Cultural Safety

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

Introduction

- Jennifer S. Nanez, MSW, LMSW currently serves as a Lecturer and Senior Program Therapist at the University of New Mexico, Department of Psychiatry and Behavioral Science, Division of Community Behavioral Health. Ms. Nanez is an enrolled tribal member of the Pueblo of Acoma, New Mexico and has been in the social work and education fields for over 25 years with an emphasis in serving the American Indian population. Ms. Nanez's interests lie in suicide prevention and mental health treatment support, working within a Healing from Historical Trauma framework.

Learning Objectives

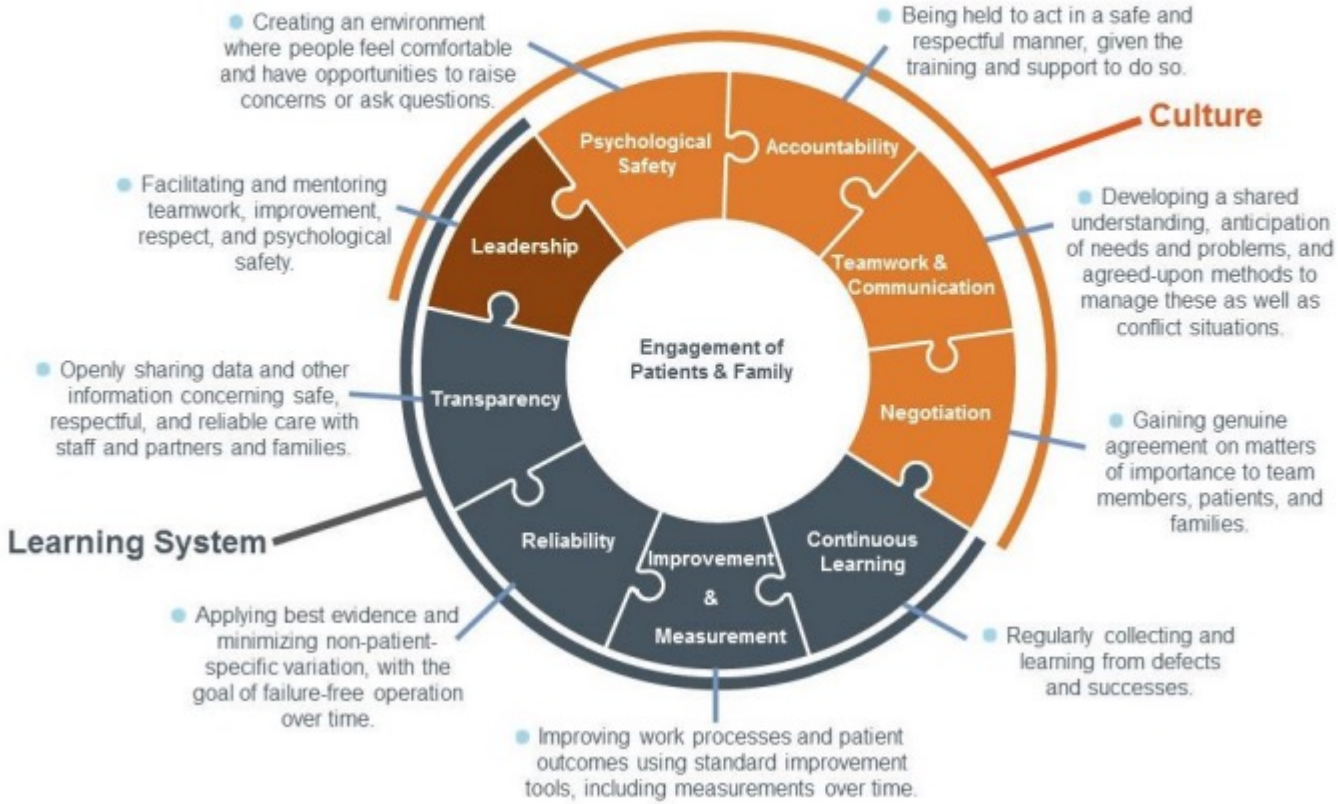
1. Differentiate between the Culture of Safety, and Cultural Safety.
2. Discuss Cultural Safety as a framework for Trauma Informed Care.
3. Examine the application of cultural safety as a tool for healthcare equity

Disclosures

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

Culture of Safety in Healthcare

Figure 2. Framework for Safe, Reliable, and Effective Care — with Descriptive Detail for the Components



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

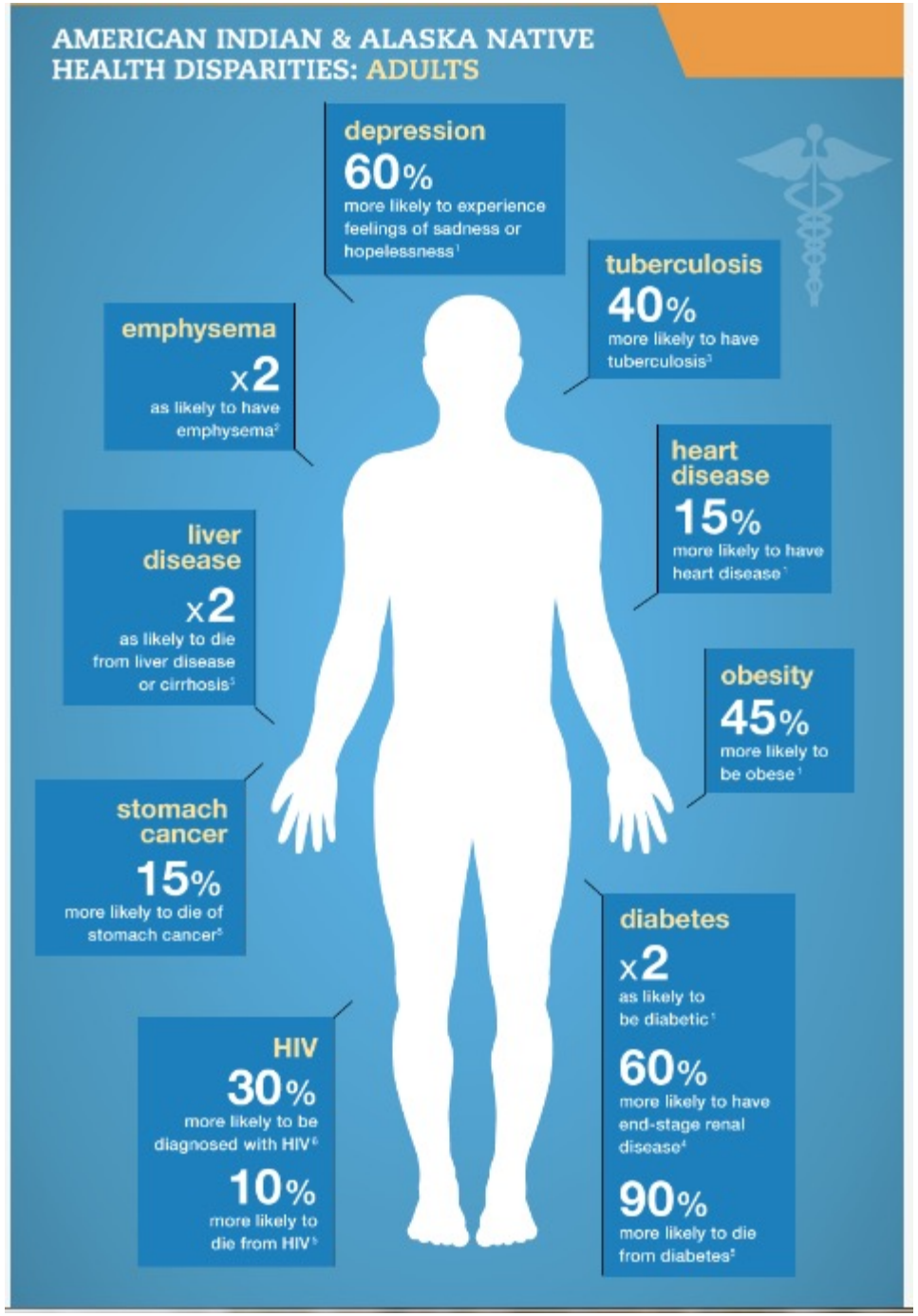
Culture of Safety in Healthcare

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

    1. Focus on what goes right as well as learning from what goes wrong;
    2. Move to greater proactivity;
    3. Create systems for learning from learning;
    4. Be humble — build trust and transparency;
    5. Co-produce safety with patients and families; and
    6. **Recognize that safety is more than the absence of physical harm; it is also the pursuit of dignity and equity.**
        - **This is where we can begin to examine the role of Cultural Safety as the underpinning for the Culture of Safety.**

Indigenous View of Health

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

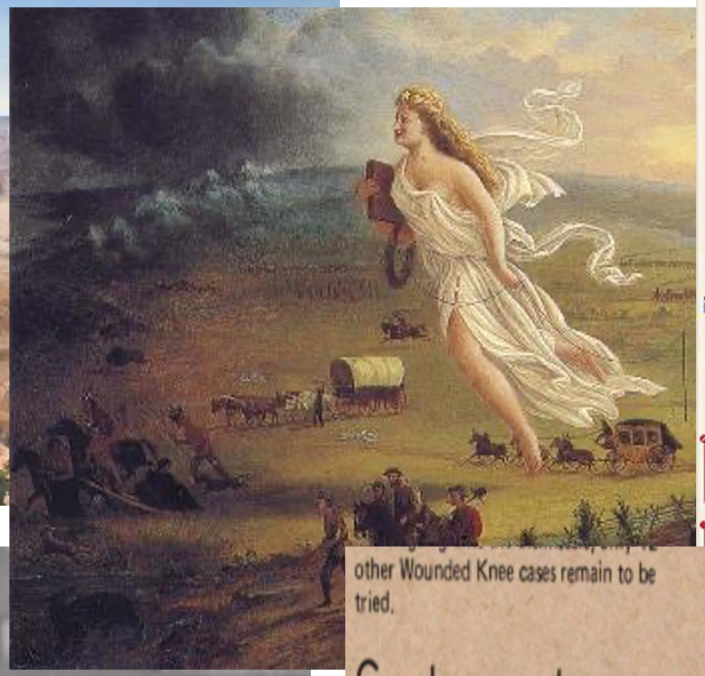


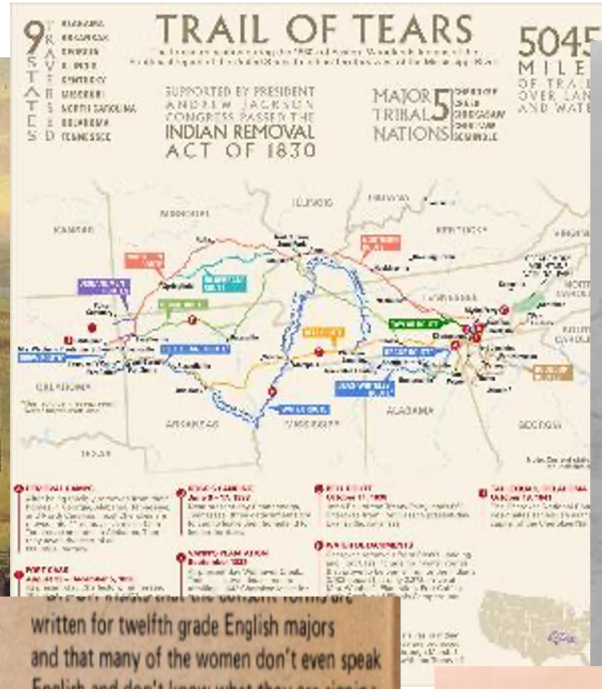
- Disparities in AI/AN health are well documented.
- Indigenous health post colonization has been influenced by histories of trauma, policy and institutional betrayals.

http://familiesusa.org/sites/default/files/product_documents/HSI-Health-disparities_american-indian-infographic_final_o.png

Role of Historical Trauma

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





other Wounded Knee cases remain to be tried.

Sterilization Is Genocide

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

According to Dr. Connie Uri, a Native American physician who has been investigating

written for twelfth grade English majors and that many of the women don't even speak English and don't know what they are signing.

Testimony before the US Senate's Permanent Investigations Subcommittee in September included testimony by Emergy Johnson, director of the Indian Health Service claiming that the IHS "considered non-therapeutic sterilization a legitimate method of family planning. We would be concerned only if these procedures were performed under coercion.

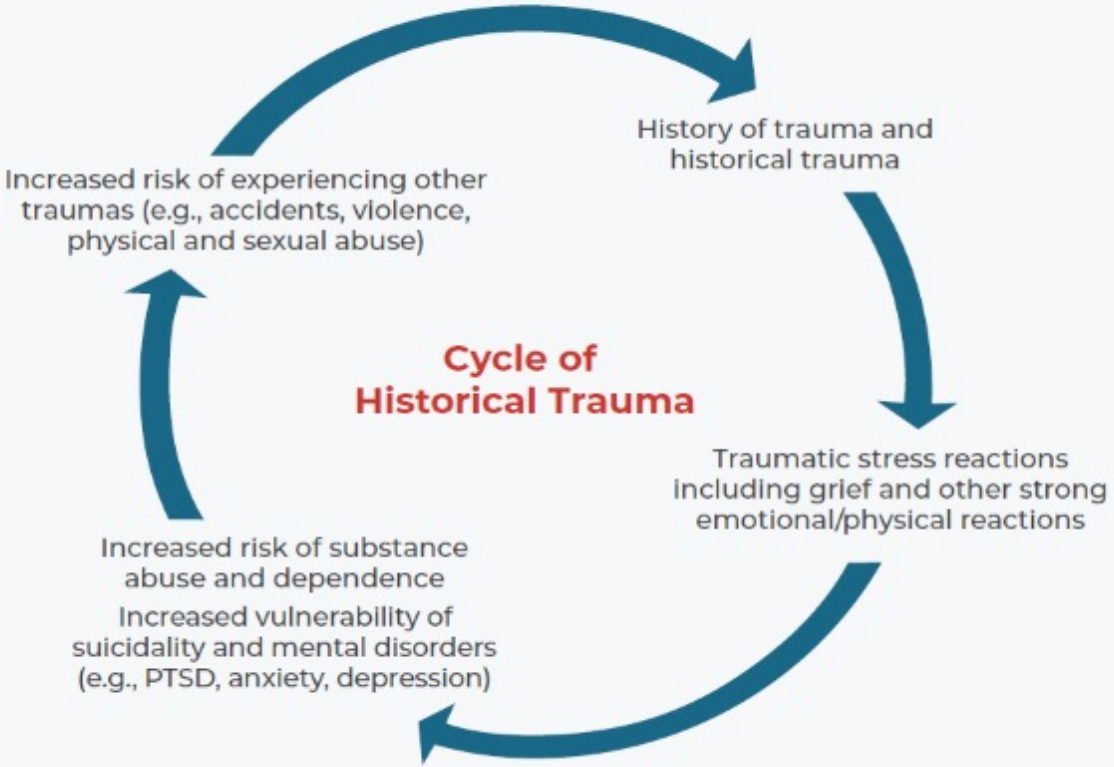
The Havasupai Trib
Arizona State Un
Genetics, Consent, and

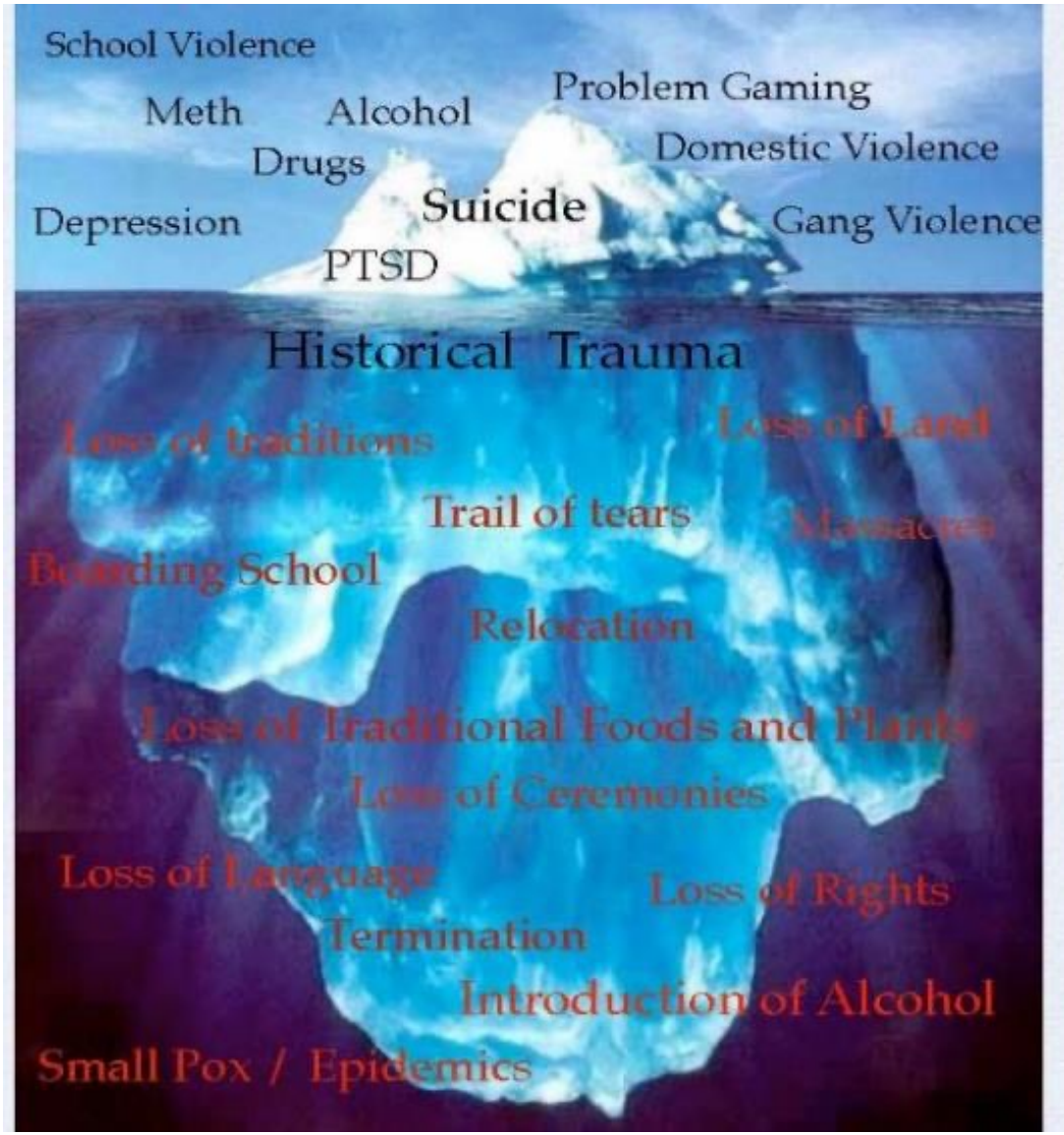
Donna Spruijt-Metz, PhD

Director, USC mHealth Collabor
Center for Economic and Social Research
Associate Professor Preventive Medicine and Psychology
Director, Responsible Conduct in Research, USC Keck School of Medicine
dmetz@usc.edu

USC CTSI Ethics Forum

EXHIBIT 1.1-2. Cycle of Historical Trauma





Historical Oppression

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


Healthcare Inequity
Missing and Murdered Indigenous Women
Lateral Trauma
Public Education Systems
Lack of Access to Resources
Challenges to Sovereignty
Elders Passing
Disconnect
Mental Health
Domestic Violence
Environmental Injustice
Challenges to ICWA
Sexual Assault
Language Loss
Abuses of Power
Discrimination
Substance Use
Intimate Partner Violence
Violence Against Women
Misogony
Violence Against Children
Patriarchal Power Systems
Violence Against Men
Land Loss
Economic Insecurity
WordItOut

What is Trauma informed care:

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

Historical Trauma Informed Care

- Historical Trauma Informed Care includes integration of recognition o tribal culture an history and the impact up to the present. Both m be incorporated assessment, rap building and treatment approaches.

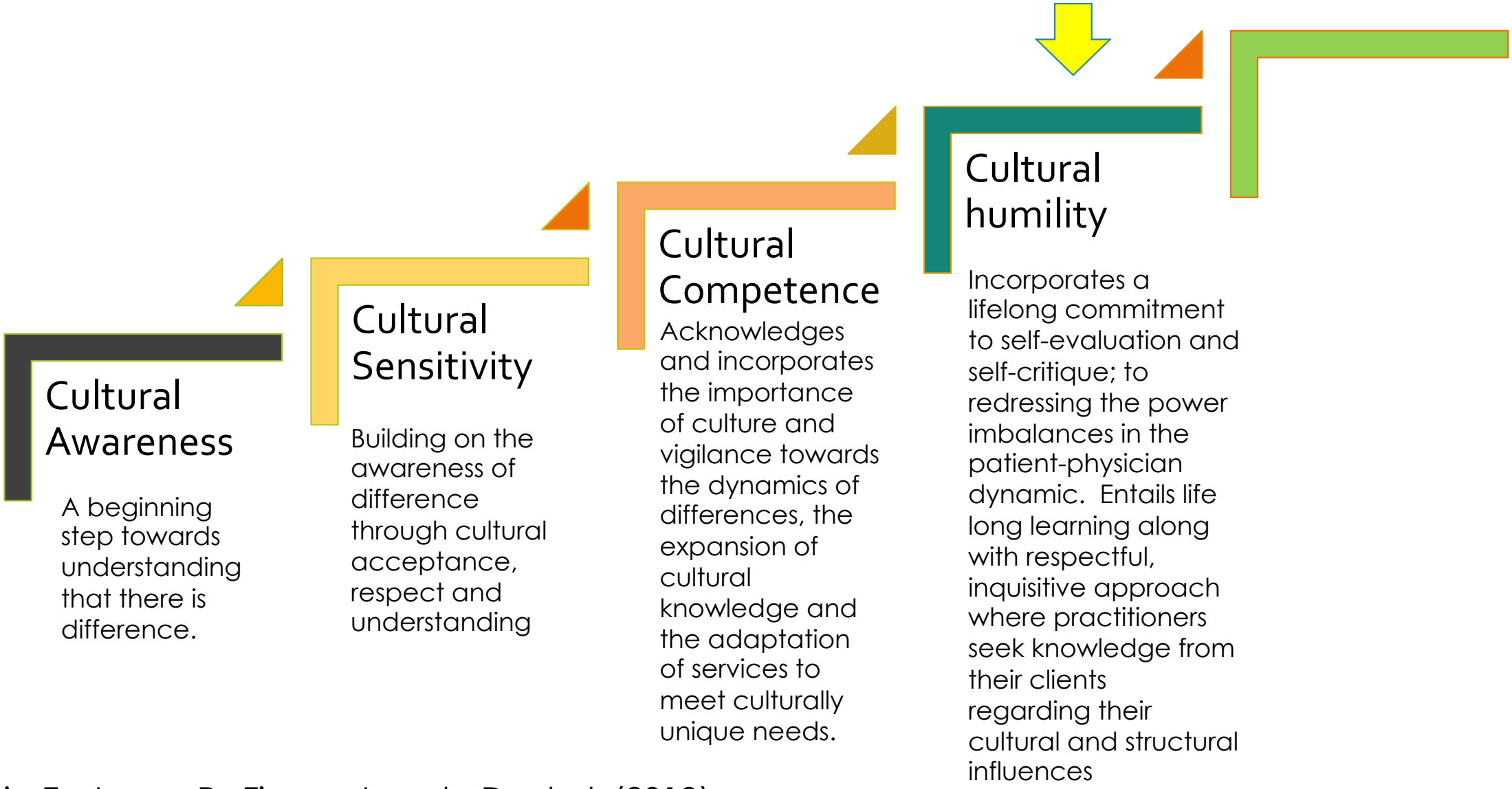
CULTURAL SAFETY

Structural systemic change and Indigenous lens

Origins of Cultural Safety

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

Moving towards Cultural Appropriate Treatment



Curtis, E., Jones, R., Tipene-Leach, D. et al. (2019)

Moving towards Cultural Appropriate Treatment

Curtis, E., Jones, R., Tipene-Leach, D. et al. (2019)

Definition of Cultural Safety

Cultural Safety is:

- an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system.
- ***Safety is defined by those receiving care***, not by those who provide it.

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

Health Equity and Cultural Safety

Shifting power

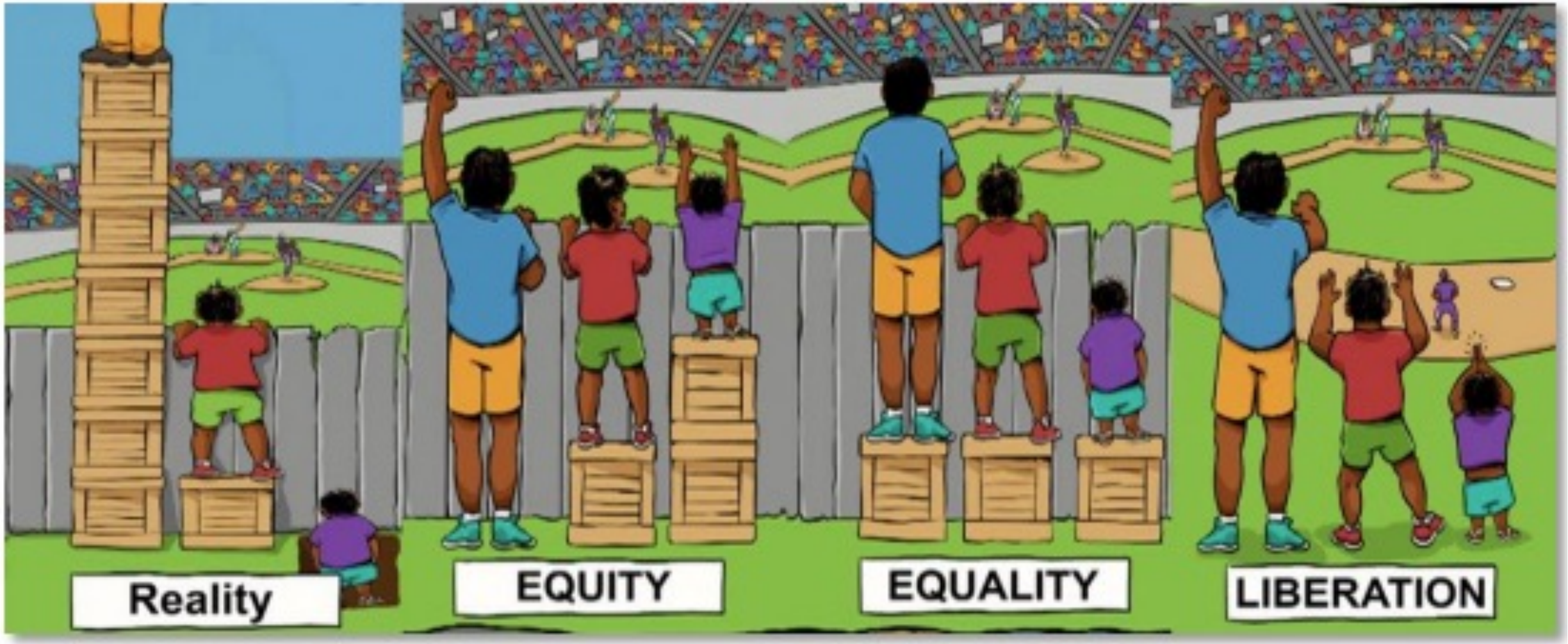
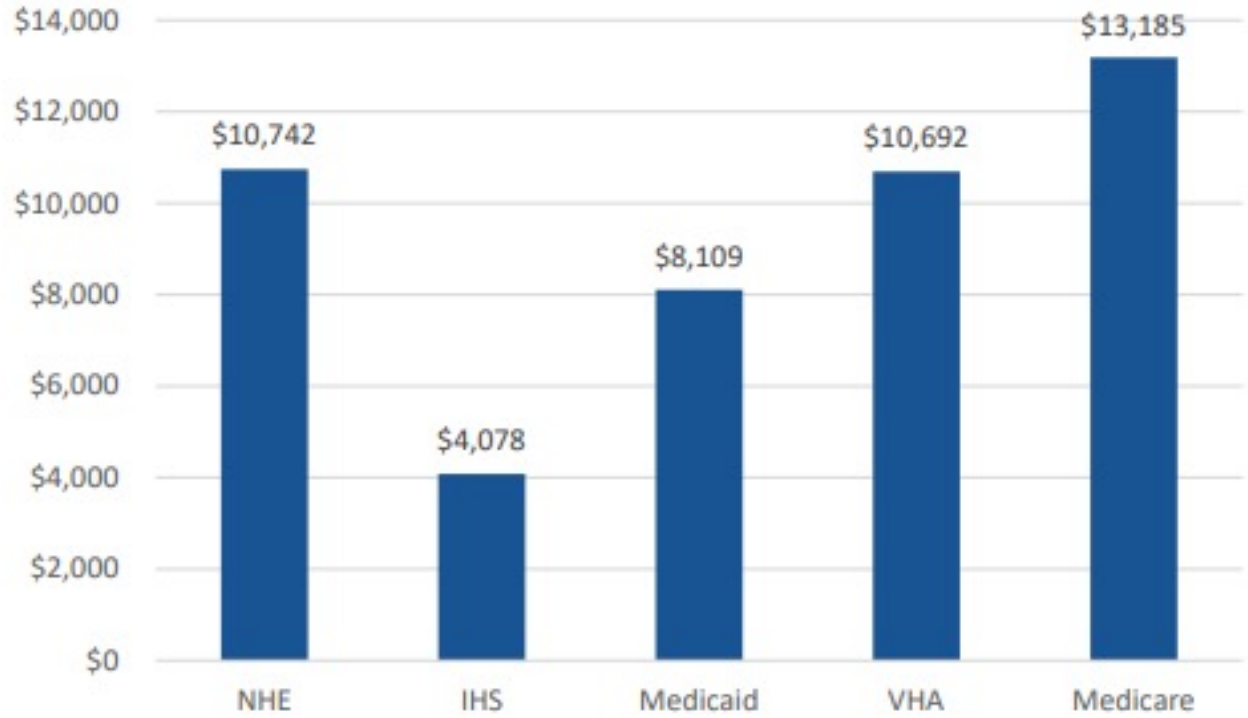

Reality
EQUITY
EQUALITY
LIBERATION

Figure 7. Estimated Per Capita Spending for Select Federal Health Care Programs, 2017



Note: IHS collects payments from various payers such as Medicare, Medicaid, and private insurance, which are captured in the per capita spending estimate for IHS listed above. For 2017, per capita funding for Medicaid ($411/user), Medicare ($126/user), Private Insurance ($78/user), and VA reimbursement ($4/user) are included in the $4,078 IHS per capita calculation.

Sources: U.S. Government Accountability Office. Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs. December 2018 (GAO-19-74R); Keehan SP, Cuckler GA, Poisal JA, et al. National Health Expenditure Projections, 2019-28: Expected Rebound in Prices Drives Rising Spending Growth. Health Affairs, 39(4), March 2020.

Health Equity and COVID

- Trembley (2021) writes "It has been suggested that the Covid-19 is not a pandemic, but a '**syndemic**', i.e. an epidemic that spreads synergistically with pre-existing inequitable social conditions (Horton, 2020).
- In the case of Indigenous populations, this syndemic is the result of the overlay of the Covid-19 pandemic on patterns of vulnerability established by systemic racism and colonialism."

Large portions of Navajo Nation reservation lacks basic infrastructure

Running water

Percentage of homes without

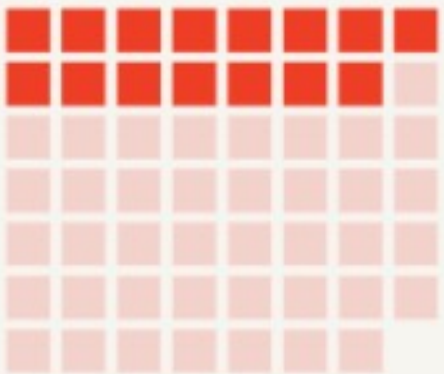
30%

1 in 3 homes:
No sink or toilet

Electricity

Number of homes without

15,000



Total:
55,000 homes

Grocery stores

in area about the size of West Virginia

13

162 supermarkets in West Virginia

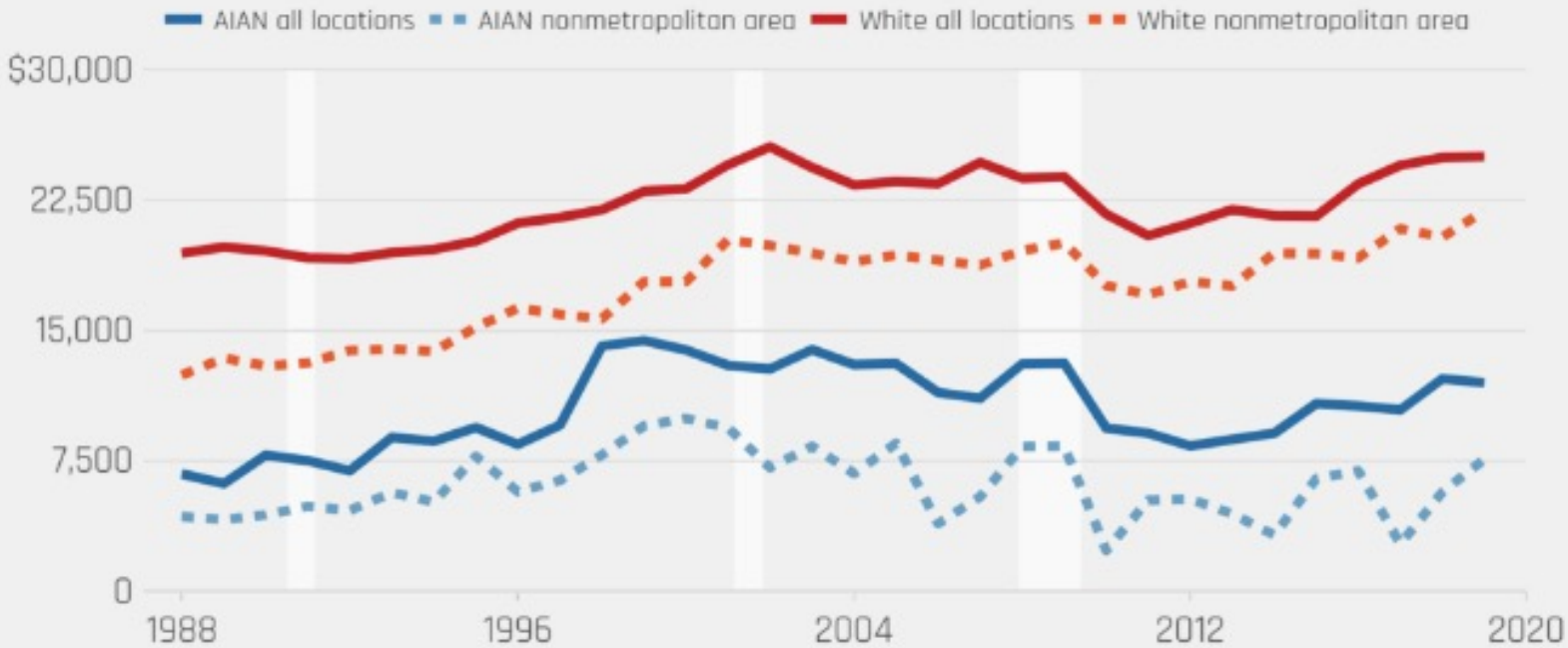
SOURCES Navajo Water Project, American Public Power Association, Partners In Health

American Indian SDH Disparities

- Housing:
  - In 2017, 88% of tribal housing officials reported homelessness was a problem in their community—not to mention the number of individuals staying in overcrowded conditions
- Digital access:
  - In 2020, 34% of AI/AN households had no high speed internet access at home, and almost 16% with out a computer.
- Educational Attainment:
  - 1 in 10 American Indian students did not complete k-12 education.
  - Between 2010 and 2018, the college enrollment rate for AI/AN students decreased by 33 percent
  - Lawsuits against State and Federal government by Tribes has been one means by which Tribal nations have sought to seek accountability for educational support for tribal children.
    - Yazzie/Martinez lawsuit in NM is one example

American Indian workers earn far less than White workers

Median earnings of American Indian and Alaska Native workers in rural and metropolitan areas, compared to White workers, real 2019 dollars, 1988–2019



Source: U.S. Census Bureau, "Current Population Survey, 1988–2019" [n.d.]; Sarah Flood and others, "Integrated Public Use Microdata Series, Current Population Survey: Version 7.0" [Minneapolis, MN: IPUMS, 2020], available at https://doi.org/10.18128/D030.V7.0.

Note: Earnings are defined as all wage income for anyone who self-identifies as either American Indian or White. All dollar amounts have been adjusted to real 2019 dollars using the CPI-U index.

Equitable Growth

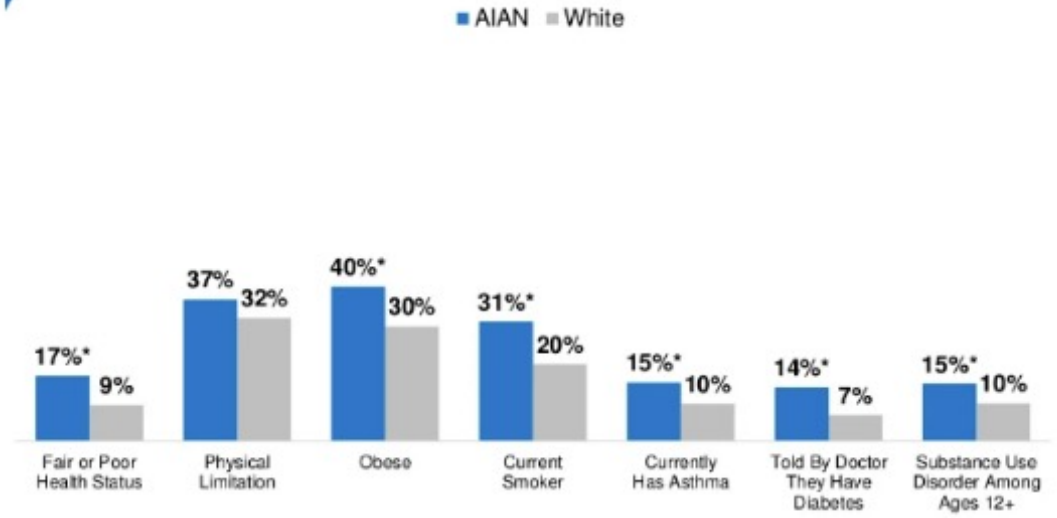
Additional SDOH Data

- 28.3% of Natives live in poverty, nearly twice the national rate of 15.5%, and the highest of any racial or ethnic group;
  - the median Native household income is $37,227, compared to $53,657 for the nation as a whole;
  - 23.1% of Natives lack health insurance coverage, compared to the national average of 11.7%;
  - and the percentage of Natives who drop out of school is 11%, compared to 5% of non-Hispanic Whites

Source Slides:

Figure 4

AIANs fare worse than Whites across many health measures.



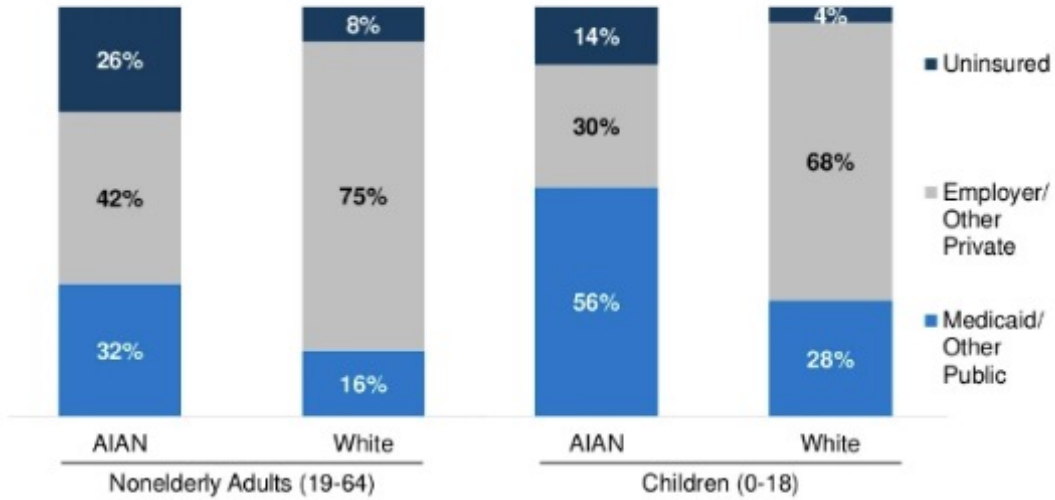
* Indicates statistically significant difference from the White population at the p<0.05 level.
Note: AIANs and Whites are non-Hispanic. Excludes individuals of mixed race. Includes nonelderly adults 18-64 years of age.
Source: Kaiser Family Foundation analysis of 2017 National Health Interview Survey (NHIS), 2017 Behavioral Risk Factor Surveillance System (BRFSS), and 2017 National Survey on Drug Use and Health.

KFF

Source Slides:

Figure 6

Medicaid and CHIP help fill gaps in private coverage for AIANs, particularly AIAN children, but they remain more likely to be uninsured than Whites.



Note: AIANs and Whites are non-Hispanic. Excludes individuals of mixed race. Includes nonelderly adults 19-64 years of age and children 0-18 years of age. Totals may not sum to 100% due to rounding. All values have a statistically significant difference from the White population at the p<0.05 level.
Source: Kaiser Family Foundation analysis of 2017 American Community Survey (ACS), 1-Year Estimates.

KFF

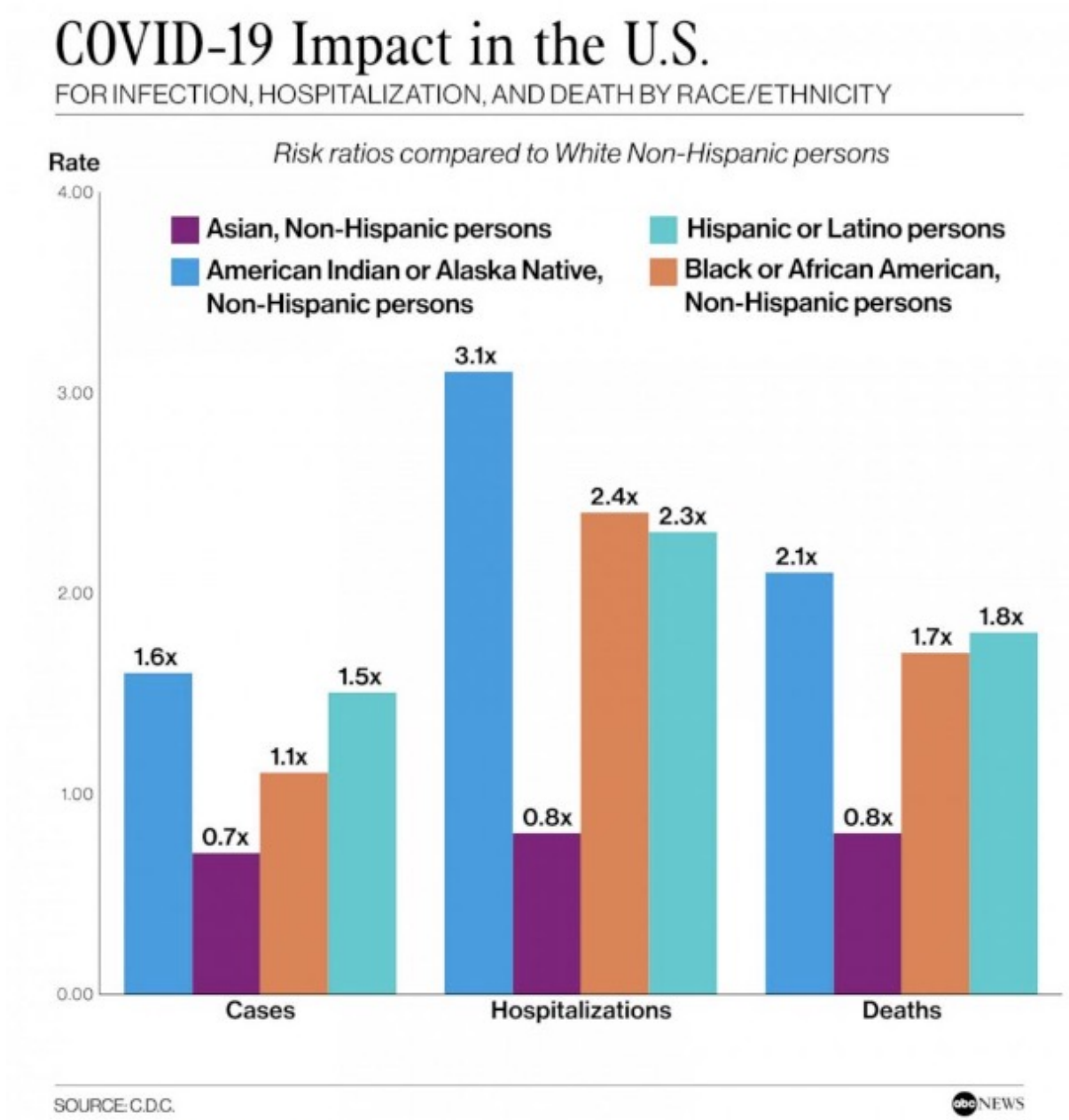
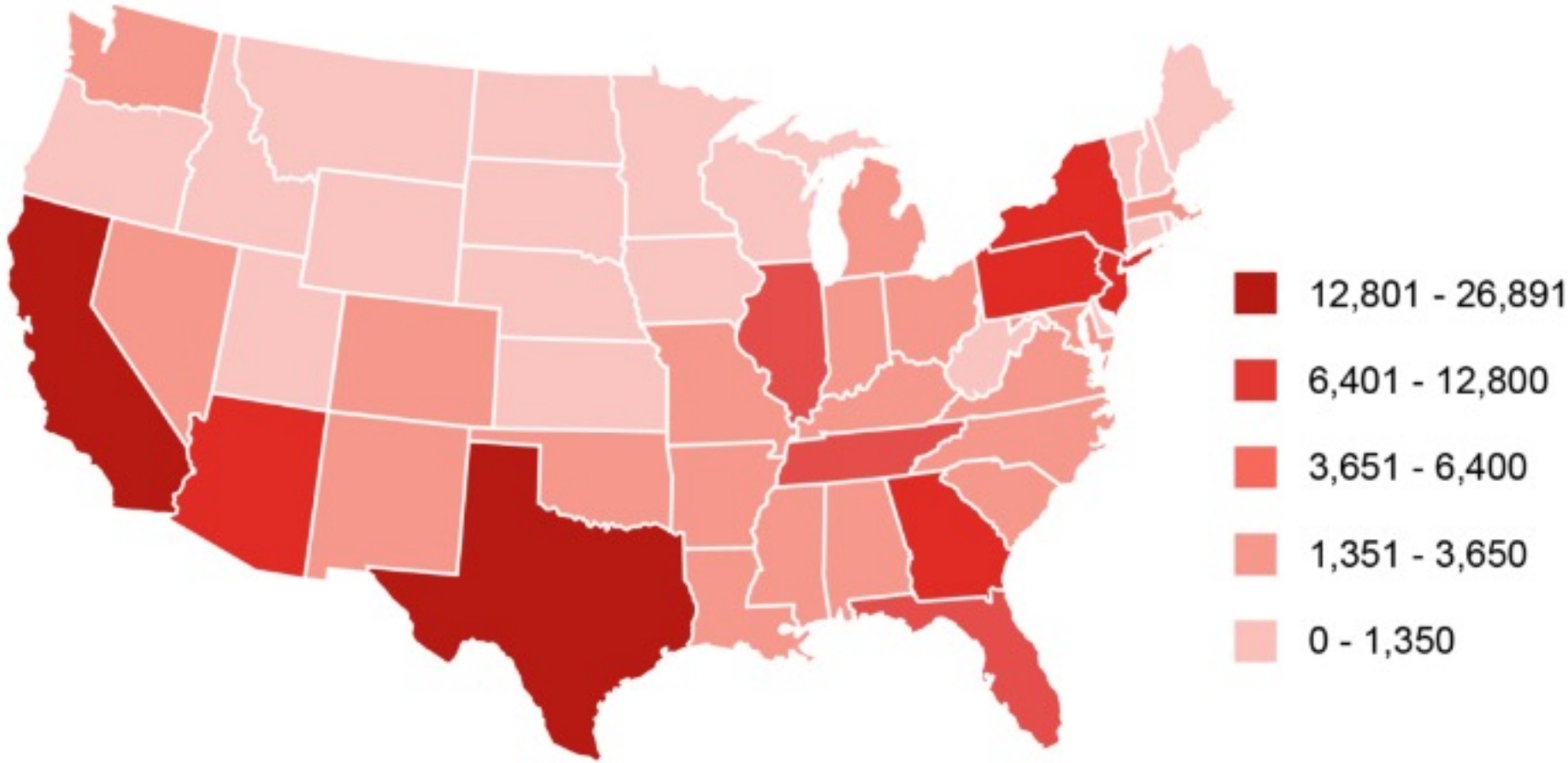


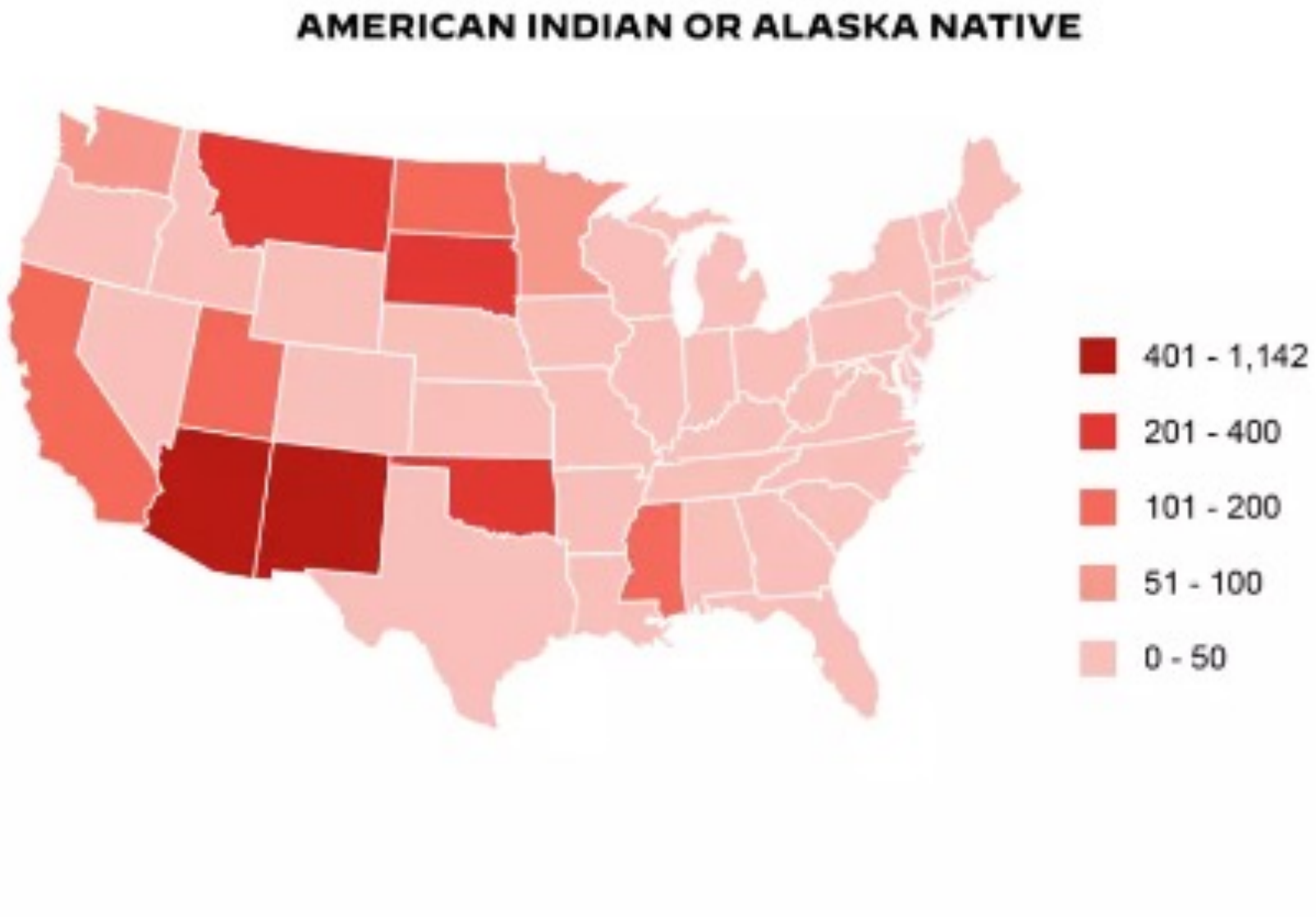
Illustration ABC News / CDC

COVID-19 Impact Risk in the U.S.

TOTAL NUMBER OF CHILDREN



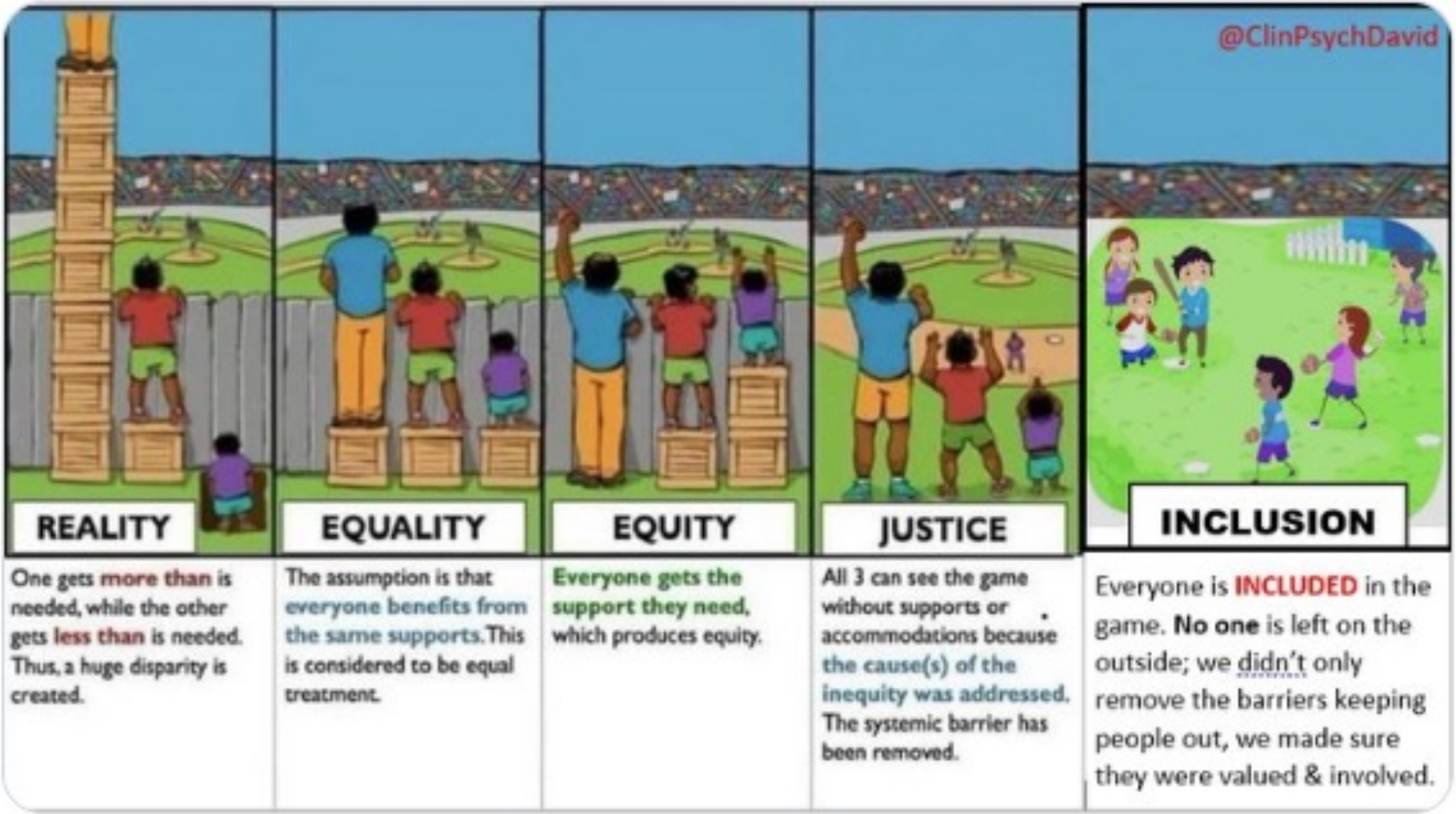
Total Number Children with Caregiver Loss Due to COVID-19

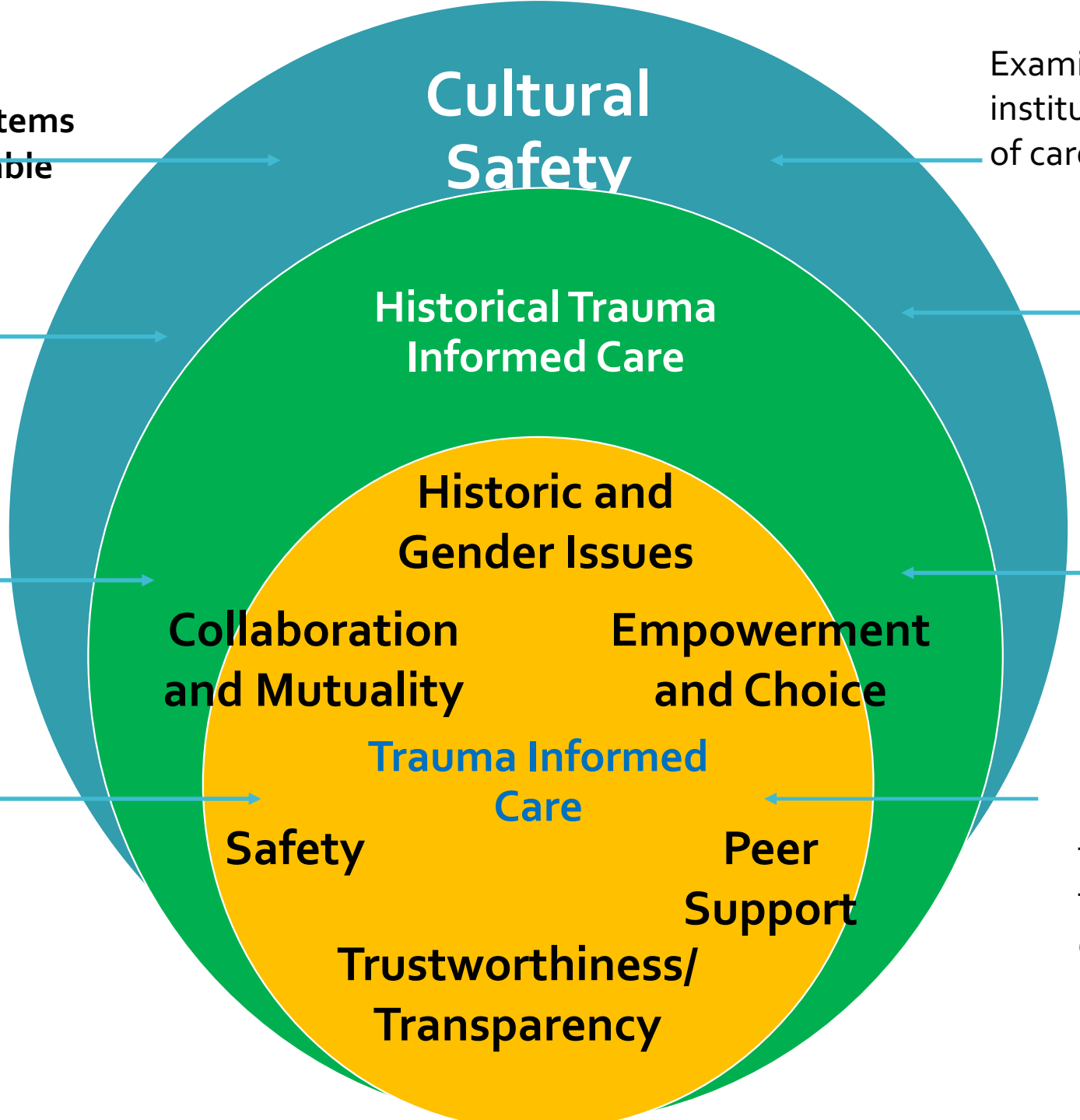


Children with Caregiver Loss Due to COVID-19 - AMERICAN INDIAN OR ALASKA NATIVE

Cultural Safety creates Safe Care

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


@ClinPsychDavid
REALITY
EQUALITY
EQUITY
JUSTICE
INCLUSION
One gets more than is needed, while the other gets less than is needed. Thus, a huge disparity is created.
The assumption is that everyone benefits from the same supports. This is considered to be equal treatment.
Everyone gets the support they need, which produces equity.
All 3 can see the game without supports or accommodations because the cause(s) of the inequity was addressed. The systemic barrier has been removed.
Everyone is INCLUDED in the game. No one is left on the outside; we didn't only remove the barriers keeping people out, we made sure they were valued & involved.



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

Examines and confronts institutional betrayal in systems of care.

Examines and confronts implicit bias

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

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

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

Working in collaboration with a patient versus Working on.

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

Operationalizing Cultural Safety: Turning to our Relatives for support.

AIDA

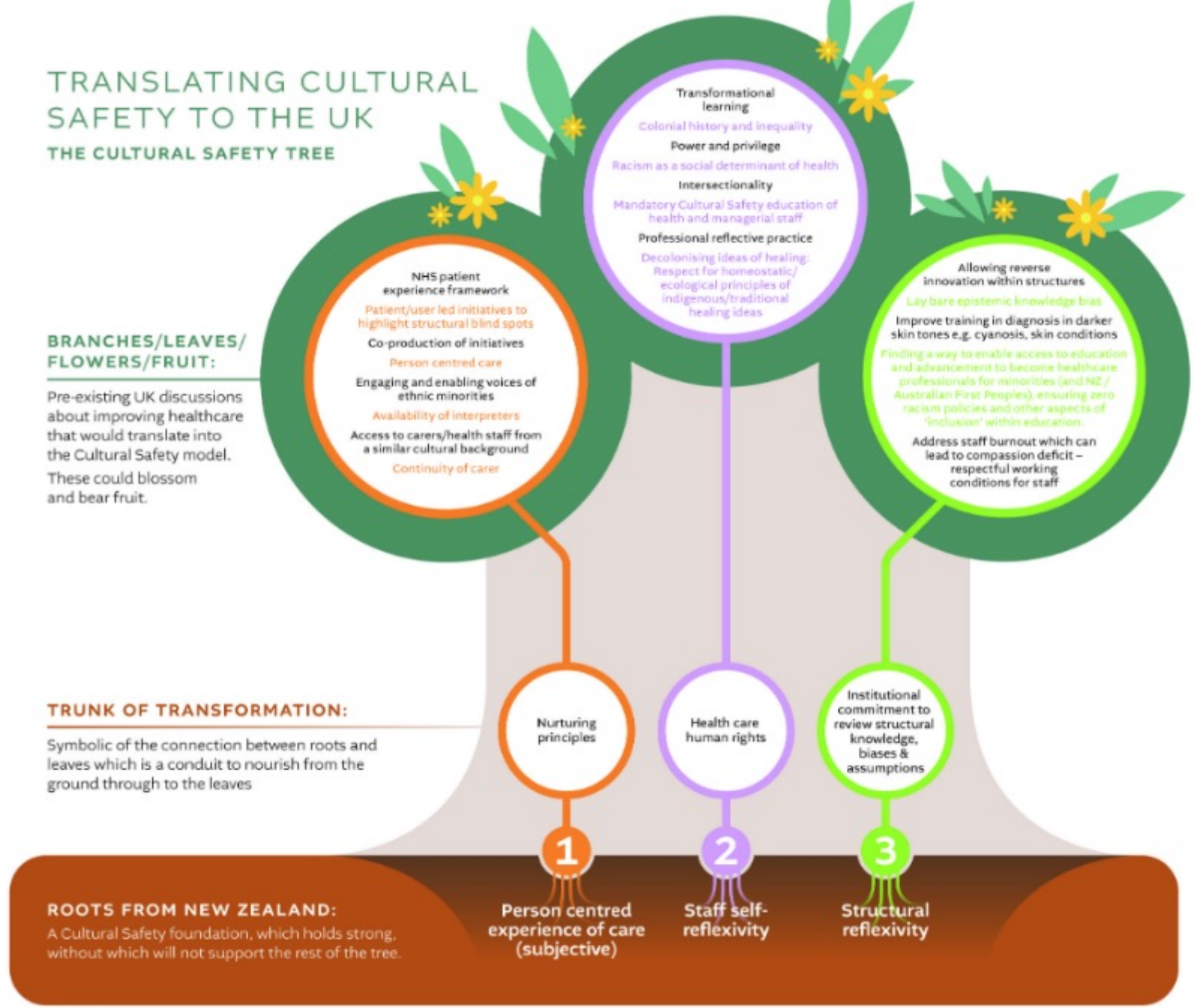
AUSTRALIAN INDIGENOUS DOCTORS' ASSOCIATION

Cultural Safety Training

Developed and delivered by Aboriginal and Torres Strait Islander doctors.

TRANSLATING CULTURAL SAFETY TO THE UK

THE CULTURAL SAFETY TREE



BRANCHES/LEAVES/ FLOWERS/FRUIT:

Pre-existing UK discussions about improving healthcare that would translate into the Cultural Safety model.

These could blossom and bear fruit.

TRUNK OF TRANSFORMATION:

Symbolic of the connection between roots and leaves which is a conduit to nourish from the ground through to the leaves

ROOTS FROM NEW ZEALAND:

A Cultural Safety foundation, which holds strong, without which will not support the rest of the tree.

COMMITTED to CULTURAL SAFETY

for Indigenous Peoples in the Health Care System

Culturally Safe Health Systems

Many factors contribute to a culturally safe health system, including:

- training on cultural safety and humility;
- reviewing and developing organizational policies for cultural safety;
- articulating a clear and accessible complaints process;
- fostering a commitment to evaluation, reporting, and continuous improvement of cultural safety and humility across the system;
- ensuring organizational definitions of quality care, and plans to deliver quality care, include cultural safety and humility;
- making efforts to ensure the workforce representatively includes Indigenous leadership and staff across all levels;
- ensuring physical environments reflect local Indigenous communities and cultures;
- supporting committment by organizational leadership to cultural safety and humility; and
- partnering with local Indigenous communities and organizations.

Poster #3 of 4.

Look for the others!

First Nations Health Authority
Health through wellness

northern health
the northern way of caring

First Nations Health Council

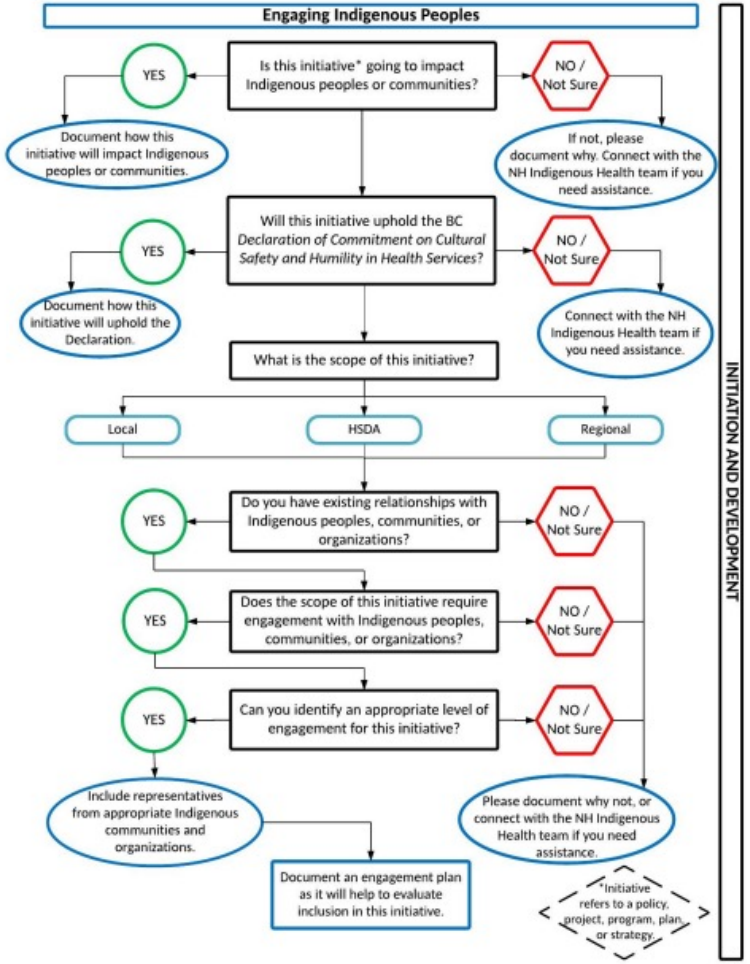
Bear by Carla Aubichon Joseph, Indigenous artist in Prince George, BC. hummingbear@shaw.ca

10-307-6035 (IND 06/17)

NORTHERN HEALTH CULTURAL SAFETY AND SYSTEM CHANGE: An Assessment Tool

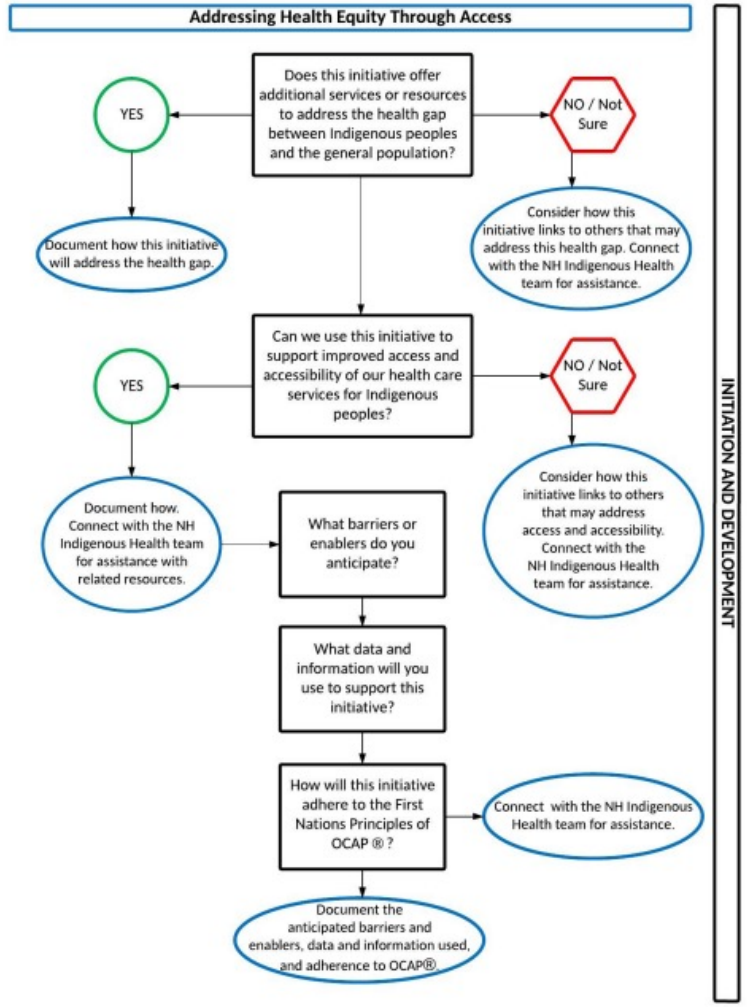
3.1 ENGAGING INDIGENOUS PEOPLES

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



3.2 ADDRESSING HEALTH EQUITY THROUGH ACCESS

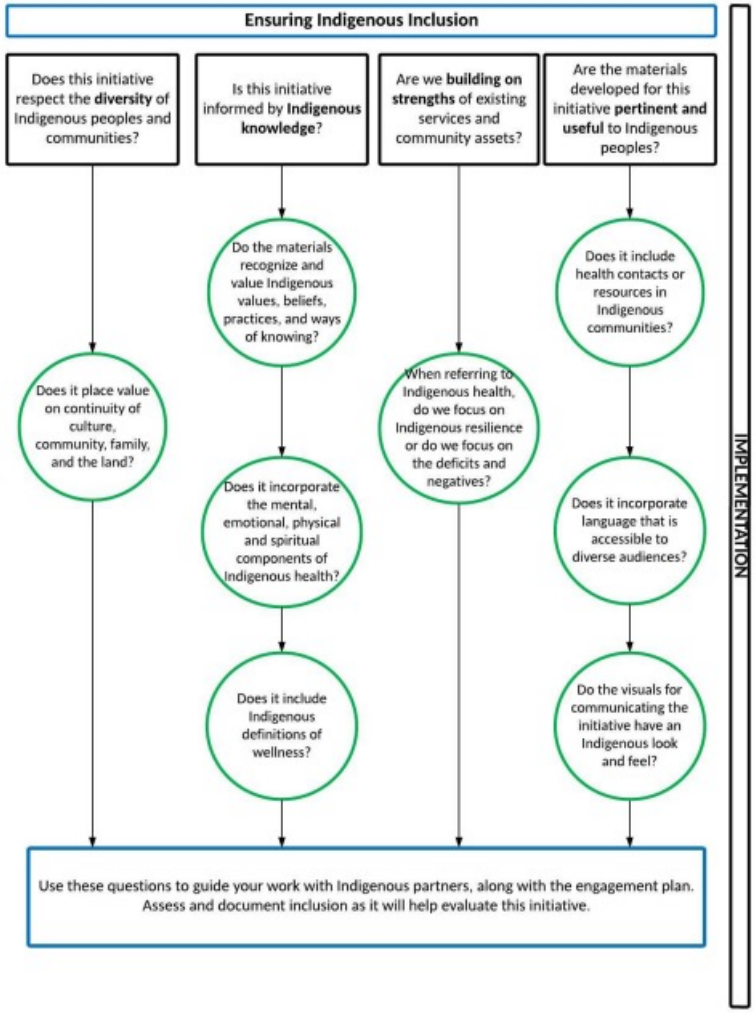
It is important to remember that working on even a single practical change to an initiative is always more powerful and effective than making plans to do so in the future. This decision-making tree provides end users and their partners opportunities to address health equity for Indigenous peoples by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



NORTHERN HEALTH CULTURAL SAFETY AND SYSTEM CHANGE: An Assessment Tool

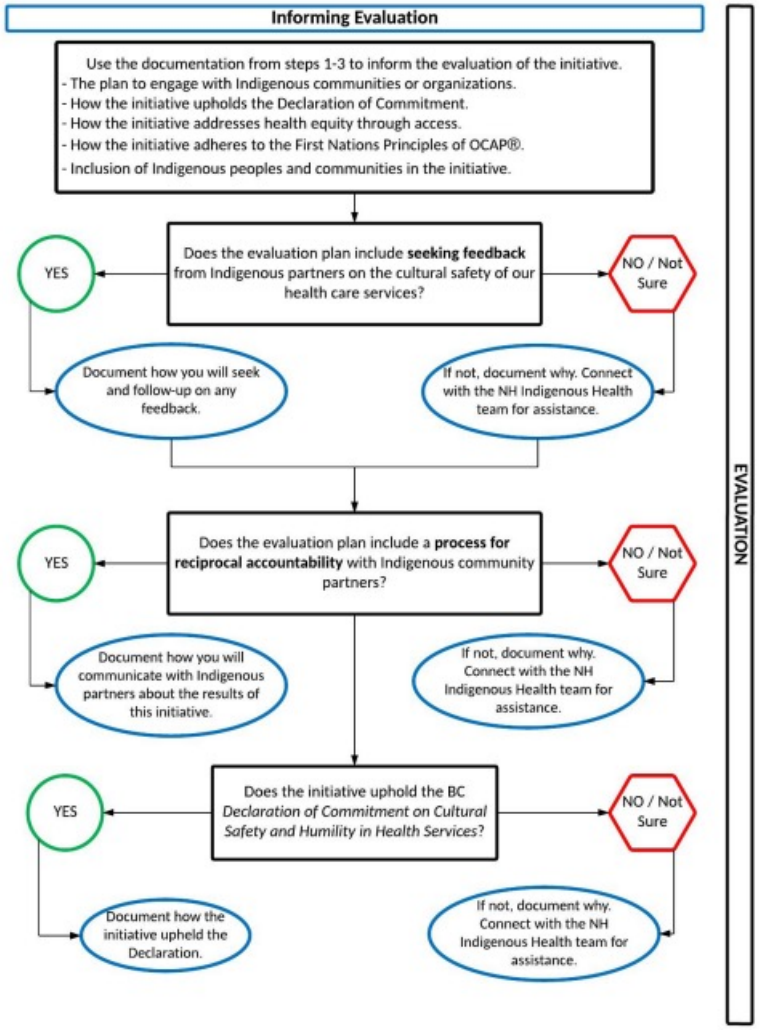
3.3 ENSURING INDIGENOUS INCLUSION

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

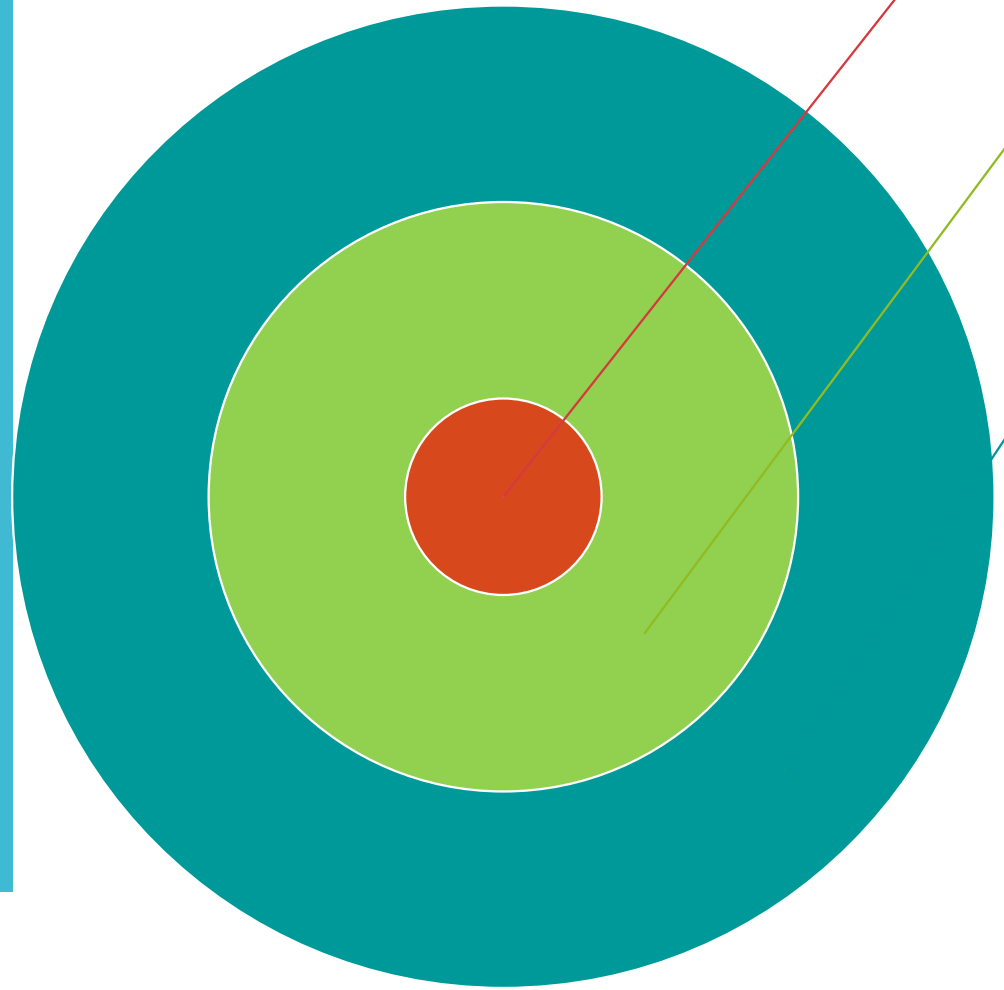


3.4 INFORMING EVALUATION

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



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



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

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

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

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

Our Role as Advocates

- Examine and advocate for social, racial, economic, environmental, health access, justice and equity frameworks.
- Meet with local Tribal, state, and national representatives to understand health needs, infrastructure support needs and impact on emergency care.
- Advocate for policies that shift power differentials in patient care
- Support full funding for the Indian Health Service and expansion of mental health prevention and treatment funding to Tribes and American Indian and Alaskan Native services.

References and Resources

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