continuous and ongoing. (H06L)

Similarly, another Indigenous respondent emphasized that learning about Indigenous issues needs a commitment of both time and accountability:

There needs to be ongoing cultural awareness continuously. ... Then the need to make time. ... It can't just be one time. And it needs to be full days. So if you had, a start would be four times a year. Each season for a full day. And that it's mandatory, and that they, they come there with respect. Respect is to accept. Are they willing to learn? And I think if they don't, they have to be accountable for not learning. (CR6S)

Having regular ongoing training is also necessary “because there is such a high turnover in the hospital. So it's like if you do a job training a group of people but then they move somewhere else, then you have new people coming in” (CR5S).

Mandates and Accountabilities

Given that inappropriate behaviour when working with Indigenous people is common in the health care system, Indigenous-specific training should be done with all staff. The regional health authority had “created an obligation ... that there needs to be deliberate action ... to enroll staff in ... the Indigenous Cultural Competency training,” and that organizations need to be “accountable for developing a plan ... to identify staff that are going to be trained” (H06L). One participant shared that online Indigenous cultural safety training should be mandated for “staff at the hospital, just like with the fire safety and the workplace violence. Like there are a lot of different modules, and doing an intro model I think would be good” (AB10P).

Indigenous cultural safety training was mandatory for hospital leadership and should be extended to all health care staff (A22L). A physician noted that Indigenous health training should be “mandatory, like human rights issues” (AH11P). Establishing institutional policies, such as mandating Indigenous cultural safety training for all staff, can provide an introductory-level understanding of Indigenous Peoples and their worldviews and history. Staff are often unsure how to implement culturally safe practice, so clinical staff recommended that there should be “direction from leadership about exactly what they want us to do” (H16P) and that they should “tell [us] what we need to do because I don't know” (A07P). A physician suggested that additional training should be provided that is tailored to specific roles or units.

Respondents noted that the “existing policy and framework is not enough. ... We really need to have a lot of engagement from the First Nations ... and there would need to be multiple agreements” across the system to ensure quality health care for Indigenous people (H06L). Policies that create a welcoming and culturally safe environment for Indigenous Peoples are required and may include creating spaces for Indigenous people to

practise or participate in cultural activities that facilitate their health and well-being in health care settings.

Limitations

This study was focused on the experiences of people working in the health care system in a single city in Canada, where progress to address Indigenous health equity has been slow. Although Indigenous respondents working within the system were able to reflect on their experiences as recipients of care, this phase of the study did not include detailed experiences of Indigenous people who only interact with the system as patients or friends and family of patients. Further research is being done to collect that information. In addition, cultural safety training was only just starting to roll out in the study location, so the results were based on limited exposure and preliminary initiatives. Further research will be focused on the impact of training on provider competencies, organizational changes, and the perspectives of Indigenous people as recipients of care.

Discussion

The Truth and Reconciliation Commission (2015) called for all health care professionals to participate in Indigenous cultural safety training. What we have demonstrated in this paper is that such training needs to be seen as a lifelong journey, not a one-off check box. The findings from this study showed a general awareness of the need for Indigenous cultural safety training among health care professionals. Staff were increasingly aware of the significant knowledge gaps regarding the history of Indigenous Peoples and Indigenous-settler relations in Canada. Ensuring all Canadians are provided with education about the real history and current reality of colonialism in Canada and its impact on Indigenous people would ensure that health care staff are prepared to discuss how colonialism continues to shape the experiences of Indigenous people today. The TRC (2015) has resulted in some of these changes taking place in the education system, and increased awareness among the population of Canada as a whole should make it easier to have these conversations in health care. Health care staff generally wanted to learn more about how to provide culturally safe care as a way to be more competent in their roles as health professionals.

Although there is an interest in more training, respondents emphasized a number of challenges in its implementation. Our research confirms past studies that suggest the effectiveness of such online cultural safety training has limitations if it is the only platform used to initiate behavioural and attitudinal changes. Online cultural safety training is an excellent first step for care providers to understand Indigenous Peoples' histories, knowledge systems, and barriers to health care; however, it is only one piece of the puzzle and should be used in harmony with other forms of cultural safety training. Based on the results from this study, most participants were willing to participate in online cultural safety training, although a few identified their reluctance to participate. Some care providers perceive additional online training as a time-consuming burden and admitted that mandated online cultural safety training was just

another item to be checked off their long list of required online training modules. Other respondents said that online training would have a limited impact, as it was less engaging than face-to-face interaction with Indigenous people who could share their lived experiences. In addition, our study demonstrates a range of challenges in the implementation of cultural safety training programs that limit the potential impact. In this health region, participation of hospital staff was generally voluntary, and thus would not necessarily draw in the people in need of the training, other than those who were assigned it due to an adverse incident. Measuring the real impact of education needs to move beyond check boxes that track completion of online training. Instead, organizations need to find a way to measure long-term behavioural and organizational changes that ensure day-to-day practice in their institutions is culturally safe.

As identified in this study, and consistent with current literature, cultural safety training has the potential to change care providers' behaviours and attitudes; however, this is a long and iterative process (Majumdar et al., 2004). Training cannot be a one-size-fits-all approach, but needs to be offered in different formats and platforms to accommodate different learning styles, schedules, and health care specialties.

Recommendations

The respondents provided five key recommendations to improve the competencies of health care providers in Indigenous health.

- Indigenous cultural safety training should be introduced in the early stages of health professional education core curricula, and there should be Indigenous-specific content throughout the curriculum, such as courses on Indigenous history. Embedding it in the education system would ensure all health professionals received the training, rather than trying to reach them once they are working, when it is harder to embed into their schedule.
- Respondents advocated for multiple modalities of training for health care providers (online, in person, and community-engaged learning), to be integrated into professional development training throughout their careers.
- Health care practitioners wanted training that spoke to specific competencies that would align with their roles and responsibilities in order to have concrete tools to inform their practice.
- Local Indigenous community members felt that the training needed to be specific to their communities and needs, rather than general information about Indigenous Peoples and histories.
- Learning from the lived experiences of Indigenous people from the communities served would ensure service providers are aware of local challenges, enabling care providers to respond to local needs of the community.

In addition, it is evident that in order to change practice, cultural safety education and learning need to be part of a broader agenda of systemic change in health care institutions. Downing et al. (2011) assert that the value of cultural safety as an approach is that it encourages

“shifting away from trying to teach about ‘indigenous culture’, toward examining processes of power imbalance,” and thus is more likely to “produce lasting change among health staff and systems” (p. 255). As Browne et al. (2016) identified, a range of strategies are needed that “can form the basis of organizational-level interventions to promote equity” (p. 13). Systems-level interventions are needed to engage and support staff who have participated in cultural safety training to change their behaviours and practices. Focusing only on frontline care providers is inadequate to create such meaningful change. As Durey (2010) concludes: “For anti-racism strategies to be effective and change implemented, collective support is required at institutional, organisational, and individual levels” (p. S91). Senior leadership teams have an important role to play in setting an example for staff and ensuring that their organizations’ policies and procedures support culturally safe care. Engagement from organizational leadership, including the introduction of mandates and accountabilities, is seen as necessary in order to actively combat racism in the health care system and to confirm the commitment to cultural safety for Indigenous individuals seeking health care.

Conclusions

In order to change practice, Indigenous cultural safety education and learning need to be ongoing and built on previous training. Indigenous cultural training in its many forms has demonstrated some effectiveness in raising awareness and improving attitudes, knowledge, and skills among health care providers. While health care providers should take the initiative to participate in Indigenous cultural safety training, there is a need for systemic change in health care institutions to support staff who are participating in cultural safety training. Care providers need support in moving from knowledge to practice to create a culturally safe space for Indigenous individuals and their families. This transformation requires genuine partnerships with local Indigenous communities, as it is the experiences of Indigenous people that will determine whether care is culturally safe. Training alone does not ensure that change will happen. Cultural safety training should not be treated as a box to be checked on completion and should not take a one-size-fits-all approach, but is rather a nuanced journey through which one develops knowledge and skills. Real change will require a long-term commitment from individuals and organizations to ensure we move beyond rhetoric toward genuine reconciliation in health care.

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