The following was submitted to us by Dr. Chris Ashton, BEng, MD, MBA/Finance. While this will be of particular interest to those in the health care field, anyone who wants to understand the anger and frustrations of our First Nations will benefit from reading this.

Cultural Safety Training Guide

1. Purpose of the guide

This guide is geared to educate healthcare providers working in aboriginal communities to understand the culture, traditions and the experience of the First Nations and Metis People as these impact the provision of appropriate, acceptable healthcare for the People.

Most of current healthcare delivery is based upon a Western biomedical model of care, grounded for the most part in a Christian belief system. It is essentially paternalistic, requiring trust on the part of clients in their healthcare professionals to allow application of evidence based treatment according to the opinion of the providers. This paper strongly cautions against assuming all individual Aboriginal People will access and accept healthcare in a uniform fashion. Nonetheless, this manual will outline the common cultural themes which may affect Native Peoples' responses to delivery of healthcare in a Western biomedical context.

It is hoped that an understanding of these themes will facilitate the development of respect for client Aboriginal culture, traditions and experience, leading to mutual respect among clients and providers. This mutual respect can be termed cultural safety; this is the outcome of an educational process both didactic and practical which begins with awareness to cultural beliefs to application of cultural sensitive practice, finally to cultural safety.

A real life case example of why this process is termed cultural safety may illuminate its significance:

"The minister also went on how aboriginal emotions are often neglected, that when an aboriginal person makes a demand often they may eventually become emotional and act in a manner which is not very dignified and this may disrupt the nursing staff that are not used to seeing aboriginals emotional in this manner. Sure they are used to seeing natives get upset, or cry when the situation demands it. I am talking about a state of emotion that is very perturbing to most people who see it and often mistake it for a case of psychological breakdown.

There is also the reaction which comes from the family when this emotion is ignored or when the hospital staff gets upset with the patient for no obvious reason and the family sees this as deterring communication. Often anger is misconstrued, both by the patient's family and by the hospital staff. In some cases such as my cousin, refused follow up dialysis for an overdose and while the family and the hospital were trying to sort out this disagreement between my cousin and the nurse, it was too late to pursue a medevac and my cousin died eventually. This is a classic example of cultural safety."

(source: conversation with a friend of the author summer 2010)

2. Introduction: The Cultural Divide

A verse from an 1868 poem by Elizabeth C. Clephane, later turned to music, called 'The Ninety and Nine,' comes to mind when considering the cultural divide among First Nations and Western societies:

"But none of the ransomed ever knew
How deep were the waters crossed;"

The 'ransomed' in the poem refers to those 99 sheep (Matthew 18:12, 13) still inside heavens walls, unaware how dangerous the outer world was for the one sheep lost. Culturally insensitive care arises from a misunderstanding of how deep the waters are, that is, the cultural divide between the old and new societies.

A cultural divide appeared with the first North American settlers from Europe who held a heritage and belief system of manifest destiny and cultural and scientific superiority, leading to the opinion that our paternalism towards First Nations and Metis Peoples is morally good and justified. Yet, this Western belief system breaks down when trying to provide the best care that is acceptable to Aboriginal People; we are often left vexed. Our heritage in Canada and role in affecting the lives of aboriginal people is characterized by uninformed decisions based upon the certain belief that our paternalism is right. Colonialism imposed upon Aboriginal People was thought to be good; imposing a more sophisticated trading society upon Native Peoples could only give longstanding benefit. This approach by colonialists has left a legacy of harm upon Aboriginal People.

With regards to healthcare, 'unfortunately illnesses do not see racial divides. (source: friend)' It is the intent of this manual to inform the reader how deep became the racial divide and lack of trust between societies from the early years of European settlement of North America to present day policies. Such policies continue to keep the wounds of colonialism alive in Canada's First Nations and Métis People.

3. Theme I - Empowerment and power imbalances

The effect of the European settler's belief of manifest destiny and ruthless treatment of Native Americans as they expanded their frontiers in America is well exemplified by the history of the 'Trail of Tears.'

The 'Trail of Tears' was the forcible relocation and movement of Native Americans, including many members of the Cherokee, Creek, Seminole, and Choctaw nations among others in the United States, from their homelands to Indian Territory (present day Oklahoma) in the Western United States. The 'Trail of Tears' phrase originated from a description of the removal of the Choctaw Nation in 1831. Many Native Americans suffered from exposure, disease, and starvation while en route to their destinations, and many died, including 4,000 of the 15,000 relocated Cherokee.

At that time, all Native People in the United States became wards of the War Department which was tasked to relocate Aboriginals from their traditional grounds to other less arable territories. In effect, Natives were pushed off their original lands allowing the new settlers to cultivate more attractive property. Other Native Bands, such as the Oneidas split into smaller groups, some leaving their native grounds and emigrating to Canada.

Importantly, the history surrounding the Trail of Tears demarcates a marked imbalance of power between white settlers and natives which exists to this day, albeit in less dramatic forms. This power imbalance, ensuring socioeconomic superiority of non-natives, is perpetuated by Canada's Indian Act and the history of residential schools and its legislation. In healthcare, lesser health status of Canada's First Nations, Inuit and Métis are

perpetuated by the implementation of the Health Transfer Policy and current jurisdictional wrangling over care responsibilities for Natives.

It is important to note that the Canadian federal government is seen by First Nations as secondary to the Crown, which is viewed as consistent and sovereign as opposed to the constant shifting of federal cabinet ministers. While the federal government has been delegated authority in aboriginal affairs, First Nations continue to have an audience from time to time with the Crown to express grievances.

a. The Indian Act

Still in effect, the Indian Act was enacted in 1876 by the Parliament of Canada under the provisions of Section 91(24) of the Constitution Act, 1867, which provides Canada's federal government exclusive authority to legislate in relation to "Indians and Lands Reserved for Indians". The Indian Act is administered by the Minister of Indian Affairs and Northern Development. (Note that 'Indian' refers to First Nations in this Act.)

The Act defines who is an "Indian" and contains certain legal rights and legal disabilities for registered Indians. The rights exclusive to Indians in the Indian Act are beyond legal challenge under the Canadian Charter of Rights and Freedoms. Section Twenty-five of the Canadian Charter of Rights and Freedoms in particular, provides that the charter shall not be interpreted as negating specific aboriginal treaties and their corresponding rights and freedoms. Section Thirty-five of the Constitution Act, 1982 also recognizes and affirms the legal validity of aboriginal treaties.

There have been over twenty major changes made to the original Act. The original Indian Act does two things affecting all Aboriginal peoples in Canada:

1. It says how Reserves and Bands can operate.

The Act sets out rules for governing Indian reserves, defines how Bands can be created and spells out the powers of "Band Councils". Bands do not have to have reserve lands to operate under the Act.

2. It defines who is and who is not recognized as an "Indian".

The Act defined a number of types of Indian people who were denied recognition as "registered" or "status" Indians, and who were therefore denied membership in Bands

In return for tax exemption and other benefits (to be discussed later), the Act deprives First Nations of an absolute right non-natives have: land ownership. Reserve lands continue to be the property of the Crown. Section 18 of the Act sets this out:

Section 18 (1)

(Reserves Held for Use and Benefit of Bands)

Subject to this Act, reserves are held by Her Majesty for the use and benefit of the respective bands for which they were set apart, and subject to this Act and to the terms of any treaty or surrender, the Governor in Council may determine whether any purpose for which lands in a reserve are used or are to be used is for the use and benefit of the band.

Section 18 (2)

(Use of Reserve Lands for Specified Purposes)

The Minister may authorize the use of lands in a reserve for the purpose of Indian schools, the administration of Indian affairs, Indian burial grounds, Indian health projects or, with the consent of the council of the band, for any other purpose for the general welfare of the band, and may take any lands in a reserve required for those purposes, but where an individual Indian, immediately prior to the taking, was entitled to the possession of those lands, compensation for that use shall be paid to the Indian, in such amount as may be agreed between the Indian and the Minister, or, failing agreement, as may be determined in such manner as the Minister may direct.

The *Indian Act* seems out of step with the bulk of Canadian law. It singles out a segment of society -- largely on the basis of race -- removes much of their land and property from the commercial mainstream and gives the Minister of Indian & Northern Affairs, and other government officials, a degree of discretion that is not only intrusive but frequently offensive. Worse, the Act gave the government the power to declare who was an 'Indian' or not. The Act has been roundly criticized on all sides: many want it abolished because it violates normative standards of equality; others want First Nations to be able to make their own decisions as self-governing polities and see the Act as inhibiting that freedom. Even within its provisions, others see unfair treatment as between, for example, Indians who live on reserve and those who reside elsewhere. In short, this is a statute of which few speak well.

Historically, the Act evolved to protect the small share of Canada's land base which remained to our original peoples. Statutes dating back to the middle of the last century created the concept of "status" to separate those who were entitled to reside on Indian lands and use their resources from those who were forbidden to do so. In this respect, the early legislation was an expression of the concepts set forth in the Royal Proclamation of 1763. The exemption of reserve lands from municipal taxation and seizure under legal process were other measures intended to secure those lands for the intended occupants: Indians themselves.

Status soon came to have other implications. Status Indians were denied the right to vote, they did not sit on juries, and they were exempt from conscription in time of war (although the percentage of volunteers was higher among Indians than any other group). The attitude that others were the better judges of Indian interests turned the statute into a grab-bag of social engineering over the years. When the Potlatch and Sun Dance were seen as uncivilized, the Indian Act was used to ban them. Possession of liquor, on or off the reserve, was punished more harshly under the Act than by general laws. Loitering in pool rooms was forbidden. Indian children were removed from their homes, under the Minister's authority to educate them, and sent to residential schools. Children who were habitually absent from school were "deemed" to be juvenile delinquents. Most telling in relation to this attitude was the definition of "person" which was in the statute until 1951: "an individual other than an Indian". Indians could become persons by voluntarily enfranchising -- renouncing Indian status -- and, in many circumstances, were involuntarily enfranchised by the Act.

A famous statement in 1920 by Duncan Campbell Scott, poet, essayist and Deputy Superintendent General of Indian Affairs, encapsulates the prevailing attitude of his day:

'Our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic, and there is no Indian question, and no Indian department.'

Over time, the measures originally intended to protect the land base were progressively loosened to open up reserve lands for farming, settlement and other purposes. At one time, Exchequer Court judges were given the discretion to remove Indians from reserves within urban area although that was only done once. Treaty provisions which permitted the federal government to take up reserve lands for public works of Canada were, in the Act, modified to enable any organization with expropriation powers to exercise them on reserve. When Indians complained of administrative abuses and, in the non-Treaty areas, to press their claims of Aboriginal title, the Act was amended to make it an offence to retain a lawyer for the purpose of advancing a claim. Not surprisingly the land base was reduced, often in return for nominal consideration or no consideration.

The Indian Act has undergone numerous amendments since its first conception:

Amendments 1884–2000

- 1881: Amended to make officers of the Indian Department, including Indian Agents, legal justices of the peace, able to enforce regulations. The following year they were granted the same legal power as magistrates. Further amended to prohibit the sale of agricultural produce by Indians in Prairie Provinces without an appropriate permit from an Indian agent. This prohibition is, as of 2008, still included in the Indian Act, though it is not enforced.
- 1884: Amended to prevent elected band leaders who have been deposed from office from being re-elected.
- 1885: Amended to prohibit religious ceremonies (such as potlatches) and dances (such as *Tamanawas* dances)
- 1894: Amended to remove band control of non-natives living on reserve. This power now rested exclusively in the hands of the Superintendent-General of Indian Affairs.
- 1895: Amended to outlaw all dances, ceremonies and festivals that involved the wounding of animals or humans, or the giving away of money or goods.
- 1905: Amended to allow aboriginal people to be removed from reserves near towns with more than 8,000 residents.
- 1906: Amended to allow 50 per cent of the sale price of reserve lands to be given to band members, following the surrender of that land.
- 1911: Amended to allow municipalities and companies to expropriate portions of reserves, without surrender, for roads, railways, and other public works. Further amended to allow a judge to move an entire reserve away from a municipality if it was deemed "expedient." These amendments were also known as the Oliver Act.
- 1914: Amended to require western Indians to seek official permission before appearing in "aboriginal costume" in any "dance, show, exhibition, stampede or pageant."
- 1918: Amended to allow the Superintendent-General to lease out uncultivated reserve lands to non-aboriginals if the new lease-holder used it for farming or pasture.
- 1920: Amended to allow the Department of Indian Affairs to ban hereditary rule of bands. Further amended to allow for the involuntary enfranchisement (and loss of treaty rights) of any status Indian considered fit by the Department of Indian Affairs, without the possession of land previously required for those living off reserve. Repealed two years later, but reintroduced in a modified form in 1933.
- 1927: Amended to prevent anyone (aboriginal or otherwise) from soliciting funds for Indian legal claims without a special license from the Superintendent-General. This effectively prevented any First Nation from pursuing aboriginal land claims.
- 1930: Amended to prevent a pool hall owner from allowing entrance to an Indian who "by inordinate frequenting of a pool room either on or off an Indian reserve misspends or wastes his time or means to the detriment of himself, his family or household". The owner could face a fine or a one-month jail term.

- 1936: Amended to allow Indian agents to direct band council meetings, and to cast a deciding vote in the event of a tie.
- 1951: Amended to allow the sale and slaughter of livestock without an Indian Agent permit. Status women are allowed to vote in band elections. Attempts to pursue land claims, and the use of religious ceremonies (such as potlatches) are no longer prohibited by law. Further amended for the compulsory "enfranchisement" of First Nations women who married non-status men (including Métis, Inuit and non-status Indian, as well as non-aboriginal men), thus causing them to lose their status, and denying Indian status to any children from the marriage.
- 1961: Amended to end the compulsory "enfranchisement" of men or bands.
- 1985: Amended to allow First Nations women the right to keep or regain their status even after "marrying out", and to grant status to the children (but not grandchildren) of such a marriage. This amendment was debated in Parliament as Bill C-31. Under this amendment, full status Indians are referred to as 6-1. A child of a marriage between a status (6–1) person and a non-status person qualifies for 6-2 (half) status, but if their child in turn married another 6-2 or a non-status person, the child is non-status. If a 6–2 marries a 6–1 or another 6-2, their children revert to 6–1 status. Blood quantum is disregarded, or rather, replaced with a "two generation cut-off clause". Under amendments to the Indian Act (Bill C-31), Michel Band members have individual Indian status restored. No provision made in Bill C-31 for the restoration of status under the Band enfranchisement provision that was applied to the Michel Band. According to Thomas King, around half of status Indians are currently marrying non-status people, meaning this legislation accomplishes complete legal assimilation in a matter of a few generations.
- 2000: Amended to allow band members living off reserves to vote in band elections and referendums.
- Under debate, Bill C-3. The proposed amendments, if enacted by Parliament, will ensure that eligible grandchildren of women who lost status as a result of marrying non-Indian men will become entitled to registration (Indian status) in accordance with the Indian Act. The proposed amendments do not extend to other situations.

In short, the Indian Act sets out legislation for the federal government, giving them an inordinate level of power over First Nations People. It is easily argued that this power discriminates against First Nations in a manner that no other race than aboriginal experiences in Canada. The power imbalance between First Nations and non-natives remains entrenched in current policies and practice. In healthcare, First Nations clients have no alternative for the most part to seek healthcare from a society they view as highly oppressive that has systematically sought to assimilate them. While this view is not universally held by all First Nations, the consequent trust issues in developing an effective client-provider relationship require deep understanding and exemplary patience.

b. The Health Transfer Policy (HTP)

Jurisdictional confusion about responsibilities for First Nations healthcare is longstanding and communities remain trapped in the divide between federal and provincial wrangling. A separation of jurisdictional responsibility was built on two documents signed during the westward colonization by settlers, the Royal Proclamation of 1763 and the Constitutional Act of 1867. The Royal Proclamation, negotiated in an attempt to create an alliance between the Crown and the aboriginal population to contain westward expansion of the American colonies, affirmed that the indigenous people retained title to their property. Following the 1867 Constitutional Act, expansion by settlers on Indigenous lands were settled by treaties between the Crown and aboriginal leaders. The 11 numbered treaties that followed formed the basis of the current reserve system, whereby aboriginal people surrendered land rights in exchange for reserve land, cash, and a variety of services including healthcare.

The treaties, as a precedent for determining responsibility for care of Aboriginals, are very much lacking and remain the subject of conflicting arguments between Aboriginal groups and government. Rather, historical care provision by the federal government has been more formative in shaping current jurisdictional responsibility and resource allocation for native care provision. Initially, in response to settlers' complaints about dismal health conditions on reserves and the potential for widespread communicable diseases, the federal government began providing a General Medical Superintendent for aboriginals in 1904. This was later followed by on-reserve nursing stations administered by the department of Indian Health when formed under the national Department of Health and Welfare in 1944. With the establishment of the current Canadian national health system in 1970, managed jurisdictionally by the provinces, on-reserve services federally funded through FNIHB remained although in complement to the provincially funded services and under federal funding.

As a result of the historical separation of jurisdictions, in addition to the developing clinical literature regarding Indigenous health, it has been pointed out that aboriginal health has emerged as a fourth sector in Canadian healthcare. Previously, three sectors were acknowledged in the health care literature, government, private/not-for-profit, and non-government organizations as those responsible for healthcare delivery in Canada.

Emergence of this sector was catalyzed by political mobilization of Aboriginal groups during the 1960's, leading to the tabling of the 1979 federal Indian Health Policy. One broad objective was clear in this act: "the goal of Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves."

This fourth sector for service provision gained formal recognition with the passage of the 1986 federal Health Transfer Policy (HTP), the result of negotiations between indigenous groups and the federal government and pilot projects with native-administered health programs. The basic objective of the Health Transfer Policy was to transfer pre-existing services to native control at the community, zone and regional levels.

FNIHB was to remain responsible for fourth level service provision including policy, planning and allocations, advice, monitoring and benchmark planning. A "turning off the lights" policy to substantially reduce the size of FNIHB to become a smaller office for policy and contract administration was a key objective of the HTP in transferring control of healthcare to indigenous groups themselves.

The HTP is applicable to 603 First Nations and Inuit communities representing 790,000 aboriginal people located south of the 60th parallel. It currently provides funds through First Nations and Inuit Health Branch (FNIHB) for three types of health programs and services:

- Public or community health programs;
- National initiatives directed at specific health and health related issues such as the Aboriginal Diabetes Initiative, the Headstart program, and the National Native Alcohol and Drug Abuse Program; and
- Individual funding to provide support for prescription drugs, dental and vision care, and medical transport.

Of these programs, public and community health programs as well as some individual funds such as medical transport were considered 'transferable' under the HTP. National initiatives remained under managerial control of

FNIHB in most circumstances, with some programs available to native groups on a competitive proposal basis for allocation. Involvement in such national initiatives required separate contribution agreement (CA) contracts to be signed by native groups with FNIHB.

It is critical to note that the HTP does not provide funding for physician treatment services. Rather, this is viewed by FNIHB as 'direct medical care' and under the purview of the provinces. Other than overburdened Aboriginal Health Access Centers available in a limited number of communities, primary and secondary care must be accessed through the general population route. The HTP clearly falls far short in ensuring access to culturally safe care for First Nations. This appears to present a paradox: while the Indian Act governs life on reserve, the HTP ensures First Nations People must gain access to the majority of healthcare outside of their community.

The original intent of the HTP to give self determination of their healthcare to First Nations and a 'turning out the lights' policy at FNIHB has hardly materialized. While some programs have been transferred to First Nations communities, the reporting requirements to sustain funding are onerous. Additionally, FNIHB retains control of most of the administration of the Non-Insured Health Benefits (NIHB) program. NIHB supports 'individual funding to provide support for prescription drugs, dental and vision care, and medical transport.' NIHB represents a large budget share of the FNIHB budget and determines what treatments are available and for what length of time. As such, NIHB is seen by some as a continued sovereign arm of the federal government now at work in healthcare. Finally, it is noteworthy that since the HTP came into effect, the size of the FNIHB bureaucracy has grown rather than retreated as was envisioned. Faced with criticism by the Canadian Auditor General over a lack of accountability of funds transferred under the HTP, FNIHB reacted by increasing the reporting requirements and their staff to manage them.

For healthcare providers serving First Nations clients, it is easy to become confused by a First Nations community with two jurisdictions each portraying giving 'special service' to native Peoples. The non-native myth exists that this special treatment provides 'too much money' for First Nations healthcare compared to the general population. In fact, much of the funding allocated (approximately 50%) is consumed by the FNIHB bureaucracy and federal insistence on direct care being provided by the provinces/territories all but ensures non-culturally safe care for the most part. Funds spent on health promotion initiatives by FNIHB have not yet appeared to improve overall First Nations health status and one wonders if these funds could be better allocated to direct care. Attempts on the part of First Nations organizations to improve their healthcare routinely fall into the abyss of federal/provincial/territorial debates over jurisdiction issues.

At a direct care level, familiarization of NIHB benefits and processes are a requirement for NIHB insured providers to understand and assist in care management of their clientele.

4. Theme II – Institutional Care

Institutional care refers to healthcare delivery in facilities such as hospitals and nursing homes, key elements of the Western healthcare model.

As an adjective, 'institutional' may be defined as:

1. Of or relating to an institution or institutions.
2. Organized as or forming an institution: *institutional religion.*
3. Characteristic or suggestive of an institution, especially in being uniform, dull, or unimaginative: *institutional furniture; a pale institutional green.*
4. Of or relating to the principles or institutes of a subject such as law.

Receiving healthcare in an institution means living in a standard room with little ability to personally customize, uniform meals and a regular schedule of life for the most part. One lives and receives care under the rules of the institution. Being a creation of Western biomedicine, in general institutions are not designed to deliver culturally safe care and are often complex and frightening places for Native People (this is increasingly true for many Westerners as well).

The effect of this is threefold:

1. Lack of access to culturally safe institutional care is, of itself, a barrier to healthcare for many Aboriginal People.

2. In the current climate of scarce resources and the constant pressures on institutions to discharge people as rapidly as possible, racial discrimination plays a role whereby minorities are often the first to be discharged. Client objections and reactions to institutionalized care rationalize the desire to discharge Native People more rapidly than the mainstream.

3. Pressure to discharge early also leaves minimal time for case management to ensure all supports for continuity of care post discharge are in place. This is made worse if case managers are not familiar with the support systems available in Native communities.

The grim history of Canadian assimilation policies has left Aboriginal People with a devastating experience regarding Canadian institutions: residential schools.

Founded in the 19th century, the Canadian Indian residential school system was intended to force the assimilation of the Aboriginal peoples in Canada into European-Canadian society. The purpose of the schools, which separated children from their families, has been described as "killing the Indian in the child."

Although education in Canada had been allocated to the provincial governments by the British North America BNA act, aboriginal peoples and their treaties were under the jurisdiction of the federal government. Funded under the Indian Act by Indian and Northern Affairs Canada, a branch of the federal government, the schools were run by churches of various denominations — about sixty per cent by Roman Catholics, and thirty per cent by the Anglican Church of Canada and the United Church of Canada, along with its pre-1925 predecessors, Presbyterian, Congregationalist and Methodist churches. This system of using the established school facilities set up by missionaries was employed by the federal government for economical expedience. The federal government provided facilities and maintenance and the churches provided teachers and education.

The foundations of the system were the pre-confederation Gradual Civilization Act (1857) and the Gradual Enfranchisement Act (1869). These assumed the inherent superiority of British ways, and the need for Indians to become English-speakers, Christians, and farmers. At the time, Aboriginal leaders wanted these acts overturned.

In 1850, attendance became compulsory by law for all children aged 6 to 15. Children were often forcibly removed from their families, or their families were threatened with prison if they failed to send their children willingly. Students were required to live on school premises. Most had no contact with their families for up to 10 months at a time because of the distance between their home communities and schools, and sometimes had no contact for years.

The attempt to force assimilation involved punishing children for speaking their own languages or practicing their own faiths, leading to allegations in the 20th century of cultural genocide and ethnocide. There was an elevated rate

of physical and sexual abuse. Overcrowding, poor sanitation, and a lack of medical care led to high rates of tuberculosis, and death rates of up to 69 percent. Details of the mistreatment of students had been published numerous times throughout the 20th century, but following the closure of the schools in the 1960s, the work of indigenous activists and historians led to a change in the public perception of the residential school system, as well as official government apologies, and a (controversial) legal settlement.

Negative impacts of residential schools have been noted to include:

- Loss of cultural identity, language, traditions and spiritual growth development, which caused a deep loss and confusion.
- Poor bonding with loved ones. Children were taken from their parents, grandparents and communities.
- Residential School Survivors were not allowed to assert themselves as they were subjected to an oppressive system, which resulted in inadequate communication skills and poor expression of feelings.
- Survivors were violated and a serious breach of trust occurred, causing distrust in authority figures, as well as an inability to trust others; survivors often became indifferent towards loved ones.
- Survivors were subjected to military-like conditions, which resulted in poor decision-making and behavioural difficulties, as well as not developing a sense of how one behaves in any given situation that causes a threat.
- Intergenerational losses have created dependency roles and underdevelopment of personal growth of survivors, their families and communities.

The need for culturally safe institutional care becomes increasingly important given the dismal legacy of Aboriginal Peoples' experience with these educational institutions. A great number of the elements of institutional care, uniformity of personal space and meals, authority figures, uniform treatment of clients irrespective of race, culture & gender would be expected to cause often severe anxiety in Native People.

5. Theme III – The Right to a Dignified Death

Most religious persons, especially those espousing the Judaeo- Christian faith, believe that life is sacred because it is created by God. They regard killing to be a dreadful sin as it amounts to destruction or rejection of a divine gift. It is believed that man is not the independent master of his life but a steward, subject to the sovereignty of God. They argue that one has not only a right to life but an obligation to go on living; they believe human dignity involves the heroic acceptance of bowing to a higher purpose of existence.

With Western culture being predominantly Judeo-Christian, most of the argument surrounding the right to a dignified death revolves around the issue of legal euthanasia. While this may be relevant in part for First Nations, Inuit and Metis People, their issue leans more to the need for prolonged visits and ceremonies with the extended clan family members. Institutional settings are generally ill equipped to allow meeting the spiritual needs of First Nations People. Where a patient is dying, the family will generally feel that it is more important to attend to the person's spiritual needs, which are permanent, rather than the dying person's physical needs, which are transient. Such needs are best met by having the terminally ill patient return to the community whenever possible.

Institutional care presents significant barriers of aboriginal people to exercise their right to a dignified death. Regardless of Western biomedical advice, the spiritual needs of First Nations, Inuit and Métis People will often predominate. The accommodation of the spiritual needs of a dying person and their family must be in the forefront of the minds of caregivers attending to Native People.

Culturally safe care is aligned with Native prophesy:

There were a group of Elders who gathered for a ceremony long, long time ago. In that ceremony they were told, "Our people are in our midnight and we will come into our daylight when the Eagle lands on the Moon. When the Eagle lands on the moon we will become world leaders."

That midnight was the government policy to outlaw our ceremonies, the Indian Act, alcoholism, death, the flu of 1918 and being removed from our families and culture and placed into residential schools.

The message the astronauts sent back to earth in 1969 when they landed on the moon was, "The Eagle Has Landed." The old people knew the time had come. The time had come tocome into our daylight.