DEVELOPMENT OF AN EDUCATIONAL RESOURCE: CULTURAL SAFETY WITH PATIENTS WHO IDENTIFY AS BLACK, AFRICAN NOVA SCOTIAN, AFRICAN OR CARIBBEAN DESCENT

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Abstract

Background: Black patients have faced health disparities and mistreatment in healthcare settings (Public Health Agency of Canada, 2020). The United Nations (UN) declared a decade for people of African descent from 2015-2024 (UN, n.d.). The UN called for recognizing this distinct population and protecting and promoting their human rights (UN, n.d.). Racial discrimination and microaggressions contribute to current and historical mistrust in the healthcare system (CDC, 2020; Cénat et al., 2022a; Cénat et al., 2022b; Waldron et al., 2023; Wolinetz & Collins, 2020). To improve the health experiences of Black patients, healthcare staff must create culturally safe environments. **Methods:** I conducted a literature review, consultations, and an environmental scan to explore and analyze the healthcare experiences of Black patients and the experiences of healthcare staff working with Black patients. Through the literature review, I focused on global experiences while I explored the local context through the environmental scan and consultations. **Results:** Black patients experienced racial discrimination, microaggressions, and a lack of trust in the health system (CDC, 2020; Cénat et al., 2022a; Cénat et al., 2022b; Waldron et al., 2023; Wolinetz & Collins, 2020). The mental health impacts of these experiences included anxiety, depressive symptoms, sleep problems, and decreased help-seeking (Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023; Waldron et al., 2023; Washington & Randall, 2023). Cultural safety training can increase healthcare providers' knowledge and improve patient interactions (Browne et al., 2021; Kaihlenan et al., 2019; Pimental et al., 2022; Yaphe et al., 2019). Based on these results, I created an educational resource, including a PowerPoint presentation and teaching guide for a one-day course in cultural safety with Black patients.

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Introduction

Black people face disparities in health outcomes because of current and historical mistreatment in healthcare settings (Public Health Agency of Canada (PHAC), 2020). The years 2015-2024 were declared the International Decade for People of African Descent, a time to recognize this distinct group and their right to equality (UN, n.d.). Throughout this report, I will use the term Black to describe people of African or Caribbean descent, African Nova Scotian (ANS) people, and people of mixed race who identify as Black. A research study that involved withheld treatment from Black patients for four decades and research using the human cells of a Black woman without permission are foundational in the historical mistrust in the healthcare system Black patients experience (CDC, 2020; Wolinetz & Collins, 2020). Current discrimination and microaggressions continue to challenge relationships in health care (Cénat et al., 2022a; Cénat et al., 2022b; Waldron et al., 2023). In Black communities, there may be a stigma associating mental illness with weakness (Waldron, 2020; Waldron et al., 2023). It is often difficult to find healthcare providers who are Black or understand the lived experiences that impact the mental health of Black patients, resulting in decreased help-seeking behaviours and increased health disparities (Waldron, 2020).

As an African Nova Scotian Nurse, patient, and parent, member of the Black Lives Matter action group, director of the Black Nurses Association of Nova Scotia, and Black nursing mentor, I believe advocating for culturally safe environments for Black patients is essential. I have witnessed and experienced racial microaggressions and discrimination from healthcare providers. My colleagues working in the healthcare system have also shared stories and experiences of microaggressions, discrimination, and feelings of mistrust. Along with the overt aggressions, discriminatory practices, and microaggressions that are intended to cause harm to

the Black community, there is a general lack of awareness of the lived experiences of Black people that impact their relationship with the healthcare system that can also cause harm. Therefore, there is a need for educational opportunities for care providers to learn about how the lived experiences of Black patients influence how they present themselves for care and participate in care. The lived experiences may also cause Black people not to seek care or participate in care as prescribed. It is also essential to ensure that the care is culturally relevant to improve the treatment uptake and ensure the treatment meets the needs of the patient and family. Two primary care programs have been successfully developed and implemented in Nova Scotia, the Brotherhood and Sisterhood, to provide care to African Nova Scotian people by Black care providers. An African Nova Scotian mental health team is also being developed. The target population for the educational resource I developed is healthcare providers of various disciplines in the Mental Health and Addiction (MHA) in a pediatric health system. This education, in the form of a workshop, is intended to provide healthcare workers with the knowledge and skills required to provide culturally safe care that is anti-racist and free from microaggressions and discrimination.

Objectives

The overall goal of the practicum project was to improve Black patients' healthcare experiences by increasing cultural safety. I developed an educational resource, a half-day in-person course on cultural safety with Black patients. The course was designed to provide healthcare staff with the knowledge required to begin to create and maintain culturally safe environments for Black people.

The key practicum objectives were:

1. Explore the factors, including staff behaviours, microaggressions, bias, and cultural competency that impact the care experiences of Black patients through a review of the literature and consultations.
2. Identify and examine strategies to support nurses and other healthcare staff to create an environment of cultural safety considering locally relevant issues through consultations and an environmental scan;
3. Develop an educational resource; and
4. Demonstrate advanced nursing practice competencies, including research utilization, use of research methods, leadership, education, and consultation and collaboration (CNA, 2019).

In the following section, I will describe the methods used to meet these objectives.

Overview of Methods

To meet the practicum project's objectives and develop the resource, I first engaged in discussions with colleagues to explore their experiences working with Black patients. Next, I completed a preliminary literature review to determine if the available research on cultural safety and the health experiences of Black patients would support the development of an educational resource. After completing a proposal with the guidance of my supervisor, I used three methods to develop the educational resource: a literature review, an environmental scan, and consultations.

Through the literature review, I explored the need for an educational resource and the experiences of Black patients in healthcare globally, in Canada, and locally. Next, I explored the mental health impacts of negative health experiences, including mistrust in the healthcare

system, discrimination, and microaggressions. I also explored and analyzed the literature about cultural safety training and potential challenges in education uptake and successful delivery models.

I completed an environmental scan to examine and identify healthcare resources in Atlantic Canada related to cultural safety in general and specifically with Black patients. The results were minimal due to a lack of responses from the organizations I contacted. I have combined the analysis and integrated the results of the environmental scan with the consultations. Through the consultations, I explored the local context and experiences of healthcare providers and community members accessing healthcare in Nova Scotia to develop content for the educational resource, analyze the congruency with the literature review results, and explore potential delivery modes. I completed a thematic analysis of the results of the environmental scan and consultations based on Braun & Clark (2006).

In the next section, I will provide an overview of the conceptual foundations for this practicum project.

Conceptual Framework

When I began the practicum project, I did not have a theoretical framework in mind; however, through discussions with my supervisor, I found a theoretical perspective to guide my overall practicum project; Doane & Varcoe's (2021) relational inquiry. Relational inquiry uses inquiry as an action and a relational consciousness (Doane & Varcoe, 2021). Using a critical lens, as described by Doane & Varcoe (2021), is essential when developing educational content to increase cultural safety for Black patients. Nurses and other healthcare providers must understand the social structures and historical mistreatment that Black patients have faced and

how these factors influence their past and current relationships with the healthcare system. The concepts of relational inquiry include hermeneutic phenomenology, which is focused on lived experiences, and pragmatism, which acknowledges that knowledge is only as valuable as it is meaningful to a situation (Doane & Varcoe, 2021). The intent of this project was to improve the care outcomes of Black patients by creating an awareness of the lived experiences of Black patients that impact their mental health and to increase cultural awareness. Learning about Black patients' lived experience is not enough. Healthcare providers must also learn how they can apply this information to their own practice and increase cultural safety and care outcomes. By using inquiry as action, nurses can enter care relationships embracing knowing (their nursing expertise) and not knowing (inquiry as action) to build relationships and collaborate to create care plans that fit within their patients' cultural values.

To develop the content and mode of delivery for the educational resource, I applied Knowles' Theory of Adult Learning (Collins, 2004). Drawing on this theory, in the resource I provided opportunities for problem-based learning and application of prior knowledge through discussions and case studies (Collins, 2004). For implementation planning to increase the potential uptake, I applied Rogers' Diffusion of Innovation Theory (Dearing & Cox, 2018). Rogers' Diffusion of Innovation Theory states that the adoption or uptake of a new idea is a social process (Dearing & Cox, 2018). In the process of adopting a new idea, there are five categories of adopters, including innovators, early adopters, early majority, late majority, and laggards (Dearing & Cox, 2018). Five factors influence adoption: relative advantage, compatibility, complexity, trialability, and observability. By engaging healthcare team members in the development process, I ensured the content was compatible with the values and experiences of potential adopters. I was also able to discuss the relative advantages of improving

care outcomes for Black patients and families, including increased collaboration and increasing the ability of the care team to meet the needs of the patient population. I worked with the key stakeholders to ensure the resource was not overly complex and therefore met the needs of the target population. I have worked with colleagues to develop a plan to trial the educational resource with a small group before implementing it on a larger scale to determine if there are any barriers to knowledge uptake or engagement.

Summary of the Literature Review

The purpose of the literature review was to explore the factors, including staff behaviours, microaggressions, discrimination, and bias, that impact the health experiences of Black patients globally. I also explored cultural safety training, successful modes of delivery, and potential challenges with uptake. The quantitative studies were critically appraised using the Public Health Agency of Canada's (2014) critical appraisal checklist. The qualitative studies were analyzed using the Critical Appraisal Skills Programme (2017) checklist. In the following sections, I will provide an overview of my findings from the literature review. For greater detail, the full literature review and literature summary tables can be found in Appendix A.

Health Experiences of Black Patients

Black patients reported historical and current mistrust in the healthcare system as well as experiences of racial discrimination and microaggressions (Boulware et al., 2003; Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023; Sacks, 2018; Schwei et al., 2014; Webb Hooper et al., 2019). Associated with these experiences were adverse mental health outcomes (Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023; Waldron et al., 2023; Washington & Randall, 2023). In

the following sections, I will describe the healthcare experiences of Black patients and the associated mental health impacts.

Historical and Current Mistrust

I found that Black patients were less likely to trust the healthcare system or providers (Boulware et al., 2003; Schwei et al., 2014; Webb Hooper et al., 2019). Historical mistrust occurred due to collective trauma and mistreatment in the healthcare system, including the Tuskegee experiment, which occurred between 1932-1972, where the treatment for syphilis was withheld from Black men, and the use of Henrietta Lacks cells for research without her knowledge (Alsan & Wanamaker, 2018; Wolinetz & Collins, 2020). Mistrust was not just historical; Black patients were more likely than White patients to be concerned about privacy breaches, misuse of information, and harmful experiences when accessing healthcare (Boulware et al., 2003; Schwei et al., 2014; Webb Hooper et al., 2019).

Racial Discrimination and Microaggressions

Black patients experienced racial discrimination in healthcare environments and in their daily lives (Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023; Sacks, 2018). The impacts of personal and vicarious racial discrimination include decreased mental health and increased symptoms of mental illness including sleep problems, anxiety, and depressive symptoms (Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023, Sacks, 2018). Black patients vigorously prepared for appointments to ensure they had the knowledge to advocate for appropriate care, dressed nicely, and attempted to connect to healthcare providers through small talk to avoid adverse treatment (Sacks, 2018).

Black patients also experienced microaggressions, which were also associated with adverse mental health impacts (Cénat et al., 2022b; Nadal et al., 2014). Examples of microaggressions include exoticism and fetishization, when a Black person is treated based on sexualized stereotypes or characterized as exotic, and being treated as though accomplishments were due to preferential treatment based on race (Cénat et al., 2022a; Williams et al., 2020). Black patients have difficulty finding Black healthcare providers or non-Black providers who understand their lived experience and provide culturally relevant care (Waldron, 2020; Waldron et al., 2023).

Mental Health Impacts

The impacts of negative care experiences include decreased help-seeking behaviours and mental health symptoms such as depressive symptoms, sleep issues, and increased anxiety (Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023; Waldron et al., 2023; Washington & Randall, 2023). Provider trust also had indirect effects on both mental health and medication adherence (Pugh et al., 2021).

As a result of these adverse health outcomes, there is an urgent need for education about cultural safety. In the following sections, I will discuss cultural safety training and its efficacy with healthcare providers.

Cultural Safety Training

The concepts of cultural safety which include cultural awareness, cultural sensitivity, and cultural competence, were generally applied to Indigenous populations globally (Browne et al., 2021; Yaphe et al., 2019). Cultural safety training has been well-received with a demonstrated increase in participants' knowledge (Browne et al., 2021; Kaihlenan et al., 2019; Pimental et al.,

2022; Yaphe et al., 2019). Participants reported improved patient interactions and demonstrated ways to incorporate cultural safety into their daily practice (Browne et al., 2021; Kaihlenan et al., 2019). Although the training sessions were intended to improve the care outcomes of Indigenous populations, the education was focused on the concepts of cultural safety (Browne et al., 2021). Part of cultural safety, is awareness; therefore, historical information was presented about Indigenous patients to increase awareness of their lived experiences (Browne et al., 2021; Yaphe et al., 2019). I extrapolated this to Black patients by applying the same concepts of cultural safety to Black patients. I provided information in the education resource about the health experiences of Black patients to increase cultural awareness and included how cultural sensitivity, competence, and humility can also be applied. Participants in the studies reviewed preferred in-person training as it allowed for discussion with their peers and, in some cases, stories from Indigenous elders that added meaning to the training (Browne et al., 2021; Kaihlenan et al., 2019; Pimental et al., 2022; Yaphe et al., 2019). Therefore, I developed an in-person workshop that includes discussions.

Resistance

Cultural safety training did not come without resistance (Browne et al., 2021; Erb & Loppie, 2023; Micheal et al., 2021). Some participants of the dominant race, White, experienced discomfort and felt attacked by teaching about White privilege (Erb & Loppie, 2023; Micheal et al., 2021). Facilitators were met with racist comments from some participants and experienced burnout as a result (Erb & Loppie, 2023). To deal with potential resistance, it was important to acknowledge and normalize the negative feelings that can be associated with learning about White privilege (Browne et al., 2021; Erb & Loppie, 2023; Micheal et al., 2021). Providing an

opportunity to discuss these feelings may help participants move through them to a place of acceptance and action.

In summary, the results of the literature review were instrumental in developing the content and mode of delivery for the educational resource. Black patients have both historical and current mistrust in the healthcare system, and have negative experiences in healthcare, including racial discrimination and microaggressions (Boulware et al., 2003; Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023; Sacks, 2018; Schwei et al., 2014; Webb Hooper et al., 2019). These experiences have adverse mental health impacts, including anxiety, depressive symptoms, and sleep issues (Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023; Waldron et al., 2023; Washington & Randall, 2023). Cultural safety training related to Indigenous populations has shown improvements in patient interactions, although there has been resistance and therefore support for facilitators is essential (Browne et al., 2021; Erb & Loppie, 2023; Micheal et al., 2021).

To gain a greater understanding of the local context, I completed consultations with local stakeholders, including one Black community member and five healthcare providers. As well, I completed an environmental scan. In the following section, I will summarize the results of the consultations with local stakeholders. The full report can be found in Appendix B.

Summary of Consultations and Environmental Scan

The purpose of the consultations was to explore and analyze the health experiences of Black patients from a local context and healthcare workers who worked with Black patients locally in Nova Scotia in the MHA program in a pediatric health system. I also aimed to explore

methods to improve cultural safety for Black patients accessing care in the MHA program. The purpose of the environmental scan was to explore educational resources related to cultural safety with Black patients currently in use in Atlantic Canada to guide the development of the educational resource. Environmental scans are a method of gathering data to inform decision-making (Charlton, 2019). Based on Rogers' Diffusion of Innovation theory, I engaged potential adopters such as healthcare providers, including nurse educators, managers, and staff nurses, in the development process to ensure the program was locally relevant and met the specific needs of the individuals and the organization (Dearing & Cox, 2008). The consultations were completed through virtual meetings that were approximately 30 minutes. The interviews were semi-structured; I used interview guides that were slightly different for healthcare workers and community members. The final sample was six people, including five healthcare staff and one community member. It was essential to have a community member as a part of the consultations to ensure the information presented in the educational resource is relevant to the community it is intended to benefit. Although only one community member was included due to the limitations of the scope of this project, the community member is an activist, and a pastor that is heavily involved in the Black community and is often working with systems, such as healthcare and government, to improve the lives of Black people. While the consultee does not claim to speak for the community, he was able to share his personal experiences as well as the many experiences that were shared by other community members. During implementation and evaluation, I will include more community members. As described in the literature review, Black people are historically left out of decisions that impact their health and well-being. I wanted to ensure I did not continue this harmful behaviour, so I engaged Black people in the development process. As the consultee stated, "Nothing for us, without us."

The environmental scan findings were limited, revealing programs related to cultural safety with Indigenous populations. I received a single email response providing further information about a course in the pilot phase. Going forward in the implementation phase, I could reach out to many more contacts at other institutions. I would also reach out to colleagues who may have connections to other institutions that could provide information on their current programs. Further, if possible, I would consider the time of the environmental scan and attempt to complete it during a time other than the summer months which are common for taking vacations. For the one course on cultural safety that was identified in the environmental scan, there were no issues identified in education uptake, and there was no information available on the impacts of the course as it was not completed. The findings of the literature review were locally relevant and congruent with the findings of the consultations with local stakeholders. Through a thematic analysis based on Braun & Clark (2006), I identified six themes: historical and current trust in healthcare, building relationships with the Black community, respect for Black patients and healthcare providers, representation of Black people in healthcare settings, microaggressions and difficulty addressing discreet discrimination, and lack of awareness of harmful behaviours and racial trauma.

The consultees were Black and White healthcare providers and one Black community member. All consultees experienced or witnessed microaggressions that were difficult to name, and therefore address or report. Black patients were met with less warmth, care, and collaborative efforts from healthcare providers. Consultees found that healthcare providers made less effort to build rapport with Black patients, and Black patients and families did not trust the healthcare system enough to report mistreatment. Consultees agreed there was a need to improve relationship building with individual patients, families, and the Black community through

collaborative provision of healthcare services to rebuild trust and create safe environments. Representation was essential to creating culturally safe environments. Cultural safety must also be present for Black healthcare providers in their practice environments. Consultees reported that Black people were represented in cleaning staff more than healthcare roles and rarely in leadership positions. Consultees also expressed genuine interest in learning to provide culturally safe and relevant care. They were interested in Afrocentric practices and principles and how they could apply these concepts in their practice. White consultees did not feel they had an adequate understanding of the lived experiences of Black people; Black consultees agreed. Overall, the results of the consultations were congruent with the results of the literature review.

As a result of the combined findings from the literature review, consultations, and environmental scan, I have developed an educational resource on cultural safety with Black patients. In the next section, I will provide an overview of this educational resource.

Summary of the Resource

I developed a one-day in-person course on cultural safety with Black patients intended for use in the MHA program in a pediatric health system. The educational resource includes a PowerPoint presentation (Appendix C) and a teaching guide (Appendix D); the estimated completion time, including breaks, is four hours and fifteen minutes. The course contains an introduction followed by eight other modules:

1. Introduction to the Course
2. African Nova Scotian People
3. The Health Experiences of Black patients
4. Cultural Safety and Black Patients

5. Relationship Building and the Black Community
6. The Importance of Representation and Afrocentric Practices
7. Applying Knowledge to Practice through Case Discussions
8. White Fragility
9. Community Resources

Drawing on the principles of Knowles' Adult Learning Theory, the course combines presentations and lectures, discussions, case studies, and games. Lectures will be used to show the relevance of the content to the participants (Collins, 2004; Twaddell, 2019). Case studies and discussions are problem-based learning, allowing participants to use the knowledge they have gained from the lectures (Twaddell, 2019). Participants will also use their prior experiences and knowledge in discussions (Twaddell, 2019). The games keep participants active and engaged throughout the day. The course was developed with a critical lens by challenging healthcare providers to examine their privilege and acknowledge the defensiveness and discomfort White people experience in relation to discussions of racial injustice and privilege, also known as white fragility, and how it upholds racism in healthcare. The course is also intended to encourage inquiry as action and challenge the participants' beliefs based on the tenets of relational inquiry (Doane & Varcoe, 2021). The discussions throughout the course provide an opportunity for participants to relate the course information to their personal lives and practice. Knowles' Theory of Adult Learning includes how adult learners must understand why the information they learn is important and how it will help them (Collins, 2004). There is also opportunity and encouragement for independent learning about the Black population in Nova Scotia, where participants work. This allows for self-direction, another essential aspect of adult learning (Collins, 2004).

The second module provides an overview of the history of African Nova Scotian people, a distinct population, and the challenges and barriers they face when accessing healthcare. Barriers include environmental racism, a lack of culturally safe care spaces, and historical trauma, such as the forced resettling that occurred in Africville (Waldron et al., 2023). This unit also briefly discusses challenges that Black immigrants face and how they are different from the ANS experience. The third module is about health experiences of Black people, not limited to the ANS population, and the mental health impacts. The health experiences include historical and current mistrust, discrimination, and microaggressions while the mental health impacts include anxiety, depression, and sleep issues Cénat et al., 2022a; Hart et al., 2021; Lavner et al., 2022; Moody et al., 2023; Nguyen et al., 2023; Washington & Randall, 2023), There is a small group activity and a game in this module. The game is intended to show how life experiences impact how patients access care and encourage healthcare providers to consider the weight that Black patients are carrying when they seek healthcare. Participants are given a set of life experiences, each with an assigned weight. The weights provide a visual representation of how various life experiences can make it difficult to access healthcare and the weight that people are already carrying before they access healthcare. Next, the concept of cultural safety and how it relates to Black patients is presented. The concepts of cultural safety include awareness, sensitivity, and competence (Yaphe et al., 2019). There is a video and group discussions in this module. The fifth module is about the importance of building relationships with Black communities, patients and families, and strategies for practice. Community partnerships provide an avenue to improve health experiences. Working with patients to ensure cultural relevance can also increase collaboration. The sixth module includes information regarding limited representation of Black people in healthcare positions, the experiences of Black healthcare

providers, and Black patients who do not see themselves represented in the care they receive. The principles of Afrocentric practice and examples of application to practice are included. The seventh module builds on the previous modules; participants are asked to apply their knowledge to case studies. This module also has a video and discussions about the Jane Elliot's Blue Eye/ Brown Eye Experiment. Finally, the eighth module is about White fragility, when a small amount of racial stress incites defensiveness and outward displays of fear, anger or guilt, and the need to address racism and acknowledge its existence throughout our society and systems (Guardian News, 2020). The final slide of the presentation is the ninth module and contains contact information for community resources that may assist Black patients and healthcare providers connect to resources or services that are culturally relevant. Relational inquiry is evident throughout the course through exploration of the lived experiences of Black patients, examination of the racial differences in healthcare experiences, and learning ways to challenge and change current practices that are not culturally safe. Participants must embrace not knowing (Doane & Varcoe, 2021) throughout their learning journey and in every patient interaction.

Discussion of Advanced Nursing Practice (ANP) Competencies

By completing this practicum project, I was able to demonstrate competencies from five of the ANP categories, including research utilization and the use of research methods, leadership, education, health systems optimization, and consultation and collaboration (CNA, 2019).

Research

The competency of *research utilization* is about identifying, applying, and appraising research (CNA, 2019). I demonstrated this competency by completing a literature review where I critically appraised, analyzed, and synthesized the research. I also collected data through the

environmental scan and consultations, completed a thematic analysis based on Braun and Clark (2006), and synthesized the results.

Leadership

Leadership can be demonstrated through identifying problems and initiating changes to address the challenges at a clinical and organizational level (CNA, 2019). I demonstrated this competency by identifying the issue of a lack of cultural safety for Black patients, resulting in health disparities. The use of change management theories is also a competency of advanced practice nurses (CNA, 2019). To meet this competency and address this problem, I developed an educational resource using Rogers' Diffusion of Innovations Theory for change management (Dearing & Cox, 2018).

Education

Education as an advanced practice nurse includes determining the learning needs of nurses and healthcare providers and developing resources to meet the identified needs (CNA, 2019). To meet this competency, I completed a literature review, consultations, and an environmental scan to identify learning needs about cultural safety with Black patients and developed an educational resource to meet the identified needs.

Optimizing Health Systems

CNA (2019) describes *optimizing health systems* as generating and incorporating new nursing knowledge for program development. I demonstrated this competency by completing a literature review, consultations, and an environmental scan and incorporating the knowledge into the program I developed. I also created a tentative plan for implementation and evaluation of the educational resource.

Consultation and Collaboration

The CNA (2019) describes *consultation and collaboration* as engaging healthcare providers and other stakeholders to develop quality improvement strategies. I demonstrated this competency by consulting with key stakeholders, including healthcare staff and a community member, to develop an educational resource. The CNA (2019) also states that advanced nursing practice involves engaging team members in resolving issues at an individual and organizational level. I engaged the healthcare team in creating culturally safe care environments to reduce healthcare disparities and improve Black patients' and families' individual care experiences accessing care in the MHA program.

Next Steps

The next step after my studies is piloting the educational resource. I am currently working with the clinical leader of development in the pediatric health system to plan course delivery in February. The participants will be nurses working in an inpatient mental health unit. Nurses are the largest group of healthcare providers; therefore, based on Roger's Diffusion of Innovation theory, they will be the ideal early majority because they can share their learned knowledge with other healthcare providers and apply it to their practice (Dearing & Cox, 2018; Health Canada, 2023). The course will be facilitated by my colleague, who is a White nurse working in education and myself. The unit manager and the nurse working in education are both early adopters, willing to engage in the education and implement it on their unit (Dearing & Cox, 2018). We will incorporate feedback into the initial pilot implementation through a post-course survey. We will also use the pre and post-tests included in the educational resource to determine knowledge uptake.

To ensure the educational resource is meeting healthcare providers' needs and improving Black patients' care experiences, a plan for evaluation is essential. For qualitative evaluation, I will aim to have a small focus group of the nurses who participated in the education one month and six months after completion. The purpose of the focus groups will be to evaluate knowledge retention, the need for further education or education reinforcement, and experiences working with Black patients. The focus groups will also assess barriers or challenges to knowledge uptake or creating culturally safe care environments. I will also engage with the leadership of the inpatient mental health unit to determine ways to incorporate feedback from experiences into the educational resource. The unit currently has a method for receiving patient feedback: a survey following an admission. Following the pilot, I will engage with leadership in the mental health program to discuss the potential to pilot the course with other health disciplines.

There is a potential need for further environmental scans as my results were limited and it could be helpful to draw on other educational resources in practice. I could also extend the environmental scan beyond Atlantic Canada when time is not as limited. Further, I will engage with the leadership of a pilot course on cultural safety with Indigenous populations in the pediatric health system. The results of this pilot, including barriers and facilitators, could assist in the further implementation of the course I developed.

Conclusion

Cultural safety for Black patients is essential. The international decade for people of African descent is a call to action for education that recognizes the rich culture of Black people and their right to equality in all systems including healthcare (UN, n.d.). Nurses and other healthcare providers must examine their practice and work environments with a critical lens and address inequities. Relational inquiry provides a framework for increasing cultural safety for

Black patients. By embracing not knowing, how culture and lived experience impact treatment encounters, and using inquiry as action, nurses can engage in education to increase their knowledge of the healthcare experiences that impact Black patients and their mental health. Nurses and other healthcare providers should learn about Black patients' collective traumas and experiences, such as mistrust in the healthcare system, racial discrimination, microaggressions, and a lack of culturally competent healthcare providers and collaborate with individual patients and familes to ensure that care is culturally relevant and appropriate. (Cénat et al., 2022; Hart et al., 2021; Lavner et al., 2022; Schwei et al., 2014; Siddiqi et al., 2021; Moody et al., 2022; Waldron et al., 2023).

Throughout the methods I employed to develop this practicum project, I demonstrated advanced nursing competencies in research, education, leadership, optimizing health systems, and consultation and collaboration. It is pivotal that advanced practice nurses develop educational resources to improve health equity to optimize health systems, and advocate for better care for Black patients.

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Appendix A: Literature Review

Abstract

Cultural safety is essential to healthcare provision, especially when working with racialized populations. Black patients' experiences within the healthcare system are shaped by their lived experiences, including historical mistrust, racial discrimination, and racial microaggressions. Cultural safety is often discussed and considered when working with indigenous populations, although cultural awareness, humility, and competence can be applied to other racialized populations. Using the theoretical framework of relational inquiry as described by Doane and Varcoe (2021), I aimed to explore and analyze literature related to factors including historical mistrust, racial discrimination, racial microaggressions, and cultural safety training in healthcare. The purpose of this review was to inform the development of an educational resource related to cultural safety with Black patients in the Mental Health and Addictions program of a pediatric health system servicing children, youth, and their families.

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Project Title: An Educational Resource: Cultural Safety with Patients Who Identify as Black, African Nova Scotian, African, or of Caribbean descent.

The United Nations proclaimed the International Decade for People of African Descent from 2015-2024, recognizing the need to protect the human rights of this distinct group (United Nations, n.d.). Within this declaration is a call for education that restores the dignity of people of African Descent and promotes knowledge of this distinct group of people's culture, history, and heritage. Throughout this review, I will use the term Black to describe people of African or Caribbean descent, African Nova Scotian people, and people of mixed race who identify as Black. In healthcare, Black people face disparities, including the overdiagnosis of mental illness (Saldana et al., 2021), increased rates of diabetes (Public Health Agency of Canada, 2020), and care that does not meet the same standard as others receive. Healthcare providers have learned biases that impact care provision and create negative experiences for Black patients accessing services (Ehie et al., 2021). In a recent study exploring the prevalence and effects of experiences of everyday racial discrimination and microaggressions on Black Canadians, racial microaggressions in healthcare were experienced by 53.1% of Black participants (Cénat et al., 2022a), and these microaggressions were associated with decreased mental health. These current experiences and historical mistrust in the health system shape the experience of Black patients accessing healthcare services.

Cultural safety must be addressed to improve the healthcare experiences of Black patients accessing mental health services. Cultural safety combines cultural awareness, sensitivity, and competence (Yaphe et al., 2019). Based on the review I completed, there is a paucity in the literature related to cultural safety training for working with Black patients. However, training related to Indigenous populations has shown success through a high degree of acceptance;

participants reported that they have learned from the training and would recommend that others receive training (Browne et al., 2019). The purpose of this literature review is to explore the health disparities and inequities Black populations face and the contributing factors. I also plan to explore how contributing factors, including historical mistrust, racial discrimination, and microaggressions, impact Black people's mental health and help-seeking behaviours. Finally, I will explore cultural safety training for nurses and other healthcare providers and the delivery modes used.

The theoretical perspective I will use to guide this project is relational inquiry, as described by Doane & Varcoe (2021). Relational inquiry as a nursing practice requires nurses to use inquiry as an action while maintaining a relational consciousness (Doane & Varcoe, 2021). The relational inquiry approach combines hermeneutic phenomenology, pragmatism, and critical inquiry (Doane & Varcoe, 2021). Nurses must consider interpersonal, intrapersonal and contextual factors (Doane & Varcoe, 2021). In relation to cultural safety, interpersonal is the relationships and interactions that occur between nurses or other healthcare providers and patients, which may include racial discrimination or microaggressions. Interpersonal also applies to interactions between healthcare providers and how they hold each other accountable for providing care that is culturally safe. Intrapersonal is within oneself; for the patient, this can include feelings of fear or anxiety when seeking care due to historical mistrust or negative care experiences. Contextual factors are things that are occurring outside of the care interaction which can include systemic racism and white privilege, and how they impact care encounters. Hermeneutic phenomenology considers life experiences such as racial discrimination and microaggressions (Doane & Varcoe, 2021). Critical inquiry considers power imbalances such as those evident in historical events experienced by Black people in healthcare settings (Doane &

Varcoe). Pragmatism acknowledges that any theory or practice is only as good as it applies to a given situation (Doane & Varcoe, 2021). By applying a cultural safety lens, nurses can embrace the expertise of the patient and provide care that is relevant and effective for the individual.

I will also demonstrate advanced nursing competencies related to the use of research methods (Canadian Nurses Association, 2019). I searched four databases: Google Scholar, CINAHL, PsychInfo, and Pubmed. Quantitative studies that are included in this literature review have been critically appraised using the Public Health Agency of Canada (PHAC) (2014) Critical Appraisal toolkit. Qualitative studies were analyzed using the Critical Appraisal Skills Programme (CASP) checklist (CASP, 2017).

Background

The Public Health Agency of Canada (2020) described racism as a determinant of health for Black people in Canada. Black Canadians' self-reported health was lower than their White peers (PHAC, 2020). The prevalence of fair or poor health was greater in Black Canadians who reported fair or poor health at a higher rate (14.2%) than White Canadians (11.3%). In Canada, the collection of race-based data has only recently been introduced. This reduces the ability to compare health outcomes by race; however, frequent discrimination has been associated with increased odds of chronic health conditions (Siddiqi et al., 2021), and Black people experience different forms of discrimination at up to four times higher rates than White people (Siddiqi et al., 2021). Black people face significant health disparities, and in the following sections, I will discuss these disparities and their subsequent impact on health outcomes.

Health Disparities

Black people face disparities in health diagnosis and health behaviours (PHAC, 2020). In Canada, the prevalence of diabetes is 2.1 times higher in Black adults than in their White counterparts (PHAC, 2020). Of women aged 12-17, 64% of Black women reported excellent or very good mental health compared to 77.2% of White women (PHAC, 2020).

Contributing Factors

Health disparities occur due to a combination of many factors, including systemic racism, the colonial history of Canada, historical mistrust, and the social determinants of health (Public Health Agency of Canada, 2020). Although historical issues impact Black people's trust in the healthcare system, current experiences of racial discrimination and racial microaggressions continue to impact the health and well-being of Black people (Cénat et al., 2022a; Cénat et al., 2022b). Advocating for client care within the health system is a competency of advanced practice nurses; therefore, understanding the contributing factors to the health disparities of Black patients provides the basis for system improvement and program development (Canadian Nurses Association, 2019). In the following sections, I will describe historical mistrust, racial discrimination, and racial microaggressions and how they contribute to the health disparities identified in the Black community.

Historical Mistrust

Healthcare professionals, including nurses, should abide by standards of practice and codes of ethics to ensure public safety. The Canadian Nurses Association (CNA) (2017) Code of Ethics for Registered Nurses states that registered nurses must provide safe care and promote health, well-being, and justice. Although these standards are intended to promote accountability

and trust within the profession, historical events have damaged the trust of Black people accessing healthcare. The Tuskegee experiment is well-known, where treatment was withheld from Black people; similarly, in another prominent event, the cells of Henrietta Lacks were used for research without permission (Alsan & Wanamaker, 2018; Wolinetz & Collins, 2020). These collective experiences can impact the way Black patients access and engage in care encounters (Boulware et al., 2003; Schwei et al., 2014; Webb Hooper et al., 2019). Awareness of the basis of mistrust in the health system can provide nurses with a starting point to dismantle negative perceptions of healthcare. Using the practice of relational inquiry, nurses can critically examine the power imbalances and social systems that led to and continue to uphold health inequities (Doane & Varcoe, 2021). These historical events relate to power imbalances that persist in the healthcare system. Black patients were not given the opportunity to direct their own care or make informed decisions (Alsan & Wanamaket, 2018; Wolinetz & Collins, 2020). Self-reflection is an essential aspect of nursing; therefore, nurses must examine what role, if any, they play in maintaining power imbalances (CNA, 2017).

For this literature review, I found four studies that assessed trust in healthcare providers, including two medium quality, weakly designed cross-sectional and two highly credible qualitative methodologies, one phenomenological and one interpretive narrative approach. Participants of three studies included Black or African American and White adults from the United States (Boulware et al., 2003; Schwei et al., 2014; Webb Hooper et al., 2019); Schwei et al. (2014) also included Mexican Hispanic participants, while Waldron et al. (2023) included African Nova Scotian youth, their caregivers, and service providers from Canada. Youths were accessing mental health services (Waldron et al., 2023). Data were collected through computer

surveys (Schwei et al., 2014), telephone surveys (Boulware et al., 2003), a community listening tour (Webb Hooper et al., 2019) and in-person interviews (Waldron et al., 2023).

Schwei et al. (2014) found that 61% of Whites reported high institutional trust compared to 47% of African Americans and 39% of Mexican Hispanics ($p < 0.001$). Compared to Whites, African Americans continued to have greater odds of reporting low trust when other variables were controlled for (OR: 1.93; 95%CI, 1.16–3.23) (Schwei et al., 2014). Black participants were more likely to be concerned about potentially harmful experiences and privacy breaches, agreed that hospitals collect unnecessary information (adjusted difference 33%, p<.01), and have done harmful experiments without patient knowledge (adjusted difference 30%, p=.01) (Boulware et al., 2003). Webb Hooper et al. (2019) found that participants believed the healthcare system had a financial focus and that Black patients received a lower standard of care.

Boulware et al. (2003) found that Black participants were less likely to trust their physician (adjusted difference 37%, p=.01). Decreased trust can increase health disparities; Waldron et al. (2023) found that trust was a barrier to help-seeking for mental illness in the Black community. Overall, Black patients are less likely to trust their healthcare providers and health institutions than white or other people (Boulware et al., 2003; Schwei et al., 2014; Webb Hooper et al., 2019).

Schwei et al. (2014) used a convenience sample increasing the risk of sampling bias and decreasing the generalizability of the results. Similarly, the sample in Boulware et al. (2003) was eligible for kidney donation; therefore, members of the target population may have been excluded from the results. Webb Hooper et al. (2014) met all criteria outlined in the CASP Qualitative checklist (2017), while Waldron et al. (2023) met all criteria but one. Both authors clearly stated their research purpose and appropriately chose a qualitative methodology to

explore lived experiences (Waldron et al., 2023; Webb Hooper et al., 2014). Waldron et al., 2023 did not adequately address their relationship with the research or examine their potential bias and influence on the research. Overall, the results of the studies included in this review showed direct and consistent evidence that trust in the healthcare system has been negatively impacted for Black people.

Racial Discrimination

Racial discrimination is a common experience among Black people globally and is associated with decreased mental health and increased symptoms of mental illness (Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023). Five weakly designed cross-sectional studies of high (Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023) and medium (Cénat et al., 2022a; Cénat et al., 2022b) quality explored the prevalence of racial discrimination experienced by Black people aged 15-40 (Cénat et al., 2022a; Cénat et al., 2022b), 22-69 (Moody et al., 2022) and transgender or nonbinary youth aged 14-25 (Chan et al., 2023) in Canada (Chan et al., 2023; Cénat et al., 2022a; Cénat et al., 2022b) and the United States (Moody et al., 2022; Nguyen et al., 2023). One constructivist approach qualitative study explored 19 Black women's experiences in attempting to mitigate stereotypes when accessing healthcare (Sacks, 2018).

Data were collected through online surveys in three studies (Chan et al., 2023; Cénat et al., 2022a; Cénat et al., 2022b), computer-assisted interviews (Moody et al., 2022), phone and in-person surveys (Nguyen et al., 2023), and in-depth interviews and focus groups (Sacks, 2018). Data collection tools included the Everyday Discrimination Scale (Cénat et al., 2022a; Cénat et al., 2022b; Moody et al., 2022; Nguyen et al., 2023), Inventory of Microaggressions Against Black Individuals (IMABI) (Cénat et al., 2022a; Cenat et al., 2022b), Major Experiences of

Discrimination Scale (Cénat et al., 2022a; Cenat et al., 2022b; Moody et al., 2022), Self-Description Questionnaire (Cénat et al., 2022a; Cenat et al., 2022b), and the Satisfaction With Life Scale (SWLS)(Cénat et al., 2022a; Cenat et al., 2022b).

Cénat et al. (2022a) found that 53.1% of participants experienced major racial discrimination in a healthcare setting. Sacks (2018) found that Black women accessing healthcare attempted to avoid discrimination by dressing well because they experienced care based on how they were dressed (Sacks, 2018). Participants also stated that there was an assumption, based on their race, that they were not intelligent; this resulted in the participants attempting to personally connect with healthcare providers through conversation to avoid negative treatment (Sacks, 2018). Other places where major discrimination was experienced included the education system (60.5%), with police (55.5%), during hiring practices (61.5%), and job dismissal (56.7%) (Cénat et al., 2022a). Everyday racial discrimination was experienced at a high rate, with at least four out of ten participants "being treated with less courtesy or respect than other people" (46%), "people acting as if they think they are not smart" (43%), or "being threatened or harassed" (41%) (Cénat et al., 2022a pp. 16756). Another 38% reported "receiving poorer service than other people at restaurants or stores" on most days (Cénat et al., 2022a pp. 16756). Similarly, most respondents experienced everyday discrimination regularly and experienced major discrimination both personally and vicariously at least once (Moody et al., 2022). Comparatively, Chan et al. (2023) found that 35% of Black, Indigenous and People of Colour (BIPOC) participants experienced discrimination by race compared to 2.1% of White participants ($p<.001$).

There were no major threats to the internal validity of Moody et al. (2022) or Nguyen et al. (2023). Moody et al. (2022) used random sampling and linear regression, while Nguyen et al.

(2023) used logistic regression. Cénat et al. (2022a) and Cénat et al. (2022b) used convenience sampling; therefore, the sample may not represent the target population. Chan et al. (2023) could not categorize BIPOC groups separately due to the low participation numbers of each group. Multiple studies found consistent evidence that racial discrimination is associated with mental health; however, due to the descriptive nature of the studies, causation cannot be assumed. Despite this limitation, the descriptive studies provide important information on the prevalence of racial discrimination (Aggarwal & Ranganathan, 2019; Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023). Evidence from three studies is direct for Black people, while the evidence from Chan et al. (2023) does not distinguish the results of Black participants from other BIPOC groups. Therefore, the results may not be representative of Black participants. Sacks (2018) was highly credible and met all CASP (2017) criteria. The author used multiple appropriate recruitment methods, and the research design, constructivist approach, was appropriate to meet the aims of the study. Locally in Nova Scotia, there is a high prevalence of environmental racism (Waldron, 2018). Historically, Black communities are often located geographically in areas that are not close to healthcare or other services and are in close proximity to dumps or other biological hazards, increasing exposure to toxins (Waldron, 2018). The implications of environmental racism include negative health outcomes, including increased cancer rates in some communities (Waldron, 2018). Often, Black people experience subtle forms of mistreatment, which are racial microaggressions.

Racial Microaggressions

Although overt racism harms the well-being of black patients, racial microaggressions, subtle and, at times, subconscious, verbal, behavioural, or environmental indignities, also negatively impact mental health (Nadal et al., 2014). Microaggressions communicate hostility,

racial slights, and insults to a specific group (Nadal et al., 2014). Three specific types of microaggressions include microassaults, microinvalidations, and microinsults (Nadal et al., 2014). Two weakly designed high (Nadal et al., 2014) and medium (Cénat et al., 2022) quality studies examined experiences of microaggressions and the associations between racial microaggressions and mental health. One qualitative interpretive phenomenology study also examined the lived experiences of Black college students who experienced racial microaggressions. Participants of the studies included 36 Black graduate and undergraduate students in the United States (Williams et al., 2020), 506 people aged 18-66 years of various races (Nadal et al., 2014), and 845 Black Canadians aged 15-40 (Cénat et al., 2022). Data collection tools used by Nadal et al. (2014) include the Racial and Ethnic Microaggression Scale (REMS) and the Mental Health Inventory (MHI-18), while Cénat et al. (2022) used the Everyday Discrimination Scale (EDS) and Inventory of Microaggressions Against Black Individuals (IMABI). Williams et al. (2020) collected data through focus groups. Two authors found associations between racial microaggressions and mental health (Cénat et al., 2022; Nadal et al., 2014).

Nadal et al. (2014) found significant differences in the overall experience of microaggressions of white participants (M=0.25) compared to other racial groups, including Black participants (M=0.40, p-.001). Nadal et al. (2014) found a significant negative correlation ($r = –.11$, $p = .047$) between average REMS and MHI-18 scores. REMS subscales of Exoticization and Similarity had a significant negative correlation with the MHI-18 average ($r = –.15$, $p = .005$). Similarly, Williams et al. (2020) found that participants also experienced exoticization being fetishized. Overall average REMS scores were negatively correlated with subscales of the MHI-18, including depression ($r = –.12$, $p = .026$) and positive affect ($r = –.11$, p

= .043. Depression was negatively correlated with Exoticization and Assumptions of Similarity ($r = –.16$, $p = .003$).

Comparatively, Cénat et al. (2022a) found that 49.8% of participants were made to feel that their achievements were due to preferential treatment because of their race, with 18.8% being slightly upset, 14.5% moderately upset, and 4.3% extremely upset. Williams et al. (2020) also found that participants experienced hostility based on the assumption that they received unfair advantages.

There were no major threats to the internal validity of the study by Nadal et al. (2014). Cénat et al. (2022a) used a sample that was not representative of the target population as surveys were only accessible online; therefore, the results may not be generalizable to other populations. Both authors used regression for analysis, increasing the strength. Due to the descriptive nature of the studies, causation cannot be determined. However, the results are essential in demonstrating the prevalence of racial microaggressions. The study by Williams et al. (2020) was highly credible and met all criteria outlined by CASP (2017).

Impacts of Historical Mistrust, Racial Discrimination, and Racial Microaggressions

Based on historical mistrust, racial discrimination, and racial microaggressions, there are noted impacts of decreased mental health, negative care experiences, and decreased help-seeking behaviours (Cénat et al., 2022a; Waldron et al., 2023). In the following sections, I will describe mental health, negative care experiences and decreased help-seeking and subsequent adverse health outcomes.

Mental Health

Mental health is described as a psychological state and emotional well-being, a factor of overall health (Government of Canada, 2022). Mental health is separate from mental illness, although mental illness may impact mental health and well-being (Government of Canada, 2020). When Black people experience racial discrimination and racial microaggressions, their mental health can be negatively impacted (Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023; Waldron et al., 2023; Washington & Randall, 2023). Racial discrimination may cause increased anxiety (Moody et al., 2023; Nguyen et al., 2023; Washington & Randall, 2023), depressive symptoms (Cénat et al., 2022a; Lavner et al., 2022), and sleep problems (Hart et al., 2021). Participants of two weakly designed cross-sectional studies were 346 Black families living in rural, southern United States (Hart et al., 2021) and the youth from the same families (Lavner et al., 2022). The participants of the qualitative portion of a mixed methods study were five Black women who received cancer screening but were not previously diagnosed with cervical cancer (Washington & Randall, 2023). The participants of Cénat et al. (2022a) were 845 Black Canadians aged 15-40, while participants in the study by Moody et al. (2022) were aged 22-69. The participants in the study by Nguyen et al. (2023) were a nationally representative sample of Black people in the United States.

Moody et al. (2022) and Nguyen et al. (2023) found that racial discrimination was associated with increased anxiety. Moody et al. (2022) found that both vicarious experiences of major discrimination and personal experiences of everyday discrimination were associated with greater anxiety levels ($p<.05$). Nguyen et al. (2023) found that racial discrimination was associated with both 12-month and lifetime anxiety disorders among African American men

(p<.01) and women (p<.001). Similarly, Washington & Randall (2023) found that participants vigilantly prepared for medical appointments due to anxiety about the possibility of experiencing discrimination at their appointment. One example was a participant who reported researching questions to ensure she had the information required to effectively advocate for herself due to her fear that this was the only way she would receive adequate care (Washington & Randall, 2023).

Chan et al. (2023) found that for BIPOC youth, racial discrimination was significantly associated with missing unspecified needed physical health care [adjusted odds ratio (95% confidence interval): 2.12 (1.25–3.59)] and having attempted suicide in the past 12 months [2.28 (1.28–4.04)]. Psychosomatic symptoms were also associated with racial discrimination. Cénat et al. (2022b) found that participants in the second 50% percentile of everyday discrimination presented higher prevalence rates of psychosomatic symptoms (89.4%) in comparison with the first 50% percentile (72.9%) ($p < .001$), indicating an association between higher levels of discrimination and increased psychosomatic symptoms.

Depressive symptoms and sleep problems were associated with racial discrimination (Hart et al., 2021; Lavner et al., 2022). Fathers and youth who reported more racial discrimination at Time 1 (T1) also reported more depressive and sleep symptoms at both T1 and Time 2 (T2) (Hart et al., 2021). Similarly, Lavner et al. (2022) found a significant positive between-person association between racial discrimination and depressive symptoms ($B = .37$, $p < .01$). Once youth experienced above personal average discrimination, they continued this trend of above personal average at the next assessment, and depressive symptoms were similar (Lavner et al., 2022). T1 racial discrimination had positive associations with T1 and T2 depressive symptoms for both fathers and youth (fathers T1: b = .32, p<.001; fathers T2: b = .32, p <.001; youth T1: b = .72, p <.001; youth T2: b =.37, p <.001) and T1 and T2 sleep problems (fathers

T1: b =.85, p <.001; fathers T2: b =.57, p =.001; youth T1: b =.09, p<.001; youth T2: b = .09, p< .001) (Hart et al., 2021). Youth who averaged higher levels of racial discrimination reported higher levels of depressive symptoms than youth averaging lower levels of racial discrimination (Lavner et al., 2022). Similarly, for mothers, racial discrimination was positively associated with depressive symptoms at T1 and sleep symptoms at T1 and T2 (Hart et al., 2021). Comparatively, it was not associated with depressive symptoms at T2 (mothers T1: b=.18, p=.04) and T1 and T2 sleep problems (mothers T1: b=.34, p=.05; mothers T2: b=.78, p<.001) (Hart et al., 2021). Therefore, the fathers and youths in this study were affected by racial discrimination more than mothers. (Hart et al., 2021).

The overall quality of the two studies was medium Hart et al., 2021; Lavner et al., 2022). The authors increased the strength of the studies through the use of appropriate statistical techniques and regression to reduce confounding (Hart et al., 2021; Lavner et al., 2022; The key threat to internal validity was the use of self-report scales, increasing the chance of response bias (Hart et al., 2021; Lavner et al., 2022). Participants of the studies were also from rural areas; therefore, the results may not be generalizable to other areas (Hart et al., 2021; Lavner et al., 2022). The third study was highly credible (Washington & Randall, 2023). The authors provided a clear research question, appropriately used semi-structured interviews to explore the life experiences of participants, and used methods to promote rigor such as keeping detailed notes and negative case analysis.

Negative Care Experiences and Decreased Help-Seeking

Negative care experiences throughout the health system may impact help-seeking behaviours (Waldron et al., 2023). Importantly, experiences of discrimination were associated with early termination of treatment for Black people (AOR=13.38, P<0.05) (Mays et al., 2017).

Among Black participants, race was the most common reason for healthcare discrimination (Mays et al., 2017). Waldron et al. (2023) described participants' negative healthcare encounters with staff who were not culturally competent. Finding a Black healthcare provider is difficult, as was finding a non-Black healthcare provider who understood Black experiences and how racism impacts mental health (Waldron, 2020). Healthcare provider trust was associated with mental health and medication adherence (Pugh et al., 2021). Pugh et al. (2021) found that there was an indirect effect of racism on provider trust through mental health, $\beta = -.063$, $b = -.127$, $p = .023$, SE = .070, 95% CI [− .265, − .033]. The authors also found an indirect effect of mental health on medication adherence through provider trust, $\beta = .030$, $b = .043$, $p = .026$, SE = .029, 95% CI [.009, .115] (Pugh et al., 2021). The multiple mediational effect of both mental health and provider trust on the relationship between racism and medication adherence was also statistically significant, $\beta = .123$, $b = .044$, $p < .001$, SE = .015, 95% CI [.023, .075] (Pugh et al., 2021). The indirect effect of racism on mental health through provider trust was statistically significant, $\beta = .049$, $b = .012$, $p = .019$, SE = .008, 95% CI [.003, .031] (Pugh et al., 2021). The multiple mediational effect of both provider trust and mental health on the relationship between racism and medication adherence was also significant, $\beta = .094$, $b = .033$, $p = .001$, SE = .013, 95% CI [.016, .060] (Pugh et al., 2021).

All studies were of medium quality; Mays et al. (2017) provided minimal information about recruitment and had a low participation rate (56%), while Pugh et al. (2021) did not provide information about participants who declined to participate, including the reason and number of people that declined. Waldron et al. (2023), and Waldron (2020) did not locate themselves within the research to address potential influence on the research.

In summary, it is clear from the literature that Black patients could mistrust the healthcare system based on historical events. Black people experience racial discrimination and racial microaggressions that negatively impact their mental health (Cénat et al., 2022a; Cénat et al., 2022b). Black patients may have negative care experiences because of healthcare providers that lack cultural competence, which decreases help-seeking behaviours (Waldron et al., 2023). Together, these experiences and subsequent impacts negatively impact health outcomes.

In the next section, I will discuss relational inquiry as a theoretical framework and how it relates to historical mistrust, racial discrimination, and microaggressions. I will also discuss how relational inquiry relates to the impacts described above, mental health, negative care experiences, and help-seeking behaviours. As the theoretical framework for this project, relational inquiry will guide the development and delivery of the educational resource.

Relational Inquiry

Advanced practice nurses play a vital role in developing culturally safe spaces to promote the health and well-being of individuals and groups. Relational inquiry can provide a theoretical framework to practice using inquiry as action and critically examining how culture and lived experiences impact care interactions. I chose this theoretical framework because of the importance of contextual factors, life experiences, and how people subsequently approach situations (Doane & Varcoe, 2021).

The lived experiences of Black patients may include mistrust in the healthcare system, racial discrimination, and racial microaggressions. Mistrust in the healthcare system is often related to events that occurred as a result of systemic racism that allowed the mistreatment of Black patients seeking healthcare (Alsan & Wanamaker, 2018; Wolinetz & Collins, 2020). The

practice of relational inquiry provides a framework for nurses to critically examine how the social structures and systems, such as that of healthcare, allowed these historical events to occur and continue to impact the way Black patients receive and access care today. Culturally safe care requires the ability to relate to patients and embrace knowing (the expertise that the nurse brings to the relationship) and not knowing (the action of inquiry) (Doane & Varcoe, 2021). In care encounters, the nurse may have specific expertise related to mental health, however they must be open to learning about how the diagnosis presents in the individual patient and how it impacts their life.

The critical lens required for relational inquiry assists care providers in understanding historical and sociopolitical contexts, including historical mistrust in the healthcare system and racism experienced in the healthcare system and beyond (Doane & Varoce, 2021). Doane & Varcoe (2021) also highlight the importance of perspective, the individual lens used to view a situation and reference points, the view from where an individual is situated. Life experiences, including racial discrimination, racial microaggressions, and negative care experiences, shape reference points. Advanced practice nurses must consider their reference point and that of the patients they interact with. Reflection is an essential aspect of nursing practice because our reference points and experience guide our thoughts and practice (Doane & Varcoe, 2021). To truly embrace inquiry as an action, nurses must embrace what they do not know about patients and their experiences, appreciating that the patient holds expertise about their care (Doane & Varcoe, 2021).

In the next section, I will discuss cultural safety, cultural safety training, and how they relate to historical mistrust, racial discrimination, and racial microaggressions. I will also discuss

how cultural safety in healthcare relates to mental health, care experiences, and health-seeking behaviours.

Cultural Safety Training

Cultural safety is often referenced in relation to working with indigenous populations (Yaphe et al., 2019); however, cultural safety is essential for diverse populations, including Black people. Cultural safety is a combination of awareness, sensitivity, and competence (Yaphe et al., 2019). Cultural awareness is recognizing and acknowledging cultural differences, while cultural sensitivity is respecting other cultures (Yaphe et al., 2019). Finally, cultural competency is the ability to work with other cultures effectively (Yaphe et al., 2019); however, I would challenge the idea of competence, which implies expertise and lean towards cultural humility (Yaphe et al., 2019). I would encourage an openness to learning how to provide culturally safe care to individuals; in my experience, when healthcare providers feel they have achieved cultural competence, they are less interested in learning about the individual patient and what cultural safety means to them. Cultural humility is the awareness that a person's culture impacts their behaviour and showing respect and empathy while being critical and self-reflective (Prasad et al., 2016). Cultural safety is related to the contributing factors noted above, including historical mistrust, racial discrimination and racial microaggressions. As described above, an aspect of cultural safety is cultural awareness which requires the knowledge of factors that create unsafe care encounters and experiences (Yaphe et al., 2019). Cultural sensitivity, also an aspect of cultural safety requires respect for other cultures, including providing care that is free of racial discrimination or racial microaggressions (Yaphe et al., 2019). To practice cultural awareness, nurses must be knowledgeable about the collective lived experiences of many Black patients, including historical medical events, racial discrimination, and racial microaggressions (Boulware

et al., 2003; Schwei et al., 2014; Webb Hooper et al., 2019; Cénat et al., 2022;). Cultural humility considers how these factors impact help-seeking, care encounters, and health outcomes (Prasad et al., 2016).

Cultural safety training has grown in healthcare settings in recent years, although it is not a new concept. Three qualitative studies (Kaihlenan et al., 2019; Pimental et al., 2022; Yaphe et al., 2019) and one program overview (Browne et al., 2021) explored the effectiveness and acceptability of cultural safety and cultural competence programs. One study was set in Finland (Kaihlenan et al., 2019), one in Columbia (Pimental et al., 2022), and the remaining two were in Canada (Browne et al., 2021; Yaphe et al., 2019). Participants included nurses (Kaihlenan et al., 2019), medical students and residents (Pimental et al., 2022), various healthcare professionals (Yaphe et al., 2019) and employees of government and health authorities (Browne et al., 2021). Three programs focused specifically on cultural safety with indigenous populations (Browne et al., 2021; Pimental et al., 2022; Yaphe et al., 2019), while Kaihlenan et al. (2019) focused on cultural competency and did not relate to one specific culture.

The San'yas is a cultural safety training program focused on indigenous peoples offered throughout the public service in British Columbia, Manitoba, and Ontario to public service employees (Browne et al, 2021). This program has multiple forms and modes of delivery tailored to specific groups, such as general healthcare in any area of practice, mental health, and public service (Browne et al., 2021). Programs are delivered online as well as in person with the inclusion of Indigenous elders (Browne et al., 2021). The program, developed using a critical theory and transformative learning, originated as a healthcare-specific program; however, it has expanded to service healthcare authorities and government organizations (Browne et al., 2021). Pimental et al. (2022) offered an in-person participatory game, Kaihlenan et al. (2019) provided

four in-person training sessions that included lectures, discussions, and web-based tasks that were four hours in length, while Yaphe et al. (2019) used an in-person training session that included Indigenous elders as facilitators. Browne et al. (2021) used multiple evaluation methods, including pre and post-testing, and evaluation of discussion postings completed as a part of training. Comparatively, qualitative methods of evaluation were used for the remaining programs (Kaihlenan et al., 2019; Pimental et al., 2022; Yaphe et al., 2019).

In a group of over 28,000 participants in Ontario, 93.4% agreed or strongly agreed that they would recommend the San'Yas program to others, and 92.8% will use the content in their everyday work (Browne et al., 2021). The 5% who were not satisfied with the program would like more content related to Indigenous culture specifically; the authors identified that clarity on the purpose of the course might be required (Browne et al., 2021).

The authors of all three studies found that participants reported an increased awareness of cultural issues and barriers to care (Kaihlenan et al., 2019; Pimental et al., 2022; Yaphe et al., 2019). Similarly, Browne et al. (2021) found that participants demonstrated increased knowledge and ways to incorporate cultural safety into their daily practice (Browne et al., 2021). Finally, participants reported improved patient interactions (Kaihlenan et al., 2019) and doctor-patient relationships (Pimental et al., 2022). The authors of the literature I reviewed consistently found that participants generally had a positive response to cultural training with Indigenous populations; however, in this review, I found a paucity of literature about how cultural safety training specifically related to working with Black patients would be delivered and received. Although there is a difference between the lived experiences of Indigenous and Black populations, the concept of cultural safety remains unchanged; therefore, the studies provide

information about the acceptance and usefulness of cultural safety training. In the next section, I will discuss modes of delivery for education related to cultural safety.

Mode of Delivery

Various modes of delivery have been described and used for cultural safety training, including in-person training and online learning. Participants have expressed satisfaction with each mode (Browne et al., 2021; Kaihlenan et al., 2019; Pimental et al., 2022; Yaphe et al., 2019). Participants who received training that involved Indigenous elders felt that the real-life stories gave meaning to the training (Browne et al., 2021; Yaphe et al., 2019). Similarly, those who received in-person training appreciated the opportunity to have discussions with their peers and felt that small groups facilitated discussion (Kaihlenan et al., 2019; Pimental et al., 2022; Yaphe et al., 2019). Comparatively, Browne et al. (2021) successfully offered multiple modes of delivery, including in-person sessions and online learning tailored to specific groups.

I explored the principles of adult learning based on Knowles Adult Learning Theory and how they relate to the modes of delivery that were identified. Adult learners must understand the relevance of the training and be given some ability for self-direction (Collins, 2004). Online education is self-directed and allows learners to work independently. Adult learners also bring life experience and require timely feedback (Collins, 2004). In-person training provides the opportunity for immediate feedback and discussions. Life experience can help to diversify the discussions if there is variation in experience in the learning group. Assessing learning needs and prior knowledge before program implementation will provide the facilitators with a reference point for education; therefore, it is important to consider these factors.

In the next section, I will discuss perceptions of cultural competence and cultural safety training as well as resistance to teaching about white privilege. According to Roger's Diffusion of Innovation Theory, the diffusion of a new practice is a social process that is impacted by the perception of the innovation (Dearing & Cox, 2018). It is essential to assess and understand the potential adopters to address barriers to change (Dearing & Cox, 2018).

Resistance

Cultural safety training may be difficult for some participants to accept, often those of the majority race (Browne et al., 2021). Training developed through a critical inquiry lens requires people to acknowledge the structural and societal power differences and how they impact the social determinants of health and health disparities (Browne et al., 2021). People can be resistant to teachings about white privilege, specifically those of the dominant race (Erb & Loppie, 2023; Micheal et al., 2021). Micheal et al. (2021) found that some White participants felt attacked and offended by discussions of white privilege. Erb & Loppie (2023) found that some participants even made racist and harmful comments toward facilitators. In contrast, participants of ethnic minorities and mature ages were more likely to be willing to accept cultural competence and safety training (Micheal et al., 2021). Facilitator burnout was linked to insufficient support from institutions and mandatory training, which increased white fragility, described as discomfort or defensiveness felt by White people when discussing racial inequities, and resistance to learning (Erb & Loppie, 2023). It is important to consider these issues because real change often comes from a place of critical self-examination and discomfort (Mills & Creedy, 2021).

Michael et al. (2021) was a weakly designed cross-sectional study of medium quality that explored perceptions about cultural competence training of students at a University in Australia. The main threat to internal validity was the use of convenience sampling and a low response rate

(29%) increasing the chances of bias. Erb & Loppie was a highly credible qualitative study that used an indigenous relational methodology to explore facilitators' experiences of Indigenous cultural safety initiatives. Erb & Loppie met all criteria of the CASP (2017) qualitative checklist.

Conclusion

Black patients face health disparities, including the overdiagnosis of mental illness and lower reported mental health (PHAC, 2020). Contributing factors include historical mistrust of the health system, racial discrimination, and racial microaggressions (Cénat et al., 2022a). Mistrust, racial discrimination, and racial microaggressions are associated with poor mental health outcomes, including poor sleep, depressive symptoms, increased psychosomatic symptoms, and increased anxiety (Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023; Waldron et al., 2023; Washington & Randall, 2023).

Cultural safety training could enhance nurses' and other healthcare providers' ability to provide safe and effective care to Black patients. Cultural safety combines awareness, competence, and sensitivity (Yaphe et al., 2019). White fragility and resistance are expected outcomes when delivering cultural safety training that addresses differences in power and opportunity, specifically, white privilege. Therefore, planning for management is required. Using a lens of relational inquiry provides a framework to relate to the recipients of the education while critically examining the power dynamics and social structures that impact care outcomes. To ensure the longevity of the educational resource, it is essential to provide adequate support and resources to the facilitators to reduce any harm they may experience. Facilitators should be experienced and skilled in educational delivery. A facilitator with lived experience and a perspective outside of healthcare can improve the acceptability of the educational resource. Opinion leaders can assist in the diffusion of new information and practices by providing

information to potential adopters (Dearing & Cox, 2018). An educational resource must provide the necessary information about systems, such as healthcare and education, and power imbalances to ensure the recipients have a critical understanding of how they impact health and health disparities while also ensuring a safe space to reflect critically. Developing and implementing an educational resource related to cultural safety with Black patients may improve the care experiences and mental health of Black patients accessing services within the MHA program at IWK.

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Appendix A: Quantitative Literature Summary Table

Study/Design	Methods	Key Results	Comments
Authors: Boulware et al. (2003) Design: Cross-Sectional (survey) Purpose: To assess the independent relationship of self-reported race (non-Hispanic black or non-Hispanic white) with trust in physicians, hospitals, and health insurance plans	N: 118 white (69) and black (49) people aged 18-75 years who would be appropriate for kidney donation Country/setting: United States Data collection: • Telephone surveys Data collection tools: • Trust in physician scale • Medical mistrust index • All tools are valid and reliable	**Trust in the health system** • Black participants were less likely to trust their physician (adjusted difference 37%, p=.01) • Black participants were more likely to be concerned about potential harmful experiences and privacy breaches. • Black participants agreed that hospitals collect unnecessary information (adjusted difference 33%, p<.01) • Black participants agreed hospitals have done harmful experiments without patients' knowledge (adjusted difference 30%, p=.01).	Strength of Design: **Weak** Quality: **Medium** Comments: • The sample was not representative of the target population because the sample was drawn from people who are eligible for kidney donation • The results demonstrated that this sample of Black participants did not have trust in the health system

Study/Design	Methods	Key Results	Comments
Authors: Cénat et al. (2022a) Design: Cross-Sectional Purpose: To document everyday racial discrimination, major experiences of racial discrimination, and racial microaggressions among Black Canadians. and to explore the consequences on life satisfaction and self-esteem	N: 845 Black people between the ages of 15 and 40 Country/setting: Canada Data collection: online surveys Data collection tools: • Everyday discrimination scale (EDS) • Inventory of Microaggressions Against Black Individuals (IMABI), • Major Experiences of Discrimination Scale, • Self-Description Questionnaire • Satisfaction With Life Scale (SWLS). • All tools are valid and reliable	**Major Racial Discrimination** • While accessing healthcare services (53.1%) • In the education system (60.5%) • With police (55.1%) • During hiring practices (61.5%) • Job dismissal (56.7%) • Experienced more by females (p=.0001) **Everyday Racial Discrimination** • Being treated with less courtesy or respect (46%), • People acting as if they are not smart (43%) • Being threatened or harassed (41%) • Receiving poorer service (38%) • Experienced more by females (p<.0001)	Strength of Design: **Weak** Quality: **Medium** Comments: • The sample was not representative of the target population because the surveys were administered online and therefore, only those with access to the internet were included

Study/Design	Methods	Key Results	Comments
Authors: Cénat et al. (2022b) Design: Cross-sectional Purpose: To document the frequency of psychosomatic symptoms and its association to racial discrimination, and resilience among Black individuals	N: 845 Black people between the ages of 15 and 40 Country/setting: Canada Data collection: Online surveys Outcomes: • Association between everyday discrimination and psychosomatic symptoms	**Association between everyday discrimination and psychosomatic symptoms** • 81.7% of participants had probable psychosomatic symptoms • headaches (81.6%) were the most common compared to other symptoms (p<.001). • Women (84.2%) and other genders (96.6%) reported more psychosomatic symptoms than men (p<.001). • those aged 25 and over experienced more psychosomatic symptoms than those 24 and younger (p<.001). • Participants in the second 50% percentile of everyday discrimination presented higher prevalence rates of psychosomatic symptoms (89.4%) in comparison with the first 50% percentile (72.9%) ($p < .001$). • After controlling for socio-demographic variables, everyday discrimination was negatively associated with resilience ($B = -1.1$, $p < .001$) and positively associated with psychosomatic symptoms ($B = 0.1$, $p < .001$). • Overall influences of racism were greater on men than women. • the indirect effect of discrimination on psychosomatic symptoms through resilience was lower in women than in men ($B = -0.01$; 95% CI; −0.01, −0.00) when age was held constant. • The indirect effect of discrimination on psychosomatic symptoms through resilience was lower in participants aged 25 years old and older than those aged 24 years old and younger ($B = -0.003$; 95% CI; −0.01, −0.00) when gender was held constant. • Gender and age partially moderated the mediation of discrimination's effect on psychosomatic symptoms via resilience.	Strength of Design: **Weak** Quality: **Medium** Comments: • The surveys were administered online and therefore only people with access to the internet could complete them.

Study/Design	Methods	Key Results	Comments
Authors: Chan et al. (2023) Design: Cross-sectional Purpose: Identify the relationship between experiences of discrimination or violence and health outcomes for transgender and nonbinary Black, Indigenous and People of Colour (BIPOC) compared to their white peers	N: Transgender and/or nonbinary youth aged 14-25 Country/setting: Canada • 1519 Transgender and/or nonbinary White youth • 390 Transgender and/or nonbinary Black, Indigenous or People of Colour Data collection: Online survey Outcomes: Types of discrimination: sex, ethnicity or culture, race or skin colour • Exposure to violence • Relationships between violence, discrimination and health outcomes	**Discrimination by race** • White: 2.1% • BIPOC: 35% • p<.001 • BIPOC significantly associated with missing needed physical health care [adjusted odds ratio (95% confidence interval): 2.12 (1.25–3.59)] and having attempted suicide in the past 12 months [2.28 (1.28–4.04)] **At least one type of discrimination** • White: 59.3 % • BIPOC: 70.2% • p<.05	Strength of Design: **Weak** Quality: **High** Comments: • Unable to categorize BIPOC groups separately due to low participation numbers. The results indicated are for all BIPOC participants and may not be representative of Black participants.

Study/Design	Methods	Key Results	Comments
Authors: Hart et al. (2021) Design: Prospective Cohort Purpose: To explore the effects of racial discrimination on depressive symptoms and sleep problems	N: 346 Black families; parents (fathers and mothers) and youths aged 9-14 years Country/setting: United States Data collection: • Surveys Outcomes: • Association of racial discrimination with depressive symptoms • Association of racial discrimination with sleep problems	**Depressive Symptoms** Racial discrimination positively associated at Time 1 (T1) and Time 2 (T2) • Youth: T1: b = .72, p <.001;T2: b =.37, p <.001 • Fathers: T1: b = .32, p<.001; T2: b = .32, p <.001; • Mothers: T1: *b*=.18, *p*=.04 **Sleep Problems** Racial discrimination positively associated at T1 and T2 • Youth: T1: b =.09, p<.001; T2: b = .09, p< .001) • Fathers: T1: b =.85, p <.001; T2: b =.57, p =.001 • Mothers: T1: *b*=.34, *p*=.05; T2: *b*=.78, *p*<.001	Strength of Design: **Moderate** Quality: **Medium** Comments: • All participants were from a rural area, results may not be generalizable to urban populations
Authors: Lavner et al. (2022) Design: Cross-Sectional Purpose: To further understand the longitudinal effects of racial discrimination on the mental health of Black youth	N: 346 Black youths aged 9-14 years Country/setting: United States Data collection: • Surveys Data collection tools: • Daily life experiences subscale of the Racism and Life Experiences Scale • Center for epidemiological studies depression scale (CES-D) Outcomes:	**Depressive Symptoms** • Significant positive between-person association between racial discrimination and depressive symptoms (*B* = .37, *p* < .01), • Youth who averaged higher levels of racial discrimination reported higher levels of depressive symptoms than youth averaging lower levels of racial discrimination • Once youth experienced above personal average discrimination, they continued this trend of above personal average discrimination at the next assessment; depressive symptoms were similar • When youth reported above average discrimination, they reported above average depressive symptoms	Strength of Design: **Weak** Quality: **Medium** Comments: • The authors used convenience sampling, introducing potential bias

Study/Design	Methods	Key Results	Comments
	• Association of racial discrimination with depressive symptoms over time		
Authors: Mays et al. (2017) Design: Cross-sectional Purpose: To assess whether perceived discrimination in mental health/substance abuse visits contributes to participants' ratings of treatment helpfulness and stopped treatment	N: 1,099 participants aged 18-72 years who completed the California Quality of Life Survey, reported past year use of mental health and/or substance use services, and answered questions related to discrimination and treatment experiences Country/setting: United States Data collection: • Survey Outcomes: • Associations between discrimination and health	**Associations between discrimination and health** • 25% of Black participants experienced discrimination during a healthcare visit in the past year compared to 12% of white participants • more frequently experienced by those who did not have a high school education (24%) and those with no insurance (27%) • Participants who met the criteria for a psychiatric disorder were more likely to experience discrimination (19% compared to 7%, p<.001) • The prevalence of discrimination in mental health and substance use services was three times higher for Blacks compared to whites (9% vs 3%, p<.01) • Race was the most commonly reported reason for discrimination among Black participants (52%) • 25% of the participants that experienced discrimination and rated their treatment as not helpful were Black • Black participants who reported discrimination were 13 times more likely to stop treatment early than Black participants who did not (AOR = 13.38, 95% CI = 1.36–131.99)	Strength of Design: **Weak** Quality: **Medium** Comments: • Minimal information about recruitment strategies, unable to determine if they were sufficient. • Members of the population without phone access were not contacted; some of the target population may not have been included. • The participation rate was low (56%).
Authors: Moody et al. (2023) Design: Cross-sectional	N: 627 Black adults aged 22-69 years who completed the Nashville stress and health study Country/setting: United	**Vicarious experiences of discrimination** • Significantly associated with greater levels of anxiety (b = 0.33, SE = 0.16, p < 0.05) • Vicarious experiences of major discrimination associated with higher levels of anxiety (b = 0.29, SE = 0.15, p < 0.05)	Strength of Design: **Weak** Quality: **High** Comments:

Study/Design	Methods	Key Results	Comments
Purpose: To assess the effects of vicarious experiences of discrimination among Black adults from a stress and coping perspective	States Data collection: • Computer assisted interviews meaning? Data Collection Tools • Everyday Discrimination Scale • Major Discrimination Scale • Both valid and reliable Outcomes: • Vicarious experience of discrimination • Personal experience of discrimination	• Interaction effects of mental health care utilization and vicarious experiences of major discrimination were significantly associated with lower levels of anxiety ($b = -0.81$, $SE = 0.31$, $p = 0.01$). **Personal experience of discrimination** • Personal experiences of everyday discrimination associated with higher levels of anxiety (b = 0.09, SE = 0.03, p < 0.05) • Interaction effects of mental health care utilization and everyday experiences of discrimination were associated with decreased levels of anxiety symptoms among Black adults ($b = -0.18$, $SE = 0.06$, $p < 0.01$). • Mental health care utilization did not moderate the relationship between personal experiences of major discrimination and anxiety symptoms	• Strengths include the use of Multivariate Linear Regression for analysis • Random sampling was used, reducing bias, enhnacing ability to generalize?
Authors: Nadal et al. (2014) Design: Cross-sectional Purpose: To examine the relationship between racial microaggressions and mental health	N: 506 people aged 18-66 years who were Asian American/Pacific Islanders, Latino, Black, White or mixed race Country/setting: United States Data collection: • Online survey Data Collection Tools • Racial and Ethnic Microaggression Scale (REMS) • Mental Health Inventory (MHI-18) Outcomes:	**Association between mental health and microaggressions** • Significant negative correlation (r = –.11, p = .047) between average REMS and MHI-18 scores. • REMS subscales of Exoticization and Similarity had a significant negative correlation with the MHI-18 average (r = –.15, p = .005). • Subscales of the MHI-18, including depression (r = –.12, p = .026) and positive affect (r = –.11, p = .043), were negatively correlated with overall REMS average scores • Depression was negatively correlated with Exoticization and Assumptions of Similarity (r = –.16, p = .003). • Significant differences in the overall experience of microaggressions of white participants (M=0.25) compared to other racial groups, including Black participants (M=0.40, p-.001).	Strength of Design: **Weak** Quality: **High** Comments: • The strength of the study was increased with the use of multiple recruitment strategies, reducing selection bias

Study/Design	Methods	Key Results	Comments
	• Association between mental health and microaggressions		
Authors: Nguyen et al. (2023) Design: Cross-sectional Purpose: To assess the associations between racial discrimination and 12-month and lifetime DSM-IV anxiety disorders among African American men and women.	N: 3570 African American people Country/setting: United States Data collection: • Surveys completed over the phone or in-person Data Collection Tools • Everyday Discrimination Scale Outcomes: • Racial discrimination and 12-month anxiety disorder • Racial discrimination and lifetime anxiety disorders	**Racial Discrimination and 12-month anxiety disorders** **Any anxiety disorder: AOR (95% CI)** • Men:1.04 (1.01, 1.06), p<.01 • Women: 1.04 (1.02, 1.06), p<.001 **Panic Disorder** • Men: 1.08 (1.04, 1.11), p<.001 • Women: 1.04 (1.02, 1.07), p<.01 **Racial Discrimination and lifetime anxiety disorders** **Any anxiety disorder:** • Men: 1.03 (1.01, 1.05), p<.01 • Women: 1.04 (1.03, 1.05), p<.001	Strength of Design: **Weak** Quality: **High** Comments: • Logistic regression increased the strength of the study by reducing confounding

Study/Design	Methods	Key Results	Comments
Authors: Pugh et al. (2021) Design: Cross-Sectional Purpose: To determine if racism and provider trust impacted medication adherence and mental health symptoms.	N: 134 Black men and women aged 22-61. Country/setting: United States Data Collection: • Paper surveys Data collection tools: • The Daily Life Events subscale of the Racism and Life Experiences scale • PHQ-9 • GAD-7 • ITPS • MAQ Outcomes: • Effect of racism on provider trust, mental health symptoms and medication adherence	**Provider Trust** • Indirect effect of racism on provider trust through mental health, $\beta = -.063$, $b = -.127$, $p = .023$, SE = .070, 95% CI [− .265, − .033], • Indirect effect of mental health on medication adherence through provider trust, $\beta = .030$, $b = .043$, $p = .026$, SE = .029, 95% CI [.009, .115]. • Multiple mediational effect of both mental health and provider trust on the relationship between racism and medication adherence was also statistically significant, $\beta = .123$, $b = .044$, $p < .001$, SE = .015, 95% CI [.023, .075]. • Indirect effect of racism on mental health through provider trust was statistically significant, $\beta = .049$, $b = .012$, $p = .019$, SE = .008, 95% CI [.003, .031] • Indirect effect of mental health on medication adherence through provider trust (p=.026) • indirect effect of provider trust on mediation adherence through mental health, $\beta = -.055$, $b = -.010$, $p = .021$, SE = .006, 95% CI [− .022, − .002]. • The multiple mediational effect of both provider trust and mental health on the relationship between racism and medication adherence was also significant, $\beta = .094$, $b = .033$, $p = .001$, SE = .013, 95% CI [.016, .060].	Strength of Design: **Weak** Quality: **Medium** Comments: • No data on the number of participants that declined participation • No data collected on reason for declining participation

Study/Design	Methods	Key Results	Comments
Authors: Schwei et al. (2014) Design: Cross-Sectional Purpose: To explore whether there are differences in institutional trust across racial/ethnic groups and contributing factors	N: 569 adults aged 18 or older who identified as African American (33%), Mexican Hispanic (33%) or white (34%) Country/setting: United States Data collection: computer adapted surveys Data collection tools: • Health-related trust measure • All tools are valid and reliable	**Trust in the health system** • 61% of whites reported high institutional trust compared to 47% of African Americans and 39% of Mexican-Hispanics ($p < 0.001$) • Compared to whites, African Americans continued to have greater odds of reporting low trust when other variables were controlled for (OR: 1.93; 95%CI, 1.16–3.23). • Participants who reported having a previous negative health care experience in the last five years had 2.81 increased odds (95%CI, 1.81–4.37) of having low institutional trust compared to participants who reported no previous negative health care experience in the last five years	Strength of Design: **Weak** Quality: **Medium** Comments: • Convenience sampling was used, the results may be related to the area or institution rather than race or ethnicity • Multivariate logistic regression was used, decreasing confounding.
Authors: Siddiqi et al. (2021) Design: Cross-Sectional Purpose: To examine population level data on associations between race, discrimination and risk for chronic disease in Canada	N: 16, 836 people aged 18 years and older who completed the rapid response component of the Canadian Community Health Survey Country/setting: Canada Data collection: • Survey Data collection tools: Everyday Discrimination Scale	**Everyday Discrimination Scale** • Discrimination more commonly impacts Black people compared to other races • Blacks had the highest proportion of reports of experiencing any form of discrimination (52.2%) • Blacks consistently had the highest proportions of experiencing each type of discrimination • Blacks (24.2%) and Aboriginals (20.1%) reported three or more times as much discrimination as Whites (8.5%) and Asians (6.6%) in the category of being feared by others • The proportion of Blacks that reported receiving poor service was more than three times that of Whites (28.8% versus 9.7%)	Strength of Design: **Weak** Quality: **High** Comments: • This was a population-based study, with a large number of participants that were representative of the population • Regression was used to decrease confounding

Study/Design	Methods	Key Results	Comments
		• Double the proportion of Blacks reported being treated with less courtesy compared to Whites	

Legend: GAD-7: Generalized Anxiety Disorder scale; ITPS: Interpersonal Physician Trust scale; M: Median; MAQ: Medication Adherence Questionnaire; PHQ-9: Patient Health Questionnaire; SD: Standard deviation

Appendix B: Qualitative Literature Summary Table

Study/Design	Methods	Key Results	Comments
Authors: Kaihlanan et al. (2014) Design: Qualitative content analysis with a conventional approach Purpose: To examine perceptions of nurses about the content and utility of cultural competence training	N: 20 nurses at a primary care facility Country/setting: Finland Data collection: Semi-structured, small group interviews Outcomes: • General utility • Personal utility • Utility of the training for patients • Quality of the training	**General utility** • Participants found it helpful that the facilitator was not a healthcare provider and offered an alternative perspective. • The small groups made it easy to interact openly. **Personal utility** • Increased awareness of how their own culture impacts communication • Participants liked the storytelling and real-life examples in the training. **Utility of the training for patients** • Participants found that it increased the respect for cultural diversity in healthcare, improving patient interactions. **Quality of the training** • Exceeded expectations • Nurses felt prespecified statements were not as effective as professional judgement in situations	Quality: **High** Comments: • The study met all criteria outlined in the CASP (2017) checklist. • The authors engaged in reflexivity, and discussed their relationship to the study • The authors did note that not all of the participants attended all of the training sessions • The sessions were not mandatory and for this reason participants were more likely to have a positive perception of training

Study/Design	Methods	Key Results	Comments
Authors: Michael et al. (2021) Design: Qualitative exploratory Purpose: To examine perceptions of students about cultural competence training	N: 1529 University Students Country/setting: Australia Data collection: • Surveys • Small focus groups Outcomes: • Acceptance • Willingness	**Willingness to engage in cultural competency and safety training** • linked to their perception of the tutor • lived experiences of students • increased in ethnic minority and mature age **Resistance to cultural competency and safety training** • Felt dominant culture was being attacked • Offended by discussions of white privilege • Students left discussions	Quality: **High** Comments: • The study is highly credible and meets all CASP (2017) criteria • The authors had a low response rate (29%) to the surveys however this is generally not an issue with qualitative research because the goal is not to generalize, but to explore the problem

Study/Design	Methods	Key Results	Comments
Authors: Pimental et al. (2022) Design: Narrative interpretive Purpose: To describe stories of change attributed to a cultural competence intervention	N: 412 Medical students at university who participated in clinical practice and medical interns Country/setting: Columbia Data collection: • Semi-structured small group interviews Outcomes: • Conscious knowledge • Attitudes • Subjective norms • Change intention • Agency • Discussion • Action	**Conscious knowledge** • Increased ability to create a positive health environment • Improved doctor-patient relationships **Attitudes** • Respect towards cultures • Importance of cultural preservation **Subjective norms** • Increased appreciation for cultural traditions in medicine and health **Change intention** • Include cultural safety in practice **Agency** • Increased ability to accept cultural differences in health **Discussion** • Helpful to discuss with peers **Action** • Better interactions with patients and peers	Quality: **High** Comments: • The study met all criteria outlined in the CASP checklist and is highly credible
Authors: Sacks (2018) Design: Constructivist approach Purpose: To explore stereotyping, bias and the use of cultural health capital as a strategy to mitigate them	N: 19 Black women Country/setting: United States Data collection: • Focus groups • In-depth interviews Outcomes: • Dressing the part • Demonstrate that you are also a person • Try to take part in your healing	**Dressing the part** • Physical presentation changes care encounters • First impressions determine how people treat you **Demonstrate that you are a person** • Efforts to connect with healthcare provider • Trying to avoid negative encounters through performative behaviours **Try to take part in your healing** • The balance of engagement and challenging • Doing prior research to be taken seriously	Quality: **High** Comments: • The study met all criteria outlined in the CASP checklist and is highly credible

Study/Design	Methods	Key Results	Comments
Authors: Waldron (2020) Design: Narrative interpretive Purpose: To collect qualitative data on mental health issues impacting Black women in HRM	N: 25 Black women over 18 dealing with current mental illness Country/setting: Canada Data collection: • In-depth interviews using an interview guide Outcomes: • Factors underlying mental illness • Common mental health problems • Cultural beliefs about mental illness and help seeking	**Factors underlying mental illness** racism, sexism, homophobia, disability, income insecurity, sexual exploitation (through sex trafficking), sexual molestation and abuse, intimate partner violence, parental abandonment, unstable neighbourhood and family environments, family and relationship conflicts, and genetic or hereditary factors **Common mental health problems** • Stress • Anxiety • PTSD • Depression • Schizophrenia • Bipolar disorder **Cultural beliefs about mental illness and help seeking in the Black community** • Mental illness as a sign of weakness • Denial of mental illness • Mental illness is taboo • Reliance on the church • Lack of access to resources	Quality: **Medium** Comments: • The author does not locate herself within the research to acknowledge potential bias and influence on the research

Study/Design	Methods	Key Results	Comments
Authors: Waldron et al. (2023) Design: Narrative interpretive Purpose: To gain an in-depth understanding of perceptions of mental illnesses (especially psychosis), help-seeking, barriers to help-seeking, and opportunities to facilitate help-seeking in the African Nova Scotian Community.	N: 75 Black youth, their caregivers, healthcare providers and community leaders from ANS communities Country/setting: Canada Data collection: • In-person interviews Outcomes: • Perceptions about mental illness among ANS youth • Perceptions about help-seeking among ANS youth • Barriers and facilitators • Content and format of educational resources	**Perceptions about mental illness among ANS youth** • Stigma • Considered crazy or weak • Lack of understanding • Denial **Perceptions about help-seeking among ANS youth** • Fear of police involvement • No safe spaces • Lack of knowledge of where to go • Reliance on church **Barriers and facilitators** • Lack of access to Black care providers • Lack of finances • Cultural emphasis on personal strength and self reliance **Content and format of educational resources** • Using virtual resources • pamphlets	Quality: **Medium** Comments: • The authors do not situate themselves in the research to acknowledge how they may influence or bias the results. This reduces the credibility of the study.
Authors: Washington & Randall (2023) Design: Narrative interpretive Purpose: To describe the experience of discrimination in medical settings for Black women	N: 5 Black women who engaged with the health system Country/setting: United States Data collection: • In-person interviews Outcomes: • Medical mistrust • Collective experiences and narrative • Vigilant coping styles	**Medical mistrust** • Contemplating how discrimination would impact care • Previous encounters decreased trust **Collective experiences and narrative** • Behaviours influenced by the experiences of others **Vigilant coping styles** • Overpreparing for medical appointments • Becoming strong self-advocates	Quality: **High** Comments: • All criteria of the CASP (2017) were met. • The authors used multiple methods to improve credibility including negative case analysis and detailed notes

Study/Design	Methods	Key Results	Comments
Authors: Webb Hooper et al. (2019) Design: Phenomenological Purpose: To identify factors related to community trust for local healthcare systems	N: 130 participants African American (80%), white (17%), other (3%) Country/setting: United States Data collection: • Listening tour, sessions with a moderator offering an initial question and encouraging participation	• Negative encounters were expressed overwhelmingly by African Americans. • African American participants believed that they received a lower standard of care • African Americans had a fear of being used for experiments based on historical experiments done to people of colour. • Participants felt that the healthcare system was more focused on money than patient well-being.	Quality: **High** Comments: • The study met all criteria of the CASP (2017) checklist and is highly credible • The authors discussed their role in the research, adequately explained their methods, and used appropriate recruitment and data collection.
Authors: Williams et al. (2020) Design: Interpretive phenomenological Purpose: To explore how Black college students' experiences correspond to or differ from the microaggression types originally proposed by Sue et al	N: 36 undergraduate and graduate students at a predominantly White university Country/setting: United States Data collection: • Focus groups	**15 categories of microaggressions identified** • Not a true citizen: beliefs and statements that only White people are true citizens • Racial categorization and sameness: all people of same race are the same • Assumptions about intelligence, competence or status: belief in racial stereotypes about people of colours intelligence, competence or status • False colour blindness or invalidating identity: refusal to acknowledge racial identities • Criminalization: belief that people of colour are dangerous or criminals • Denial of racism: deflection of racist behaviours by • Myth of meritocracy: denial of white privilege	Quality: **High** Comments: • The study met all criteria of the CASP (2017) checklist and is highly credible

Study/Design	Methods	Key Results	Comments
		• Reverse racism hostility: jealous or hostility based on on the assumption that people of colour get unfair advantages • Pathologizing minority culture: judging people based on real or perceived cultural differences • Second class citizen: treating people of colour with less respect • Connective via stereotypes: attempts to communicate based on stereotypes • Exoticization and eroticization: characterizing differences as exotic, sexualization • Avoidance and distancing: people of colour are avoided • Environmental exclusion: exclusion of decorations related to a specific culture • Environmental attacks: decorations that insult culture or heritage	
Authors: Yaphe et al. (2019) Design: Phenomenological Purpose: To evaluate the satisfaction and feasibility of providing cultural safety training to health care professionals	N: 45 healthcare professionals who completed a cultural safety course Country/setting: Canada Data collection: • Interviews	• Many providers defined cultural safety as cultural competence, which is only a part. • Participants found the elders to be meaningful as a mode of delivery • Smaller groups allowed for better delivery and opportunity for questions and discussions • Participants acknowledged that structural and organizational constraints make it challenging to provide a culturally safe environment	Quality: **High** Comments: • The study is highly credible and met all criteria outlined by the CASP (2017) checklist • The authors provided a clear statement of results and analysis of their reactions to the dissatisfaction expressed by participants

Legend: ANS: African Nova Scotian; HRM: Halifax Regional Municipality

Appendix B: Environmental Scan and Consultations Report

Environmental Scan and Consultations Report

In the health system, Black patients are exposed to racial discrimination and microaggressions that lead to health disparities, including increased mental health symptoms such as anxiety, depressive symptoms, and poor sleep (Cénat et al., 2022; Hart et al., 2021; Lavner et al., 2022). Black patients often distrust the healthcare system based on historical mistreatment and current personal or vicarious experiences of discrimination or poor treatment when accessing care (Moody et al., 2022; Schwei et al., 2014). As an African Nova Scotian nurse providing and accessing care, I found a gap in culturally responsive care for Black patients in Nova Scotia. I discussed my experiences with colleagues who shared similar thoughts. I chose to develop a resource for my practicum project with the aim of beginning to fill this gap and improve the care experiences of Black patients accessing mental health care in a pediatric health system in Nova Scotia.

I began my practicum project by completing a review of the literature to explore and analyze the factors that impact the care experiences of Black patients globally. I found that Black patients experienced racial discrimination, racial microaggressions, and lacked trust in the healthcare system (Cénat et al., 2022; Schwei et al., 2014; Siddiqi et al., 2021). To analyze and explore the factors that impact the care experiences of Black patients in Canada, I conducted an environmental scan of institutions in Atlantic Canada. I limited my search to Atlantic Canada due to the timeframe of my practicum project. During my environmental scan, I discovered multiple educational resources on cultural safety with Indigenous populations; however, I did not locate resources for Black patients. To explore the local context, I completed consultations with healthcare providers and a Black community member in Nova Scotia. In the literature I reviewed, some African Nova Scotians avoided care due to a lack of culturally competent care

providers and negative past experiences (Waldron et al., 2023). The aim of the consultations was to explore the local experiences of Black patients and healthcare providers working with Black patients in the mental health and addictions program (MHA) of a pediatric health system in Nova Scotia and to determine what was known about cultural safety. I also aimed to explore ways for my institution's Mental Health and Addictions (MHA) program to become more culturally safe for Black patients.

Methods

To collect locally relevant data, I completed an environmental scan of Atlantic Canadian institutions and consultations in the Halifax and Annapolis Valley areas of Nova Scotia. With the guidance of my supervisor, I developed plans to implement the environmental scan and the consultations. In the next sections, I will describe the objectives, data collection methods, and analysis of the environmental scan and consultations.

Environmental Scan

The purpose of the environmental scan was to determine if there were any educational resources available about cultural safety and Black patients in Atlantic Canada that could guide the development of an educational resource. Environmental scans are used to gather information to inform decision-making (Charlton et al., 2019). The specific objectives of the environmental scan were as follows:

1. Identify and examine resources from health institutions related to cultural safety to analyze and compare themes to data collected through a literature review and consultations.

2. Identify and examine any educational resources related to working with Black patients or those other than the dominant (White) culture in health institutions and a private school that offers healthcare in Atlantic Canada.
3. Review and analyze data that is collected to inform decision-making regarding the content and mode of delivery of the educational resource
4. Demonstrate advanced nursing practice competencies, including research utilization, use of research methods, leadership, education, and consultation and collaboration (CNA, 2019)

To complete the environmental scan, I searched institutional websites in Atlantic Canada, and I sent an email to contacts within each institution, included in Appendix A, to request further information. In the next sections, I will further describe these two methods I used to complete the environmental scan.

Websites

To begin my search, I searched the names and websites of health institutions in Atlantic Canada, including New Brunswick and Nova Scotia. I also searched the website of Kings Edgehill School, a private school in Nova Scotia that offers healthcare services for its students. I searched the institutional websites using the keywords “culture,” “cultural safety,” “education,” and “orientation.” Next, I searched “diversity,” “inclusion,” and “equity.” I took detailed notes of my findings to analyze for themes based on Braun & Clark’s (2006) thematic analysis.

Email

I attempted to contact the same institutions to inquire further about cultural safety education. I recruited contacts based on having a role in education at their organization. Contacts included nurses and other healthcare providers who provided education, an Indigenous health

consultant, and a school nurse. In the email (Appendix A) I included a brief overview of my request and a list of questions to answer. I requested a response by either email or phone.

In the next sections, I will describe the consultation purpose, sample, and methods.

Consultations

The purpose of the consultations was to collect data about care experiences with Black patients that were locally relevant to a certain geographic area in Nova Scotia to inform the development of an educational resource related to cultural safety with Black patients. To increase the uptake of the educational resource, the content must be relevant to the local context (Dearing & Cox, 2018). Engaging potential adopters in the process can also increase interest and ensure the resource offers positive attributes that meet the needs of the organization and the individual adopters (Dearing & Cox, 2018).

The specific objectives for the consultations were as follows:

1. Explore and analyze the factors, including racial discrimination, racial microaggressions, racial bias, and cultural safety, that impact the care experiences of Black patients in Nova Scotia in the MHA program at a pediatric health system.
2. Identify and examine strategies, such as open dialogue or training, and resources that are currently available to support nurses and other healthcare staff to create an environment of cultural safety within the MHA program, considering locally relevant issues.
3. Explore and analyze the experiences of the Black community accessing care in the MHA program.
4. Identify locally relevant modes of education delivery.
5. Demonstrate advanced nursing practice competencies, including research utilization, use

of research methods, leadership, education, and consultation and collaboration (CNA, 2019)

I planned to consult with a total of ten healthcare staff members in a pediatric health system and one community member. I developed an interview guide with separate questions for staff and the community, included in Appendix B. I requested and received permission from my institution to complete consultations with staff in the organization.

Emails

To begin the consultation process, I sent an email, included in Appendix C to the eleven planned consultees. One manager was unexpectedly away from the office and unable to participate. Two other staff members could not participate due to staffing issues in their respective units. I sent a request to an alternative contact to fill this gap. The contact is a registered nurse (RN) and project manager for an African Nova Scotian mental health team currently in the development stage at a pediatric health system. The final sample consisted of the following:

- a clinical manager (RN) of corrections health, forensic assessment and treatment, and an urgent care clinic,

-a clinical team lead (RN) of an African Nova Scotian mental health team that is in the developmental phase at a pediatric hospital

-a nurse practitioner (NP) who practices in corrections, forensics, and new immigrant health

-the clinical leader of development, who organizes educational opportunities (RN) of an acute inpatient mental health unit, corrections, and forensics.

-two staff nurses (RN) practicing in the acute inpatient unit, one with two years of experience, and one with four years of experience

-A community activist and pastor who lives and works in a historic Black community.

Semi-Structured Interviews

I arranged 30-minute semi-structured interviews that were completed virtually using Microsoft Teams. At the start of each meeting, I provided a brief overview of the project. I informed each consultee that I received formal approval from my institution and the director of the MHA program for the consultations. I described how I would use the data I collected, both in reports submitted to my supervisor, to develop content and determine the mode of delivery for the educational resource.

In the following sections, I will describe how I maintained ethics throughout the environmental scan and consultations.

Ethics

I did not require ethical approval as this project qualifies as a quality improvement project. The HREA checklist is included in Appendix C. I received institutional approval from the research department at the IWK. I also received approval from the director of the MHA program. I maintained ethics throughout the project, specifically in the data collection, analysis, and reporting.

Environmental Scan

The majority of the data that I collected was from publicly accessible websites. This data did not require any specific safekeeping. The data I collected from an email I received was kept

on a password-protected computer. I included the information anonymously in this report to maintain the confidentiality of the person who provided it.

Consultations

All of the consultees provided informed consent for the use of the data I collected during the interviews. I explained to each consultee that the report of the data would be submitted to my supervisor and that the data would be anonymous in this report. I also informed the consultees that I received approval from the IWK research department and the director of the MHA program to engage in the consultations. I kept the collected data on a password-protected computer; I am the only person with the password. The data is reported anonymously to maintain the confidentiality of the consultees.

In the next section, I will describe the results of the environmental scan and the consultations.

Environmental Scan Results

Noted in the 2015 highlights of the board of directors meeting, Vitalité Health New Brunswick introduced an initiative called Braiding First Nations' Culture, with a focus on providing building ties with First Nations communities while also improving the cultural competencies of health employees (Vitalité Health Network, 2015). This training has been offered to all staff and physicians within the network, which includes Horizon Health (Vitalité Health Network, 2019). Similarly, in 2018 Public Health staff at the Nova Scotia Health Authority (NSHA) began taking cultural safety training for working with Indigenous populations (NSHA, 2019). The training provided by NSHA takes place in the community and has received a positive response from service providers who have taken the course (NSHA, 2019). IWK Health

is introducing a six-module cultural safety training focusing on two-eyed seeing, which uses strengths from both an Indigenous worldview and Western practice (IWK, 2022). The training will initially be introduced to 375 healthcare providers from IWK, NSH and Mi'kmaw community health (IWK, 2022). The search of the Kings Edgehill school website did not yield any results.

I received an automatic email response from the Kings Edgehill school that their office is closed as school is out for the summer; however, I was able to speak to a school nurse who lives in my community who informed me that there was no specific training related to cultural safety. All staff nurses at the private school were provided education about working with different cultures that was not specifically about cultural safety. I did not receive a response from two health networks in New Brunswick despite sending two emails to two separate contacts at each organization. I emailed two nurse educators at one institution in Nova Scotia, who did not respond to the initial or follow-up emails. I did receive a response from an institution in Nova Scotia outlining a course on cultural safety with Indigenous populations that is currently in the pilot stage and being offered to staff at the two health institutions in Nova Scotia.

This pilot cultural safety course includes six modules that are one hour in duration each and offered online to ten physicians and ten nurses. A general email was sent to physicians and nurses asking for volunteers to participate, which received an overwhelming response. The respondent to my inquiry, an Indigenous health consultant (RN), did not note any barriers to implementation, which she interpreted as being facilitated by a shifting culture in the institution towards reconciliation with Indigenous populations and a genuine desire to meet the needs of racialized communities. The content of the modules includes cultural safety with Indigenous populations, Indigenous knowledge and Two-Eyed Seeing, a worldview combining Indigenous

knowledge and Western perspectives, and clinical strategies to improve Indigenous health. Although the course is focused on Indigenous populations, the structure of the course can offer guidance for the development of an educational resource for cultural safety with Black patients. For example, the resource could highlight Afrocentric practices in health rather than Two-Eyed Seeing. I completed a thematic analysis of the data based on Braun & Clarke (2006). The steps included familiarizing myself with the data which I did by reading and re-reading my notes from each website and the single email response (Braun & Clarke, 2006). Second, I completed the initial coding of the data (Braun & Clarke, 2006). Finally, I identified and named a theme. Due to the limited amount of data gathered during the environmental scan, there was a single theme identified, cultural safety with Indigenous populations. Although the data was minimal, there is a clear shift in healthcare towards cultural safety. The characteristics of potential adopters of innovation heavily impact the uptake (Dearing & Cox, 2018). Therefore, this may positively impact the likelihood of uptake of an educational resource related to cultural safety with Black patients. The pediatric healthcare system services all Maritimes and may be seen as an opinion leader, making their support essential. Opinion leaders adopt early in the innovation process and can influence others to adopt the innovation (Dearing & Cox, 2018).

Consultation Results

To analyze the data I collected through the consultations, and as with the environmental scan, I completed a six-step thematic analysis guided by Braun & Clarke (2006). I read and re-read the notes from each interview until I felt familiar with the data. The purpose of this step is to immerse yourself in the data and search for meaning and patterns (Braun & Clarke, 2006). During this process, I took notes about initial codes. Second, I began the initial coding of the data (Braun & Clarke, 2006). Coding of data involves the creation of initial codes that indicate a

feature of the data that is interesting to the analyst (Braun & Clarke, 2006). The purpose of coding is to begin meaningfully sorting the data (Braun & Clarke, 2006). Examples of the codes I determined were personal experiences, vicarious experiences, fear, and safety.

Following the initial coding, I began steps three through six, identifying, reviewing, and naming themes (Braun & Clarke, 2006). Themes are broader groupings for the patterns identified during the coding process (Braun & Clarke, 2006). To determine themes, I analyzed the codes to determine meaningful connections and overarching themes (Braun & Clarke, 2006). I completed the analysis on the semantic level, only what was actually said instead of higher-level interpretation because of the focus of the project (educational resource development) as well as time limitations for completing data collection and analysis, (Braun & Clarke, 2006). I identified six overarching themes through data analysis, including historical and current trust in healthcare, building relationships with the Black community, respect for Black patients and healthcare providers, representation of Black people in healthcare settings, microaggressions and difficulty addressing discreet discrimination, and finally, lack of awareness of harmful behaviours and racial trauma. A sample analysis is of the first theme is included in Appendix D.

Historical and Current Trust in Healthcare

The first theme, historical and current trust in healthcare, was found throughout all consultations. The theme of trust encompasses historical and current mistrust in healthcare providers and the healthcare system as a whole. One community member described a personal avoidance of seeking care due to a lack of trust in the healthcare system and healthcare providers. The consultee described not trusting the healthcare provider to take his concerns seriously or attempt to treat his medical concerns adequately. This community member also reported similar stories from other community members.

Multiple healthcare staff members described experiences when they felt Black patients and families did not report poor treatment due to a lack of trust and fear of further mistreatment. Similar stories and feelings were shared by the community member. The community member also described historical mistrust and how the previous experiences of others continue to impact how community members see the healthcare system as a whole. The community member also stressed that trust-breaking experiences are not all in the past. Black people in the community continue to report negative experiences when accessing healthcare. An example of a negative experience was not being taken seriously when seeking healthcare in Nova Scotia. The consultee recently took his mother to a hospital in Toronto, she fell ill during their trip. She received care at a hospital there and was directed to present to the hospital upon her return to Halifax. When she arrived, the healthcare providers she interacted with were dismissive of her concerns despite having documentation from another hospital. The consultee associated this experience with their race. Another example is Black patients being brought in by police for mental healthcare; one healthcare provider stated that she noticed that Black patients were brought in by police when they were unwell while a White patient with the same clinical presentation would be brought in by a mobile crisis team.

Building Relationships with the Black Community

The second theme I identified was relationships with Black people, both in the community and in healthcare. Building relationships with the community was an important aspect of care, described by the community member and healthcare staff. One nurse stated that she did not feel the healthcare team always made the same effort to build relationships with Black patients and their families. The nurse was unable to determine why this occurred; however, was able to identify that it happened with most Black patients. This lack of effort on the part of the

healthcare team often led to decreased collaboration and care plans that were developed without the input of the patient and their families. These care plans were often not culturally relevant or appropriate because the care team did not accept family input. Another aspect of this theme was the need to build relationships with Black healthcare staff. Multiple consultees described the need for visible allies in education delivery, team meetings, and leadership tables. Allies are people of the dominant race, White, who speak up for and stand with the Black community. The consultees stated that when allies are visible and speak up about racial discrimination and microaggressions, it decreases the occurrence.

Both healthcare staff and the community member described the importance of working with Black churches. The community member described his experience hosting a vaccine clinic in a church; this provided a safe space for community members to access a healthcare service. Healthcare providers described their experience working with Black patients and the importance of spirituality. One consultee stated that Black patients were more likely to share information with their pastor or other church members than healthcare providers; therefore, building a relationship between the church and the healthcare system is essential.

Respect for Black Patients and Healthcare Providers

The next theme I identified was respect for Black patients and healthcare providers. Both the community member and healthcare staff described situations where Black families and patients were not treated with the same respect as their White counterparts. This was evidenced by a lack of collaboration and assumptions that Black families could not care for their children or meaningfully participate in developing care plans. Black parents and patients were reported to be named “difficult” or “challenging” when advocating for better care or care that meets their

individual needs. Consultees all shared similar stories, indicating that a White patient or parent expressing the same concerns was named an advocate.

Consultees of African descent shared stories of being treated poorly by colleagues and patients. White consultees also witnessed this lack of respect from their colleagues. Black people were assumed to have gotten their jobs solely based on being Black rather than their credentials, education, or hard work. The voices of Black staff were often disregarded during team meetings and at leadership tables. One consultee shared his experience accessing healthcare with a family member and being compared to a rapper by one nurse and being ignored by another. The same consultee shared that he, and other Black community members felt they needed to dress nicely to be taken seriously or treated with respect, although this did not always work. When a community member was taken to the hospital by her son during a medical emergency, she was assumed to be someone who uses substances because she arrived in her pajamas despite arriving at the emergency room late at night.

Representation of Black people in Healthcare Settings

The fourth theme I identified was the representation of Black healthcare providers and other staff members in the healthcare system. I heard this theme in all of the consultations. Black care providers must be available to provide a feeling of safety to Black patients and families. Consultees felt that there needs to be intentional hiring of Black staff at all levels, including management and executive leadership, to offer a truly diverse program. Black people are often seen in roles such as cleaning or laundry but not in management. Black patients feel more comfortable working with care providers who can relate to their experience; they feel heard.

Consultees also wanted to see Black people represented in the types of mental health services that are provided. The current model of care in the MHA program does not meet the needs of many Black patients who access care in this system. If Black patients are not responsive to the care being provided, they are named “difficult patients,” there is an assumption that it is the patient's fault rather than a need for a different approach. No effort is made to create a plan of care that works for the patient. Some consultees expressed interest in learning about Afrocentric practices and engaging in research, while others expressed concern that Afrocentric services were not readily available.

Microaggressions and Difficulty Addressing Discreet Discrimination

The fifth theme I identified as microaggressions. Most of the consultees did not name their experiences as microaggressions. There were common phrases such as *“I couldn’t put my finger on the difference*” or *“it was hard to name”* when describing why they felt race was a factor in the scenario. Microaggressions ranged from comments such as *“playing the race card”* to a lack of culturally appropriate personal care products available such as hair products for textured hair or skin moisturizer in an inpatient unit. Consultees reported that Black patients were often discharged after a shorter admission, and remained more ill than their White counterparts at discharge. Although there was no direct discussion by the care team during the patient's admission that it was related to race, and this did not occur with every Black patient, this was a difference noted by multiple healthcare staff members that they associated with race. Other examples of microaggressions included delaying the start of treatment, assumptions that Black families and patients did not have the capacity for meaningful engagement, and not taking the concerns of Black patients and families seriously. Both White and Black consultees felt that, at

times, these microaggressions were subconscious and that people did not know the harm they were causing.

Lack of Awareness of Harmful Behaviours and Racial Trauma

Lastly, I identified the theme of lack of awareness of harmful behaviours and racial trauma. Multiple consultees felt that people did not have an awareness of the historical and current mistreatment that Black people experienced in healthcare, how it continues to impact their lives, and how and when they access healthcare services. White people are not always aware that their comments or behaviours are harmful. Healthcare providers also need to be aware of the diversity of Black experiences, new immigrants may have different needs and experiences compared to African Nova Scotians. For example, African Nova Scotian patients may have had negative interactions with the healthcare system, while new immigrants may have not previously engaged in mental health services and fear accessing services related to their immigration status.

When I asked the consultees what they knew about cultural safety, they all responded with answers that reflected an awareness of cultural sensitivity, awareness, and competence, as described by Yaphe et al. (2019). In relation to education delivery, all of the consultees responded that they would prefer this education to be in person to facilitate discussions. All consultees also felt that there should be a Black person involved in the education delivery because lived experience is important; however, it is also important to have allies take part to ensure the burden of educating White people is not placed on equity-deserving populations. I found that all consultees wanted to ensure a safe space for reflection and learning and where people can be wrong and ask questions without judgment.

Synthesis of Findings

Overall, the data from the consultations and environmental scan findings indicate an openness and desire to engage in cultural safety training. The data collected from the environmental scan was limited; however, the desire to provide culturally appropriate care was a facilitator that was identified in both the environmental scans and consultations. The themes I identified in the consultations were similar to those that I identified in the literature review. The theme of historical and current trust in the healthcare system was identified in the consultations. Consultees expressed that Black patients lacked trust in the healthcare system, which was also identified in the literature review (Boulware et al., 2003; Schwei et al., 2014; Webb Hooper et al., 2019). In the literature review, microaggressions negatively impacted the mental health of Black people and impacted help-seeking behaviour (Cénat et al., 2022a; Cénat et al., 2022b; Chan et al., 2023; Moody et al., 2022; Nguyen et al., 2023; Waldron et al., 2023; Washington & Randall, 2023). Similarly, in the consultations, I identified the theme of racial microaggression and difficulty addressing discreet discrimination. Importantly, a desire to increase awareness was identified throughout the themes of the consultations, and environmental scan; therefore, an educational resource can be developed that increases awareness of how to provide care to Black patients that is culturally safe and considers the local context.

Conclusion

In conclusion, I completed an environmental scan and consultations to determine if there was a need, and to inform the content, and mode of delivery for an educational resource about cultural safety with Black patients. I received limited responses to my email during my environmental scan; this may have been related to the timing. This course took place in the summer months when many people are on vacation and some programs, such as schools, are

closed entirely. I was able to identify programs related to cultural safety with Indigenous populations being offered in other health institutions in Atlantic Canada by searching institutional websites. I did not identify any programs related to Black patients.

During the consultations, I collected rich data that offered a perspective of health care providers, both White and Black and a Black community member. I identified six themes, including historical and current trust in healthcare, building relationships with the Black community, respect for Black patients and healthcare providers, representation of Black people in healthcare settings, microaggressions and difficulty addressing discreet discrimination, and lack of awareness of harmful behaviours and racial trauma. I found there was a willingness and desire to learn about cultural safety in the healthcare institution. I have also found that my initial goals for this project may exceed the scope and timeline of this practicum. Due to scheduling conflicts and time limitations, I could not consult with as many stakeholders, particularly staff nurses and community members, as I had planned. Although I still intend to create an educational resource related to cultural safety with Black patients, it will likely be a first draft of the resource. I had originally thought I would develop an educational resource ready for immediate use after the practicum was complete. As I continue with this practicum project, I will work with community members and healthcare staff to develop an educational resource that meets the population's needs and, ultimately, improves the healthcare experiences of Black patients and families accessing care in the MHA program.

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Appendix A: Environment Scan Email

To whom it may concern:

Hello,

My name is Olivia Riley. I am a Master of Science in Nursing student at Memorial University of Newfoundland. I am in the final year of my program, and I am completing my practicum project. For this project, I plan to develop an educational resource related to cultural safety and working with Black patients in a Mental Health and Addictions program at IWK Health in Nova Scotia. To develop this project, I completed a literature review and will conduct local consultations with key stakeholders. Additionally, I am completing an environmental scan to determine if similar resources are currently used in Atlantic Canada.

As an MScN student at the Memorial University of Newfoundland, I am sending this email to inquire if you have educational resources related to cultural safety. Specifically, information from other resources will help inform both the content as well as educational delivery of the resource I plan to develop. I would greatly appreciate if you can answer the following questions related to your resource. To answer these questions, you can respond to this email; alternatively we could have a short phone call to discuss if you prefer and my contact information is below.

1. Does your institution offer any education related to cultural safety?

2. Does your institution offer any education related to working with Black patients specifically?

3. If either of the above resources exist, can you provide me with the resource or an overview of what is provided?

4. When is the education provided, for example, at the time of hire?

5. What is the mode of delivery? For example, online, or workshop?

6. Who are the target population for the resource?

7. Has this resource ever been evaluated for effectiveness or acceptability? If so, what were the results?

8. Were there any barriers to uptake? What were the facilitators to uptake?

Any information you provide will be included anonymously in reports, and further used to develop the content and determine the mode of delivery for the educational resource.

Thank you for your time. I look forward to hearing from you.

Kind regards,

Olivia Riley BScN RN

MScN Student

Memorial Uiversity of Newfoundland

Faculty of Nursing

oriley@mun.ca

Phone: 289-541-6402

Appendix B: Interview Guide

Questions for MHA Staff

1. How long have you worked in the MHA program? What is your role?
2. What has your experience been like working with Black patients?
3. Have you ever experienced or witnessed racial discrimination in a healthcare setting? If so, can you tell me about it?
4. Have you ever experienced or witnessed racial microaggressions in a healthcare setting? If so, can you tell me about it?
5. Has a Black patient or community member ever reported to you any form of discrimination or negative treatment due to their race? If so, can you tell me about it?
6. What do you know about cultural safety?
7. How can we be more culturally safe for Black patients as a program?
8. What should be included in an educational resource regarding cultural safety and working with Black patients?
9. How would you prefer to receive education about cultural safety and working with Black patients? OR how do you think education should be delivered?
10. Is there anything you think I should know as I move forward with the development of an educational resource related to cultural safety and working with Black patients?

Questions for Community Members

1. Can you tell me what your relationship is to the Black community?
2. Have you ever experienced or witnessed racial discrimination in a healthcare setting? If so, can you tell me about it?
3. Have you ever experienced or witnessed racial microaggressions in a healthcare setting? If so, can you tell me about it?
4. Do you feel that you can trust the healthcare system or those who work in healthcare? Why or why not?
5. Has a member of the Black community ever told you about experiencing any form of racism or discrimination in a healthcare setting? If so, can you tell me about it?
6. What do you know about cultural safety?
7. How can we be more culturally safe as a program?
8. Is there anything you think I should know as I move forward with the development of an educational resource related to cultural safety and working with Black patients?
9. What should be included in an educational resource regarding cultural safety and working with Black patients?

Appendix C: Consultation Email

Hello,

My name is Olivia Riley. I am a Master of Science in Nursing student at Memorial University of Newfoundland. I am in the final year of my program, and I am completing my practicum project. For this project, I plan to develop an educational resource related to cultural safety and working with Black patients in a Mental Health and Addictions program at IWK Health in Nova Scotia. To develop this project, I completed a literature review and will conduct local consultations with key stakeholders. Additionally, I am completing an environmental scan to determine if similar resources are currently used in Atlantic Canada.

As an MScN student at the Faculty of Nursing, Memorial University of Newfoundland, I am sending this email to inquire if you are interested in participating as a consultant. The consultation will involve a 30-minute semi-structured interview. I will ask you questions regarding what you feel might be relevant to developing the content for the educational resource or the mode of delivery. All of the information you provide will be anonymously included in my reports.

Please respond to this email indicating whether you are able to participate. We can arrange a date and time for a virtual or in-person meeting.

Thank you for your time. I look forward to hearing from you.

Kind regards,

Olivia Riley BScN RN

MScN Student

Memorial University of Newfoundland

Faculty of Nursing

Appendix D: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Olivia Riley

Title of Practicum Project: Development of an educational resource: Cultural safety and working with patients who identify as Black, African Nova Scotian, African, or Caribbean descent.

Date Checklist Completed: June 5, 2023

This project is exempt from Health Research Ethics Board approval because it matches item number _____3_____ from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix E

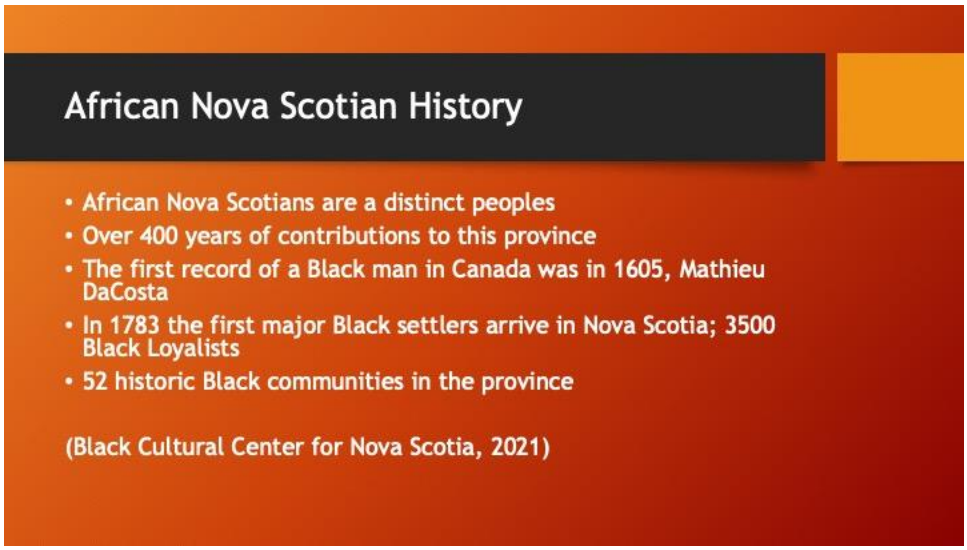
Theme 1:

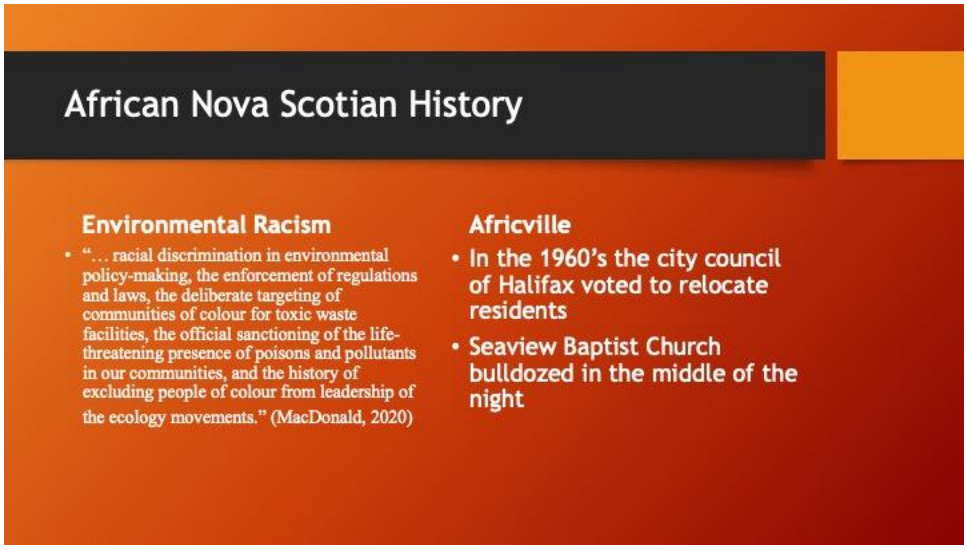
Initial Codes
Fear of judgement
Needing to present well
Not being taken seriously
Feeling like concerns aren't heard
Avoiding care
Not reporting mistreatment
Fear of not being treated fairly or well or adequately
Impact of historical events

Initial Themes
Fear of healthcare providers
Lack of trust in healthcare providers
Historical mistrust

Overarching Theme: Historical and current mistrust in the healthcare system

Appendix C: PowerPoint Presentation


African Nova Scotian History
• African Nova Scotians are a distinct peoples
• Over 400 years of contributions to this province
• The first record of a Black man in Canada was in 1605, Mathieu DaCosta
• In 1783 the first major Black settlers arrive in Nova Scotia; 3500 Black Loyalists
• 52 historic Black communities in the province
(Black Cultural Center for Nova Scotia, 2021)


African Nova Scotian History
Environmental Racism
• "... racial discrimination in environmental policy-making, the enforcement of regulations and laws, the deliberate targeting of communities of colour for toxic waste facilities, the official sanctioning of the life-threatening presence of poisons and pollutants in our communities, and the history of excluding people of colour from leadership of the ecology movements." (MacDonald, 2020)
Africville
• In the 1960's the city council of Halifax voted to relocate residents
• Seaview Baptist Church bulldozed in the middle of the night

The Health Experiences of Black People

Health Disparities

- Poorer self rated mental health
- Depressive symptoms
- Anxiety
- Sleep concerns

Contributing Factors

- Historical mistrust
- Structural and systemic racism
- Discrimination
- Microaggressions

What is the impact?

- Decreased help seeking
- Increased mental health symptoms
  - Poor sleep
  - Depressive symptoms

Cultural Safety

- What is cultural safety?
  - Awareness
  - Sensitivity
  - Competence

How does this relate to your work with Black patients?

Northern Health BC (2017)

Relationship Building and the Black Community

- Why is it essential to build relationships with the Black community?
- How can we reach community members?

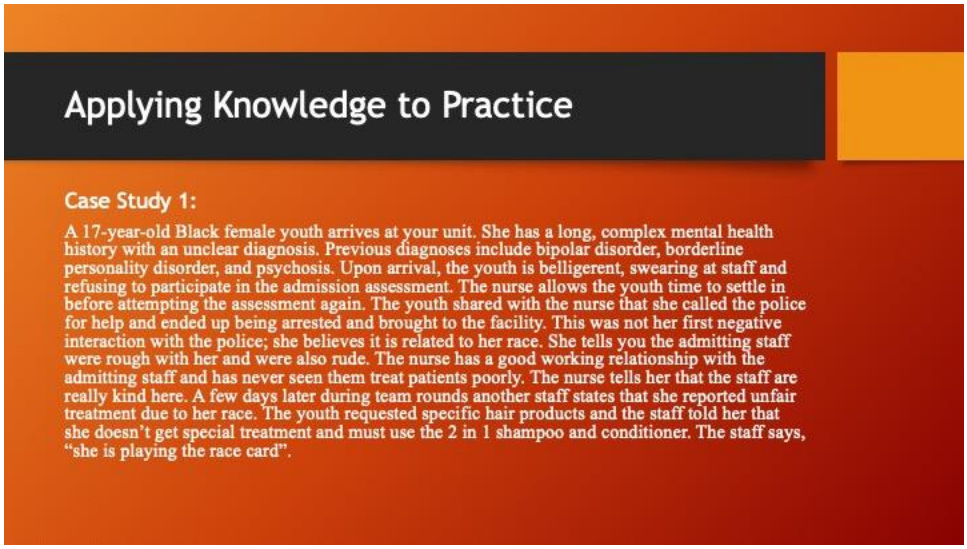
The Importance of Representation and Afrocentric Practices

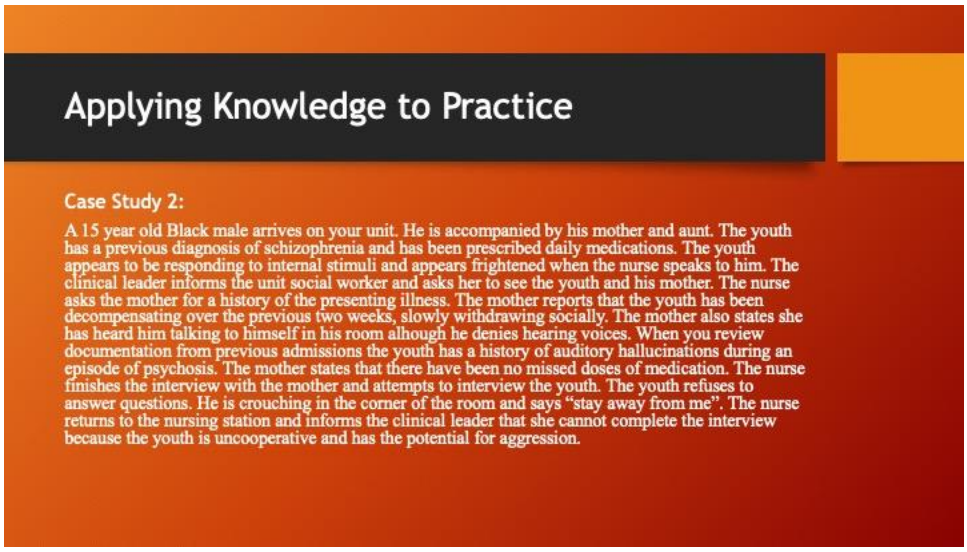
What is Afrocentric practice?

- Afrocentric practices are culturally relevant approaches to Black health
- Grounded in values, worldviews, lived experiences and history of Black people
- Based on the "Nguzo Saba" or the seven principles of Kwanzaa
- Afrocentricity may be described and practiced in different ways

Nguzo Saba Principles

- Umoja (unity)
- Kujichagulia (self-determination)
- Ujima (collective work and responsibility)
- Ujamaa (cooperative economics)
- Nia (purpose)
- Kuumba (creativity)
- Imani (faith)


Applying Knowledge to Practice
Case Study 1:
A 17-year-old Black female youth arrives at your unit. She has a long, complex mental health history with an unclear diagnosis. Previous diagnoses include bipolar disorder, borderline personality disorder, and psychosis. Upon arrival, the youth is belligerent, swearing at staff and refusing to participate in the admission assessment. The nurse allows the youth time to settle in before attempting the assessment again. The youth shared with the nurse that she called the police for help and ended up being arrested and brought to the facility. This was not her first negative interaction with the police; she believes it is related to her race. She tells you the admitting staff were rough with her and were also rude. The nurse has a good working relationship with the admitting staff and has never seen them treat patients poorly. The nurse tells her that the staff are really kind here. A few days later during team rounds another staff states that she reported unfair treatment due to her race. The youth requested specific hair products and the staff told her that she doesn't get special treatment and must use the 2 in 1 shampoo and conditioner. The staff says, "she is playing the race card".


Applying Knowledge to Practice
Case Study 2:
A 15 year old Black male arrives on your unit. He is accompanied by his mother and aunt. The youth has a previous diagnosis of schizophrenia and has been prescribed daily medications. The youth appears to be responding to internal stimuli and appears frightened when the nurse speaks to him. The clinical leader informs the unit social worker and asks her to see the youth and his mother. The nurse asks the mother for a history of the presenting illness. The mother reports that the youth has been decompensating over the previous two weeks, slowly withdrawing socially. The mother also states she has heard him talking to himself in his room alhough he denies hearing voices. When you review documentation from previous admissions the youth has a history of auditory hallucinations during an episode of psychosis. The mother states that there have been no missed doses of medication. The nurse finishes the interview with the mother and attempts to interview the youth. The youth refuses to answer questions. He is crouching in the corner of the room and says "stay away from me". The nurse returns to the nursing station and informs the clinical leader that she cannot complete the interview because the youth is uncooperative and has the potential for aggression.

Applying Knowledge to Practice

Jane Elliot's blue eyed/ brown eyed racism experience

Applying Knowledge to Practice

(Center for Prevention MN, 2017)

White Fragility

(Guardian News, 2020)

Conclusion

Cultural Humility

Attributes:

- openness
- self-awareness
- egoless
- supportive interactions
- self-reflection and critique

Benefits:

- empowerment
- partnerships
- mutual benefits
- optimal care
- respect

"Do the best you can until you know better. Then when you know better, do better." –Maya Angelou

Community Resources and Contacts

- Nova Scotia Brotherhood: nsbrotherhood@nshealth.ca
- Nova Scotia Sisterhood: nssisterhood@nshealth.ca
- Black Nurses Association of Nova Scotia: nsblacknurses@gmail.com
- Health Association of African Canadians: http://haac.ca
- Black Health Alliance: https://blackhealthalliance.ca

References

- Black Cultural Center for Nova Scotia. (2021). *Black History.* Available at: https://bccns.com/our-history/
- Center for Prevention MN. (2021). *White Privilege.* https://www.youtube.com/watch?v=7kfi3NKlQaU
- Guardian News. (2020). *How 'white fragility' reinforces racism.* https://www.youtube.com/watch?v=YvIO2GU8yTU
- Northern Health BC. (2017). *Cultural Safety: respect and dignity in relationships.* [Video]. https://www.youtube.com/watch?v=MkxcuhdgIwY
- OWN. (2020). *Jane Elliot's"Blue Eye/Brown Eye" Anti-Racism Exercise.* [Video]. Youtube. https://www.youtube.com/watch?v=ebPoSMULI5U

Appendix D: Teaching Guide Cultural Safety with Black Patients

Table of Contents

Introduction to the course for facilitators

Welcome to Cultural Safety with Black Patients. This course was developed for use in the Mental Health and Addictions program in a pediatric health system in Nova Scotia. The content was developed using the theoretical framework of relational inquiry. This framework is essential when considering cultural safety as it applies a critical lens while considering lived experiences, contextual factors, and encourages ongoing learning through inquiry as action.

Inquiry as an action and relational consciousness are key aspects of relational inquiry (Doane & Varcoe, 2021). Creating an environment of cultural safety requires us to take action, and learn about the systems and power dynamics that impact people accessing and delivering healthcare. As health care professionals, we do not have all the answers; relational inquiry encourages you to embrace ***not knowing*** as you facilitate this course. Not knowing refers to inquiry as an action (Doane & Varcoe, 2021). This is important because nurses must approach care encounters with openness to learning about how health symptoms and diagnosis impact individual patients based on their lived experiences. Pragmatism, hermeneutic phenomenology and a critical lens are the pillars of relational inquiry (Doane & Varcoe, 2021). Pragmatism indicates that knowledge is only as important as it is valid, so it is essential to relate the course content to the practice of the course participants (Doane & Varcoe, 2021). Knowles' adult learning theory and Roger's diffusion of innovation theory foster the importance of delivering content that is relevant to improve the uptake and interest in learning (Collins, 2004; Dearing & Cox, 2018). Hermeneutic phenomenology focuses on lived experience (Doane & Varcoe, 2021). To truly embrace cultural safety, we need to understand the lived experience of Black patients, and then relate to adult learning theory and diffusion of innovations. Without being a Black person, you will not be able to have a complete understanding; however, I encourage you to

really listen to the individual stories and experiences of your Black patients and colleagues. Although there are common cultural norms and shared experiences not all Black patients will have the same history or lived experience; therefore, you should not make assumptions about any individual. The information provided in this course is intended to provide a foundation for providing culturally safe care and does not replace engaging with individual patient families to determine their needs.

This course is recommended to be co-facilitated by a Black facilitator and an ally likely of the dominant race. This suggestion ensures the burden is not placed on the equity-deserving group, Black people, to educate others and create safe spaces. While this is essential, it is also important to provide the opportunity and space for Black people to lead educational experiences that relate directly to them to ensure the message is delivered as intended. Self-determination is a principle of Afrocentric practices. Lived experience provides an irreplaceable connection to this work. Finally, a critical lens provides a reference point for understanding the social structures and hierarchies that continue to be upheld in our colonial society, such as the power imbalance in health research that allowed Black people to be used in experiments without consent (Doane & Varcoe, 2021; CDC, 2020).

The course is also recommended to be delivered to groups of 20 participants or less. Keeping the groups small allows for better discussions and opportunities for more people to contribute and participate. Open and safe discussion spaces are an essential aspect of this course.

You will notice that throughout this course, some information will be noted as anecdotal. Consultations were completed to collect local data for this course, so the examples provided are from the lived experience of Black people here in Nova Scotia and allies, both community members and healthcare professionals. The consultees identified as Black and White.

A pre and post-test is found in Appendix A to determine prior knowledge and knowledge uptake.

In each module, you will find the following headings:

Ask the group- a question to ask the group, allow a brief amount of time for responses. If participants do not offer any response, provide the answer.

Activity- provide the instructions to the group. Detailed instructions for the game are provided in Appendix B.

A PowerPoint presentation accompanies the facilitator's guide. The guide is organized by module, and notes are provided for each slide. Words written in italics are notes to the facilitator and not intended to be read aloud.

Prior to facilitating this course, please review the brown eye blue eye exercise by Jane Elliot. A video of Jane Elliot's 1992 appearance on Oprah can be found on YouTube (https://www.youtube.com/watch?v=ebPoSMULI5U)

We will be doing a variation of this exercise. One facilitator should be at the door when participants are entering. Any participant who does not have brown eyes will be given a neon-coloured sticky note and asked to put it on their person in a visible place. The facilitators should treat these participants differently by not being as courteous or friendly. We will not go as far as the staff did on the Oprah show; however, the difference should be notable. The participants must be informed that there will be an activity occurring throughout the duration of the course that might make them uncomfortable and that it is intended for learning purposes. Encourage patients to approach a facilitator if they have immediate concerns. An example is to always answer a person's hand without a sticky note first when asking questions or showing surprise when a person with a sticky note gets an answer correct. Make a verbal comment such as, "I am

surprised someone with blue eyes knows the answer to that question." Do not inform participants that you are doing the experiment; we will discuss it at the end of the course.

Required Supplies for the course:

1. 3 cases of 24 bottles of water
2. Neon sticky notes
3. Participant cards included with "how heavy is your load" game should be cut out
4. Copies of the pre/post-test for participants

Land acknowledgements

I would encourage facilitators to explore the purpose and meaning behind land acknowledgements. As we embark on a journey of creating culturally safe spaces, acknowledging that we are in Mi'kma'ki, the ancestral unceded territory of the Mi'kmaq people, is essential. Acknowledging the over 400-year history of African Nova Scotian people's contributions to this province is also integral. This can be as brief as what is written here or longer; it is more meaningful if done in a way that resonates with the facilitator.

Module 1:

Introduction to the course

Slide 2

This course is intended to encourage you to critically reflect on your own practice and the overall practices within healthcare in Nova Scotia. The topics we cover might make you feel uncomfortable if they challenge your thoughts about yourself or your peers or expose biases you were unaware of (Hantke et al., 2022). This is expected. Change does not generally come from a place of comfort, so I will ask you to embrace your own hard feelings and be respectful of others so we can maintain a safe space to ask questions and share thoughts.

While we encourage you to ask questions and seek opportunities to learn, we also ask that you be mindful of how impactful words can be. We do not know the lived experiences of our peers or what discussions may be difficult to others. Ask questions and be intentional about learning, but also be intentional about respecting others and their perspectives. We each have our own perspectives and views based on our lived experiences.

This educational experience was developed from the theoretical perspective of relational inquiry. As described by Doane & Varcoe (2021), relational inquiry combines pragmatism, hermeneutic phenomenology, and a critical lens. According to a pragmatic perspective, knowledge is only as good as it is useful; hermeneutic phenomenology is about lived experiences, while the critical lens provides a perspective for viewing the power dynamics and social structures that impact how we provide care to Black patients and how they receive it. These power dynamics are often hidden and it is through the development of a safe space for reflection and dialogue that we can bring some of these power dynamics to light. We will discuss

and learn about the contextual factors that must be considered to develop culturally safe spaces for Black patients.

The topics we will cover include:

10. African Nova Scotian people *(estimated time: 15 minutes)*
11. The health experiences of Black patients *(estimated time: 30 minutes)*

Suggested 15-minute break

12. Cultural safety and Black patients *(estimated time: 20 minutes)*
13. Relationship building and the Black community *(estimated time: 15 minutes)*
14. The importance of representation and Afrocentric practices *(estimated time: 15 minutes)*

Suggested lunch break 45 minutes- one hour

15. Applying knowledge to practice through case discussions *(estimated time: 60 minutes)*

Suggested 15-minute break

16. White Fragility *(estimated time: 15 minutes)*
17. Community resources *estimated time: (10 minutes)*

Module 2:

African Nova Scotian History

Slide 3

This course is intended to encourage cultural safety for Black patients regardless of their place of origin; however, as we work and reside in Nova Scotia, it is essential to acknowledge and discuss the African Nova Scotian population that we serve and their history in this province.

African Nova Scotians are a distinct people who have lived in and contributed to the growth of Nova Scotia for over 400 years. The history and culture of Black people run deep in Nova Scotia. Fifty-two historic Black communities span Nova Scotia from Sydney Mines in Cape Breton to Greenville in Yarmouth.

Slide 4

Environmental Racism

This term was coined in 1982 by a Black American civil rights activist named Benjamin Chavis (MacDonald, 2020). He defined environmental racism as

> "… racial discrimination in environmental policy-making, the enforcement of regulations and laws, the deliberate targeting of communities of colour for toxic waste facilities, the official sanctioning of the life-threatening presence of poisons and pollutants in our communities, and the history of excluding people of colour from leadership of the ecology movements." (MacDonald, 2020)

Black communities were intentionally positioned far away from services and resources. For many years, transit services did not go to the Preston areas at regular times that would allow

people to use them to travel to and from work making it increasingly difficult to be gainfully employed. In 2021, the first transit bus serviced East Preston on a weekend (Byard, 2021). Anecdotally, communities did not have adequate services such as snow removal making it difficult even for those with their own forms of transportation. Black people were settled on barren land, making it difficult to be self-sufficient as a community. Some communities were placed in close proximity to dumps and other toxins. A 2002 study found that 30% of African Nova Scotians lived within 5km of a landfill (Waldron, 2018). Although this study is dated, historic Black communities remain in the same place. Lincolnville is a historic Black community that is beside a landfill, and the residents have higher levels of cancer than the general public (Waldron, 2018).

Africville

Ask the group: Can anybody tell me about Africville?

Africville was also beside a dump. The city decided they would move everybody out to increase the size of the dump. Residents were forcibly removed from their homes, and their church was bulldozed in the middle of the night (McRae, 2017).

The church is an important part of the Black community. The church remains a meeting place for many people and purposes in Black communities today. Not all things are religious; however, they are driven by a desire for community progression, togetherness, and building up the Black community through mutual support. There are many other examples of the mistreatment of Black people in Nova Scotia, both historic and current. Consultees described healthcare providers making assumptions about Black patients using substances because they arrived to the hospital in pyjamas despite it being the middle of the night. Similarly, Black

patients were not believed when they reported symptoms of an illness despite providing reports from previous healthcare providers confirming their diagnosis or symptoms.

Encourage participants to continue their learning in their own time. Resources include:

- the Black Cultural Centre in Cherry Brook,
- the Black Loyalist Heritage Centre in Shelburne
- the Africville Museum in Halifax.
- There's also a movie on Netflix called There Is Something in the Water that discusses Lincolnville and other examples of environmental racism.

Although it is easy to find negative information about Black communities, it is important to highlight some of the excellent work that has occurred in these communities.

A recent example is the development of a community food pantry in the Preston township to assist families in need. Many thriving churches serve as a connection to other necessary services, such as vaccine clinics and social services, removing barriers to access for community members.

Black patients who are not ANS

In 2016, Statistics Canada found that Black people in Canada were born in more than 170 different places (Statistics Canada, 2019). While the majority of Black people in Nova Scotia were born here, it is important to note that we do care for Black people who are the first or second-generation of their family in Nova Scotia. Black patients who have recently immigrated may face other barriers related to trauma history or country of origin, lack of understanding of the health system, or language barriers. African-born immigrants have a higher unemployment rate than other immigrants; professional credentials may not be recognized (Kaduuli, 2021).

African refugees face discrimination in the refugee process prior to arriving in Canada (Kaduuli, 2021). An example of this is refugees from Ethiopia waited an average of 68 months to come to Canada, compared to Iraqi refugees who waited an average of 15 months (Kaduuli, 2021). Healthcare providers should be aware of the diversity of Black people in Nova Scotia and use inquiry as action to explore what being Black means to the individuals and families in their care. Haing a general understanding that non-ANS Black patients have had an experience that is different from ANS patinets is essential. Embracing not knowing, as described by Doane & Varoce (2021) provides an opportunity for healthcare providers to explore what being Black means to their individual patient and families.

The health experiences we will discuss in the following slides apply to all Black patients, regardless of country of origin.

Module 3:

The Health Experiences of Black People: Historical Mistrust, Structural and Systemic Racism, Discrimination and Black Patients

Slide 5

In this module, we will talk about the health experiences of Black people, including historical mistrust in healthcare, discrimination, and microaggressions. Historical mistrust in the healthcare system is an issue that permeates present-day healthcare experiences and interactions.

Historical Mistrust

Ask the group: Is anyone aware of the Tuskegee experiment?

During this experiment, treatment was withheld from Black patients suffering from syphilis to study the natural history and course of the disease (Alsan & Wanamaker, 2018; CDC, 2020). The participants did not provide informed consent. Importantly, during the study, which ran from 1932 to 1972, penicillin became the course of treatment for syphilis; the participants were never provided penicillin (CDC, 2020). A class action lawsuit was later filed and won by the surviving participants (CDC, 2020).

Ask the group: Can anyone tell me about Henrietta Lacks?

Henrietta Lacks' cells were collected during a biopsy and used for research for many years beyond her passing without her permission or knowledge (Wolinetz & Collins, 2020). John Hopkins Hospital, where the cells were collected, states the practice was completely legal at the time of collection; however, it would not be acceptable today (Wolinetz & Collins, 2020).

These historical experiences highlight the power imbalances that make it difficult for Black patients to be in control of their care and their bodies. Racialized differences continue to occur in care today. Healthcare providers have found a notable difference in efforts to collaborate with patients and families to develop care plans. The result is care and treatment that happens *to* patients instead of *with* them in a culturally relevant and safe way. Treatment decisions are made for Black patients without adequate patient input.

Ask the group: Encourage discussions and reflection on how this may impact Black patients' arrival for care in our health system.

Historical mistrust creates a lack of trust in healthcare providers and systems today (Cénat et al., 2022a; Cénat et al., 2022b). Why does this matter? Many Black patients do not trust their healthcare providers which can lead to increased health disparities and decreased help-seeking (Pugh et al., 2021; Waldron, 2020; Waldron et al., 2023).

Ask the group: Do you take advice from people you don't trust?

Do you reach out to them when you have a concern?

A lack of trust can cause a decrease in help-seeking behaviour and increased healthcare disparities (Waldron, 2020; Waldron et al., 2023). Healthcare provider trust affects medication adherence and mental health (Pugh et al., 2021; Waldron, 2020; Waldron et al., 2023).

Not surprisingly, Black patients were more likely to be concerned about privacy breaches, collection of unnecessary healthcare information, and potentially harmful experiences (Boulware et al., 2003; Schwei et al., 2014; Webb Hooper et al., 2019). We can better understand the current perspectives when we are aware of the historical experiences.

Ask the group: Have you ever heard someone say something like "they chose not to take care of themselves" or "why didn't they come to the doctor earlier?"

There are so many factors that Black patients must consider when they are deciding if they should seek healthcare. The mental health impacts of experiencing racial discrimination might outweigh the perceived benefit of seeking care until their symptoms have progressed. It may not be as simple as choosing not to take care of themselves, the decision to avoid healthcare systems may be a self-care mechanism.

Encourage the participants to consider the perspective of Black patients and why they may choose not to seek care.

Discrimination

Ask the group: What do you think about when preparing for a healthcare appointment?

Some things that Black people think about are: am I dressed well enough to be taken seriously? Will the provider think I'm smart enough to understand my health information? Will I be treated with respect? (Sacks, 2018) Healthcare appointments can be stressful for anybody but there is added stressors for Black patients who have to wonder if they will be treated differently because of their race. These feelings are warranted, based on the results of the studies we have discussed here today.

Ask the group: How difficult is it to absorb information at a healthcare appointment when you are distracted? Imagine having all of these things on your mind, on top of your everyday stressors, when attending a healthcare appointment. Would you still go? You don't have to answer out loud, but I would encourage you to think about this the next time you question why a Black patient did not seek healthcare sooner.

Many Black patients have experienced discrimination in many places, including healthcare. One Canadian study found that 53% of participants had experienced discrimination in a healthcare setting (Cénat et al., 2022a). Here in Nova Scotia, anecdotally, Black patients have been questioned about the legitimacy of their symptoms. They have also been discharged before they were adequately treated or before a White person with the same diagnosis and presentation was discharged. Consultees found that Black patients were also more likely to arrive by police than crisis intervention services compared to White patients with a similar presentation. Discrimination is associated with early termination of treatment for Black people, and race was the most common reason for discrimination experienced by the study participants in a healthcare setting (Mays et al., 2017).

Microaggressions

Ask the group: Can anyone tell me what a racial microaggression is?

A racial microaggression is a subtle verbal, behavioural, or environmental indignity that can sometimes be subconscious and communicates hostility, racial slights or insults to a specific group (Nadal et al., 2014). Some examples of microaggressions that have been identified here in Nova Scotia include not respecting Black patients and their families as a part of the care team and, therefore, not collaborating with them. Assuming Black patients and families cannot care for themselves or their family members or naming them as "challenging" or "difficult" when they speak up about their care. Black staff may be invited to sit at certain "tables," but their opinion is not valued. For example, designating a managers position for a person of African descent but not considering their perspective or respecting their contributions in meetings. This allows an organization to meet a quota by having a Black person in the manager role; however, it does not help to diversify practices or bring real change.

Ask the group: What is particularly challenging about microaggressions compared to overt aggressions?

They are difficult to name or point out and can be challenging to address. For example, if a colleague refers to a patient as a racial slur, it is easy to address this behaviour and you can likely find a policy to support the way it should be addressed; however, when you feel that a patient is being treated differently but you aren't able to state the exact difference you won't likely find support from leadership to address the situation.

Ask the group: What are the possible impacts of experiencing microaggressions?

Microaggressions were associated with increased mental health symptoms such as depression; people who experienced microaggressions were more likely to experience depressive symptoms. (Cénat et al., 2022a; Nadal et al., 2014).

Activity:

- In small groups, brainstorm ways to address microaggressions in everyday practice.
- If there is racial diversity among participants, make an effort to have different races in each group to increase the richness of the discussions
- Walk around to the groups to encourage discussion and provide suggestions.

White and Black healthcare staff identified the importance of visible allies to mitigate microaggressions. When people who are not Black make a statement and call out microaggressions, it sends the message that the behaviour will not be tolerated without burdening the equity-deserving group.

Impacts

Why is this important?

Both vicarious and personal experiences of racial discrimination can cause increased anxiety (Moody et al., 2023; Nguyen et al., 2023; Washington & Randall, 2023),

Missed physical health needs, vigorous appointment preparation due to anxiety, attempted suicide, and psychosomatic symptoms were all associated with racial discrimination (Cénat et al., 2022b; Chan et al., 2023; Washington & Randall, 2023). Increased depressive symptoms and poor sleep are also associated with racial discrimination (Cénat et al., 2022a; Hart et al., 2021; Lavner et al., 2022),

Play "How heavy is your load?"

Module 4:

Cultural Safety

Slide 6

Ask the group: What is your understanding of cultural safety?

Cultural safety combines three things: cultural awareness, cultural sensitivity, and cultural competence (Yaphe et al., 2019). We will watch a short video to expand on these concepts.

Play video.

https://www.youtube.com/watch?v=jmRFsVAXmiQ

While this video is about working with Indigenous populations, the concepts of cultural safety can be applied to all diverse cultures.

Have you ever heard someone say I don't see colour? Although this is generally a well-intentioned comment, it is important to understand that this is not the goal. Black patients want to be seen, heard, and recognized as they are. Black.

Ask the group: How do the concepts of cultural safety relate to your work?

Activity:

- Have participants get into small groups of 4 or 5. Provide paper and markers and ask participants to write ways that the concepts of cultural safety relate to their roles.
- Allow 10 minutes. Ask one person from the group to bring up all the papers. Go over the responses, discuss similarities and differences.
- Provide responses if needed. Examples include: increasing awareness of contextual factors that impact patients, relationship building, developing care plans

Ask the group: How do we make our workplaces culturally safe for Black patients?

Acknowledging that the needs of Black patients might not be the same as white patients. This could be anything from the presentation of an illness to a need for different personal care products.

Do you know how to access appropriate hair care products for your Black patients? Some Black patients may require specific care products for that are intended for textured hair.

You can contact social work to get them. If they are not readily available on your unit, I would encourage you to advocate to change that with your manager.

Module 5:

Building Relationships and the Black Community

Slide 7

Black people are a relational people. Activities such as talking and sharing meals can be important aspects of the community.

Ask the group: Why is building relationships with our patients important?

- Build trust
- Collaborate and build care plans

Individual: As healthcare professionals, it is essential to build relationships with the Black community; this includes creating trust and providing care that meets the same standard of care provided to others. Although relationship building is important for any patient care interaction, we must be aware of the challenges that exist specifically for Black patients accessing healthcare, including those that were discussed in previous modules such as mistrust in healthcare providers and systems, and experiences of discrimination and microaggressions. Black people and communities are impacted by actions taken by healthcare providers and systems. Regardless if we were a part of those experiences, we must be a part of the solution.

Building relationships improves collaboration and allows healthcare providers to ensure that care is patient-centered and culturally relevant.

Community: It is also important to become visible allies. As an organization, we can build relationships within Black communities to show that we are here and want to help. Black

churches are often the center of the Black community, where people come together. Black churches are host to pastors and members who can be an initial point of contact when people in the community are experiencing distress or difficulties long before reaching out for mental health services (Hatcher et al., 2017). Anecdotally, in Nova Scotia, building relationships with churches and other community organizations has provided opportunities to provide healthcare in safe spaces through events such as vaccine clinics.

Module 6:

The importance of Representation and Afrocentric practices

Slide 8

Why are Black people represented in some places and not others? An example described during discussions with healthcare providers in Nova Scotia was a high number of Black cleaning staff and a low number of Black people in formal leadership roles.

Has anybody ever walked into a place and been the “only”?

Maybe it was the only female

Maybe it was the only person of colour.

How inviting did that space feel when you walked in? Was it comfortable? Was it safe?

This is a common experience for Black people seeking treatment. That is why representation is important. Black patients seeking mental health care in Nova Scotia also found it difficult to find care providers who understood their lived experiences, including racism. There are various ways that organizations can increase representation. One of the methods is through designated positions. Designated positions are when a position is designated for a person of African descent. It is important to understand that a designated position does not mean that the person does not require the same qualifications as others in the same or similar positions. It simply means they must also be a person of African descent, if that is the designation. Black healthcare providers experience discrimination and mistreatment when colleagues and others around them believe they have been given a position due to their race rather than their qualifications. Creating culturally safe spaces extends beyond patients and includes staff as well. Learn to be an ally and

support your Black colleagues by sharing your knowledge of the meaning of designated positions if you hear this type of discussion among your peers.

Designation is to counteract the barriers that impact Black people getting into positions. When applying for positions with resumes containing names that may *sound Black* applicants were less likely to receive a call back (Bertran & Mullainathan, 2004). This is just one example of discrimination when Black people seek employment.

Afrocentric Practices

Another essential aspect of care is care that fits your needs.

Ask the group: Has anyone ever been presented with a plan of care that they knew they couldn't do at home? One that didn't make sense to them? Didn't fit within your values?

This is a common experience for Black patients accessing healthcare. The majority of care provided has historically been based on Eurocentric principles and practices and is not culturally relevant to Black patients. Discussions with healthcare providers in Nova Scotia revealed that patients who did not agree with the proposed care, based on Eurocentric principles, are often deemed *challenging* or *noncompliant*. Historically, the term noncompliance has been used to remove the responsibility of treatment progress from the physician and place it on the patient and their perceived inability to follow the direction of the care provider (Lerner, 1997). However, I would encourage you to challenge this in your practice and use inquiry as action to determine why a patient is not taking the advice of the healthcare provider. It may lead to improved relationships, increased patient participation, and the development of care plans that are culturally relevant (Lerner, 1997).

Afrocentric practice is based on African principles and is culturally relevant to Black patients. It is grounded in the culture, history, and lived experiences of Black people (Hatcher et al., 2017). While Afrocentric practices may look different for different providers and patients, they are commonly based on the seven principles of Nguzo Saba, which include:

Umoja (unity)

Kujichagulia (self-determination)

Ujima (collective work and responsibility)

Ujamaa (cooperative economics)

Nia (purpose)

Kuumba (creativity)

Imani (faith) (Hatcher et al., 2017)

How can we apply these principles in our everyday practice?

Ask participants to provide examples for each principle

Umoja: Understanding the relevance and importance of unity in care. We talk about family centered care but we need to understand that community is family. The need for unity may extend beyond the nuclear family. Work with your patients and their families as a team. Show that you are an ally and stand in solidarity with your Black patients and peers to fight discrimination (Hatcher et al., 2017).

Kujichagulia: Give space for patients and families to make their own decisions, determine their own path and what works for them. Black people have the right to self-determination in all spaces (Hatcher et al., 2017).

Ujima: Understanding that there is collective responsibility among community members and families. When we consider the unity of the community, this extends to failures and triumphs. The community comes together and works to solve problems and create solutions. This principle highlights the importance of building relationships within communities (Hatcher et al., 2017).

Ujamaa: The Black community creates their own resources to increase self-reliance (Hatcher et al., 2017). An example is the church creating an opportunity to access vaccines and health services or the creationg of a community food pantry for those in need.

Nia: This principle is important, especially as we work with Black youth. Creating a sense of purpose and cultural awareness can help Black youth understand their place in society. By having knowledge of the contributions that Black people have made to the development of this province, we can help instill this sense of purpose in our patients (Hatcher et al., 2017).

Kuumba: We can encourage creativity and growth in our patients (Hatcher et al., 2017). By collaborating with patients we can help them discover ways to optimize their health and wellness.

Imani: We should encourage our patients to believe in themselves and the community. As discussed previously, some Black people are also connected to spiritual beliefs. It is important to allow space for spirituality within mental health spaces and incorporate this into care planning as desired (Hatcher et al., 2017).

It is important to understand that Afrocentric practices may look different to different people and populations. Be careful not to put all Black patients into a box. The African diaspora is vast, and so are the lived experiences of Black patients. We need to engage our patients in a collaborative process to determine how we can provide care in a way that meets their individual needs. Again, relational inquiry and embracing not knowing are essential to ensure we remember that all Black patients are not the same although many share collective traumas and lived experiences.

Module 7:

Applying Knowledge to Practice

Slides 9 & 10

Activity:

- Divide participants into groups of 4-5. If there are multiple disciplines, try and make sure each group has a mixture of disciplines.
- Provide each group with a case study and ask them to read the case study, and discuss for 10 minutes. Answer the questions provided.
- Walk around to the groups and encourage discussion as needed.
- After 10 minutes, ask the groups to pass their case study to the group to the right.
- Continue until each group has completed both case studies.
- Come together as a large group and discuss the responses to each case study.

***Case Study 1*:**

A 17-year-old Black female youth arrives at your unit. She has a long, complex mental health history with an unclear diagnosis. Previous diagnoses include bipolar disorder, borderline personality disorder, and psychosis. Upon arrival, the youth is belligerent, swearing at staff and refusing to participate in the admission assessment. The nurse allows the youth time to settle in before attempting the assessment again. The youth shared with the nurse that she called the police for help and ended up being arrested and brought to the facility. This was not her first negative interaction with the police; she believes it is related to her race. She tells you the admitting staff were rough with her and were also rude. The nurse has a good working relationship with the admitting staff and has never seen them treat patients poorly. The nurse tells her that the staff are really kind here. A few days later during team rounds another staff states

that she reported unfair treatment due to her race. The youth requested specific hair products and the staff told her that she doesn't get special treatment and must use the 2 in 1 shampoo and conditioner. The staff says, "she is playing the race card".

Questions to consider:

Are there any microaggressions?

What are some possible considerations for this patient?

What should the nurse do?

What should leaders do (manager, clinical leader?)

What are your other concerns about this case?

Is the service culturally safe?

How can we improve cultural safety?

***Case Study 2*:**

A 15-year-old Black male arrives on your unit. His mother and aunt accompany him. The youth has a previous diagnosis of schizophrenia and has been prescribed daily medications. The youth appears to be responding to internal stimuli and appears frightened when the nurse speaks to him. The clinical leader informs the unit social worker and asks her to see the youth and his mother. The nurse asks the mother for a history of the presenting illness. The mother reports that the youth has decompensated over the previous two weeks, slowly withdrawing socially. The mother also states she has heard him talking to himself in his room although he denies hearing voices. When you review documentation from previous admissions, the youth has a history of auditory hallucinations during an episode of psychosis. The mother states that there have been no missed doses of medication. The nurse finishes the interview with the mother and attempts to interview the youth. The youth refuses to answer questions. He crouches in the room's corner and says "Stay away from me". The nurse returns to the nursing station and informs the clinical leader that she cannot complete the interview because the youth is uncooperative and has the potential for aggression.

Questions to consider:

Are there any microaggressions?

What are some possible considerations for this patient?

What should the nurse do?

What should leaders do (manager, clinical leader?)

What are your other concerns about this case?

Is the service culturally safe?

How can we improve cultural safety?

Slide 11

Blue Eye Brown Eye Experiment

You may have noticed that some people were given a sticky note when they came into the room.

Ask the group: Has anybody figured out why?

Can someone with a sticky note tell me about their experience today?

How did that make you feel?

Can someone without a sticky note?

How did that make you feel?

Did you think about

Play video

The blue eye brown eye race experiment by Jane Elliot. Watch the first 13 minutes

https://www.youtube.com/watch?v=ebPoSMULI5U

Encourage discussion

Ask the group: How easy is it to spread misinformation and stereotype a certain group?

What we hope you take from this day is the ability to appreciate the differences of Black patients. Be a salad bowl, not a melting pot.

Slide 12

Ask the group: Who in this room has been told that they are lucky? It can be for any reason.

How did that make you feel?

What about when you worked really hard for something? Maybe your degree. Has someone ever said, “hey, you’re really lucky because you make good money and have a degree”?

I have heard this statement. I felt a bit annoyed when I heard it because I thought, I worked really hard to earn this degree and I don’t feel like that was luck.

But, the reality is that my life allowed me access to the resources I needed to get my degree. Many walk around us with the skills and abilities to do something but lack the qualifications. A lot of the time, those are people of colour.

Do you remember earlier in this course we talked about the placement of historically Black communities? The access to public transportation? Environmental racism?

This is where the day gets really difficult. These are the discussions that have been found to make White people disengage. As we discussed earlier, this course is about critical reflection and acknowledging the systems and structures that unfairly impact Black people. This means we need to acknowledge that White privilege exists.

Play video.

Ask the group: Is anybody willing to discuss their feelings about White privilege? Is it hard to talk about? What makes it hard?

Ensure that the discussion remains respectful even if it becomes difficult. Allow people the space to express their feelings. If participants become defensive, challenge their responses.

For example: Participant states "I grew up in a tough neighborhood, and my parents didn't have a lot and I still went to university". Possible response: Even though you had difficulties, they were not because of your race. That is what White privilege is.

Participant states: "Now it's hard to get a job when you're White because everything is designated". Possible response: Designated positions were created because there is a lack of representation. This does not mean there will never be an opportunity for a White person.

This section may be difficult for facilitators. Facilitator burnout is associated with a lack of support. Please ensure you seek support, as needed, from your colleagues and leadership team.

Slide 13

Play video.

Ask the group: Does anybody have any thoughts on this video?

Encourage discussions about White fragility.

As discussed in the video, White fragility works to uphold racism and racial hierarchies (Guardian News, 2020). White supremacy, racial bias and Eurocentric methods of health and healing are deeply socialized into Canadian healthcare (Hantke et al., 2022). It is important that as healthcare providers we move away from defending actions based on intentions and embrace the idea that racism exists, you are a part of it, and being complicit is problematic (Hantke et al., 2022).

Slide 14

To truly create a place that is culturally safe for Black patients, we need to ask ourselves what can we do both as individuals and organizations. This course is a start but we need to take

action when we are outside of this room. Critically reflect on your own biases and problematic thoughts and behaviours; we all have them. When you have a case that doesn't feel right, ask questions of yourself and your peers. Are you making subconscious assumptions? Is the care plan culturally relevant? Am I working alongside this patient and family?

As healthcare providers we need to have cultural humility in every care interaction and space. The attributes of cultural humility include openness, self-awareness, egoless, supportive interactions and self-reflection and critique. Cultural humility requires lifelong learning; this is a process that we need to be constantly engaged in. It doesn't end here. The impacts of cultural humility are empowerment, partnerships, mutual benefits, optimal care, and respect.

I will leave you with this quote: "Do the best you can until you know better. Then when you know better, do better."- Maya Angelou

Module 8:

Community Resources and Contacts

- Nova Scotia Brotherhood: nsbrotherhood@nshealth.ca (a free program for Black men to access overall healthcare and health education in their communities from healthcare providers of African descent).
- Nova Scotia Sisterhood: nssisterhood@nshealth.ca (a free program for Black women to access overall healthcare and health education in their communities from healthcare providers of African descent)
- Health Association of African Canadians: http://haac.ca (the mandate includes promoting and improving the health of African Canadians in Nova Scotia through various methods including education and research)
- Black Health Alliance: https://blackhealthalliance.ca (to take on issues that impact Black communities throughout Canada such as health promotion and community engagement, and research)

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Appendix A: Knowledge Test

1. What is cultural safety?
2. How many historic Black communities are there in Nova Scotia?
3. What is a racial microaggression?
    a. What are the health impacts?
4. What is a designated position?
    a. What is the purpose?
5. What is environmental racism?
    a. Can you provide an example in Nova Scotia?
    b. How does this impact health?

Knowledge Test Answer Key

1. A combination of cultural awareness, competence and sensitivity. Discussion about cultural humility, accepting people as they are, giving people the space to be themselves, and respecting and acknowledging differences are all acceptable responses.
2. 52
3. A subtle verbal, behavioural, or environmental indignity that can sometimes be subconscious and communicates hostility, racial slights or insults to a specific group
    a. Mental health symptoms, health disparities, decreased help-seeking. Any health disparities are acceptable responses.
4. A position that is reserved or designated for a person from an equity deserving group.
    a. To counteract barriers that those groups face.
5. "… racial discrimination in environmental policy-making, the enforcement of regulations and laws, the deliberate targeting of communities of colour for toxic waste facilities, the official sanctioning of the life-threatening presence of poisons and pollutants in our communities, and the history of excluding people of colour from leadership of the ecology movements." (MacDonald, 2020). Any aspects of this are acceptable.
    a. Black communities are located near dumps, away from service, and less desirable land.
    b. Increased exposure to toxins or other health hazards, inability to access employment and income, inability to access health services

Appendix B: Game: How heavy is your load?

1. Set up 4-5 tables around the room, each at a different distance from the front of the room. There should be a case of bottled water at each table and 4-5 bags, one for each participant.
2. Each participant should pick up a card from the table.
3. Each card has a section that includes socioeconomic status, parental marital status, trauma history, and healthcare experiences.
4. The facilitator will call out sections of the cards, indicating if participants must pick up a bottle of water.
5. Once the facilitator has called out all of the sections, each participant will walk to the front of the room carrying their bags.
6. Ask the group: How difficult was your journey? What made it more or less difficult?
7. Possible answers: number of bottles in the bag, fitness level, how tired you are.
8. Discuss how each patient has a load they bring with them when they access healthcare. Historical mistrust, discrimination, and microaggressions are only a part of Black patients' load. As healthcare providers, we need to increase our awareness of harmful behaviours to avoid them and support patients who have experienced them.

Number of bottles:

Socioeconomic status	Parental marital status	Trauma history	Healthcare experiences
Wealthy = 0	Married = 0	None = 0	Positive = 0
Middle Class = 1	Divorced = 1	Moderate = 1	Positive, Peers negative = 1
Low Income = 2	Single Parent =2	Extensive = 2	Negative, Peers positive = 2
	Unknown = 3		Negative = 3

Participant cards

socioeconomic status: wealthy parental marital status: married trauma history: none healthcare experiences: positive, heard negative experiences from peers	socioeconomic status: low income parental marital status: married trauma history: moderate healthcare experiences: negative
socioeconomic status: wealthy parental marital status: married trauma history: extensive healthcare experiences: positive	socioeconomic status: middle class parental marital status: divorced trauma history: none healthcare experiences: negative
socioeconomic status: low income parental marital status: divorced trauma history: extensive healthcare experiences: negative	socioeconomic status: wealthy parental marital status: divorced trauma history: extensive healthcare experiences: negative
socioeconomic status: middle class parental marital status: single parent trauma history: moderate healthcare experiences: mixed	socioeconomic status: middle class parental marital status: married trauma history: none healthcare experiences: positive
socioeconomic status: low income parental marital status: single parent trauma history: none healthcare experiences: negative, negative stories from peers	socioeconomic status: low income parental marital status: divorced trauma history: extensive healthcare experiences: positive
socioeconomic status: low income parental marital status: married trauma history: none healthcare experiences: positive, negative stories from peers	socioeconomic status: low income parental marital status: single parent trauma history: moderate healthcare experiences: negative
socioeconomic status: wealthy parental marital status: single parent trauma history: none healthcare experiences: negative, positive stories from peers	socioeconomic status: wealthy parental marital status: divorced trauma history: extensive healthcare experiences: positive, negative stories from peers
socioeconomic status: wealthy parental marital status: unknown trauma history: extensive	socioeconomic status: wealthy parental marital status: married trauma history: moderate

healthcare experiences: positive	healthcare experiences: negative
socioeconomic status: middle class parental marital status: unknown trauma history: extensive healthcare experiences: negative	socioeconomic status: middle class parental marital status: married trauma history: moderate healthcare experiences: positive
socioeconomic status: middle class parental marital status: single parent trauma history: moderate healthcare experiences: negative, positive stories from peers	socioeconomic status: wealthy parental marital status: divorced trauma history: none healthcare experiences: positive, negative stories from peers